HEALTH AS A CATALYST FOR PEACE: EMERGING LESSONS FROM SRI LANKA

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Introduction

It is well known that prolonged armed conflict invariably leads to escalation of injury, disease, disability and death, devastation of health infrastructure, displacement of health personnel and weakening of health systems. This is indeed the primary rationale for adopting emergency health as a cornerstone of humanitarian assistance in war situations. In this context emergency health interventions are merely seen as a humanitarian exercise designed to minimize human suffering and harm caused by armed conflict.

There are others who have recently advocated a move beyond this minimalist perception of health interventions in civil war. Taking a broader view of health as human well-being and not merely the absence of disease, WHO conducted a series of pilot projects in certain war-affected countries, including Sri Lanka, from 1991 to 1995 with a view to integrate peace building with health initiatives. "Shots of Vaccine instead of shots of artillery" (Swartz 1996) was the theme of the War and Health Programme of the McMaster University, Canada, identifying health as a potential means to bring together parties in conflict. "Health Bridges for Peace" (Peters 1996) launched in 1996 in former Yugoslavia embarked on a programme of training health professionals exposed to ethnic strife, in conflict management and mediation skills (Gutlove 2000). Using Sri Lanka's recent transition from war to peace, the present paper further explores the potential role of health in promoting peace and societal transition from a bitterarmed struggle to a path of peaceful negotiation of conflicts.

Sri Lanka experienced one of the bloodiest of civil wars in the world in recent years. It rapidly progressed from a low intensity ethnic conflict in the 1980s, to an intractable civil war consuming over 50 per cent of the annual budgetary allocations of the state towards the end of the 1990s. Even though active armed conflict was largely restricted to parts of the Northern and Eastern provinces, ramifications of the ethnic conflict engulfed the whole of Sri Lanka from time to time. This was due to devastating suicide bomb attacks on southern civilian and military targets by the Liberation Tigers of Tamil Eelam, periodic outbreaks of ethnic riots and an overall breakdown of the law and order situation. The 18 year war left more that 60,000 people killed, at least 20,000 people disabled, an unknown number of men, women and children traumatised, over one million civilians displaced, and the economic and physical infrastructure and livelihoods of many inhabitants in the war-affected areas completely disrupted. The health services in particular suffered, due to shelling or military occupation of health facilities, displacement or departure of health human power, logistic difficulties as well as security concerns in delivery of medical supplies to war-affected areas and war-induced pressure on available health facilities.

The catalytic role of health, in the transition from war to peace can be understood by considering the prospects for developing an integrated approach to health and peace during war following the cessation of hostilities.

Windows to Peace During War

As the civil war escalated, Sri Lanka was broadly divided into three zones, on the basis of the evolving security situation in each area. They consisted of: areas held by the LTTE; areas adjacent to the LTTE controlled territory, with a heavy presence of Sri Lanka security forces; and the remaining parts of Sri Lanka under civilian rule. Depending on successful military incursions by each side, the sizes of the first two zones ebbed and flowed. The unhealthy impact of the war was most severe in these two zones, and accordingly, humanitarian assistance by multilateral and bilateral donors largely focused on these two areas. Both the Government of Sri Lanka (GOSL) and the LTTE tried to attract donor assistance to areas militarily controlled by them, but the donors opted to operate directly through multilateral implementation agencies such as ICRC and UNHCR or through a multitude of local and international NGOs identified as neutral agencies (Ofstad 2002).

In spite of the war the GOSL maintained skeleton services inclusive of health facilities in all conflict-affected areas, including LTTE-held territory. This was difficult due to staff turnover, restrictions imposed by armed forces and the LTTE on mobility of people and goods, and war-related disruption of services, but clearly shows the pronounced legacy and educational facilities even in rebel-held areas. These services, however were grossly inadequate to meet the demand stemming from the war situation. In war-affected areas humanitarian agencies such as ICRC and MSF conducted mobile clinics to supplement the state-run health services. On the other hand, large numbers of Tamil, Muslim and Sinhala civilians living in conflict-affected areas became displaced due to the escalation of war. The Jaffna Rehabilitation Project and the Integrated Food Security Project implemented by GTZ demonstrated that some donors were willing to go beyond relief work in areas where security situations had improved.

The presence of multiple players, including international donors in war-affected areas itself served as an important deterrent to large-scale violation of human rights. Agencies such as ICRC and UNHCR made some effort to raise awareness among conflicting parties about international humanitarian law. More importantly, medical supplies provided by the Ministry of Health to the war-Affected areas were excluded from the list of banned items. While the flow of medical supplies to the North and East remained a constant source of contestation between the centre and health officials in conflict-affected areas, the interviews with Colombo officials revealed that they were fully sensitive to the implications of any serious shortages of medical supplies in the conflict areas. One high-ranking official noted, "If drugs are in short supply in the South it can only become a national issue. But if there is a shortage of vital drugs in the conflict zone it has the potential to become an international issue."

There was a degree of mutual cooperation between hostile parties in responding to certain medical emergencies. For instance, while pass systems had been introduced to by the Sri Lankan security forces and the LTTE, in order to regulate the flow of people in and out of the territories held by them and prevent infiltration from enemy forces, there was considerable leeway for people form one area to visit health services in another area. Given the rudimentary nature of health facilities in the LTTE-held areas, the typical flow of care seekers was from such areas, to health facilities in nearby army-held areas ("uncleared areas" in military jargon) and back. Both the LTTE and the Sri Lankan security forces gradually accommodated this care-seeking behaviour among civilians in affected areas.

While the Internally Displaced Peoples (IDPs) in welfare centres (camps) received regular attention in public health activities implemented by the GOSL and NGOs, routine immunization programmes were also implemented by government health workers in rebel-held areas with the consent of the local LTTE cadres. International agencies such as ICRC often served as mediators between government and LTTE in facilitating such public health campaigns. When a serious malaria epidemic did break out during 1997 to 2001 in many parts of the Vanni hinterland held by LTTE fighters, the government anti-malaria campaign carried out a mass campaign to contain the epidemic through focal spraying and mass administration of drugs (Sivaraja 2001). This campaign did receive approval of the LTTE. After reviewing various problems faced by aid agencies involved in humanitarian interventions in Sri Lanka, one observer concluded: "In spite of these problems, humanitarian assistance has been maintained throughout the war, and there has never been a major outbreak of starvation or epidemic diseases with catastrophic results so common in other war-affected countries" (Ofstad 2002: 175).

Health as an Emerging Catalyst for Post-Conflict Transition

Following a peace initiative mediated by the Norwegian government, open hostilities between GOSL and the LTTE were halted since February 2002. Even though there are many uncertainties about the long-term sustainability of this peace process, health-related interventions have been identified as an important component of the proposed rehabilitation and reconstruction programmes backed by various international donors. Planned and ongoing activities in the conflict-affected areas include a WHO-supported project for rehabilitation of the Kilinochchi hospital, training of additional health workers, de-mining operations assisted by a variety of foreign donors, and an ILO-supported initiative for rehabilitation and reintegration of disabled ex-combatants from both sides of the armed conflict (WHO 2002, Specht n.d) Each of these projects has received blessings from the GOSL as well as from the LTTE and various other stakeholders. The successful implementation of these projects will largely depend on the future of the ongoing peace process, which in turn will rest on the ability of conflicting parties to evolve a workable political formula for resolving existing differences. If successfully implemented, these projects can be expected to contribute to and indeed strengthen the post-conflict transition in Sri Lanka. While such projects are by no means a substitute for required political and institutional changes, and health is by no means a conflict-free sphere, health may provide a path of least resistance in the difficult campaign to heal the wounds of a deeply divided society.

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