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SWEDISH INTERNATIONAL
DEVELOPMENT COOPERATION AGENCY

GLOBAL HEALTH AND SECURITY: HEALTH AS A PEACE DIVIDEND

Conference summary
15–16 December 2011, Stockholm

CONTENTS

This conference summary was prepared by
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INTRODUCTION

In December 2011 Stockholm International Peace Research Institute (SIPRI), together with the Swedish International Development Cooperation Agency (Sida) and with the generous support of the Bill & Melinda Gates Foundation, hosted a conference to discuss the policy implications of the research findings of the SIPRI Global Health and Security Programme's interdisciplinary expert task force, which had carried out research during a six-month period, and to find new follow-on research ideas for the first half of 2012.

The conference was an opportunity for the expert task force to present research findings to the Programme's Senior Consultative Group and to discuss innovative policy thinking to promote health as a central component in sustainable development, stability and state building, especially in fragile and low-income regions and countries.

Objective

The principal objective of the first session of the conference was for the expert task force to present its research reports on health in fragile states to its peers and to the Senior Consultative Group for a general discussion of its findings.

The second session focused on discussing the policy implications of the research findings and conclusions. The presence of the Senior Consultative Group allowed for an exchange between the researchers and the experts on how the research findings could contribute to developing informed policy and how such policy may be presented. This entailed developing the proper policy context for health in fragile (and developing) states and identifying the policy target groups in Europe and how best to approach them.

The objective of the third session was to find follow-on or novel research ideas for a new round of papers to be commissioned by the SIPRI Global Health and Security Programme in the first half of 2012. Discussions among the experts and lead investigators of the research on health in fragile states should explore how health can be perceived as a peace dividend and should continue to build on the March 2011 conference discussions on gaps in knowledge.

Format

In the first session, 30-minute presentations of research and research findings were followed by 15 minutes of discussion. The second session consisted of informed policy discussions, introduced by Ambassador Anders Nordström, chair of the Senior Consultative Group. The first session concentrated on follow-on research activities on health as a peace dividend, which was discussed in separate groups that were followed by plenary presentations and discussion of the research activities.

SESSION 1, 15 DECEMBER 2011. RESEARCH ON HEALTH IN FRAGILE STATES

Opening and introductory remarks

Dr Peter Clevestig, Senior Researcher and Director of the Global Health and Security Programme at SIPRI
Dr Bates Gill, Director of SIPRI

In his introductory remarks Dr Peter Clevestig outlined the structure of the conference.

In the opening speech Dr Bates Gill presented the history of the Global Health and Security Programme and how the research that has been conducted was initiated.

Gender and identity groups and health

Professor Valerie Percival, Carleton University, London

Professor Valerie Percival explained that the research group chose to divide into two groups, one looking at gender and one looking at identity.

1. Gender

Dr Percival began her presentation by asking the research question that guided the group: *Have health reform efforts in post-conflict states integrated gender equity in their approach to health system reform?* She highlighted the fact that gender equity is neglected in health system reconstruction and during the 'window of opportunity' that opens up in the post-conflict period.

From its review of the literature and the case studies on Timor-Leste and Northern Uganda the research group made the following *arguments*:

- Health reconstruction reform in post-conflict states has improved health indicators for women, but it has neglected gender equity. There has been a strong focus on sexual violence and maternal health, but these issues represent a limited view of the relationship between gender and health. Gender inequity in health results from a combination of biological and gender factors.
- Research on health systems has given little guidance on how health system reform can be shaped to advance gender equity. The World Health Organization's health system framework has made no effort to develop health indicators, and policy literature lacks evidence-based research.
- United Nations Security Council Resolution 1325 does not address the broad social sector, but focuses on the political aspects of participation.

The following two recommendations go hand in hand:

- *Research recommendations*. More research should be conducted on how to measure gender equity and health systems and on the indicators that should be used. A need exists for more case studies, for example on Liberia and Rwanda.
- *Policy recommendations*. National Action Plans on Women, Peace and Security present an important opportunity for countries, such as Sweden, to influence the participation of women in other sectors than peace process negotiations and legislation, for example as in female participation and leadership in health-related issues.

2. Identity groups

The research question was: *What are the motivations for these organizations to deliver humanitarian assistance and how closely do they adhere to the humanitarian principles of neutrality, impartiality and independence?*

Dr Percival explained the intelligence community's fear that the humanitarian relief provided by Islamic non-governmental organizations (NGOs) has political rather than humanitarian motivations and could thereby pave the way for radical Islamic parties, by winning the hearts and minds of people, and could also provide cover for terrorist activity, by financing charitable work. Humanitarian organizations, on the other hand, see the work done by Islamic NGOs as valuable since they can reach people who are outside the spectrum of other international humanitarian organizations, although they are also somewhat wary of the commitment of Islamic NGOs to humanitarian principles.

The *key findings* from the literature:

- The goals for providing aid vary among the different actors. The Islamic organizations' objectives in providing assistance also differ. Some do so to meet the religious obligations of Islam, while some do so because of political motivations.
- The secular approach that underscores humanitarian principles is alien to the Islamic world. Religion, social and political actions are not separated since charity is one of the pillars of Islam.

The research group will continue to conduct further interviews.

In discussion, the points made and the questions asked included the following:

- What is the definition of an Islamic NGO?
- The focus on sexual violence and maternal mortality was presented as too narrow. What can be done to broaden the focus?

Information communication technology to strengthen health systems

Dr Alexander Finlayson, King's College, London

Dr Finlayson explained that the group's case studies focused on the question of how feasible the Information Communication Technology for Global Health (ICT4GH) was for countries such as Somalia. The group's research showed that technology can have a massive impact in fragile states in many different ways. The health system priorities in states must be known in order to understand whether the use of technology is because of commercial opportunity rather than due to strategic health system priorities.

The report focuses on Somalia.

At the level of *legislation* the issues concerning the accountability of ICT must be addressed. The mobile phone applications developed by the group would enable a person to give medical advice via the Internet to people in, for example, Somaliland. While it is relatively easy to create such an application, its creation brings with it issues of accountability and validity.

On the *policy level* there is generally a strong international commitment to using technology. A need exists to develop policy that both protects patients and allows for strategic coordination.

Infrastructure is a complex structure of technology, and access to e-health depends primarily on access to power, which is a question of equity. Lack of technology means a lack of health.

A flourishing sector for private telecommunication exists in Somalia, but regulations, a standardized evaluation framework and strategic coordination are absent.

Military medical services in humanitarian interventions

Lt Gen. (ret.) Louis Lillywhite and **Katharina Reinhardt**, Chatham House, London

Katharina Reinhardt outlined the trend of acceptance of military humanitarian interventions. Starting in 1989 there was no real questioning of military involvement and the interventions were naive, but questioning has gradually increased. One of the explanations of this naivety can be found in the military vacuum after the cold war. Some types of intervention were, however, questioned more than others. Little consensus exists on the problem with military humanitarian interventions. Reinhardt pointed out that quick military interventions

can be harmful and that there is a need for increased military training. However, the military is aware of this potential harm. Evidence is lacking on the actual role of the military in humanitarian operations that are conducted in developing countries.

Lt General (ret.) Louis Lillywhite noted that the concerns expressed in military publications about the lack of 'hard' outcome measures are not present in articles in the civilian press; this could have a cultural explanation. The literature does not address what the beneficiaries think about military humanitarian interventions. Needs exist to further explore the role of insurgencies and also that of the medical services of lower- and middle-income countries' military when they are a component of interventions in other countries. Ample evidence is available on where interventions 'do good'. Definitions of subjective, objective and political good are needed.

Successful health reconstruction

Professor Richard Garfield, Columbia University, New York

Professor Garfield presented the quantitative study on health services that was conducted by his group. He showed that, generally, the quality and availability of health services has not been good in the five years post-conflict. The group's research showed that a stronger government does generally better in terms of the provision of health services. A government with high legitimacy and efficiency scores provides better health services.

The trend observed by the group showed that larger countries, Afghanistan for instance, had more international influence, such as from the World Bank. While smaller countries, Liberia for instance, had a higher level of national planning where ministers worked closely with the president.

There were little room for participation at the local level in the countries covered. One reason for this was that those at the national level had little contact with people at the local level, which should be a key policy priority. Another key policy implication for national governments in search of support is the development of ways to communicate with local representatives. The creation of local employment, especially for women, is one of the key contributions that the health system can make to stabilize societies and improve the quality of life. The level of development prior to the conflict will affect all these areas.

Polio eradication in fragile states

Rachel Irwin, SIPRI, Stockholm

Ms Irwin described the Global Polio Eradication Programme (GPEI), which began in 1988. Although polio was eliminated from much of the world by 2000, progress has since slowed and the disease remains endemic in four countries, including Afghanistan and Pakistan, which were the focus of this project.

The Afghanistan programme has been praised for its management and willingness to innovate in delivery, but it still faces difficulties in reaching children due to insecurity. In contrast, Pakistan's programme is failing. The country also suffers from insecurity, particularly in the regions bordering Afghanistan, but failure stems mainly from poor management and lack of commitment at the local level. Many of the worst affected areas are autonomous from national or even regional governments, making irrelevant many high-level decisions about the initiative.

Key messages for policymakers in donor countries include:

Leverage soft diplomacy. Make a point of bringing up the issue of polio eradication or offering assistance during trade or other negotiations that are not health-related in order to show solidarity with polio-affected countries and keep it on the agenda.

Utilize multilateral forums. Polio is a significant topic for the World Health Organization's annual Assembly in May 2012. Countries should also highlight the lack of access to children in areas of conflict for the provision

of basic health services, including immunization and polio vaccinations, in the Annual Report on Children and Armed Conflict that is submitted by the UN Secretary-General to the UN Security Council.

Funding. Although the GPEI has fallen out of favour with some donors due to being a 'vertical' programme, the reality is that in many countries polio eradication efforts have helped contribute to the strengthening of overall health systems by improving both methods in immunization reach and surveillance systems. Polio eradication efforts are also more successful in countries with good coverage of routine immunizations and access to proper nutrition. At the very least, governments can continue their multilateral support to vaccine and nutrition initiatives.

Hard diplomacy. Due to the sensitive geopolitical situation in the area, recommending 'hard options' must be done with caution, but if these were to be advocated, the international community should urge Pakistan to allow the operation of the International Committee of the Red Cross (ICRC), which has been banned.

SESSION 2, 15 DECEMBER 2011. INFORMED POLICY DISCUSSION

Introductory remarks

Ambassador Anders Nordström, Chair of the Senior Consultative Board

Ambassador Nordström stressed the importance of economic wealth for sustainable health systems when it comes to health as both the means and the end to security. Building and improving health systems can be an entry point not only to improving health, but also to improving governance, including local governance, and transparency.

Ambassador Nordström also pointed out the opportunity that the final report presents for the participants to send a message about policy changes.

In the policy environment there have been changes. One illustration is the existence of a department for conflict and post-conflict countries at Sida, which reflects that the world is putting more efforts into such countries. The political landscape is also different. The BRIC countries have a strong influence on decisions today. The question of aid must be rethought. Aid cannot solve conflicts, but can serve as a catalyst.

Presentation on development priorities and policy

Hans Magnusson, Director of Conflict and Post-conflict Cooperation, Sida

By presenting the donor perspective, Mr Magnusson noted the key challenges of operationalizing policy documents. How does investment in health as a peace dividend create sustainable access to health services?

Sida tries to support local capacity by focusing on health system support in primary health care. Sida also supports humanitarian assistance, although it is difficult to support and integrate the two approaches.

Panel discussions on health in fragile states research with the Senior Consultative Group

Moderated by **Ambassador Anders Nordström**

Ambassador Jan Eliasson stressed the importance of the health sector in the nexus between peace, development and human rights. Health should also be viewed in the light of the Millennium Development Goals

(MDG). Water is another area that needs more attention and should be used as a confidence-building measure (CBM).

Ambassador Olof Skoog stated that the European Union (EU) has real potential to be a player in the health area and has potential leverage as regards political aspects. However, the EU is currently suffering a major economic crisis.

Ambassador Jack Chow highlighted that health should be prioritized on the global agenda. The Global Fund to Fight AIDS, Tuberculosis and Malaria was negotiated in only four months and can be considered an 'opening chapter' of such efforts. SIPRI plays a valuable role in the areas of information, illumination and inspiration. A global health workforce should be built to present skills and enhance will.

Dr Denny Vågerö noted that the case of Russia exemplifies that peace does not necessarily bring health. A long period of time and the political commitment of the government is needed to build a healthy population. Wars and conflict have long-lasting consequences.

Ambassador Anders Nordström expressed the view that the international health community could connect development and security with other health issues in the same way as occurred with HIV/AIDS. HIV is not different from other diseases.

SESSION 3, 16 DECEMBER 2011. RESEARCH ON HEALTH AS A PEACE DIVIDEND

Plenary presentations and discussion on research activities: reports from the groups

Information communication technology to strengthen health systems

The group is interested in publishing its reports as a SIPRI publication. As a follow-up activity the group will interview stakeholders in Nairobi and London and their respective networks to determine their priorities in regards to using e-health. They will also conduct more research on user experience to ascertain what the health care workers find useful about the technology. Using interdisciplinary group work they will also study digital health exclusion. Finally, the group will explore how these are interlinked.

Suggestion from conference participants. Look at exclusion from a gender perspective.

Military medical services in humanitarian interventions

The group wants to do more research on the views of the recipients of aid from the military and from Islamic and Western NGOs. This would require case studies, questionnaires etc. The group would also like to investigate the contributions made by insurgents. Finally, the group would like to study the health care that is provided by low- and middle-income countries.

Suggestion from conference participants. Look into how the military in low- and middle-income countries provide health care in non-conflict situations, for example in China.

Polio eradication in fragile states

The group will look at the health care system in Afghanistan 'post-2014' with the underlying goal of ensuring that health issues are on the agenda when Afghanistan's future is discussed.

Suggestion from conference participants. As part of the planned follow-up, the group should also examine how the lessons learnt from combating polio—in surveillance and vaccine delivery—can be incorporated into health system reconstruction.

Successful health reconstruction

The group plans to look into the quality of 'flash appeals', through the UN system, to donors to gain quick access to funds when an emergency occurs.

Suggestion from conference participants. It is important to look at effectiveness rather than efficiency.

Gender and identity groups and health

The group will broaden its research by articulating a comprehensive framework approach that takes into account the information acquired by and the research done by the group and that brings coherence to donor strategies which prioritize effectiveness and efficiency. Such strategies bring legitimacy to the actions of local implementers and include community and coalition building. The group will also explore new research indicators and matrices and look at innovations such as using a life-cycle approach.

SENIOR CONSULTATIVE GROUP

Ambassador Anders Nordström (Chairman)

Dr Anders Nordström is Ambassador for HIV/Aids at the Swedish Ministry for Foreign Affairs. He is presently a board member of Joint United Nations Programme on HIV/Aids (UNAIDS), the Global Fund and GAVI. As a medical doctor from Karolinska Institutet, Dr Nordström has a background that combines development experience in the field, national and international health policy and planning, and strategic leadership. His first international assignments were with the Swedish Red Cross in Cambodia and the International Committee of the Red Cross (ICRC) in Iran. He worked for the Swedish International Development Cooperation Agency (Sida) for 12 years, including as Director-General from January 2008 to June 2010. During 2002 Dr Nordström was the Interim Executive Director of the Global Fund to Fight Aids, Tuberculosis and Malaria and Acting Director-General of the World Health Organization (WHO) from May 2006 until January 2007.

Ambassador Jan Eliasson

Ambassador Jan Eliasson has a long record in the fields of diplomacy, humanitarian action and conflict resolution. He is currently chairman of WaterAid and a member of the United Nations Millennium Development Goals Advocacy Group appointed by the UN Secretary-General. Mr Eliasson has a special focus on Millennium Development Goal 7 on environmental sustainability, which includes water and sanitation. He was Sweden's Ambassador to the United States from September 2000 to July 2005 and was president of the 60th session of the UN General Assembly in 2005/2006. He served as the Swedish Minister of Foreign Affairs from April to October 2006. Following this, he was Special Envoy of the UN Secretary-General for Darfur until 2008. In 1992 he was appointed as the first UN Under-Secretary-General for Humanitarian Affairs. He was involved in operations in Somalia, Sudan, Mozambique and the Balkans.

Ambassador Olof Skoog

Ambassador Olof Skoog is the Permanent Chair of the EU Political and Security Committee (PSC), appointed by the High Representative, Catherine Ashton. Prior to this, he was Sweden's permanent representative to the PSC. Ambassador Skoog has worked for the Swedish Ministry for Foreign Affairs since 1988; his posts have included director-general for political affairs, ambassador to Colombia, Panama, Venezuela and Ecuador, as well as serving at the Permanent Mission of Sweden to the United Nations in New York, the delegation to the Conference on Security and Co-operation in Europe (CSCE) in Vienna, and the Swedish Embassy in Havana.

Ambassador Jack C. Chow

Ambassador Jack Chow has a background in public service and global health diplomacy. He was the first Assistant Director-General of WHO on HIV/Aids, Tuberculosis, and Malaria and was the Special Envoy of the WHO Director-General. In the United States, Dr Chow held the rank of ambassador as the Special Representative of the Secretary of State on Global HIV/Aids and as the Deputy Assistant Secretary of State for Health and Science. He led the establishment of the Global Fund to Fight Aids, Tuberculosis, and Malaria and efforts to counter global infectious diseases and bioterrorism threats. Dr Chow is a medical doctor trained at Stanford University Hospital and earned his MD from the University of California at San Francisco School of Medicine.

Dr Kathleen Cravero

Dr Kathleen Cravero is President of the Oak Foundation. Between 2005 and 2009 she was Assistant Secretary General and Director of the Bureau for Crisis Prevention at the United Nations Development Programme. Dr Cravero also held the position of Deputy Executive Director at the UNAIDS between 2000 and 2005. Apart from UNAIDS, she has over two decades of experience in international development from two other UN organizations: the United Nations Children's Fund (UNICEF) and WHO. Dr Cravero leads the development of the Global Coalition on Women and Aids, a broad-based network of partners and organizations working to mitigate the impact of Aids in women and girls worldwide. Dr Cravero has a doctorate in political science and a masters degree in public health.

Dr Bernhard Schwartländer

Dr Bernhard Schwartländer is the Director for the Evidence, Strategy and Results at UNAIDS. Prior to this Dr Schwartländer held a number of senior international positions including UN Country Coordinator on Aids in Beijing, China, as Director for Performance Evaluation and Policy at Global Fund to Fight Aids, Tuberculosis and Malaria, Director of the World Health Organization's HIV Department, and as the Director of Evaluation and Strategy Information at UNAIDS. Dr Schwartländer is a medical doctor and holds a doctorate in medical epidemiology and has also been the Director of the National Aids programme in Germany and Director of the Division of Infectious Disease Epidemiology at the Robert Koch-Institute in Berlin.

Professor Denny Vågerö

Dr Denny Vågerö is a professor of medical sociology. In 2000–2008 he was the Director of the Centre for Health Equity Studies (CHESS), a joint research institute of Stockholm University and Karolinska Institutet. He was a member of the WHO Commission on Social Determinants of Health in 2005–2008 and is presently senior advisor to the European Review of Social Determinants and the Health Divide for WHO/Europe. He is also a member of the board of the Swedish Red Cross. His research, published in leading medical and social science journals, focuses on how human society influences human health and in particular on health inequalities in Sweden and Europe. Dr Vågerö is a member of the Royal Swedish Academy of Sciences.