K4D | Knowledge, evidence and learning for development

Health programmes and peacebuilding in FCAS

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Question

Please provide an overview of how health programmes can build stability and promote peacebuilding? What the evidence tells us about how health programmes can address drivers of conflict and instability?

Contents

1. Summary

Research on the linkages between health programmes and peacebuilding in fragile contexts has experienced peaks and troughs of interest in the last 30 years or so. It started gaining attention in the 1980s and 1990s then dissipated again, with another peak in interest, research and papers in the mid- to late-2000s. The issue remained on the international agenda but received less attention and interest waned. In the last few years there has been another resurgence in interest and discussion, with a number of papers being released and research agendas being set (Arya, 2019). The linkages between health and peace have long been theorised, and there is a strong intuitive logic that delivering basic services contributes to state legitimacy and by extension to state-building (Gordon, 2013). However, the evidence remains weak either way on the possible contributions and linkages (both positive and negative) between health programmes and peace- and state-building processes in fragile and conflict affected states (FCAS), especially in the long-term. The relationship is under-researched and the debate among both health and peace actors continues.

This rapid review draws on academic sources, with some grey and practitioner literature included. Interest in the subject has been on the rise again in recent years, and this review is limited to literature from the last 5 years or so. As previously highlighted, the evidence base remains weak, and is hampered by limited research capacity and challenges relating to insecurity. Much of the literature continues to theorise the linkages, with some qualitative evidence, but with little empirical, concrete evidence to demonstrate these. Furthermore, there are a number of different definitions of state-building, which itself is a contested concept that faces criticism. It is beyond the scope of this paper to go into further details about the different definitions, concepts and arguments around state- and peacebuilding. Furthermore, due to the array of sources used, the definitions are left open. This review includes some information on "state legitimacy" in relation to state-building. These factors are also influenced by context, which is key when discussing FCAS and interventions. It is hence important to keep context in mind and note that there is no single prescriptive approach to working in FCAS as the underlying drivers of conflict and the dynamics of such contexts are complex and unpredictable.

Key findings in this review include:

- *Unintended consequences*: It is thought that if there are any benefits to state-building from health programmes they are more likely to be unintended by-products rather than a deliberate planned outcome in itself (Witter & Hunter, 2017). It is also possible for unintended negative consequences of current state-building approaches on health interventions in such uncertain and fragile environments (Philips & Derderian, 2015).
- *State legitimacy, stability and social cohesion*: Health interventions have the potential to contribute to developing state legitimacy through demonstrating capacity to deliver services, accountability to population needs and contributing to increasing social cohesion, trust and confidence within and between communities (Witter and Hunter, 2017). An appropriately trained, managed and incentivised health workforce can provide services in ways that encourages positive perceptions of the public health system and its legitimacy (Witter and Hunter, 2017). Efforts to promote good governance in the health system post crises can enhance state legitimacy. The post-crisis period must be used to urgently restore and expand health system functions and to promote the legitimacy of the state as the lead for health system governance.

- *Areas of research*: Aspects of health interventions and state-building that have been slightly more researched include: health system governance (i.e. efforts to promote good governance in the health system after crises can enhance state legitimacy): quality and visibility of health services (i.e. effective provision of health services during crises can promote state-building, while inadequate provision undermines the process); human resources for health (i.e. inclusive health workforce policies can expand equitable access to health services while promoting state legitimacy); and state-building beyond the health sector (i.e. importance of health service provision for increasing the visibility and reputation of government, thereby improving its legitimacy in general) (Witter and Hunter, 2017).
- *Gender*: Research suggests that gender equality plays an important role in contributing to more peaceful and prosperous societies. But the literature is limited in terms of the impact of health sector reform on gender equity (Percival et al., 2014). Several authors stress the importance of taking gender issues into account, but few overtly link gender and gender relations in post conflict settings to health (mental health and psychosocial support (MHPSS)) and peacebuilding. Most literature on gender focuses on women, their social position and violence perpetrated against them (Tankink & Bubenzer, 2017).
- Further research is needed to build the evidence base and get a deeper understanding of the possible pathways through which health system strengthening contributes to conflict transformation.

2. Health programmes and peacebuilding

Frameworks on linkages between health and peace

Health and peace are fundamentally interlinked, and are the basic rights of every human being. Sherin (2018: 1) highlights how “Peace is an important determinant of health while attainment of peace depends upon health of all.”

Woehrle (2019: 170) puts forth four ways in which health and peace come together: “first, through utilizing a socioecological worldview; second, through complexity thinking/ problem mapping; third, through the continuum of resilience and trauma; and fourth, through seeing the community as a place of practice.” However, Woehrle (2019: 168) argues that scholars of peacebuilding and community health “lack interdisciplinary thinking through collaborative projects and the development of transdisciplinary theoretical and methodological insights.”

The linkages between health and peace have long been theorised. A number of frameworks and initiatives have been put forward and gained attention over the last 30 years, as interest in the potential of health to influence peacebuilding has waxed and waned.

Health as a bridge for peace

Access to health services is valued across ideologies and offers a way of encouraging reconciliation and preventing future crises (Witter & Hunter, 2017). **The health sector is considered as a “connector” to peacebuilding.** The concept of “Health as a Bridge for Peace (HBP)” was introduced in the 1980s and was formally adopted by WHO in 1998 (Chattu & Knight, 2019). The concept of health as a bridge for peace is a multidimensional, dynamic policy and planning framework based on the principle that shared health concerns can transcend political,

economic, social and ethnic divisions.[1] It is rooted in values derived from human rights and humanitarian principles as well as medical ethics. The concept has seen some success, with case studies of using vaccinations to negotiate "days of tranquillity" during the 1980s and 1990s in Afghanistan, Angola, Chechnya, Democratic Republic of Congo, El Salvador, Guinea Bissau, Iraq, Lebanon, Philippines, Sierra Leone, Sri Lanka and Sudan (Chattu & Knight, 2019). Other activities may include joint projects among health professionals, which can reduce negative stereotypes and open up channels for communication and co-operation; advocates argue that these informal channels of communication can change the dynamics of the conflict and contribute to peacebuilding (Thompson & Kapila, 2018). There are others that argue there is little evidence of long-term impacts and sustained peacebuilding. Furthermore, although health sector strengthening can contribute to building trust, the 'do no harm' approach reflects the idea that the health care sector can be a divider as well as a connector. **It should not be assumed that health providers are natural connectors and that there is trust.** It is hence important to consider what the role of the health system was in the pre-conflict and current context (Servaes & Zupan, 2013).

Peace through health (PtH)

Peace through health is another peace work initiative from McMaster University addressing the role of health workers in promoting peace through various health interventions in context of war and conflict (Sherin, 2018: 1). Developed in the 1990s, it built on the HBP policy and planning framework; it is a theoretical concept with practical applications such as field projects (Arya, 2019).

Health diplomacy

Chattu and Knight (2019: 1) argue that "not only can health be a bridge to peace, but...the world is witnessing the emergence and growth of health diplomacy." Global Health Diplomacy is an interdisciplinary concept linking health and international relations, although it is yet to be clearly defined and various definitions are given by different experts. Chattu and Knight (2019: 151) define it as:

> first, a discipline with transformative potential for furthering human rights dialogue; second, a platform for providing a framework that allows us a better understanding of global health issues and a better grasp of the negotiations around those issues taking place in many different global governance venues; third, a concept that is concerned with the design, selection, and delivery of global health interventions and programs in accordance with diplomatic criteria, thereby simultaneously advancing the health of the poor and contributing a health perspective in international relations, peacekeeping, nation building, and other traditional "non-health" concerns, including health and non-health security; and last, a paradigm that positions health in foreign policy negotiations.

[1] World Health Organisation (WHO). Humanitarian health action: Health as Bridge for Peace (HBP). Available at: www.who.int/hac/techguidance/hbp/en/ [Accessed 01/06/2020].

Kelman (2019) explores how disaster-peace interactions might contribute to understanding health-peace connections, using the framework of disaster diplomacy.[2] Kelman (2019) scrutinises disease diplomacy, vaccine diplomacy and disaster diplomacy, and finds poor evidence for the effectiveness of any to promote peace. He concedes that there may be short term effects, but asserts that no case studies have shown lasting peacebuilding effects (influence on conflict, violent and non-violent or cooperation, inter-state, intra-state, and non-state) that were initiated or fully supported by humanitarian ventures.

Lack of systematic or long-term evidence

There is no evidence-based, systematic evaluation of the impact of peace through health initiatives (Sherin , 2018: 1). Some question whether health workers should be involved in peacebuilding, as health interventions in FCAS work on the principle of neutrality and impartiality. Although, Sherin (2018: 1) highlights that **there is also no evidence to refute the usefulness of the peace through health theory**.

Role in state-building?

Limited evidence

There is a strong intuitive logic that delivering basic services contributes to state legitimacy and by extension to state-building.[3] However, Gordon (2013: 29) highlights how there is "**only limited data** to support the efficacy" of health interventions for supporting wider state-building outcomes. This is still the case; **the evidence base remains weak either way.** Gordon (2013: 29) further argues that "this approach may instead invert the desired outcome of social legitimacy and undermine the rationale for which it is intended." The review also finds broad agreement that the **primary objective of health provision in FCAS should remain the enhancement of health outcomes, with state-building only being a "secondary consequence"** (if a consequence at all) (Gordon, 2013: 39). Further empirical evidence and new research is still required.

There are increasingly high expectations for health interventions to demonstrate transformative potential, including towards more resilient health systems as a contribution to state-building agendas in FCAS (Philips & Derderian, 2015). Philips and Derderian (2015) also highlight that **there is little conclusive evidence on linking state-building efforts to conflict prevention**, nor on transformative effects of health systems support. **Unintended negative consequences of current state-building approaches on health interventions are possible in such uncertain and fragile environments**. Here, health systems approaches might override goals associated with more immediate emergency response, increasing tension (Philips & Derderian, 2015: 1). Philips and Derderian (2015) identify three key areas of concern where potential unintended negative consequences from dominance of political agendas over health needs may

[2] Disaster diplomacy investigates how and why disaster-related activities do and do not influence conflict and cooperation, including through diplomacy- and peace-related activities (Kelman, 2019: 158).

[3] There is the argument that peacebuilding needs to move away from state-building and focus more on delivering services to cover basic human needs (including health and WASH). This is seen as more realistic and achievable. Delivering these basic human needs could then build the capacity of communities experiencing violent conflict to construct new relationships, and from this collective approach, improve the quality of life for all. Brennan (2019: 140) calls this new peace formation "Biopolitical Peacebuilding".

arise: quality of humanitarian health interventions, tangible contributions to population level health benefits, perception of health and humanitarian workers. Despite the general lack of evidence on the feasibility and benefits of health systems support for state-building, donors continue to envisage that there is a linkage.

State-building itself as a concept is contested, with some scepticism about the wisdom or feasibility of this as an external project. **It is thought that if there are any benefits to state-building from health programmes they are more likely to be unintended by-products rather than a deliberate planned outcome in itself** (Witter & Hunter, 2017). In a policy brief for the ReBUILD consortium, Whitter and Hunter (2017) summarise the evidence on the contribution of health systems investments to reduced fragility and state-building in FCAS. They find that there is general "consensus that **health systems have the potential to be an important part of developing the legitimacy of a state through demonstrating capacity to deliver services, accountability to population needs and contributing to social cohesion**." There are risks and opportunities for health interventions in the post-crisis moment, including capture of resources by privileged elites or increased opportunities for patronage and nepotism.

Possible links between health systems and state-building

Witter and Hunter (2017: 2) summarise the literature on possible links between health systems and state-building, highlighting a number of models that have been put forward:

- **Social cohesion:** One model highlights the importance of state capacity to fulfil its health promotion role, of mechanisms for accountability that enable the state to meet its social contract responsibilities, and of encouraging social cohesion through the health system. Effective health system governance and information systems provide a basis for improved service provision, while equitable financing arrangements can protect users from healthcare costs and promote social cohesion.
- **Security, stability and legitimacy:** Other models have placed additional emphasis on using health systems to provide security and stability to communities, and on how equity and responsiveness can enhance state legitimacy. An appropriately trained, managed and incentivised health workforce can provide services in ways that encourages positive perceptions of the public health system and its legitimacy. Those perceptions may extend beyond the health sector if legitimacy is enhanced across all areas of government.
- **The post-crisis period and legitimacy:** Efforts to promote good governance in the health system post crises can enhance state legitimacy. The post-crisis period must be used to urgently restore and expand health system functions and to promote the legitimacy of the state as the lead for health system governance.

Witter and Hunter (2017: 2) caution that there are important concerns around attempts to use health systems to promote state-building and the risk that this will lead to politicisation of the health system and the potential social exclusion of non-elite groups. There is also the risk that funds will be diverted towards attempts to enhance state legitimacy through health programming and away from less visible but still important services.

Gender equality and health systems

Percival et al. (2014) in their narrative literature review look at the role of gender equity in health system reform in post-conflict contexts. They find **the literature to be limited in terms of the**

impact of health sector reform on gender equity. Furthermore, there is little clarity on what a gender equitable health system would look like nor have key indicators been identified to measure how health systems could promote such equity. Within their discussion they draw attention to the impact of reform on broader social wellbeing and gender equality, and ask whether "the effort to build gender equitable health systems, could contribute to gender equality and have cascade effects throughout society as it works to rebuild" after conflict (Percival et al., 2014: 12). Especially as research suggests that **gender equality plays an important role in contributing to more peaceful and prosperous societies.**

3. Evidence on peacebuilding through health programmes

Despite the lack of a strong evidence base on peacebuilding through health programmes, there are a number of anecdotal and qualitative case studies and papers. Some of these are included below.

ReBUILD – empirical evidence base

The ReBUILD consortium was established to jointly analyse health systems reconstruction post conflict and crisis in order to provide guidance to policymakers, donors and others working in FCAS (Martineau et al., 2017). Across the ReBUILD consortium's interdisciplinary research programme, three cross-cutting themes have emerged: **communities, human resources for health and institutions**[4] (Martineau et al., 2017). Although the empirical evidence base is weak, Witter and Hunter (2017: 2) identify and summarise the evidence that exists for specific aspects of health interventions and impacts on state-building (please see the policy brief for more detail and further references). These include :

- **Health system governance:** Efforts to promote good governance in the health system after crises can enhance state legitimacy. In Timor-Leste, training for mid-level civil servants facilitated the transfer of health services management from international organisations to the Ministry of Health, thereby enabling the state to take responsibility for health services (Witter et al., 2015 *cited in* Witter & Hunter, 2017: 2). However, it is important to also include other levels of health management, such as districts (Bertone & Witter, 2015 *cited in* Witter & Hunter, 2017: 2).
- **Quality and visibility of health services:** Effective provision of health services during crises can promote state-building, while inadequate provision undermines the process. In Nigeria and Mozambique, privately contracted health services that were more accessible and of better perceived quality were associated with better perceptions of the state by the public, and failures in health service provision by private contractors were blamed on the state (Eldon, Waddington & Hadi, 2008; Witter et al., 2015 *both cited in* Witter & Hunter, 2017: 2). Evidence therefore indicates that state-building can be supported by effective public and private provision, however there is also evidence that extensive private contracting for health service management and provision during crises can undermine legitimacy of the state, as reported in Afghanistan (Palmer et al., 2006 *cited in* Witter & Hunter, 2017: 2). Reconstruction initiatives that follow conflicts and that have tangible manifestations – or rather, are 'visible' – to the public can demonstrate the capacity and

[4] I.e. the organisations, rules and relationships affecting the health system (Martineau et al., 2017: 4).

willingness of the state to fulfil the social contract (Waldman, 2006 *cited in* Witter & Hunter, 2017: 2). However the risk that health system strengthening initiatives become politically driven is real, and an inappropriate focus on high-status infrastructure has been reported in Nigeria (Eldon, Waddington & Hadi, 2008 *cited in* Witter & Hunter, 2017: 2).

- **Human resources for health:** Inclusive health workforce policies can expand equitable access to health services while promoting state legitimacy. The post-conflict reintegration of health workers from opposing factions in Angola, Ethiopia, Mozambique and Sierra Leone ensured greater geographical coverage of health services (Witter et al., 2015 *cited in* Witter & Hunter, 2017: 3). There is a risk that recruitment for government positions is dominated by nepotism among particular social groups, so it is important to place emphasis on meritocratic hiring practices for health system employees, as done in Burundi (Christensen & Edward 2015 *cited in* Witter & Hunter, 2017: 3). Those efforts bring together disparate groups in order to protect health, thereby enhancing social cohesion and the perceived legitimacy of the state. Appropriate training and incentives for health workers are important as perceived inadequate compensation for work has resulted in the emergence of user fees in many settings (Witter et al., 2015 *cited in* Witter & Hunter, 2017: 3).
- **State-building beyond the health sector:** Empirical research in this area points to the importance of health service provision for increasing the visibility and reputation of government, thereby improving its legitimacy in general. Decentralised health management in Sierra Leone appeared to raise the profile of local government and improve community perceptions of the state (Eldon, Waddington & Hadi, 2008 cited in Witter & Hunter, 2017: 3). Policy lessons that diffuse from health to other sectors provide a basis for further state-building.

UNICEF – peacebuilding as a secondary objective

UNICEF's Conflict Sensitivity and Peacebuilding Programming Guide (UNICEF, 2016) advocates undertaking conflict analysis, then using the findings to inform and guide programming. It recommends that if working within a conflict-affected setting, "you may want to identify opportunities to more explicitly contribute to peacebuilding or 'Do More Good'...and strive[] to *address* (rather than only avoid exacerbating) the root causes and dynamics of conflict" (UNICEF, 2016: 21). They recommend determining whether peacebuilding will be planned as a 'primary objective' or 'secondary objective' for an intervention, but ensuring that peacebuilding is an explicit intent from the outset.

The guide provides a number of examples of UNICEF WASH and health programmes where peacebuilding was a secondary objective. These examples include the following (although little empirical evidence on the case studies or their sustainability is provided):

- Community-level programming: In **Sudan**, in 2008 UNICEF developed the Community Action Plan (CAP) as a planning mechanism for WASH programming to facilitate community participation in decision-making and address inequalities and disparities of access to water supplies within communities, which had in the past led to violence and insecurity. The primary objective was addressing issues of access to water supplies, with **a secondary objective of strengthening horizontal social cohesion through enhancing inter-group community WASH mechanisms** (UNICEF, 2016: 24).
- Community-level programming: In **Afghanistan**, Community-Led Total Sanitation programmes provided space for community collaboration in the village of Surkh, where

close and inclusive collaboration between households was observed for latrine construction. The primary objective was providing methods for improvement of sanitation practices through the Community-Led Total Sanitation model, with **a secondary objective of strengthening horizontal social cohesion through enhancing inter-group community engagement for sanitation** (UNICEF, 2016: 24).

- Individual level programming: In **Mozambique**, youth-friendly health centres in neutral locations include programmes that bring youth from different groups together to discuss sexual and reproductive health issues, and to offer psychosocial care. The primary objective was addressing issues of access to health services by youth, in particular through youth centres in a neutral location; **a secondary objective was strengthening horizontal social cohesion through enhancing joint inter-group youth spaces for reconciliation** (UNICEF, 2016: 24).
- Policy and state-level programming: In **Somalia**, as part of the Joint Programme on Local Governance and Decentralized Service Delivery (JPLG), **UNICEF has worked on improving local government capacity for equitable service delivery.** Achievements of relevance to health and nutrition include the introduction of participatory planning systems, the reform and restructuring of village committees to include marginalized populations, piloting of decentralized service delivery, and capacity assessment of government social affairs departments. A mid-term review found that JPLG had made a **substantial contribution to entrenching peace and stabilization by supporting the emergence of more accountable and legitimate local governance institutions** that can peacefully mediate between competing and at times opposing demands (UNICEF, 2016: 45).

Health programmes and fragility – South Sudan and Haiti

Erismann et al. (2019) in their journal paper explore how health programmes implemented by donors can affect the overall fragility of a context (both positively and negatively). Commissioned by the Swiss Red Cross and looking at South Sudan and Haiti, the study consisted of a literature review, qualitative field research undertaken between June and August 2015 in South Sudan and Haiti, two data triangulation/validation workshops, and semi-structured key informant interviews and focus group discussions. The study's two case studies suggest that the **community-based health programmes "may have influenced certain drivers of fragility**" (Erismann et al., 2019: 1). However, due to the lack of a baseline for the projects, the impacts cannot be measured or quantified. Against a backdrop of weak government structures and institutions, the Swiss Red Cross engagement in South Sudan and Haiti focused on "community-based health programmes as a means to strengthening community resilience and government institutions from the local (district) up to the national level and thus promoting their role as a service provider" (Erismann et al., 2019: 12). The primary drivers of fragility identified by the study for both settings were (1) inability or unwillingness of the state to provide basic services; (2) lack of effective mechanisms to ensure inclusive citizen participation; (3) erosion of social cohesion and community spirit; and (4) high external aid dependency (Erismann et al., 2019: 8). The study suggests that opportunities and entry points for mitigating some of the identified drivers exist, albeit to varying degrees. It is vital to work not only on building institutional capacity but also on the relationship between the state and the public, as strengthening communities can have adverse effects on state legitimacy. Erismann et al. (2019) highlight several key points from the case studies that need attention in designing and implementing future health programmes in FCAS, which experience rapidly changing (conflict) dynamics and vulnerabilities. In particular, it is crucial to

anchor programmes within already existing and established community structures and involve, as much as possible, state structures from the local up to the national levels. Strengthening local partners who have a wide reach is key, this proved to be a critical factor in South Sudan which ensured a smooth transition from development aid to humanitarian activities after critical outbreaks of violence (Erismann et al., 2019: 14).

Secure Livelihoods Research Consortium (SLRC) – discourses on fragility in the DRC

The Secure Livelihoods Research Consortium (SLRC) is a global research programme exploring basic services, livelihoods and social protection in fragile and conflict-affected situations. Aembe and Dijkzeul (2018) examine how the discourse on state fragility affects the preferences of key actors in humanitarian governance for different types of health-sector interventions (horizontal, vertical or hybrid) in the Democratic Republic of Congo (DRC). Based on field work in South Kivu and Kinshasa, they argue that attention should be paid to "the interactive processes around the state fragility discourse among stakeholders in the health sector" (Aembe & Dijkzeul, 2018: v). They find that divergent discourses on state fragility in the DRC account for the failure to build a policy coalition on intervention models to improve the health sector. They argue that "the lack of consensus on state fragility influences humanitarian governance, especially the mutual perceptions of and interactions among the host-government, donors, and international non-governmental organisations (INGOs)" (Aembe & Dijkzeul, 2018: v). Donors and INGOs focus on vertical, emergency-based interventions by emphasising fragility, whereas, host government have "preferred to assert political statehood and a higher degree of state control" (Aembe & Dijkzeul, 2018: v). Nevertheless, there is agreement that donors' financial contributions ensure the survival of the public health sector. Looking forward, it is important to build a policy coalition based on harmonised views on addressing fragility in order for effective engagement and the sustainability of interventions.

Tearfund WASH programmes – DRC and Sudan

There is little rigorous evaluation to test the impact of service delivery on peace-building and state-building outcomes. Wild and Mason (2012) aimed to contribute to this by looking to understand how Tearfund WASH programmes on the ground, in a selection of project sites in DRC and South Sudan, may have impacted on peace-building and state-building. It also looked at how future WASH programmes might be designed in order to have the most positive impact on these processes. The paper was not a formal evaluation and draws on limited evidence and a limited number of project sites; it uses qualitative research methods to assess some of these wider processes. It identifies a number of key findings (Wild & Mason, 2012: iv):

- Research points to the need to challenge assumptions that the delivery of WASH services per se will contribute to positive peace-building and state-building effects. Drivers of these processes are complex and often reflect historic legacies and systemic features not easily shaped by any one intervention.
- On the other hand, WASH service delivery can be hugely important in many FCAS. A mindset shift is needed to better take on board the implications of peace-building and state-building, so that WASH programming (as with other sector programmes) adopt engagement with local conflict and community dynamics as a default position when working in FCAS, rather than as an optional add-on.

Building cooperation between peacebuilding and psychosocial support

A paper by Tankink and Bubenzer (2017) explores the literature on **building sustainable peace through an integrated approach to peacebuilding and mental health and psychosocial support** (MHPSS). Although there is "an increasing awareness of the need to bring some of the knowledge and tools traditionally belonging to the field of mental health and psychosocial support into peacebuilding interventions (and vice versa), this is not yet practiced in a way that is fully integrated." They conclude that **the evidence base for the outcomes and impact of an integrated approach is still very thin and that integration is currently only done piecemeal.** In the literature reviewed, almost all frameworks used were community based, which "emphasise the interpersonal and social linkages between individual health and wellbeing and community wellbeing and rehabilitation" (Tankink & Bubenzer, 2017: 202). According to the literature reviewed, for sustainable change, a holistic, integrated approach needs to be utilised from the very beginning of an intervention. Although the approaches taken by the papers reviewed by Tankink and Bubenzer (2017) vary greatly, they highlight a number of common elements including:

- **Defining peace and violence:** How key concepts, such as peace and violence, are defined fundamentally shapes the way peacebuilding and MHPSS projects are developed and implemented.
- **Human security:** In the aftermath of conflict, meeting people's basic physiological and psychological needs ought to be a priority. However, given resource constraints, as well as the uncoordinated and imbalanced rush to provide services to war ravaged communities, the sequencing and prioritisation of the provision of basic services tends to be skewed. Not prioritising human security means that people continue to experience perceived and real fear. Providing a safe space is often key to the success of interventions.
- **The centrality of narrative in mental health and peacebuilding approaches:** The literature reviewed refers to a wide variety of narrative approaches that are used for multiple purposes. Narrative is used to tell the experience of an event in terms of the emotional and existential sense making. However, some authors found that the relationship between truth telling, psychological healing and peacebuilding is dubious. For many people, the effects of truth telling are negative in that they have the potential of opening psychological wounds.
- **Restoring trust and rebuilding intercommunal relationships:** Rebuilding trust between victims, perpetrators and bystanders after conflict is fundamental to building long-term peace and reconciliation. Peacebuilding and psychosocial support interventions in conflict affected communities aim to reconstruct social networks and rebuild trusting relationships.
- **Health as societal and ecological rather than individual and medical:** It is important to acknowledge the nature of, and difference between, individual and collective experiences of trauma.
- **Health as an entry point to social and political transformation:** Using health as the entry point for interventions holds comparative advantages, such as health not being perceived as a political discipline, it can effectively be used as a conduit to addressing social and political issues within the community. The health community has a unique and crucial role to play in promoting a healthy society, not only by mending the physical and

psychological wounds of individuals, but also by rebuilding structures for public health care and creating bridges for community reconstruction and social reconciliation.

- **Gender:** Several authors stress the importance of taking gender issues into account, but few documents overtly link gender and gender relations in post conflict settings to MHPSS and peacebuilding. Most literature on gender focused on women, their social position and violence perpetrated against them.

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Key websites

- Health Systems Global: The Thematic Working Group on Health Systems in Fragile and Conflict Affected States: https://www.healthsystemsglobal.org/twg-group/8/Health-Systems-in-Fragile-and-Conflict-Affected-States/

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