CHAPTER 13

Rights-Based Approaches in Conflict-Affected Settings

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INTRODUCTION

Armed conflict has a significant impact on the health of populations. Injury, malnutrition, disease, disability, sexual and gender-based violence, and death are the most direct and visible manifestations of violence (Krug, Mercy, Dahlberg, & Zwi, 2002; The University of New South Wales Health and Conflict Project, 2004; Zwi, Garfield, & Loretti, 2002). Less visible are the indirect impacts to the health sector in conflict-affected settings, including the destruction of critical health facilities, severely disrupted health services, and voluntary or forced migration of health professionals to safer settings (Murray, King, Lopez, Tomijima, & Krug, 2002). Further, conflict disrupts access to other basic necessities including food, water, shelter, education, and the means to generate income (Krause, Muggah, & Wennmann, 2008). Underlying these manifestations of conflict and instability lie deeper roots of exclusion, inequalities, and persistent denial and deliberate violations of human rights, which evidence suggests can act as a catalyst of violence and feed into a longer term cycle of conflict (Galtung, 1969; Geiger, 2000; Krause et al.; Stewart, 2002).

In spite of the deterioration of health systems in conflict-affected settings, health professionals have historically played a critical role in the humanitarian response by protecting life, responding to medical emergencies, and alleviating suffering (International Committee of the Red

Cross, 1996). Although conflict and instability have significant public health dimensions, responding to the root causes of conflict, mitigating their effects, and assisting in broader postconflict recovery have not always been considered responsibilities of the public health community. Recently, however, there has been growing recognition of the potential health practitioner contributions to a broader role in fostering longer term peace, well beyond providing medical care and supporting large-scale public health interventions during the acute phase of a humanitarian response. The scope for health practitioners' meaningful contribution to a sustainable peace is far-reaching and may include building trust, supporting reconciliation, promoting social cohesion, addressing psychological responses to conflict, and creating healthier environments (Banatvala & Zwi, 2000; The University of New South Wales Health and Conflict Project, 2004).

Despite the increased recognition of the potential for health practitioner roles in peace building,[1] there are few methods and instruments to assist field-based work. This chapter provides a brief overview of the links between health, international law, human rights, conflict, and peace building, including historical perspectives on the health practitioner's contribution in achieving these goals. It then describes a field tool for health practitioners, The Health and Peacebuilding Filter (Peacebuilding Filter), which offers a framework for health practitioners to consider principles related to fostering peace building that is inclusive of many components of a rights-based approach (RBA). This practical tool, complemented by a more thorough RBA, could provide a more comprehensive framework for addressing the complex interconnections between conflict, human rights, peace building, and health in conflict-affected settings.

INTERNATIONAL LAW AND THE RIGHT TO HEALTH

The field of international law is vast, and there are many components applicable to a discussion on health, human rights, conflict, peace, and security. International law, in relation to conflict, constitutes such components, though not limited to the laws of war (such as the Hague Conventions of 1899 and 1907), humanitarian law (such as the Geneva Convention of 1949), war crimes and crimes against humanity including genocide (including for example the International Criminal Court and ad hoc Tribunals for the former Yugoslavia in 1991, and Rwanda in 1994), and human rights law (e.g., the Optional Protocol to the Convention on the Rights of the Child [United Nations, 2000a] on the involvement of children in armed

conflict in 2000). Two distinct, yet complementary fields of international law are particularly relevant to conflict-affected settings: international humanitarian law (IHL) and international human rights law. This chapter does not intend to offer an extensive overview of these fields, as many others have done so (Fleck, 2008; Lubell, 2005; Steiner, Alston, & Goodman, 2008). However, it is important to note the overarching legal frameworks guiding the work of health practitioners in conflict-affected and postconflict settings.

International Humanitarian Law

Both IHL and international human rights law stem from discussions and debates anchored in underlying values of human rights following the end of World War II. IHL applies norms and standards, established by treaty or custom, which are specifically intended to characterize, prevent, and respond to humanitarian problems directly arising from international and noninternational armed conflicts. It protects persons and properties that are, or may be, affected by an armed conflict and sets boundaries to the legitimacy and the use of methods and means of warfare. IHL's main treaty sources applicable to international armed conflict is the Geneva Convention (1949) and its Additional Protocols (1977 and 2003). Beyond these core treaties, there are several other conventions and declarations, which guide IHL, related to refugees, genocide, criminal courts, treatment of prisoners, and torture, to name a few. IHL is the overarching legal framework applicable to conflict-affected settings and guides health practitioners working to provide humanitarian care and treatment.

International Human Rights Law

Although the Geneva Conventions were revised to include earlier conventions and readopted in 1949, another international legal framework was taking shape: international human rights law. Several legal documents under the international human rights law framework either explicitly or implicitly refer to health in conflict-affected settings as well as in times of peace. The foundation document is the Universal Declaration of Human Rights (United Nations, 1948). Although not legally binding, it laid the groundwork for legally binding treaties, such as the International Covenant on Civil and Political Rights (United Nations, 1976a), the International Covenant on Economic, Social and Cultural Rights (ICESCR; United Nations, 1976b), and their Optional Protocols. A broad array of legally binding treaties and nonlegally binding human rights declarations relevant to

health in conflict-affected settings, such as the Declaration on the Protection of Women and Children in Emergency and Armed Conflict (1974), the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (United Nations, 1984), and the Convention on the Rights of the Child (United Nations, 1989) have also been developed.

The Right to Health

As the international human rights framework is applicable both in times of conflict and in peace (Lubell, 2005), there is increased recognition of the value of using human rights principles, norms, and standards to guide health work. Several authors have more thoroughly explored the links between health and human rights (see, for example, Gruskin & Tarantola, 2001; Mann, Gruskin, Grodin, & Annas, 1999; Tarantola, 2008). In the context of focusing on health practitioners' work in postconflict settings, the right to highest attainable standard of physical and mental health (here within referred to as the "right to health") is particularly applicable. The right to health, as stipulated in Article 12 of the ICESCR (United Nations, 1976b), recognizes that both health care and social conditions are important elements of the right to health (Hunt et al., 2009). Impediments to the right to health include factors such as gender and age discrimination, inequitable resource distribution, poor sanitary conditions, and events that may damage health such as violence and armed conflict.

Substantive issues related to the right to health are elucidated within General Comment 14, which elaborates on the interrelated and essential elements guiding its application, notably the concepts of *availability*, *accessibility*, *acceptability*, and *quality* of health facilities, goods, and services (United Nations, 2000b; see Figure 13.1). Of particular note, it acknowledges that a wider definition of health must be inclusive of the impact of violence and conflict and that states should be held to account for health-related impacts during armed conflicts in violation of IHL (sections 10 and 34, respectively). Applying the international human rights framework, including the right to health, in practice through an RBA to health is explored further in this chapter.

MEDICAL ETHICS AND HUMAN RIGHTS

Complementing the broader legal framework inclusive of international human rights law is the ethical framework that guides the work of health practitioners (Kass, 2009). This framework was founded on the spirit of the

FIGURE 13.1 Elements of the Right to Health

The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular state party:	
Availability	Functioning public health and health care facilities, goods, and services, as well as programs, have to be available in sufficient quantity within the state party. The precise nature of the facilities, goods, and services will vary depending on numerous factors, including the state party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics, and other health-related buildings; trained medical and professional personnel receiving domestically competitive salaries; and essential drugs, as defined by the World Health Organization Action Programme on Essential Drugs.
Accessibility	Health facilities, goods, and services have to be accessible to everyone without discrimination, within the jurisdiction of the state party. Accessibility has four overlapping dimensions: *Nondiscrimination:* Health facilities, goods, and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. *Physical accessibility*: Health facilities, goods, and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities, and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities. *Economic accessibility* (affordability)*:* Health facilities, goods, and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households. *Information accessibility:* Accessibility includes the right to seek, receive, and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(Continued)

FIGURE 13.1 Elements of the Right to Health *Continued*

Acceptability	All health facilities, goods, and services must be respectful of medical ethics and culturally appropriate, that is, respectful of the culture of individuals, minorities, peoples, and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
Quality	As well as being culturally acceptable, health facilities, goods, and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

Source: United Nations, 2000b.

Hippocratic oath. It was further elucidated with the World Medical Association's adoption of the Declaration of Helsinki (1964), which focused on research of human subjects, and later the Declaration of Tokyo (1975), which set out guidelines for medical practitioners concerning torture and other cruel, inhumane, and degrading treatment or punishment in relation to detention and imprisonment. These were complemented by the updated physician's oath, known as the International Code of Medical Ethics (World Medical Association, 2006), which is an amended version of the Declaration of Geneva (1948) and is central to the provision of health care and services. The Nuremberg Code (1947), which lays out a set of research ethical principles for human experimentation following the end of World War II and contributed to forming the basis for the Helsinki Declaration, is also of critical importance in relation to conflict and the role of the health practitioner.

Although it is beyond the scope of this chapter to link human rights and medical ethics, both historically and conceptually, some authors have noted the divergence of the paradigms of human rights ethics, in particular in relation to their origin, application, processes, and audience, as well as their convergence as they are bound by shared values, principles, and commitment to supporting the dignity of every individual (Gruskin & Dickens, 2006; Rubenstein, 2009). These ethics drive the work of health practitioners in conflict-affected settings.

Human Rights, Conflict, and the Role of the Health Practitioner

In conflict-affected settings, the human rights concerns involving health practitioners are multifaceted. On the one hand, the protection of health care professionals' own human rights is of paramount importance to

ensure their safety and well-being and capacity to deliver services. In many conflict-affected settings, health workers may be explicitly targeted (Rubenstein & Bittle, 2010).

On the other hand, health care professionals are often witness to grave human rights abuses of populations including, although not limited to, injury, mutilation, rape, torture, enslavement, trafficking, and death. The latter evokes considerable debate in the field as to the duties and responsibilities of health care workers when witnessing such violations (Orbinski, Beyrer, & Singh, 2007). Some argue that health practitioners, whose professional and ethical values should align with realizing human rights, have a duty to intervene when bearing witness to human rights abuses, through documenting and measuring the health effects of denials of human rights and acting as advocates to denounce such violations (Hannibal & Lawrence, 1999). However, when confronting such atrocities, health service providers face dilemmas regarding their responsibility to bear witness or intervene in any other form, often at the perils of having to suspend health services to the population they are meant to serve, and compromising the safety of fellow health professionals and humanitarian workers (Fox, 1995; Gruskin, Mills, & Tarantola, 2007; Médecins Sans Frontières, 2006; Redfield, 2006; Terry, 2002).

Despite the complementarities of medical values and the advancement of human rights, health professionals' role can often be overstated as some practitioners place self-interest over ethics at the sacrifice of public health and, in some egregious scenarios, become complicit in rights violations (Rubenstein, 2009). It is well documented that health professionals have contributed to inhumane experimentation and torture, most recently in relation to interrogation techniques associated with the so-called "War on Terror" (Farberman & American Psychological Association, 2005; Hargreaves & Cunningham, 2004; "How Complicit," 2004; Miles, 2004; Lifton, 2004; Marks, 2005). In conflict-affected settings, "these deplorable violations exist alongside more subtle activities that also have severe and long-lasting effects on health and human rights such as the absence of basic health-care systems" (Gruskin, Mills, & Tarantola, 2007), recruitment of child soldiers, disruption of education systems, and violations of civil and political rights (Orbinski et al., 2007). Such human rights challenges are often not adequately addressed within health interventions in conflict-affected and postconflict settings. As health practitioners are forced to navigate increasingly complex situations, and as only few have the necessary training in human rights to respond appropriately and effectively, much more support is critically needed in this field (Hunt, 2007).

THE CONVERGENCE OF HEALTH AND PEACE BUILDING

The creation of the International Committee of the Red Cross and the Geneva Convention, and later the founding of such organizations as Amnesty International, Médecins Sans Frontières, Médecins du Monde, and Physicians for Human Rights, linked humanitarian emergencies and medical responses. However, the associations between peace and health are neither well developed nor well defined within the bodies of international law and ethics, described earlier in this chapter, despite the fact that many refer to armed conflict and health.

Nevertheless, several public health fora acknowledge the important links between health and peace, most notably the World Health Assembly resolution in 1981 stating that "the role of physicians and other health workers in the preservation and promotion of peace is the most significant factor for the attainment of health for all" (World Health Assembly, 1981), as well as the Ottawa Charter for Health Promotion (1986), which identifies that "peace" is the first fundamental prerequisite for health.

In practice, recent history has begun to delineate the different forms of connection that are present, and they have become more evident and better documented. Advocacy is evident in the actions of some practitioners who opposed the Vietnam War and later the wars in Iraq from a health perspective, and globally, physicians have opposed weapon systems, such as nuclear arms, landmines, and small arms because of their inherent inhumanity (Arya, 2002). Others have identified collaborative work on the ground, seeking to bring together opposing groups to address health issues of mutual concern. This approach became more developed, with some commentators crediting the Pan American Health Organization's (PAHO) initiative to promote transborder health system cooperation during conflict. The PAHO negotiated transborder mass immunization programs in Central America, which was viewed as a defining moment in history linking health and peace and contributing to the Health as a Bridge to Peace approach taken forward by the World Health Organization (WHO; de Quadros & Epstein, 2002). The WHO (2010) defined Health as a Bridge to Peace as:

> a multidimensional policy and planning framework which supports health workers in delivering health programs in conflict and post-conflict situations and at the same time contributes to peace building. It is defined as the integration of peace building concerns, concepts, strategies and practices into health relief and health sector development.

The premise for Health as a Bridge for Peace was based on the imperative of health as a shared human aspiration, which should transcend any political, cultural, or other divisions among nations or peoples. The concept seeks to integrate peace building concerns and strategies into health relief and health sector development in postconflict settings. Although many practical activities related to such initiatives focused on negotiating ceasefires for the provision of short-term public health interventions and humanitarian assistance, its scope expanded to include sectoral cooperation in countries such as Mozambique, Croatia, Bosnia, Sri Lanka, and Angola (WHO, 2009).

Although there was considerable enthusiasm by WHO, some key donors, and concerned health workers for this approach, there was also a critique that emerged from experiences of its application. For example, Large, Subilia, and Zwi (1998), in their evaluation of the WHO project in Eastern Slavonia, in the former Yugoslavia, found that there were somewhat overambitious targets of integrating the peace building components of health into health system development and program design with insufficient sensitivity to the experience of conflict and the different cultures of those affected, both health workers and clients. Health as a Bridge for Peace did, for a while, pave the way for larger scale integration of health interventions as a mode of promoting peace, but suffered some setbacks as more effective means of engaging at this interface were explored and evidence of effectiveness and impact was sought (Rushton & McInnes, 2006).

Although the Health as a Bridge for Peace approach highlights how government and international organization action can contribute to peace building, another movement, which highlights the importance of the role of the individual health worker, often working together, began to take shape (Arya, 2007; Arya & Santa Barbara, 2008; MacQueen, McCutcheon, & Santa Barbara, 1997; MacQueen, Santa Barbara, Neufeld, Yusuf, & Horton, 2001). The Peace Through Health movement can be simply defined as the theory and practice of how health workers and health perspectives can contribute to peace building and the reduction of violence (Arya, 2004). Peace Through Health was founded on five important ethical values and principles that, building on general medical ethics, provide the basis for connecting health work with peace work: conflict management, solidarity, strengthening the social fabric, dissent, and restricting the destructiveness of war (MacQueen & Santa Barbara, 2000; Santa Barbara & MacQueen, 2004). This work has largely centered on programs based in Croatia, Gaza, and Sri Lanka, documenting mental health consequences of war and the effects of prejudices largely on children (Chase et al., 1999; Miller, el-Masri,

Allodi, & Qouta, 1999; Santa Barbara, 2004; Woodside, Santa Barbara, & Benner, 1999). Although the underlying ethical values and core implementing principles of this approach are admirable, critical analysis of this work has focused on concerns regarding whether health workers necessarily play the positive roles they could play, whether the assumptions regarding respect for dignity and autonomy, acting honestly and with compassion, are necessarily present, and whether they do indeed have a lasting impact on either health outcomes or longer term peace (Grove & Zwi, 2008). If meaning to do well is not good enough, how can health practitioners approach health and peace building more systematically?

THE HEALTH AND PEACEBUILDING FILTER

There are several practical tools available to health practitioners in the field to assist in identifying gaps, designing and developing new programs, and providing monitoring and evaluation mechanisms. Many of the available tools, however, tend to focus on one domain, or at most, the intersection of two, from the fields of health, conflict, security, peace building, and human rights. Notable examples include the Health Impact Assessment (Harris, Harris-Roxas, Harris, & Kemp, 2007), Human Rights Impact Assessment (Human Rights Impact Assessment Resource Centre, 2009), Health and Human Rights Impact Assessment (Gay, 2008; Gostin & Mann, 1994; Tarantola et al., 2008), The Right to Health (Asher et al., 2007), Do No Harm (Anderson, 1999), Peace and Conflict Impact Assessment (Bush, 2005), Participatory Rights Assessment Methodologies (Department for International Development, 2000), United Nations International Children's Emergency Fund's Implementation Handbook on the Rights of the Child (Hodgkin & Newell, 2002), the Health and Peacebuilding Filter (Zwi, Bunde-Birouste, Grove, Waller, & Ritchie, 2006a), and many others. Despite the plethora of tools available, they may not be appropriate for the specific purpose at hand. In such instances, health practitioners may be required to adapt tools to suit their specific need.

In particular, although these tools provide guidance for several settings, issues, and outcomes, few provide health practitioners with an overview of the key issues to address when establishing or strengthening health services and systems in postconflict and peace building settings. The Health and Peacebuilding Filter (herein denoted as the Peacebuilding Filter) sought to fill this gap and to systematically address health, conflict, and peace building needs through a rapid assessment tool that could be used proactively for planning and programming (Zwi et al., 2006a).

The Peacebuilding Filter was designed to provide a rapid assessment of conflict prevention and peace building components of health initiatives in conflict-affected settings. The Peacebuilding Filter can be applied to new or existing health projects or programs to guide policy and program cycles so as to enhance conflict sensitivity and the health-related contributions to peace building (Bunde-Birouste & Ritchie, 2007; Bunde-Birouste & Zwi, 2008; Grove & Zwi, 2008). The Peacebuilding Filter is not prescriptive and can feed into an analysis of a project or program by (a) identifying project areas already applying peace building principles, seeking to reinforce these; (b) drawing attention to where health-related activities might make matters worse, seeking to refine these approaches and to do better; and (c) suggesting further actions and resources.

The Peacebuilding Filter is designed to assist practitioners to bring key values, ethics, and rights principles into their day-to-day practice. It complements and extends traditional modes of assessment and monitoring by ensuring attention to less quantifiable dimensions of project activity, shedding light on the relationships and processes underpinning health-related activities in fragile settings (Galtung, 1969; Grove & Zwi, 2008). In doing so, debate and response to issues such as building trust, promoting social cohesion and social justice, or assuring cultural, conflict and gender sensitivity are legitimized and enabled. The Peacebuilding Filter comprises of five core principles of health and peace building and 10 subcomponents, framed around 29 points of inquiry, which provide a structure for addressing whether a health project is effectively contributing to broader peace building goals (see Figure 13.2).

Although informed by human rights principles, during its development and application, these are implicit and not explicit within the Peacebuilding Filter. The tool focuses more specifically on drawing out key principles relevant to postconflict recovery and peace building, but provides a base that can be strongly complemented and deepened by a complementary application of RBAs.

RIGHTS-BASED APPROACH TO HEALTH IN CONFLICT-AFFECTED SETTINGS

Because many of the root causes and outcomes of conflicts are embedded in large-scale human rights abuses, it is important that responses toward creating and maintaining the peace embody and reflect a commitment to all human rights, including the right to health. A prominent approach to systematically applying and integrating international human rights norms, standards, and principles in policy and program planning, implementation, monitoring, and

FIGURE 13.2 Health and Peacebuilding Filter Principles and Components

Core Principles	Subcomponents	Key Elements Promoted Within the Tool
Cultural sensitivity	• Cultural sensitivity	• Promotes cultural sensitivity • Recognizes local capacities and responses to health • Respects cultural rituals and practice
Conflict sensitivity	• Conflict awareness • Trust	• Trains staff to conflict-sensitive approaches • Demonstrates sensitivity to the nature of the conflict • Promotes the building of trust among stakeholders and community groups
Social justice	• Equity and nondiscrimination • Gender	• Promotes tolerance and eliminate discrimination • Contributes to reducing inequalities within the community • Demonstrates sensitivity to gender issues and supports gender training for staff
Social cohesion	• Community cohesion • Psychosocial well-being	• Contributes to bridging the divide among different groups in the community • Supports and reinforces community reconciliation efforts • Demonstrates sensitivity to the community's psychosocial health and well-being and supports social recovery
Governance	• Capacity building and empowerment • Sustainability and coordination • Transparency and accountability	• Establishes mechanisms for genuine community participation • Promotes local ownership of the project • Includes mechanisms to coordinate with other service providers and build networks with communities • Encourages transparency and accountability of decision making to local communities • Strengthens the ability of community members to elicit greater accountability from service providers and government departments

Source: Zwi, et al., 2006a.

evaluation is the RBA (United Nations, 2003). An advantage of applying an RBA is that it offers a comprehensive framework inclusive of both guiding principles for analysis and a corresponding set of monitoring mechanisms and indicators (Gruskin & Tarantola, 2008; Tarantola, 2007). The value of bringing a human RBA to health in conflict-affected settings is that it links aid assistance to questions of obligation and responsibilities, rather than welfare or charity. It systemically shifts the approach to a human rights framework that considers survivors of war, conflict, and displacement as rights holders and state actors as duty bearers[2] of obligations under international treaties. By recognizing affected communities as rights holders, it is argued that they will be more empowered, and local capacity will be strengthened to address the broader public health issues during their postconflict recovery.

There is no single RBA, and many stakeholders have characterized the approach in different ways to suit their needs. The United Nations has developed a Statement of Common Understanding of an RBA to development cooperation as one means of identifying the core components of this approach (see Figure 13.3). Beyond the agreed common principles to an RBA, the right to health includes specific elements to guide policies and interventions: availability, accessibility, acceptability and quality of health structures, and goods and services (as depicted in Figure 13.1).

A RIGHTS-BASED APPROACH AND THE HEALTH AND PEACEBUILDING FILTER

This section examines the Peacebuilding Filter against the principles of an RBA. In particular, we consider the interdependence of rights including attention to the legal and policy context, participation, nondiscrimination, accountability, and elements of the right to health, including availability, accessibility, acceptability, and high quality of systems, services, care, and treatment (Gruskin, Ferguson, & Bogecho, 2007).

Interdependence

The RBA emphasizes the interdependence of rights and their mutual complementarities. No one right can be achieved without securing and promoting others. For example, a focus on health in conflict-affected settings will emphasize the right to health, although other rights, including rights to be free from violence, security, autonomy, physical integrity, information, education, food and nutrition, housing, and freedom of association, to name a few, also deserve due consideration (Tarantola et al., 2008).

FIGURE 13.3 UN Statement of Common Understanding on Human Rights-Based Approach to Development Cooperation

<table>
<tr><td colspan="2">1. All programs of development cooperation, policies, and technical assistance should further the realization of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments.</td></tr>
<tr><td colspan="2">A set of program activities that only incidentally contributes to the realization of human rights does not necessarily constitute an RBA to programming. In an RBA to programming and development cooperation, the aim of all activities is to contribute directly to the realization of one or several human rights.</td></tr>
<tr><td colspan="2">2. Human rights standards contained in, and principles derived from, the Universal Declaration of Human Rights, and other international human rights instruments guide all development cooperation and programming in all sectors and in all phases of the programming process.</td></tr>
<tr><td colspan="2">Human rights principles guide programming in all sectors, such as health, education, governance, nutrition, water and sanitation, HIV/AIDS, employment and labor relations, and social and economic security. This includes all development cooperation directed toward the achievement of the Millennium Development Goals and the Millennium Declaration. Consequently, human rights standards and principles guide both the Common Country Assessment and the UN Development Assistance Framework.

Human rights principles guide all programming in all phases of the programming process, including assessment and analysis, program planning and design (including setting of goals, objectives, and strategies), implementation, monitoring, and evaluation.

Among these human rights principles are universality and inalienability, indivisibility, and the following principles explained here:</td></tr>
<tr><td>Interdependence</td><td>The realization of one right often depends, wholly or in part, on the realization of others. For instance, realization of the right to health may depend, in certain circumstances, on realization of the right to education or information.</td></tr>
<tr><td>Participation and inclusion</td><td>Every person and all people are entitled to active, free, and meaningful participation in, contribution to, and enjoyment of civil, economic, social, cultural, and political development in which human rights and fundamental freedoms can be realized.</td></tr>
<tr><td>Equality and nondiscrimination</td><td>All individuals are equal as human beings and by virtue of the inherent dignity of each human person. No one, therefore, should suffer discrimination based on race, color, ethnicity, gender, age, language, sexual orientation, religion, political or other opinion, national, social or geographical origin, disability, property, birth, or other status as established by human rights standards. In relation to health, facilities, goods, and services must be accessible to all, especially the most vulnerable.</td></tr>
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(Continued)

FIGURE 13.3 UN Statement of Common Understanding on Human Rights-Based Approach to Development Cooperation *Continued*

Accountability and rule of law	States and other duty bearers are answerable for the observance of human rights. In this regard, they have to comply with the legal norms and standards enshrined in human rights instruments. Where they fail to do so, aggrieved rights holders are entitled to institute proceedings for appropriate redress before a competent court or other adjudicator in accordance with the rules and procedures provided by law.
3. Programs of development cooperation contribute to the development of the capacities of duty bearers to meet their obligations and of rights holders to claim their rights.	
In an RBA, human rights determine the relationship between individuals and groups with valid claims (rights holders) and state and nonstate actors with correlative obligations (duty bearers). It identifies rights holders (and their entitlements) and corresponding duty bearers (and their obligations) and works toward strengthening the capacities of rights holders to make their claims and of duty bearers to meet their obligations.	

Source: United Nations, 2003.

Although the Peacebuilding Filter does not emphasize and bring to the fore this interdependence, it does recognize that the different dimensions to promote peace are mutually supportive. Even though the tool is not specifically rights based, it was, in its development and potential application, rights informed, and highlights several principles (discussed later in this chapter) that illustrate these links. The language employed, however, is more focused on a social justice framework, resulting, in part, from field testing that suggested that the social justice framework might be less contentious and easier to advance in conflicted and highly politicized settings. In making this trade-off, some weaknesses may have resulted, although other elements might be stronger and more flexible than an RBA. Seeing both as valuable and being able to draw on appropriate tools and frameworks as required is of benefit but demands a more sophisticated analysis by the health or development worker on the ground.

Participation

Participation is a key component of an RBA because it allows for the process of decision making to be led by the community, especially those who are likely to be affected by the health intervention. Despite the centrality of promoting community participation, the reality can be challenging, especially

in a conflict-affected setting where "communities are fragmented, people displaced, resources eroded, services undermined and tensions widespread" (Zwi, Bunde-Birouste, Grove, Waller, & Ritchie, 2006b). These challenges, however, are not insurmountable and facilitating widespread participation should be a priority for health service providers prior to, as well as during the development of, policies, programs, and/or interventions.

The Peacebuilding Filter explores the concept of participation under the principle of good governance and the community capacity building and empowerment indicators. The underlying value guiding participation is that community members should be recognized as decisive, rather than passive, actors. According to Zwi et al. (2006b),

> too often community participation has been merely a part of the rhetoric but not of the practice; participation occurs at a token level, consultation is seen as a means to ensure cooperation and agreement from communities is sought after key decision have already been made by project staff. (p. 26)

As such, the Peacebuilding Filter encourages users to consider whether the project or program has established mechanisms for genuine community participation in all phases, including monitoring and evaluation. For example, the Peacebuilding Filter reminds users that communities are not homogenous and that some members of the community may present themselves as speaking on behalf of all, when in fact many communities are divided and fragmented into groups with different interests and viewpoints. Health practitioners should ensure that there is a wide and meaningful representation of community members invited to participate in discussions, rather than a select few. Other issues to pursue include local ownership of the project, engaging with communities during all phases, and supporting community members and the project to demand appropriate levels of support at the national, district, and local level of government.

Closely related to participation is the concept of empowerment, which aims to give women, men, and young people the power, capacities, capabilities, and access to resources to enable them to change their own lives, improve their own communities, and influence their own destinies. In the Peacebuilding Filter, empowerment is viewed as an outcome of effective community capacity building, where community members feel confident in their ability to effect change, lead activities, and take decision-making roles. Empowerment is essential to peace building activities as it supports populations to regain a sense of control over their lives, which is central to the long-term healing and recovery process.

The Peacebuilding Filter addresses the issue of empowerment by first seeking to establish that there is local ownership of the health project. Do community members believe the project is theirs? Does the project provide opportunities to build and reinforce local structures (if they are positive for all community members) and to engage community members through involvement in planning and implementation? It should be noted that in the case of international health assistance, ownership should not simply apply at the community level, but should extend up to the national level. One Timor-Leste senior project officer noted,

> It is important that government representatives are present – not just at the start and the end but all the way through. For us, it is important that government is involved and seen to be involved, otherwise there is no ownership (Zwi et al., 2006b, p. 28).

Secondly, the Peacebuilding Filter prompts discussion around the idea that the project provides for the development of leadership and advocacy skills among staff and community members. Gaining agency and control, with community members as drivers and pacesetters, is especially important in communities emerging from periods of violence.

Nondiscrimination

Health programs have the opportunity to promote social justice, human rights, and dignity by respecting patients and health service users, and reducing inequalities (in service access, delivery, and staffing) and discrimination. Discrimination is the unfair treatment of individuals or communities on the basis of such attributes as race, color, gender, language, religion, political or other opinion, national or social origin, wealth, or other status (General Comment 20 – United Nations, 2009). Discrimination may perpetuate practices that precede or contribute to the conflict. The Peacebuilding Filter specifically highlights the need to promote, and wherever possible, ensure nondiscrimination as part of a health intervention. The tool forces one to consider existing tensions and forms of discrimination within the country or community and to consider how such discrimination manifests itself within health service provision. The Peacebuilding Filter promotes a commitment by the government and other actors in positions of power to provide transparent and fair grievance procedures for project personnel, patients, and the community in relation to public services.

A key component of nondiscrimination within an RBA is ensuring that specific attention is given to the most vulnerable groups. It is critical that work across all sectors in conflict-affected settings incorporates

safeguards to protect the rights of marginalized persons, including, although not exhaustively, women and girls, minorities, indigenous populations, migrants, unaccompanied minors, child soldiers, survivors of sexual violence and/or torture, older persons, widowers, and those who have a physical and mental disability. Applying the RBA principles of participation and empowerment is a critical step in ensuring that vulnerable populations are included within the decision-making process, thus guarding against reinforcing existing power imbalances while meeting their specific needs.

The Peacebuilding Filter recognizes that particular attention must be paid to the most vulnerable communities and individuals, such as those with the fewest resources to protect and sustain themselves. The tool specifically prompts users to consider whether "the project promotes dignity and respect for beneficiaries, community members and all social subgroups, especially the most vulnerable groups" (Zwi et al., 2006b, p. 18). The Peacebuilding Filter encourages users to consider the special measures needed and/or taken to ensure health services reach vulnerable populations. In addition, the tool encourages health service providers to consider how the program or project assesses the access to services by vulnerable populations. Collecting and analyzing disaggregated data, such as by gender, age, and, where appropriate, ethnicity, is critical in ensuring that services are reaching all members of the population, especially the most vulnerable.

Accountability

Accountability is an important concept linked to human rights, and yet it is also one of the most difficult to implement (Organisation for Economic Co-operation and Development, 2005). Accountability enables rights holders to claim their rights and ensures that the state fulfills its obligation as duty bearer. With an RBA, states must be held to account against their obligations of treaties they have ratified. This component is important as it explicitly links an RBA to human rights legal documents. As indicated previously, the Peacebuilding Filter does not explicitly refer to legal mechanisms. Adapting the concept of accountability within the tool to consider these dimensions could add considerable value.

The Peacebuilding Filter views accountability from both the obligations that health service providers have to protect lives, promote health, and provide care and services, as well as refrain from perpetrating violations of rights. The Peacebuilding Filter states that health projects should strengthen the ability of community members to elicit greater

accountability from central health service providers and government departments. It prompts greater public accountability by both state actors and nonstate actors alike, promoting availability and discussion of information on project achievements, limitations, and constraints. It also highlights the need to consider establishing a complaints procedure as a component of improving development practice. For example, in a remote Malaitan community in the Solomon Islands, community health centers had routinely requested medical and other related items, such as radios, from provincial and national health departments based in the capital, Honiara. Their requests had gone largely unheard, which frustrated the community. In the short term, a simple communication procedure could have provided the community with updates on the status of their requests, thus diffusing any potential tensions, but state services failed to do so. Making provisions to ensure accountability mechanisms are activated throughout the life of the health service delivery project enables it to better respond to community demands and contributes to building community capacity and social cohesion.

Availability, Accessibility, Acceptability, and Quality of Health Services, Care, and Treatment

In conflict-affected settings, health systems may be destroyed and services severely disrupted. As such, health service providers play an important role in (re)building these systems and providing services in postconflict settings. Applying an RBA to health includes ensuring health services, care, and treatment are *available*, *accessible*, *acceptable*, and of *good quality* (as indicated previously in General Comment 14; see Figure 13.1). These four elements of the right to health also include attention to physical, economic, and information accessibility, as well as reemphasizing the principle of nondiscrimination. Incorporating these elements into an RBA to health is critical.

The Peacebuilding Filter does make specific provisions for the consideration of two elements of an RBA to health: accessibility and acceptability, though the latter is not framed explicitly in this term. The tool specifically directs health practitioners to consider whether the project ensures that access (to health systems, services, care, and treatment) is not limited by economic or other barriers, including geographic and/or social factors. Examples of such barriers include service fees, lack of public transportation, travel distance and time, and discrimination based on ethnicity, gender, economic status, and other attributes (see earlier discussion under "Nondiscrimination"). The Peacebuilding Filter prompts consideration on

the equitable access to health services when resources are severely constrained, particularly for the most vulnerable. In addition, the tool considers whether information is accessible by illiterate persons, various language groups, and other marginalized populations of society to fully benefit from the health program, service, or project.

The notion of "acceptability" of health services, care, and treatment is defined as

> all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, that is respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned (United Nations, 2000b, par. 12.c.).

The Peacebuilding Filter implicitly refers to the acceptability of health services, care, and treatment by emphasizing cultural sensitivity and prompting users to ensure that there is local ownership of the project through genuine community participation in all phases of its development. The key challenge is translating these principles into practice. This is difficult in developed and developing countries alike, let alone in postconflict settings where tensions remain high, resources are scarce, and distrust is often rife. Although the Peacebuilding Filter does not offer specific solutions to address these issues, it does, however, allow health practitioners to reflect on them in relation to their work and determine how they could be better incorporated in practice.

There are elements of the right to health to which the Peacebuilding Filter does not implicitly or explicitly refer: *availability* and the *quality* of health structures, goods, and services. Adapting the Peacebuilding Filter to include these elements would add value to the tool. Assessing the available health care facilities, goods, and services should be done systematically (although even a crude picture could be useful) to identify gaps and place the particular health program or project in context of the greatest health needs. In addition, striving to provide the highest possible quality of services should be a guiding principle of health professionals. Noting that achieving a high quality of health care in conflict-affected settings is particularly challenging, applying the human rights principle of "progressive realization of rights" could be useful for health practitioners for this element of the right to health, as well as to the others (availability, accessibility, and acceptability). The principle of progressive realization is grounded in Article 2 of the ICESCR, which imposes on the state to "take steps . . . to the maximum of its available resources, with a view to

achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures" (United Nations, 1976b, Art. 2.1). The progressive realization of the right to health would require health practitioners to provide the highest quality of services within their means in the short term, while striving to work with governments and other actors, in particular nongovernmental organizations (NGOs), to improve the overall performance of health services as more resources become available from domestic or international sources. The Peacebuilding Filter acknowledges that there may be other important health, peace, and conflict issues associated with the program or project that need consideration and provides space within the tool to highlight these issues. Adapting the Peacebuilding Filter to include RBA principles that are currently not fully elaborated within the tool is an important step in creating a stronger synergy between the health and peace building tool and the RBA.

Adding Value to a Rights-Based Approach in Conflict-Affected Settings

Within the Peacebuilding Filter, there are several principles that build on an RBA in conflict-affected settings, including promoting conflict sensitivity, psychosocial well-being, project sustainability and coordination, gender, and trust. One issue, highlighted by many individuals and communities whose experiences fed into the development of the Peacebuilding Filter, can illustrate the benefit of these dimensions: trust.

In conflict-affected settings, the breakdown of the fabric of society, including networks, institutions, and governments spreads mistrust, suspicion, and may exacerbate tensions in situations prone to violence and instability. Violence and abuse experiences by members of different groups and perpetrated by somebody with a different background, may be generalized, at times exaggerated and fuelled by conflict "entrepreneurs," with a net result often of simmering collective distrust, exacerbated by further episodes of violence, between groups.

In the health sector, mistrust may be present especially when health workers are seen as reflecting (or representing) a particular group or authority structure, and may (sometimes unfairly) be thought to have political rather than professional motives for their work. Expatriate groups, from international NGOs, sometimes faith based, may also be distrusted. Although measuring and evaluating issues of trust is fraught with complications, the Peacebuilding Filter raises such questions for consideration: "Were health facilities a target of fighting, violence, or intimidation? Were health services perceived to be aligned with any of the groups involved in the tensions or

conflict?" The Peacebuilding Filter highlights the issue of trust—promoting exploration of this "soft" issue (see Grove & Zwi, 2008) rather than the hard indicators usually measured in development projects—promoting an understanding of how it is eroded, and how it may be built up. As one project highlights: "It is difficult to measure the contribution of polio eradication to the final achievement of peace in that region, but, undoubtedly, the collaboration among all those working in health helped to raise the level of trust among people" (de Quadros & Epstein, 2002, p. 26). It is important for health practitioners to recognize fractures in trust, and incorporate mechanisms within their service delivery and projects to contribute to the rebuilding of trust within the community and between the community and health service providers.

In addition, it is worth noting that the Peacebuilding Filter makes explicit focus on gender issues as one of its subcomponents, whereas gender is implicit across an RBA. The issue of gender in relation to health and human rights, conflict, and peace building has been more thoroughly explored by other authors (Cook, 1999; Skjelsbæk & Smith, 2001), and thus the topic, though deeply warranted, remains outside the scope of this chapter. However, within the Peacebuilding Filter, it prompts users to be aware of the socially structured roles of women, men, and children and promotes a gender-sensitive perspective in delivering health services, programs, and projects. It also encourages the capacity building of staff members to raise their awareness of gender issues in relation to the provision of health service, care, and treatment. By explicitly naming gender as a central component to health and peace building, it ensures that the issue will be considered and encourages gender-sensitive action in the process of both delivering services and training of staff.

Highlighting additional issues, alongside the RBA in conflict-affected settings, may open the way for health practitioners to consider some of the specifics that characterize postconflict recovery and peace building. The Peacebuilding Filter not only provides a framework that promotes some human rights principles but also takes into consideration the complex network of factors that influence the day-to-day work of health practitioners and highlights issues that would benefit from more sensitive attention.

CONCLUSION

In conflict-affected and postconflict settings, the need to promote human rights and their achievement in practice is evident. Realizing these rights will be progressive, requiring attention, education, time, and both human

and financial resources. Health practitioners have an important role to play in ensuring the key human rights principles, norms, and standards inform their day-to-day work. Given the lack of human rights training within medical and public health curriculum, and despite the fact that this field is growing and becoming more "practical" in its guidance to practitioners, making available useful tools to assist practitioners is of value. Although there may be a vacuum of such tools at their disposal, health practitioners should be cognizant of the key principles of an RBA to health to adapt existing tools.

Although the perfect tool for realizing the right to health during peace building may not exist, and work on this is ongoing, this chapter highlights the Peacebuilding Filter. This tool has been developed and is being used in a range of different settings, consistently with RBAs, which it can reinforce in these fragile settings. Enabling health practitioners to reflect on the synergy of health, peace, and human rights, while ensuring sensitive design of systems and ongoing delivery of services that will promote health and human rights into the future, is key: The Peacebuilding Filter, alongside human RBAs, will help apply best public health practice and build peace in postconflict settings.

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NOTES

[1]For the purpose of this chapter, we define peacebuilding in the context of development cooperation as "measures designed to consolidate peaceful relations and strengthen viable political, socioeconomic and cultural institutions capable of mediating conflict, as well as strengthen other mechanisms that will either create or support the creation of necessary conditions for a sustained peace" (Forum on Early Warning and Early Response, & International Alert and Saferworld, 2003). This definition of peacebuilding does not encompass broader peace mandates related to peacekeeping and/or peacemaking.

[2]Duty-bearer responsibilities also apply to surrogate authorities temporarily replacing the state as stipulated in the Geneva Convention's Additional Protocols, such as the UN-led transitional administrations in Cambodia (1992)—the first instance in which the United Nations had taken over the administration of an independent state, organized and ran an election, had its own radio station and jail, and been responsible for promoting and safeguarding human rights at the national level—as well as in Kosovo (1999), East Timor (1999), and Afghanistan (2001).