Alfred Bader

Queen's University

Queen's Rehabilitation

1995-1997

FAX FROM :
28 JUN '95 10:05

28/06/95 11:11 PG. 1
P.1/1

Canadian High Commission
Macdonald House
1 Grosvenor Square
London W1X 0AB

Canada

Haut Commissariat du Canada
Macdonald House
1 Grosvenor Square
London, W1X 0AB

UNCLASSIFIED

June 27, 1995

FACSIMILE / TÉLÉCOPIE

To/À: Dr. Alfred R. Bader
52 Wickham Avenue

From/De: Royce Frith
High Commissioner

City/Ville: BEXHILL-ON-SEA

City/Ville: LONDON

Fax No./No de télécopie: 01424-22-22-23

Fax No./No de télécopie: 171-258-6303

Number of pages including this page/Nombre de pages avec cette feuille: 1

COMMENTS/COMMENTAIRES:

W.R. Bader,

I'm happy to be able officially to tell you that should you make a financial donation to the International Centre for the Advancement of Community Based Rehabilitation (ICACBR) of Queen's University, for their operations in Former Yugoslavia, it will not reduce Canadian Government financial support for their current project or any project in the planning stage.

Regards.

Royce Frith

If there is any problem upon receipt of this fax, please call / S'il y a des problèmes à la réception de cette télécopie, prière d'appeler: 171-258-6328

FAX FROM : 613 545 6652 28/06/95 20:55 PG 1

Queen's University at Kingston

OFFICE OF NEWS AND PUBLIC RELATIONS
Richardson Hall, Rm. 14
Kingston, Ontario,
K7L 3N6, CANADA
Tel 613 545-2035
Fax 613 545-6652

FAX TRANSMISSION SHEET

ATTENTION: **Florence Campbell**
Vice-Principal (Advancement)

FROM: **Nancy Dorrance**
Staff Writer
Queen's News & Public Relations, 545-2035, ext. 4498

DATE: June 28, 1995

PAGES TO FOLLOW: 2

Hi Florence,

Thanks for your message yesterday. I'd appreciate it if you do have time to scan this release as well. (The Bader one has gone to his fax machine at Sussex, where his Milwaukee assistant told me he should be returning tomorrow evening.) With regard to this release, a copy is being faxed today to the Principal and has already been seen by Margot Northey. She made several minor corrections and provided a great quote. I'll take her photo tomorrow when she's here to meet with Dean Anderson. In light of the long weekend coming up in both countries, we thought next Tuesday (or even Wednesday for Bader, assuming it's all approved by then) would have the best chance of getting good play. Thanks again for your help.

Nancy

DRAFT RELEASE

One of Queen's University's most generous benefactors has added his support to the institution's humanitarian aid project for disabled war victims in the former Yugoslavia.

Dr. Alfred Bader will contribute approximately $685,000 ($500,000 U.S.) toward the initiative, which was launched in 1993 by Queen's School of Rehabilitation Therapy and the International Centre for the Advancement of Community Based Rehabilitation (ICACBR) in collaboration with the government of Bosnia-Herzegovina and the World Health Organization (WHO).

The project is funded by the Department of Foreign Affairs and International Trade until December 1996. The additional resources provided by Bader will be used entirely in Bosnia-Herzegovina, and directed toward

- supplying "low tech" equipment and aids for use in war victims' homes and in community clinics;
- further development of community outreach programs and rehabilitation clinics;
- preparation of rehabilitation kits to enable disabled people to live independently; and
- assessment, treatment and social reintegration programs in refugee camps.

According to Dr. Malcolm Peat, director of both the School of Rehabilitation Therapy and ICACBR, the program will be significantly enhanced by Bader's gift. "All of us involved in the project, our colleagues in Bosnia-Herzegovina and ourselves, appreciate his generous support and understanding," says Peat. "The additional resources will make a major impact on the development of community based rehabilitation programs in Bosnia-Herzegovina."

Working with local counterparts to develop practical, realistic programs at the community level has helped to alleviate some of the pressure on hospital services, Peat notes. At least 10 per cent of war casualties need prolonged rehabilitation, which severely strains the country's diminished technical, financial and human resources in rehabilitation services. The Queen's project involves clinical education and support for the development of community based rehabilitation programs in Sarajevo and in other centres of Bosnia-Herzegovina.

Bader, a Queen's alumnus with degrees in engineering chemistry, art history, and an honorary doctorate (1986), as well as a doctorate in chemistry from Harvard University, was himself a refugee during the Second World War when he was forced to flee the Nazi occupation of his native Austria at the age of 14. He spent time in internment camps in England and Canada before his release in 1941, and subsequent enrolment at Queen's University.

"This extremely generous contribution from Dr. Bader -- a loyal friend of Queen's -- will have a direct impact on those most affected by the conflict in Bosnia-Herzegovina, the victims of war," says Queen's Principal Dr. William Leggett. "Through this continuing project, funded by the Department of Foreign Affairs and International Trade, the university will be able to expand its international involvement in the area of disability and health activities."

Both the School of Rehabilitation Therapy and ICACBR -- one of only five Canadian International Development Agency (CIDA) funded centres of excellence -- are deeply involved in forging Queen's links in the area of international research and development. ICACBR, with an annual budget of $1 million, is a partnership between persons with disabilities, health rehabilitation, behavioural and social sciences, and members of non-governmental organizations, committed to promoting community-based rehabilitation internationally.

-- END --

Queen's University
at Kingston

Working with local counterparts to develop practical rehab programs at the community level has helped to alleviate some of the pressure on hospital services. Peat notes. At least 10 percent of war casualties need prolonged rehabilitation, which is severely strains the country's diminished technical, financial and human resources in rehabilitation services. The Queen's project involves clinical education and support for the development of community based rehabilitation programs in Sarajevo and in other centres of Bosnia-Herzegovina.

Bader, a Queen's alumnus with degrees in engineering, chemistry, an honorary doctorate (1986) as well as a doctorate in chemistry from Oxford University, himself a refugee during the Second World War, when he was forced to flee the Nazi occupation of his native Austria at the age of 14. He spent time in internment camps in England and Canada before his release in 1941. [illegible] Queen's University.

COMMUNITY BASED REHABILITATION

Yours sincerely,

Malcolm Peat, Ph.D
Executive Director

FAX FROM

DR. ALFRED R. BADER
52 Wickham Avenue
Bexhill-on-Sea
East Sussex TN39 3ER
Telephone/Fax: 0424-22-22-23

Date:

Page 1 of 1

To: Florence Campbell &
Fax: Nancy Morrance 613 545 6652

To Nancy Morrance:
Thanks for yeur fax of June 28. Please conpider these minor corrections to draft:
Par. 2 " has contributed ... I am certain that Principal Leggett has deposited the check.
Par. 6: I wish I had a degree in art history - just think how much more I could do, but Queen's did not teach this in the '40s

To Florence

This gift, from Isabel & me, is a way of marking the 50. anniversary of my graduation in Science '45, but in view of the urgent need we did not want to delay making the gift until October.

I suppect there are many people who want to help victims of racial hatreds, but dont quite know how. We are happy that the involvement of Queen's assures competence & integrity.

Best wishes. Yours Always

FAX FROM

DR. ALFRED R. BADER
52 Wickham Avenue
Bexhill-on-Sea
East Sussex TN39 3ER
Telephone/Fax: 0424-22-22-23

Date: June 14 1995

To: Dr. Malcolm Peat
Fax: CBR Centre, Queen's 001 613 545 6882

Dear Dr. Peat

Thank you for your fax of June 13 assuring us that a contribution from us would in no way diminish contributions from Queen's or the Canadian government to your efforts to the CBR Centre in Bosnia Herzegovina (B H)

With that assurance, Isabel & I would like to give US $500000.- to Queen's to be used as follows:

Using your two-page seven point options, we would like these funds to be spent only in B. H. - including of course Sarajevo - on options one through five and also - if needed and as you see fit - on antibiotics, painkillers and other

Check received with personal funds from Alfred Bader 95/06/14 [illegible]

medicinals. Allocation between these five options and medicinals is at your and Queen's discretion.

When we meet (perhaps at my 50. reunion in October ?) Isabel & I would like to discuss the excluded option b €] with you.

To bring BH clinical personnel to Queen's seems – at least on first sight – problematic. Is it cost-effective ? Could you not train many more Bosnians at the same cost in, say, Slovenia or even in England ? Does not bringing Bosnians to Queen's create enormous frustration – even jealousy – among the Bosnians who cannot possibly hope for our state-of-the-art equipment ?

We would also like to ask you to allocate the funds of our gift among options 1–5 as much as you can to help

(1) children and

(2) to create as many jobs as you can for Bosnians to help themselves

Please forgive us if we are "running into an open door" and want to share with you [illegible] Christian comments.

Keep up your great work

With all good wishes

(Yours [illegible])

DR. ALFRED R. BADER
2961 N. SHEPARD AVE.
MILWAUKEE, WIS. 53211

151

June 16 1995

12-5/750

PAY TO THE ORDER OF Queens University $ 500,000.00

-Fideicomiso Kampana ana

100

M&I Marshall & Ilsley Bank
Milwaukee, Wisconsin 53202

M & I PARTNERSHIP SAVINGS

Memo

[redacted]

THE PRINCIPAL
AND VICE-CHANCELLOR

Queen's University
Kingston, Canada
K7L 3N6
Tel 613 545-2200
Fax 613 545-6838

April 24, 1995

Dr. Alfred Bader
Alfred Bader Fine Arts
Astor Hotel Suite 622
924 East Juneau Avenue
Milwaukee, WI 53202
U.S.A.

Dear Alfred:

Following our discussion regarding your interest in the possibility of contributing to the support of those disadvantaged by the war in Bosnia, I contacted Malcolm Peat, Director of our School of Rehabilitation Therapy. As I indicated to you, the School has been very active in providing assistance to the Bosnians for some time now.

Malcolm has provided a brief overstatement of their Community-Based Physical Rehabilitation Project and has provided some indications of ways in which funding could be of direct assistance to the Bosnians.

It should be noted that in each of the suggestions given, no overhead would be charged by Queen's, nor would any Queen's professor benefit directly or indirectly from the aid provided. The monies would go directly to assist the Bosnian people.

I hope that this information will be useful to you, and would be pleased to provide you with any additional information that you might require on these matters.

With best wishes,

Yours truly,

William C. Leggett
Principal and
Vice-Chancellor

WCL:dsh
Encls. (2)

SCHOOL OF REHABILITATION THERAPY
FACULTY OF MEDICINE
OFFICE OF THE DIRECTOR

Queen's University
Kingston, Canada
K7L 3N6
Tel 613 545-6103/4/5
Fax 613 545-6192

April 18, 1995

Dr. William C. Leggett
Principal and Vice-Chancellor
Queen's University
Kingston, Ontario
K7L 3N6

Dear Principal Leggett:

Please find attached a two page summary of the Queen's University Bosnia project in community rehabilitation. I would be happy to provide any additional if required. We at present we have three Queen's personnel in Sarajevo and I will be visiting the region from May 6 to May 20, 1995.

Sincerely yours,

Malcolm Peat, Ph.D.
Professor and Director
Associate Dean (Rehabilitation)

MP:lje
Encl.

COMMUNITY BASED PHYSICAL REHABILITATION
PROJECT in BOSNIA-HERCEGOVINA
Queen's University

The goal of the project is to participate in the development of sustainable community based programs for the rehabilitation, relief and reintegration of war victims in the Former Yugoslavia. The beneficiaries of the program are persons with disabilities within the population of refugees, displaced persons, homeless and vulnerable citizens such as elderly persons and children.

The CBR Project has established four (4) community physical rehabilitation clinics in partnership with clinicians, the government, the World Health Organization, and the community of Sarajevo. In addition, we have developed outreach rehabilitation programs in cooperation with other non-governmental organizations which involved visiting citizens in their home location wherever that may be. An important element of this project is program sustainability and the development of community linkages to integrate the delivery of rehabilitation services to the community of Sarajevo. There has been tremendous interest and enthusiasm in the project and still a great deal more could be offered.

The war has effectively destroyed the economy of Bosnia-Hercegovina (B-H) to the extent that there are no salaries for health, social and education personnel. "Work" is done on a voluntary basis with exceptional commitment on the part of all. The community rehabilitation programs in Sarajevo, therefore, receive no financial support except for the occasional honoraria from humanitarian assistance programs. The skilled clinicians donate their time and energy to operate the clinics throughout the community. The commitment is impressive.

The Queen's project will be relocating its program in Sarajevo to another region of Bosnia-Hercegovina at the end of June following a final symposium and seminar on clinical education, policy and research issues in community rehabilitation. Queen's will, however, continue to maintain linkages in Sarajevo with colleagues in the community and with the Governments. The Government of Bosnia-Hercegovina and Sarajevo are committed to including community strategies (clinic and outreach programs) in the re-development of their health and rehabilitation services system and Queen's will continue to participate over the long term to assist with this objective.

Opportunities to contribute to the rehabilitation programs directed at alleviating some of the burden on the citizens of Sarajevo and other regions of B-H who have become disabled are many and varied. We would like to propose that consideration be given to supporting the following options:

/(Please note: Calculations are based on our current experience)

1. low technology rehabilitation equipment and aids suitable for use in the home and/or in the community clinics.

   Funding recommended: $15,000 per clinic/outreach program

2. support the further development of the community outreach programs with funding for training and staff honoraria and in-home aids for one year.

   Funding recommended: $5,000 per month per program

3. support the operation of community rehabilitation clinics in Sarajevo by providing honoraria for staff (clinicians, housecleaning and other support staff) for one year

   Funding recommended: $5,000 per month per clinic

4. support the preparation of rehabilitation kits to be adapted for use in community clinics and in-home settings to enhance the ability of the beneficiary to live independently.

   Funding recommended: $5,000 per kit

5. support a rehabilitation assessment, treatment and social reintegration program directed for refugee camps. (training of staff and members of the refugee population to detect, assess and provide services, supply equipment/aids) for one year

   Funding recommended: $10,000 per month

6. Clinical education at Queen's University for short periods of time for B-H clinical personnel (approximately 4 to 6 weeks)

   Funding recommended: $8,000 to $10,000 per person/visit

7. Learning resources, textbooks and training materials in rehabilitation

   Funding recommended: any amount

In any of the above Queen's will provide ongoing support through clinical and management personnel as required for project coordination, identification of equipment requirements, and the development and implementation of training programs.

In the current Queen's University project, the Canadian Department of Foreign Affairs and International Trade supports the following program activities: clinical education by Canadian personnel, honoraria for local clinicians, equipment, and seminars. The grant is for a period of two years and Queen's will carry out these program activities in a minimum of three communities in B-H.

FAX FROM

DR. ALFRED R. BADER
52 Wickham Avenue
Bexhill-on-Sea
East Sussex TN39 3ER
Telephone/Fax: 0424-22-22-23

Date: June 12 95

To: Dr. Malcolm Peat
Fax: Dean, School of Rehab. Therapy
Queens

Dear Dr. Peat

Jabil & I are considering making a contribution to the Queen's Bosnia project, now funded by Queen's and the Canadian government

Can you give prospective donors absolute assurance that funds donated will be "add-on" funds and will in no way replace present Queen's and government funding?

Are you leaving paragraph at the end of this month because you are giving up on paraplegia - because help is needed even more elsewhere in BH?

Thank you for your commitment to help desperate people. With all good wishes

Alf Bader

Office of the Vice Principal
(Operations and Finance)

International Centre for the Advancement of Community Based Rehabilitation
A Canadian International Development Agency funded Centre of Excellence
Centre international pour l'avancement de la réadaptation à base communautaire
Un centre d'excellence subventionné par l'Agence canadienne de développement international
Queen's University Kingston, Ontario, Canada K7L 3N6 Telephone (613) 545-6881 Fax (613) 545-6882

July 31, 1995

Dr. Alfred Bader
52 Wickham
Bexhill-on-Sea
East Sussex TN39 3ER

FAX 0424-22-23

Dear Dr. Bader:

I would like to bring you up to date on the status of our rehabilitation program in Bosnia, particularly in relation to your generous donation

- Sarajevo - We have been in contact with our colleagues in Sarajevo and have their full support and appreciation for the continuation of the CBR program in the four community clinics. We have agreed that your donation will provide the resources for the continuation of the clinics for an initial period of three months (June/July, August, September). As you know, the Government of Canada's support for our initiative in Sarajevo, had ended in June with the development of our program in Central Bosnia. The continuation of the clinics in Sarajevo is critical as we know they are under increasing stress.

  I hope to be able to visit Sarajevo within the next few days during the period of my visit to Central Bosnia. This will give me an opportunity to discuss directly with our Sarajevo colleagues the longer term continuation of the Sarajevo program made possible by your support.

- Central Bosnia - David Packer, our Program Manager, and I, will be in Central Bosnia this month initiating the CBR program in Zenica. In addition, we will be exploring the possibility of rehabilitation programs in other locations including Tuzla and Mostar. The recent events have significantly increased the refugee population and we intend to give priority to their rehabilitation needs. Following this planning and management initiative, our rehabilitation program, with the involvement of our Canadian staff, will start in Central Bosnia in September.

PARTICIPATING ORGANIZATIONS

Rehabilitation Council for the Disabled (Canada); Council of Canadians with Disabilities (Canada); Disabled Peoples' International; The Hugh MacMillan [illegible]
University of Bombay (India); Voluntary Health Services Society, Bangladesh; Yayasan [illegible]

FAX FROM [illegible]

I understand you will be visiting Queen's in October, and would welcome the opportunity of reviewing with you in detail the Bosnia project.

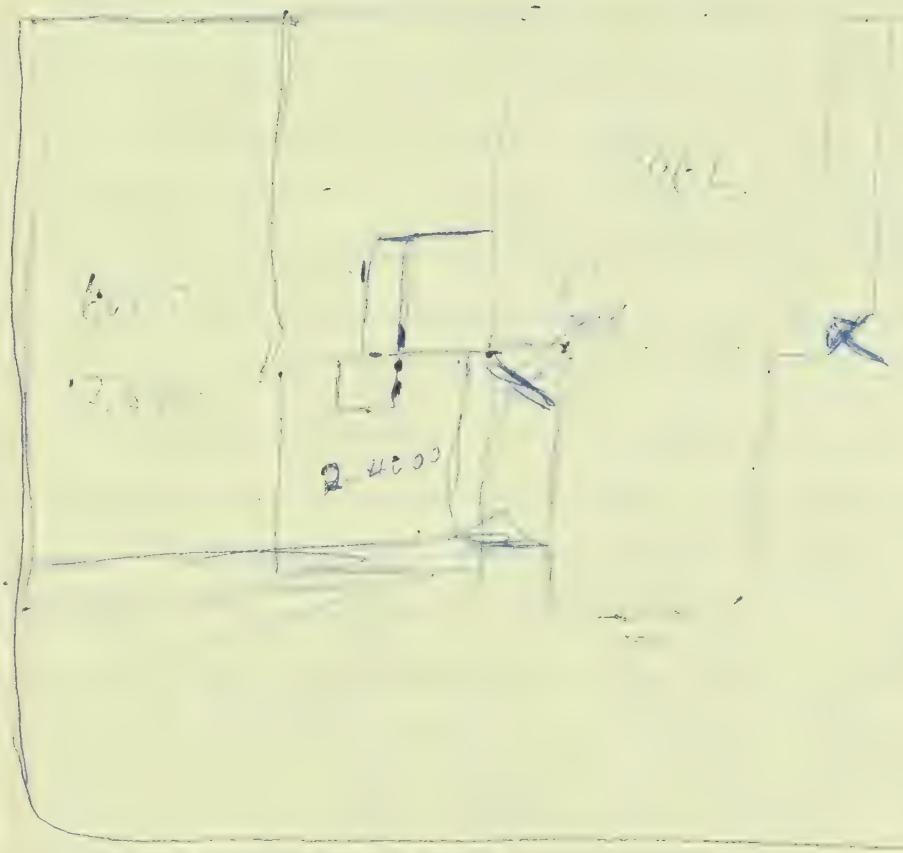
I am forwarding by mail, a copy of the recent Evaluation Report of the Sarajevo project. This was prepared for the Canadian government and submitted in July. It reflects the hernories specifically in Sarajevo and will provide you with a detailed review of the activities which will now be continued. Thank you for your support.

Yours very truly,

Malcolm Peat, Ph D
Executive Director

17/8/95

200 M ⟶ 1.5 m.



MEDICAL WORK IN BOSNIA

I think by now you both know me pretty well, if I'm given a task that on paper I am totally unqualified to do, I rush in all directions trying to make connections -- and I'm like a dog with a bone -- I give it energy and won't let go. I suppose networking and being a catylist are my skills rather ephemeral qualities..... but then so are we humans.

Because I believe targeting the right project amoung the plethora that exist is so important I want to make sure that any comment I give is as accurate as possible whether or not it becomes a direction to follow or discard. Having an excuse to explore has been fascinating I have learnt so much and now feel more competent to assess the situation and the value of some of the projects, at least to my own satisfaction.I do think with 220 agencies working in Sarejevo possibly the greatest need is for cooperation and coordination It is not surprising that people do not know of other projects in the city as they probably have their heads down putting their energy into the needs and work that asails them on all sides. I think there is competition between aid agencies, both governmental and NGO's partly because many people are involved in their career as well as their work so priorities can get confused. There is also a distinction between "relief" and "development" Relief agenciestend to think short term unfortunately what they do is bound to have an effect on future development, so not to consider the long term development issues is detrimental and causes problems. For this reason doing something for the long term medical training and infrastructure in the country could have extremely far reaching positive affects if it is appropriate carefully targeted and has the cooperation and is enthusiastically sought by those on the ground rather than being imposed by outsiders. It is in this context that Dr Redman impressed me so much. He is aware that Health Clinics in Yugoslavia in the 1920's were way in advance of the rest of the world, that their plastic surgery until recently was world famous, that they have many medical strengths to be proud of and there is a need to build from there, as well as by building in the areas that were found to be inadequate when war and deprivation showed up gaps in their system and also to change areas where they have taken wrong turns. Chief amoung these was to concentrate on hospitals and specialisation and to see general medicine as an area for those who failed to make it in the hospital world. (Is that so different from the U.K. or USA?) The other area that was ommitted was to have an emergency intake system to sort out patients and to direct them to the appropriate service. So training in general medicine as a respected career is really important long term. Right now improving primary care and emergency care are seen as top priorities. Nurses are not well trained medically but could be trained up to fill some of the gaps. Right now many of the doctors working in Sarejevo are not paid and half trained but are becoming very experienced in dealing with extreme injuries and trauma.

Another person who really impressed me was Alison Butcher. She is a nurse trainer who is well known for her work in Rumania and has recently been working north of Tuzla at Gradacac. Her focus has been care in the community and training nurses up to deal with the pressing problems around them. Her approach is to concentrate on what is "affordable, appropriate, accessible and home made equipment" her work is in basic training with an accent on diversity, management, lab, trauma response etc. (There are still so many land mines causing injuries.) Collaboration with the people and helping the people to help themselves. So often orphans, elderly and traumatised are kept clean, fed, clothed, kept warm and left to die where minimal community training can save many people. S he believes in small non dramatic approaches where there is a lot of local collaboration. She therefore thought the Queen's programme sounded very good and although she hadn't run into it, said the Canadian troops had provided food, medicine and equipment, although they have now gone.

Prior to this I had contacted the Memorial Fund, (synopsis enclosed) the Medical Foundation for victims of torture, Balkans Relief and a couple of Bosnian contacts. Three people refered me to World Jewish Relief as providing good medical and other aid in Sarejevo and I found Eli Benson at the agency so helpful and committed. I realize you are now in touch with them so have not tried to speak to Jacob Finci direct. His number in Sarejevo is 0038771 663473. I have not yet managed to speak to Edie Freeman at the Royal Free hospital; she is in touch with many doctors from former Yugoslavia so would be aware of what they believe the shortcomings in the medical world in their country were now they can view it from a distance and now that they work in England at the Royal Free.

I think in my brief research Dr Tony Redman impressed me the most. He seems to have a broad picture of the situation, to have many good contacts. He has to have been there often over a considerable period. He sees emergency and primary care as the areas of greatest need and the opportunity being ripe to change the training and infrastructure in collaboration with the committed medical staff in the hospital and school those who have stayed behind. Professor Mulabegavic who is Dean of the Medical School and now Rector of the University he sees as a key figure in the process, I hope you will call and speak to him at Keele University Stoke on Trent, he also runs the Emergency services at Stoke Hospital. His numbers are (office) 01782749722, home 01619 736276 or mobile 0585 626927. Like the Memoral Fund he also works through Telemedicine Link for world medical relief in the US.

I've tried to quickly gather my thoughts hoping they will provide some useful references to some of the things I have found are happening in post Yugoslavia. So a peace has been signed, I wish it wasn't based on partition and related to US politics as well as Balkan needs. I fear it is short term so any work that has long term effects may prove of even greater signifigance in this unstable time.

One of the things that has struck me in this brief research project that I have set myself as a result of your request for my oppinion is that many high profile organisations do not coordinate their work. There is Red R which provides engineers of all descriptions to help in disasters, U.K.-Med which does the same medically, World Jewish Relief, The International Red Cross, Save the Children etc., Post war Reconstruction Unit which provides architects etc. As well there are several organisations that provide help with mediation and peace keeping and others and Universities that work on development but there is no overall coordinating body that puts them altogether at times of disaster. I realise the government Overseas Aid Development might provide this function, but does it? I think not. There is also the U.N. but that has limitations -- maybe this needs looking at?!

Jane Shisler

to be shared if appropriate with Drs Cowan + Peat

Dear Dr. Cowan

Please share with Dr. Peat.

Anna Bacon

[illegible]

on 212 535 061[illegible]

UK-Med

Ms Jane Whistler
Pond Cottage
Henley Down
Battle
East Sussex
TN33 9BN

22nd November 1995

Dear Ms Whistler,

Thank you for your telephone call of this morning enquiring about medical needs in Bosnia. I have spoken with Professor Redmond who is happy to discuss this with you and will contact you as soon as possible.

I have taken the opportunity to detail below some of the projects we wish to implement when funds are available and the work we have been able to carry out to date.

*UK Med is a non-governmental organisation and registered charity. During August 1995 BBC2 television showed a documentary series called **"SIEGE DOCTORS"** which documented the work that Professor Redmond and the UK-Med teams carried out with the sick and injured people of all ages in the besieged city of Sarajevo during 1994. There is much work that the teams wish to continue for all sides of the conflict.*

*The intention of Operation Phoenix featured in the **"SEIGE DOCTORS"** series was to help rebuild the medical services in Sarajevo.*

Our aims were:

a) To work with the Bosnian Ministry of Health and WHO to help redevelop their medical services following the war.

b) To help develop postgraduate medical training and education.

c) To re-establish plastic surgery in Sarajevo.

d) To support WHO on their work in TB

North Staffordshire Hospital
Windsor House, 223 Princes Road, Hartshill, Stoke on Trent, ST4 7LN
Tel/Fax: 0782 749722 Mobile: 0585 495348 / 0850 723476

e) To supply specialist medical drugs.

f) To supply dental equipment and drugs.

g) To develop an A&E department and training in emergency medicine at Kosovo Hospital.

Our objective was to support Bosnian colleagues to regain their former standard of medical care and improve on them, providing training and text books and much needed drugs and equipment.

The aims and objectives of UK Med is to take aid to disaster areas and war zones, and help rebuild an effective health service with the necessary equipment and medical and management expertise. It needs special medical and communications equipment, drugs, transport, as well as sponsorship for training courses to benefit teams from all over the country and the world.

Our future plans include an Ophthalmology project in Sarajevo where there are areas of great need and a programme has been planned.

Before the civil war Sarajevo Eye Institute served the whole of Bosnia as a tertiary referral centre. We hope to develop links throughout Bosnia and plan to serve patients from both sides of the conflict.

There is an absence of a lot of basic equipment and specialised instruments need servicing or repairing. We have the technicians to repair the equipment and we can supply the spare parts required but we need to raise the money to finance it. The specialists who are working in the hospitals are mostly young and inexperienced with very little support from more senior colleges who have either left the country been killed or are away sick. None of the doctors have been paid for three years and those who have stuck to their posts have shown extraordinary courage. Any sponsorship received will go directly to helping in international emergency and disaster situations.

UK-Med is launching an appeal to raise £400,000 to provide new equipment, service and repair of existing equipment, drugs, training facilities/courses, text books, and sponsorship for Bosnian doctors to train in England. A more detailed break down of costs is available for your perusal along with our end of year accounts.

What is happening in the former Yugoslavia is beyond comprehension, but everyone of us can play a part in helping to respond to the tragic situation.

At the present time we have ongoing projects in the United States of America where we are working on a joint telemedicine link. Some funding has been given to us by our american colleagues to set up a telemedicine line here in Stoke-on-Trent and we envisage a long working relationship across the Atlantic.

We hope that this information will be of assistance to you and you will give consideration to our request, but should you require further details please do not hesitate to contact me.

I enclose for your perusal our brochure and two programmes of training courses we are directing in 1995/6.

Yours Sincerely

DOROTHY GRIFFITHS
ADMINISTRATOR
UK MED

+crm/frtf

20 July, 1995

Dr A. Bader
52 Wickham Avenue
Bexhill
Sussex

Dear Dr Bader,

A recent newspaper article indicated your early relationship with this organisation. Known as the Central British Fund for German Jewry, then the Central British Fund for Jewish Relief and Rehabilitation, then CBF World Jewish Relief and now just World Jewish Relief, we were responsible for the care and maintenance of some 80,000 refugees including nearly 10,000 Kindertransporte and currently hold an extensive archive (not open to the public) on these refugees.

Over the years the work of the organisation expanded. We still care for Jewish refugees seeking asylum in the UK and have dealt with waves of immigrants from Eastern Europe, Hungary, Egypt and other Arab lands - our current caseload are from Sarajevo in the former Yugoslavia. We also deal with rescue operations, mostly clandestine, and humanitarian aid. Of major concern to us is the rapidly deteriorating situation in Bosnia. We have sent a convoy of food into Tuzla where the Jewish community (numbering one hundred) will distributed it to the thousands of refugees who are seeking safety. Our regular food convoys into Sarajevo have ceased due to the shelling and supplies are running out. On the telephone yesterday we were advised that the elderly, housebound who are totally dependent on food parcels had not received a delivery for 15 days. The food stores in the community are almost depleted - they only have rice and pasta and the pasta will be finished in 5 days. We have transferred money which a courier will delivered today (a very dangerous task) as food can be purchased on the blackmarket but it is a very expensive alternative. However, we cannot leave people to starve. The elderly in Sarajevo are all holocaust survivors and we are particularly concerned about them.

Enclosed is some additional information about World Jewish Relief which I hope you will find interesting.

Yours sincerely,

Cheryl Mariner
Executive Director

Wife of Rabbi Mariner

WORLD JEWISH RELIEF

DRAYTON HOUSE
30 GORDON STREET
LONDON WC1H OAN
TEL: +44 (0)171 387 3925
FAX: +44 (0)171 383 4810
EMAIL: WJR@ORT.ORG

The Central British Fund for
World Jewish Relief
A company limited by guarantee
Registered Office as above
Registered in England No. 1874886
Registered Charity No. 290767
Trading as World Jewish Relief

Environmentally Friendly Paper

DR ALFRED BADER
52 WICKHAM AVENUE
BEXHILL-ON-SEA
EAST SUSSEX
TN39 3ER

Mr. Cheryl Marinus
World Jewish Relief
London

July 23 95

Dear Mr Marinus

Thank you so much for your most interesting letter of July 20.

Your efforts and hope of my family and me are very similar, as you will see from the enclosed. As my wife is Canadian & I American, we try to help through efforts here, but the central purpose is the same: you should not stand idly by the blood of your neighbour.

I found Barry Turner's The Long Horizon most interesting. U.K. Jewish, British & American Jewry should have done much more. But to write (on p.1) 'Love of Jews by blood' is to adopt Nazi terminology, and I see no terms like 'Jew by blood' and 'half Jewish'. But I am nit-picking, and hindsight is always so easy. Even now is Yugoslavia like Munich — and why should we help a people far away whom we hardly know. Winston & Major are wrong now as Chamberlain was then.

Do you know my best friend in England, Ralph Emanuel? His parents helped me among hundreds, [illegible]

We are just returning to the U.S but on my next visit to England, in November - December I would much like to visit with you to discuss your efforts in Bosnia.

With regards, also to Rabbi Marinus

Yours truly,

PROPOSAL FOR

THE DEVELOPMENT OF REGIONAL COMMUNITY BASED REHABILITATION PROGRAMS IN THE FORMER YUGOSLAVIA

Prepared by:
Community Based Rehabilitation (Europe)
School of Rehabilitation Therapy
Queen's University
Kingston, Ontario

PROPOSAL FOR

THE DEVELOPMENT OF REGIONAL COMMUNITY BASED REHABILITATION PROGRAMS IN THE FORMER YUGOSLAVIA

Prepared by:
Community Based Rehabilitation (Europe)
School of Rehabilitation Therapy
Queen's University
Kingston, Ontario

TABLE OF CONTENTS

THE DEVELOPMENT OF REGIONAL COMMUNITY BASED REHABILITATION PROGRAMS IN THE FORMER YUGOSLAVIA

PREAMBLE

The following proposal is intended for review by a potential donor interested in the development of community initiatives for disabled persons in the Former Yugoslavia. The topics identified in the budget categories reflect the areas of activity in order of priority. The components of the project will be administered by the current Queen's University initiative in the Former Yugoslavia. Those submitting this proposal would welcome comments and suggestions regarding the activity areas and project design.

1. BACKGROUND

Since October 1993, the School of Rehabilitation Therapy, Queen's University, has been active in the development and implementation of community based rehabilitation (CBR) services in Bosnia-Herzegovina. The project has been funded by the Department of Foreign Affairs and International Trade, Government of Canada and was developed in collaboration with the Government of Bosnia-Herzegovina and the World Health Organization (WHO).

Up to this time, the project has:

- been instrumental in the development of CBR services in Sarajevo;
- facilitated the development of a national policy in Bosnia-Herzegovina for the expansion of CBR as a component of the redevelopment of health services for disabled persons; and,
- contributed significantly to the development of clinical education programs for health and community personnel in the application of rehabilitation services at a community level.

1.1 Queen's University Contribution

The School of Rehabilitation Therapy as recipient of the award from the Department of Foreign Affairs, is responsible for the organization, management, and implementation of the Canadian contribution to the international humanitarian program in the Former Yugoslavia focusing on the needs of disabled persons. This project is an illustration of the involvement of Queen's University in international activities in the area of disability and health. Other externally funded projects in which the School of Rehabilitation Therapy plays a major role include the International Centre for the Advancement of Community Based Rehabilitation (ICACBR), (a CIDA funded Centre of Excellence) and the development of rehabilitation services in Russia through a collaborative program with Volgograd Medical College and again funded by the Department of Foreign Affairs and International Trade. Prior to this, the School of Rehabilitation Therapy has been a recipient of a number of awards from the Canadian International Development Agency (CIDA) and other agencies supporting programs in international development in a number of regions including: Caribbean, Europe, South Asia, and China. Queen's University is a recognized international resource in the area of CBR.

The international experience of Queen's University in community rehabilitation programs was critical in the award to develop CBR in areas of hostilities in the Former Yugoslavia and the appointment as the implementing partner of the World Health Organization in this activity.

1.2 The Development of Community Clinics in Sarajevo - October 1993 to June 1995

The present Queen's program is funded by the Department of Foreign Affairs and International Trade through to December 1996. From October 1993 to the present the program has focused on the development of four community clinics in Sarajevo. The remainder of this project will continue to consolidate the activities in Sarajevo and extend the program to other regions in Bosnia-Herzegovina with a possible extension of the program to Croatia.

1.3 Impact of Hostilities on Rehabilitation Services

The severe destruction of the major institutional health care resources has stimulated the development of local community facilities which would meet the essential health care needs including emergency services. Prior to the war, the health care system in the Former Yugoslavia was based on large, specialized institutional facilities and local Primary Health Care Centres (PHC) (dom Zdravija - *house of health*). The concept of family practice or the use of family doctors was not part of the pre-war medical practice system. Health needs were met by attending a community clinic with its range of services or attendance or admission to a hospital facility.

Rehabilitation resources prior to the war were essentially focused in institutional facilities including general hospitals and specialized rehabilitation centres. Both facilities provided a range of in-patient and ambulatory services for the physically disabled population. In the current war environment, the lack of public transportation, the difficulty of access to the hospital sector, together with the physical destruction of health care facilities provided a major stimulus to the design and implementation of community based facilities.

1.4 Need for Community Rehabilitation

Since the outbreak of hostilities there has been an increasing awareness of the need for community based resources, with the result that demonstration model CBR clinics have been established in Sarajevo. This has provided the government authorities with the opportunity to develop a CBR strategy appropriate to the needs of Sarajevo and other areas which have been impacted by hostilities.

In addition to the lack of physical resources, there is a lack of skilled personnel including occupational therapists, social workers, and psychologists. The population of physical therapists is the largest single group of rehabilitation personnel available. However, the number of physical therapists is not sufficient to meet the needs of the population of disabled persons. The current lack of resources, such as payment for services for health personnel, further hampers the rehabilitation process.

At least 10% of war casualties need prolonged rehabilitation. Approximately two-thirds of these attempt to receive rehabilitation in the existing diminished health care system. Those with disabilities have very limited access to public transportation. As a result, they often remain confined to a hospital, unnecessarily utilizing limited hospital facilities, and further straining the dimished technical, financial, and human resources in rehabilitation services.

1.5 Disability Categories

Estimated Numbers of Disabled

The number of wounded is extremely difficult to estimate. No centralized information system currently exists to the extent that an accurate database can be developed. According to the Ministry of Health, Sarajevo, more than 250,000 people have been injured - 40,000 to 60,000 in Sarajevo alone. An estimated 15% need long term rehabilitation.

Causes of Injury

The data in relationship to causes by hostilities shows that:

- 55% are caused by shrapnel wounds
- 20% gunshots
- 25% miscellaneous causes including trauma

Attitudes to Disability

Sensitizing the population to the needs of the disabled is a major task in accomplishing successful rehabilitation. Community rehabilitation services have a major impact on enhancing the knowledge of the community regarding the nature of disability and the major factors which facilitate reintegration of the disabled into community life.

Vulnerable Populations

- General Population of Disabled - In addition to the population of persons injured by hostilities, there is the continuing need of rehabilitation services for the elderly and those with disabilities resulting from injuries and diseases unrelated to the war situation. This would include those affected by degenerative joint disease, cardio-respiratory and neurological dysfunction. In addition, the elderly population require rehabilitation services to maintain function, prevent disability, and enhance independent living.

- Refugees - Throughout the Former Yugoslavia there is a large population of refugees. It is estimated that 80% of the refugee population are adults, and 20% are children. The disabled within the refugee population have in effect no "community" support and so create a unique need for government and humanitarian organization support. Refugees are located in over-crowded and temporary facilities with very limited resources for rehabilitation of physically disabled persons.

- Children Experiencing Violence - The number of children experiencing violence is unknown. It has been suggested that these children may form the largest single group in need of rehabilitation. The need for psychological rehabilitation greatly outweighs the need for physical rehabilitation of children.

Major Categories of Disabled

- Peripheral Nerve Injury - Sniping and shrapnel injuries have resulted in a large population of soft tissue injuries with damage to one or more peripheral nerves leading to motor paralysis and sensory loss. This group is the single largest disability category.

- Amputees - Below knee amputations are the most common, followed by above knee and amputations of the arm which account for approximately 10% of all amputees.

- Spinal Cord Injured - Nearly all spinal cord injured patients are paraplegics with partial or total injury to the spine. Almost all have bladder and bowel complications. Their main threat to life is urinary tract complications and pressure sores.

- Craniocerebral Injured - The largest group in this category are those with hemiplegia and limited ability of function of the upper and lower limb of one side. This group includes those with visual impairment and hearing disfunction.

- General Trauma - Hostilities have produced a wide range of musculo-skeletal injuries including fractures to upper and lower extremities and damage to peripheral joints. This has also produced complications including contractures, severely limiting function.

1.6 Major Difficulties in the Development of Rehabilitation Services

The period of hostilities has demonstrated to the government and to agencies such as WHO that the major difficulties in the development of rehabilitation services at this time are:

- limited availability of community rehabilitation resources
- lack of centralized, specialized services
- extremely limited community rehabilitation for refugee populations
- limited physical therapy services
- total absence of occupational therapy services
- limited adaptable equipment for community and home use
- absence of educational programs for health professionals in rehabilitation
- lack of professional rehabilitation staff at all levels
- lack of coordinated services
- absence of a database on the prevalence of disability
- insufficiently regulated rights of individuals with disabilities

2. FURTHER DEVELOPMENT OF THE QUEEN'S REHABILITATION PROGRAM

The present program for the development of CBR in Bosnia-Herzegovina, funded through to December 1996, could be significantly enhanced by additional resources which would focus on the following areas which are identified in order of priority:

- the development of ***community outreach programs***
- the development of ***rehabilitation*** assessment, treatment and social integration programs for ***refugees***
- the expansion of ***CBR*** facilities to regions in Bosnia-Herzegovina ***outside the community of Sarajevo***
- the provision of ***rehabilitation equipment*** for community practice and outreach services
- the ***expansion*** of the community clinic program in Sarajevo
- the provision of practical ***clinical education*** programs for rehabilitation and community personnel
- the development of ***learning resources*** and training materials in rehabilitation
- ***clinical education at Queen's University*** for Former Yugoslavia clinical personnel

2.1 The Development of Community Outreach Programs

A significant proportion of the disabled population are unable to attend hospital or access community resources for a number of reasons. Severely disabled and elderly persons are unable to leave their home environment because transportation is impossible in many locations. Refugee populations are effectively excluded as they are isolated in centres or camps.

The experience of the current project has shown that local volunteers and health workers can be trained to provide *outreach* or home visiting programs which would bring essential rehabilitation services to vulnerable populations who are unable to access community clinics.

2.2 The Development of Rehabilitation, Assessment, Treatment and Social Integration Programs for Refugees

This component has not been addressed in the existing CBR initiatives in Bosnia-Herzegovina. Rehabilitation programs could be developed within the refugee community through the training of staff and members of the refugee population and the provision of health personnel (outreach) from the rehabilitation clinics currently existing or developed in the next phase of CBR expansion.

2.3 The Expansion of CBR Facilities to Regions in Bosnia-Herzegovina Outside the Community of Sarajevo

The current rehabilitation resources in Bosnia-Herzegovina are largely limited to Sarajevo. In order to bring essential rehabilitation services to other locations including Mostar, Zenica, Tuzla, and Vitez it is necessary to provide each of those locations with a community rehabilitation and outreach service. The CBR resources developed would be based on the Sarajevo model and would include the development of clinical services, provision of equipment, and the training of health and community personnel.

2.4 The Provision of Rehabilitation Equipment for Community Practice and Outreach Services

The development of new CBR clinics would require basic low-technology rehabilitation equipment. The experience of the current project has identified the type of equipment appropriate for community practice in regions in which technical support and utility services are unavailable.

2.5 The Expansion of the Community Clinic Program in Sarajevo

The four community clinics currently developed by Queen's University in Sarajevo meet the needs of only a segment of the population. The expansion of the CBR programs in Sarajevo would be an effective mechanism of expanding rehabilitation services. The WHO and the Government of Bosnia-Herzegovina are promoting the further development of CBR through the primary health care centre program. They perceive this as the strategy for the future and the most effective mechanism for the general dissemination of rehabilitation services.

2.6 The Provision of Practical Clinical Education Programs for Rehabilitation and Community Personnel

There is a need to continue the provision of short-term practical clinical education programs for health personnel, volunteer groups and families of the disabled. These programs would be aimed at enhancing clinical skills and in training volunteer groups in basic disability prevention and management procedures. These short-term programs could be provided by the existing CBR clinics as an expansion of their role. This would enhance the concept of communities becoming more active in the development of local programs for disabled persons.

2.7 The Development of Learning Resources and Training Materials in Rehabilitation

There is a need for locally produced, educational material for the disabled and their families which would focus on the functional needs of the disabled in the home environment. Many basic programs emphasizing functional activities could be implemented by family and community members if they were provided with the appropriate educational material produced in a practical format in the local language.

2.8 Clinical Education at Queen's University for Bosnia-Herzegovina Clinical Personnel

Short term visits by key personnel to Queen's University would provide the opportunity to participate in an advanced and intensive clinical program in strategies appropriate to CBR. This would include exposure to clinical skills, techniques, learning resources, equipment design, and other components that would be appropriate to the needs of the Former Yugoslavia. These programs could be designed for small groups visiting Queen's University for four to six week periods.

3. BUDGET FRAMEWORK

The budget is based on the following principles:

- Costs would be specific to project activities with no Queen's University administrative or overhead component applied;
- Queen's University Bosnia Project personnel would manage the program without direct cost;
- Queen's University full-time faculty contributions would be offered as "in kind" activity;
- Canadian clinical personnel would participate only for specific clinical activities within the Former Yugoslavia in the CBR initiatives. This is the current policy under which the present program operates;
- Local rehabilitation personnel would be involved in all program activity and provide the infrastructure for sustainability;
- The time frame is for two years; and,
- A budget of $500,000 US or $685,000 CDN is used and the amount distributed across all program areas. However, if it is decided that priority will be given to a select number of program activities, the funds could then be redistributed to maximize the objectives of these initiatives.

BUDGET SUMMARY

		YR 1 ($CDN)	YR 2 ($CDN)
3.1	The Development of Community Outreach Programs	95,000	60,000
3.2	The Development of Rehabilitation Assessment, Treatment, and Social Integration Programs for Refugees	85,000	50,000
3.3	The Expansion of CBR Facilities to Regions in Bosnia-Herzegovina Outside the Community of Sarajevo	85,000	50,000
3.4	The Provision of Rehabilitation Equipment for Community Practice and Outreach Services	45,000	0
3.5	Expansion of the Community Clinic Program in Sarajevo	70,000	45,000
3.6	The Provision of Practical Clinical Education Programs for Rehabilitation and Community Personnel	35,000	35,000
3.7	The Development of Learning Resources and Training Materials in Rehabilitation	15,000	0
3.8	Clinical Education at Queen's University for Bosnia-Herzegovina Clinical Personnel	15,000	0
	TOTAL:	**$445,000**	**$240,000**

BUDGET DETAILS BY PROGRAM ACTIVITY:

3.1 The Development of Community Outreach Programs

	YR 1	YR 2
Clinical service and training		
- Clinicians	25,000	5,000
- Local staff	30,000	30,000
Logistics	40,000	25,000
- (Communications, transportation (fuel), supplies, accommodation, secretarial support)		
TOTAL:	**$95,000**	**$60,000**

3.2 Rehabilitation Programs for Refugee Populations

	YR 1	YR 2
Clinical service and training		
- Clinicians	25,000	5,000
- Local staff	30,000	30,000
Logistics	30,000	15,000
- (Communications, transportation, supplies, accommodation, secretarial support)		
TOTAL:	**$85,000**	**$50,000**

3.3 The Expansion of CBR Facilities in Bosnia-Herzegovina

	YR 1	YR 2
Clinical service and training		
- Clinicians	25,000	5,000
- Local staff	30,000	30,000
Logistics	30,000	15,000
- (Communications, transportation, supplies, accommodation, secretarial support)		
TOTAL:	**$85,000**	**$50,000**

3.4 The Provision of Rehabilitation Equipment

	YR 1
Equipment (3 clinics)	45,000
TOTAL:	**$45,000**

3.5 Expansion of Community Clinic Program in Sarajevo

	YR 1	YR 2
Clinical service and training		
- Clinicians	20,000	5,000
- Local staff	25,000	25,000
Logistics	25,000	15,000
- (Communications, transportation, supplies, accommodation, secretarial support)		
TOTAL:	**$70,000**	**$45,000**

3.6 Provision of Clinical Education Programs for Clinical Personnel

	YR 1	YR 2
Clinical service and training		
- Clinicians (.1 FTE)	5,000	5,000
- Local clinicians (1.5 FTE)	15,000	15,000
Logistics	15,000	15,000
- (Communications, transportation, supplies, accommodation, secretarial support)		
TOTAL:	**$35,000**	**$35,000**

3.7 Development of Learning Resources

	YR 1
Clinician preparation (.1 FTE)	5,000
Translation	5,000
Production	5,000
TOTAL:	**$15,000**

3.8 Clinical Education at Queen's

	YR 1
Clinicians (2 x 6 weeks)	
- Travel	3,000
- Accommodation	1,500
- Per diem	3,000

-	Translation and learning resources	6,500	
-	Clinical Service placements	1,000	
	TOTAL:	**$15,000**	
TOTAL :		**$445,000**	**$240,000**

SUMMARY

This proposal has included a budget which provides support to each of the areas identified. All areas are a high priority and it is difficult to choose one program over another. This proposal would address a number of high priority areas and will make a significant difference to the lives of many individuals who are dealing with disability under war conditions. This initiative builds and complements the current Queen's University initiatives in Bosnia-Herzegovina.

If the level of hostilities excludes entry to Sarajevo or other particular areas the project will continue in those areas in which humanitarian assistance is permissible. The projections by the WHO is that humanitarian assistance and rehabilitation for war victim will continue.

ammc:\wpwin60\wpdocs\files\proposal.fy

International Centre for the Advancement of Community Based Rehabilitation
A Canadian International Development Agency funded Centre of Excellence

Centre international pour l'avancement de la réadaptation à base communautaire
Un centre d'excellence subventionné par l'Agence canadienne de développement international

Queen's University Kingston, Ontario, Canada K7L 3N6 Telephone (613) 545-6881 Fax (613) 545-6882

August 12, 1997

Dr. Alfred Bader
662-924 East Juneau Avenue
Milwaukee, Wisconsin
532022

Dear Dr. Bader:

It is with great pleasure that I enclose with this note a copy of our most recent research project report: "Community Based Rehabilitation: A Peace Building Opportunity".

This research project grew out of a Symposium we held in Ottawa last September on the "Post Conflict Integration of Persons with Disabilities". As a result of the dialogue and discussion which transpired during the course of the Symposium, we were encouraged to submit a proposal to the John Holmes Fund which is managed by the Canadian Centre for Foreign Policy Development at the Department of Foreign Affairs.

We have discussed the main points of this report with officials at CIDA and the World Bank especially with reference to the development of CBR initiatives in southern Africa. In Angola and Mozambique, the issue of land mines and demobilized and disabled soldiers are enormous problems. In South Africa itself, there are opportunities which we are investigating this fall in collaboration with partner universities and NGOs. In KwaZulu Natal there continues to be severe inter-ethnic rivalry and we think CBR as part of a package of community health interventions may assist in building relations of trust and non-violent conflict resolutions skills into these communities as they embrace expanded civil and human rights.

Also of note is interest from the Canadian Department of Foreign Affairs' Japan Desk to include CBR as a possible area for Canada-Japan cooperation in non-military peacebuilding interventions. As you know, we have for some time been interested in developing programmes in Sri Lanka and Cambodia. Japan is interested in pursuing regional security via the ASEAN member states, leading us to think that we may benefit from a link with the Japanese government as well as Japanese partners in pursuing CBR project opportunities in south-east Asia.

This foreign policy paper would not have been possible without the financial support which you have so generously provided to Queen's and to the project activities of the ICACBR in Bosnia. Not only has this resulted in important concrete improvements in the quality of life for Bosnians, but we are also taking steps to assure that the experience and knowledge we have gained through these projects is transmitted to people and via fora which may be in a position to achieve similar results elsewhere.

We will continue to keep you informed regarding the evolution of these opportunities, and will assure that you are made aware of new programming initiatives as they take shape.

Thank you for your continued interest, collaboration and support.

Sincerely,

Malcolm Peat, PhD
Executive Director

c: Jane Whistler

COMMUNITY BASED REHABILITATION:
A PEACE BUILDING OPPORTUNITY

by

Malcolm Peat
Lorna Jean Edmonds
Will Boyce
Sandra Ballantyne
Jennifer Smith
Michael J. Koros

This foreign policy paper was researched and written by the International Centre for the Advancement of Community Based Rehabilitation (ICACBR) at Queen's University, Kingston. This research project was supported with a financial contribution from the John Holmes Fund of the Canadian Center for Foreign Policy Development at the Department of Foreign Affairs and International Trade (DFAIT), Planning Secretariat (CPD).

COMMUNITY BASED REHABILITATION:
A PEACE BUILDING OPPORTUNITY

by

Malcolm Peat
Lorna Jean Edmonds
Will Boyce
Sandra Ballantyne
Jennifer Smith
Michael J. Koros

This foreign policy paper was researched and written by the International Centre for the Advancement of Community Based Rehabilitation (ICACBR) at Queen's University, Kingston. This research project was supported with a financial contribution from the John Holmes Fund of the Canadian Center for Foreign Policy Development at the Department of Foreign Affairs and International Trade (DFAIT), Planning Secretariat (CPD).

COMMUNITY BASED REHABILITATION: A PEACE BUILDING OPPORTUNITY

Table Of Contents

Executive Summary

This research paper has been written with the objective of contributing to foreign policy consultations in Canada, especially in the area of peace building. We expect that it will be circulated to Department of Foreign Affairs bureaux, namely, the Global and Human Issues Bureau (AGD), in the Human Rights Division (AGH), in the Human Security Division (AGM), and Peace Building and Human Development (AGP). Officers in CIDA's humanitarian assistance division would benefit from this paper, as would other CIDA officers working in the social and health sectors in CIDA's geographical divisions. Health professionals in Canada will also derive value from the paper especially insofar as they are involved in disability issues or in the implementation of programmes of technical assistance and technology transfer. This paper should also contribute to the construction of the Peace Building Capacity Map being managed by the Peace Building Coordinating Committee and involving substantive contributions of Canadian NGOs.

Canada has significant expertise in the area of Community Based Rehabilitation (CBR) and disability issues more broadly. It is also an area which few other nations are pursuing with vigour through bilateral, multilateral or diplomatic channels. Sweden and Norway are active international advocates on disability issues, but have not systematically explored CBR in conflict zones or as a peace building opportunity. As an approach which develops and relies on non-violent conflict and dispute resolution skills, CBR merits serious consideration as part of Canadian peace building operations. For peace building through CBR to occur, foreign policy, and the policies and procedures which are employed to administer technical and emergency humanitarian assistance, need to be informed by an understanding of disability. Policy makers and managers in government, NGOs, and the peace building community need to know when CBR as an approach can make a difference.

As this paper addresses and expands upon the benefits of CBR as an element of the peace building process, an important implication is that emergency humanitarian, and development (technical) assistance efforts (by CIDA, IDRC, and other funding and implementing agencies), would also benefit from adopting community based perspectives on disability. Section 5 of this paper is particularly relevant in this regard. Canadian efforts in the field would then complement each other more readily, have greater overall impact, and be more visible, especially in war torn societies. Attention to the needs of persons with disabilities can be woven through each of CIDA's six programming priorities and by so doing, additional process benefits, especially to peace building, can be realized. In addition, a revision of CIDA's sectoral health strategy would benefit from explicit discussion of disability issues, especially since the basic human needs of persons with disabilities are effectively addressed through CBR.

Several key benefits result from the integration of disability issues and CBR into the peace building process in the manner we suggest:

1. The immediate impact of CBR intervention with a critical vulnerable group, whose *immediate*

human security is in jeopardy, is significant. This early humanitarian response demonstrates compassion and may be viewed as both *symbolic and tangible catharses* to warring factions, to donor agencies, and to civilian victims of conflict. Local visibility is achieved in the early stages of CBR intervention because local capacity and domestic resources must, by the very nature of the intervention, be employed to a significant degree. Furthermore, CBR can alleviate poverty in families in which a member is disabled, as well as minimize the social costs which accrue to long term disability.

2. The process of integrating a CBR focus on disability, which by definition attempts to transcend gender, cultural, social class, religious, and political divisions, contributes to de-legitimizing politics and conflict which draw their legitimacy from the exclusion of human beings on the basis of these characteristics. CBR, addressing an issue held in common, can *diminish perceived barriers between disparate groups*, thereby decreasing the legitimacy of exclusionist political rhetoric.

3. CBR, as one element of humanitarian intervention and multi-track peace building, diplomacy and conflict resolution, can provide examples of solutions to the difficulties which complex emergencies present in organizational and management terms. CBR promotes a *multi-sectoral approach to problems which require interaction and negotiations*. This example can alter the disposition of key local managers controlling the health and social service infrastructure, increasing their propensity to view local cooperative non-hierarchical action, as effective and worthwhile to support.

4. Conflict can create opportunities to re-establish the philosophy and basis for social service and economic reconstruction. CBR, due to its focus on both personal change and social adaptation through community based strategies, demonstrates *opportunities for health, social, and economic reform in a non-contentious arena*. This can create community capacity and awareness of the organizational forms and relationships required to address the interacting causes of poverty and disability. It can also heighten the expectation in local communities that they be consulted in the design of longer term social reconstruction and development projects.

Those who choose to wage war have only one remaining relation of interdependence, and that is the objective of mutual destruction, in a sense the very negation of that remaining relation. To achieve peace, this one relation of interdependence must be transformed into several positive relations of interdependence on the cultural, economic, social and productive planes. While a focus *only* on CBR is clearly insufficient on its own, it is a remarkably useful starting point. CBR addresses an extreme form of vulnerability. If public services and support can reach the most vulnerable in society, especially in difficult circumstances such as low intensity conflict (LIC), then processes, systems and relationships are established whereby less extreme vulnerability and its social impact may be addressed.

In cases where disability is the consequence of violent armed conflict, it becomes important psychologically for the traumatized society to perceive the actual human result of the conflict. A tangible and direct manner of doing this is to create the means whereby those who were

engaged in or affected by violent conflict as combatants or as civilians come to grips with the need to (re-) integrate a disabled person as part of the psychological healing of the population at large.

At the point of overt violent conflict, there are elements in society, in the polity, in the economy, and in the culture, which have become incapable of handling conflict in a peaceful non-violent manner. It is also possible, and indeed likely, that at the community level, the balance which existed to deal with conflict through peaceful means may be undermined. Civil war and conflict at the level of society in general or, as the case may be, between nations, destroys the trust upon which relations of interdependence have been constructed. It may be that some elements of these pre-conflict relations were extremely positive and beneficial to peaceful conflict resolution and mediation. What seems to be clear is that conflict presents an opportunity to re-found these relations of interdependence, and that CBR, because of its process nature and because of its focus on diversity and access to the means needed to lead a fulfilling life, is a very positive means of re-founding relations of interdependence on a basis which can promote and sustain peaceful conflict resolution and mediation.

Although Canadian foreign policy objectives include the projection of Canadian values, we must be very careful in how this is implemented in post-conflict situations. The imposition of alien values upon individuals struggling to regain their own identity, independence, and confidence, not only risks causing unintended harm by inhibiting authentic cultural identities, but is also difficult to accept on moral grounds. In building peace in post-conflict situations, we ought to be providing compromised groups with an opportunity to rediscover their identities and situate themselves in a context of peace, rather than imposing liberal values and alien identities upon them.

Furthermore, this opportunity for rediscovery of self is essential if any peace is to be lasting; the inhibition of self-rediscovery can be extremely deleterious. Compromised individuals cannot enter into the healthy, trusting relationships that are necessary for a society to build sustainable peace; peace building requires confident, self-assured individuals with secure identities, if it is to result in a lasting peace.

The impact of CBR will be enhanced as a peace building activity if it works in a complementary manner with other community based initiatives. For example, community based delivery of health services generally is something which can occur in a conflict zone and have a major influence on the reconstruction and further development of the health care sector, often with significant economic benefits. CBR is an excellent basis for this extension of community based service delivery because of its multi-disciplinary nature. More research is required about the benefits to peace building associated with various types of community level public health and social development interventions. These include water, sanitation, agriculture and income generating projects such as those which extend credit and appropriate technology. All of these types of projects do have community based approaches and this knowledge base needs to be tapped so that peace building as a process, and as a Canadian foreign policy initiative, is robust and multi-sectoral, drawing on the extensive experience of our development and humanitarian

assistance agencies.

We suggest that a paper of this nature would benefit from a follow-up Symposium. CIDA, DFAIT, IDRC, the IISD, Canadian think-tanks such as the Institute on Governance, Canadian development assistance NGOs, professional groups such as the Canadian Nurses Association, organizations such as Disabled Peoples' International, governments in such countries as Bosnia, Lebanon, Eritrea, Cambodia, and Mozambique, CBR policy makers in Palestine, multilateral agencies such as Unicef, UNDP, WHO and the ILO need to comment on the conclusions and recommendations of this paper so that a broad consensus not only emerges in Canada, but is also projected in the various international and multilateral fora in which Canada is, and Canadians are, engaged. This process of continued consultation is required to operationalize fully the policy recommendations of this paper via organizations and institutions which have the competence, skills, networks, and ongoing activities in post-conflict theatres, and in those areas of the world where peace building as a conflict prevention instrument can be beneficial.

1.0 Foreword

This foreign policy paper is the product of a three-month research and writing effort by a multi-disciplinary team assembled by the International Centre for the Advancement of Community Based Rehabilitation (ICACBR) at Queen's University. It grew out of the need, recognized at a Symposium hosted by ICACBR (Ottawa, September 1996), for a more thorough articulation of the benefits which may derive from foreign policy which integrates consideration of persons with disabilities in post-conflict situations. It has also become clear during the course of our research that recent efforts by the Canadian government to develop peace building policy would benefit from consideration of CBR perspectives and approaches.

This paper is part of ICACBR's continuing efforts, as a CIDA-funded Centre of Excellence, to develop, examine, apply and assess the effectiveness of CBR as a model and as an operational development instrument.

The research team was led by Dr Malcolm Peat (Executive Director, ICACBR), and included Lorna Jean Edmonds (ICACBR Administrative Officer), Professor William Boyce (ICACBR and Queen's School of Rehabilitation Therapy), Michael J. Koros (International Programmes Coordinator, Faculty of Health Sciences), Jennifer M. Smith (MA candidate in Philosophy, York University), and Sandra Ballantyne (MSc. candidate in the School of Rehabilitation Therapy, Queen's University).

The paper draws on the extensive experience of the team members who have worked in those parts of our world which have seen civil conflict in the past ten years. These countries include Afghanistan, Bosnia-Herzegovina, Cambodia, Croatia, Lebanon, Mozambique, Palestine (the

West Bank and Gaza), and Sri Lanka. In addition, the team members have worked for extended periods over several years in the following countries: Bangladesh, India, Indonesia, Myanmar, Nigeria, Nepal, Pakistan, Philippines, Thailand, Russia, and Zimbabwe.

There is a vast literature on the phenomenon of globalization and rapid technological change, and the challenges these pose to foreign policy, economic relations, and to the concept and practice of western liberal democracy. Many present-day conflicts can be traced to cold war alliances, and their accelerated breakdown as people seek to improve their economic opportunities, or, more negatively, to hold on to power. This macro-level discussion is a backdrop to the very specific issue of human disability, the incidence of which is significant especially in zones of the world experiencing low intensity conflict. This paper takes a critical look at the lack of consideration of disability issues in Canadian foreign policy and proposes a set of steps, informed by a community based perspective on disability, that can be taken to more readily achieve the foreign policy and peace building objectives of the Canadian government. In this sense, this paper is constructively critical and highly relevant to a human reality faced by millions of courageous individuals each day, in every corner of our world.

2.0 Methodology and Structure of the Discussion

In September 1996, the ICACBR sponsored a Symposium entitled "Post-Conflict Integration of Persons with Disabilities" (see Annex I). At the Symposium, it was recognized that approaching this subject as a foreign policy issue would be required in order to assure that those in a position to influence operations on the ground would understand and appreciate the benefits of a community based approach to rehabilitation of persons with disabilities. Accordingly, a proposal was submitted to the Canadian Centre for Foreign Policy Development (CFPD) and the John Holmes Fund. Mr Patrick Wittmann, Secretary of the Fund, encouraged the proposal because of the innovative direction it was promising, and the team was subsequently encouraged in the undertaking by Mr Steven Lee of the CFPD.

The team also benefitted from participation in the two Bosnia Roundtables held in 1996 (in April and October), the October 1996 Land Mines Conference, the January 1997 Winnipeg Victim Assistance Conference, and the 7 February 1997 consultations on peace building. Most recently, the 20 - 23 March 1997 "Lessons of Yugoslavia" conference, held at Innis College of the University of Toronto (organized by Science for Peace, and supported financially by the CFPD), provided the research team with an opportunity to informally test various elements of the discussion which follows. Over all, we are encouraged by the reaction to the approach suggested here and believe that it will build on other research endeavours being financially supported by the CFPD, filling a gap in current thinking on peace building issues.

The literature drawn upon for this paper is extensive. The bibliography is divided into two sections: disability issues, and development and humanitarian assistance issues.

Notwithstanding the academic composition of the team, an editorial effort has been made to express concepts in terms which are accessible to foreign policy analysts and to development, technical and humanitarian assistance officers in government and NGOs.

Structure of the Discussion

This paper will proceed with the following plan. In the next section (3), the ICACBR's involvement in the post conflict integration of persons with disability in Bosnia is summarized. Innovations in CBR can be developed in response to the extreme conditions war and Bosnia is a case in point. Success in implementing CBR in Bosnia was first achieved under emergency humanitarian operations, and later as part of technical assistance and reconstruction efforts. The peace building outcomes become discernable in this discussion, but become even more evident as the reader proceeds through section 4.

With the Bosnian experience as a specific case in point, section 4 sets forward the thesis of this paper. The current context of foreign policy development in Canada is summarized, and elements of current global foreign policy which relate to conflict and are relevant to this paper are highlighted. Section 4 also discusses issues of conflict in some depth as well as pointing out some limitations to international humanitarian law and UN intervention in this area.

Section 5 focuses on the nature and scope of disability issues in conflict situations and sets forward the key features of community based approaches in this area as well as issues and caveats drawn from ICACBR's experience in the more conventional 'development' environment. The ethical and moral foundations of these issues are also discussed.

Section 6 is summary in nature, drawing together elements of the discussion in sections 3, 4, and 5. Constraints to CBR management and implementation are summarized, followed by a set of policy principles. Finally, the key benefits of CBR as a peace building approach, and as such to Canadian foreign policy, are summarized, and a set of implementation modalities are suggested to effectively capture these benefits.

Finally, section 7 identifies the significant expertise resident in Canada which could be mobilized to integrate the community disability and rehabilitation perspective in efforts to achieve Canadian foreign policy objectives.

Throughout the paper, we employ 'Text Boxes' to provide further information on, or evidence for, statements made in the body of the text. These Boxes allow the reader to proceed through the entire discussion relatively quickly, and to return for evidence and a complete appreciation of the conclusions and recommendations, especially in relation to Canadian foreign policy objectives.

3.0 Origins of a Foreign Policy Issue: War in Bosnia

The ICACBR was invited by the Department of Foreign Affairs and International Trade (DFAIT) to visit Sarajevo in October of 1993,[1] during a period of intense hostilities which devastated the environment and traumatized the population. Damage and disruption were extensive: hospital buildings had been almost destroyed, health care personnel were diminished in numbers, standards for service were drastically reduced, and essential services and utilities including electricity and water were either absent, or severely limited. In addition to the direct destruction of infrastructure by bombing and shelling, there were secondary effects of war, such as the reduction in the numbers of trained personnel and resources for maintenance and repair. In sum, the war rendered the health system, as it was, ineffective.

Destruction of Infrastructure

The destruction of infrastructure was one of the principal causes of poor health in the general population. Bombing, shelling, sniper firing and the burning of institutions, work places, schools, shops, restaurants, and homes all had a profound effect. One source calculates that 60% of houses in BiH, half of the schools, and one third of the hospitals were destroyed (Vesilind 1996). The BiH Institute of Public Health recorded major damage to electrical systems, coal mines, railways, vehicles, bridges, and to postal and telecommunication resources.[2] Fifty percent of the road network, or about 21,000 kilometres of road were ruined. The post-war declines in economic activity was a direct result of the destruction of industry by war which accounted for 52.6% of the gross national product in 1990 (BiH 1996).

The environment suffered increased toxicity due to war from the increased usage of vehicles of war, artillery and landmines deposited in the soil. Fires in cities and the countryside following shelling added to other pollutants. The rodent population increased because of exposed garbage and sewage, the lack of resources for pest control and the simple physical danger of circulating in open areas to address such issues. Rodent infestations, contaminated water, pollution of streets, destruction of health facilities and living quarters are all factors which diminish environmental hygiene and contribute to a general decline in health status.

Destruction of Dwellings

One of the greatest disruptions to the general population was the loss of their homes. Many civilians were targeted in their residences in order to completely disassemble their lives. The loss of homes created staggering numbers of displaced persons who first sought refuge in collective camps or in the remaining homes of family and friends. Refugees and displaced

[1] At that time, the decision to move the programmes assisting Eastern Europe and the former Soviet Republics from DFAIT to CIDA had not yet been implemented.

[2] The estimate of damage done to the railways is almost US$1,000,000,000; damage done to road traffic was US$2,500,000,000

persons in collective camps or communes suffered much graver conditions. Overcrowding and poor sanitary conditions in these camps led to infections and disease.

Destruction of Health Sector Infrastructure

According to the BiH Institute for Public Health, about 65% of health care organizations in BiH were destroyed (Smajkic 1994). Of approximately 80 'ambulanta' clinics that operated before the war in BiH, only 47 remained. Of the 38 Dom Zdravljas (houses of health) that were present before the war, 7 were totally destroyed. In partial compensation for the losses, 23 war hospitals have been established since 1992; many of them converted Dom Zdravljas (BiH 1996). The BiH Ministry of Health also recorded that there has been a loss of about 35% of available hospital beds. With only half the pre-war number of hospital beds available, there are only three hospital beds per 1000 people. Numbers of psychiatric beds were at 15-20% of the pre-war levels in some areas. It was reported that 38 of 42 ambulances that served Sarajevo were either destroyed outright or seized (Brady et al. 1993). The destruction communication infrastructure, medical schools and libraries, and transportation vehicles have also had a detrimental effect on health service delivery. The health sector did not function properly or well, lacking as it did the means to transport supplies, and to move patients and health care workers on field visits or between institutions.

Before the war, health care expenditure was approximately 6.5 % of GDP. As more peaceful conditions were restored, health care received 1.25% of GDP. Apart from the destruction of health facilities, economic decline caused many institutions to shut down for lack of operating funds. During the winter of 1993-1994, inflation reduced the value of the Yugoslav currency (dinar) to the point where the health care system and public services in general were compromised. Even when medical supplies were available, institutions often could not afford them (Luhan 1995, 35).

Post-war Profile of Health Care Personnel

Among the many civilians that were killed or debilitated by military attack, many were health care workers. Many migrated or left their positions to seek refuge from the hostilities. Others left their jobs due to the declining purchasing power of their wages. Financial hardship caused great strain on the availability of health care workers, as salaries and pensions became worthless, while living costs increased and better paying jobs could be found outside of the health care system. This resulted in a 20-30% drop in the number of the health care staff in Yugoslavia, according to the WHO (Luhan 1995).

In the middle of 1994, the BiH Public Health Institute estimated that there were 21,440 practicing health care workers, only 79% of the pre-war number. The number of medical specialists who left Sarajevo was 39%; Zenica: 30%; Tuzla: 19%. In February 1996, the BiH Ministry of Health estimated that 15,000 active staff were left in the health sector. This represented almost a 40% drop in total staff, with a 35% drop in the number of nurses. The departure of some general practitioners opened the way for other qualified, but previously unemployed physicians, to enter the system; however, a serious shortage in nursing staff and other health care staff continued.

Health Sector Supplies and Services During the War

Without the emergency humanitarian assistance of international organizations, bilateral donors, and NGOs, the provision of even minimal community services and supplies during the war would have been impossible. Throughout the war, hospitals, rehabilitation centres and other facilities had inadequate equipment for diagnosis and treatment. It is estimated that three quarters of the equipment currently available in BiH is either out of date or damaged beyond repair (BiH 1996).

Most laboratories were not functioning and hospitals lacked testing facilities for viruses such as HIV and hepatitis. Disease prevention programs also deteriorated, causing increased incidence of conditions that would have been controlled under normal conditions. In 1993, less than 35% of children in BiH were immunized whereas over 95% were immunized before the war (Horton 1994). The availability of drugs for treatment was also a problem during the war. The BiH Ministry of Health reported in February 1996 that only 8% of the demand for pharmaceuticals was being met (BiH 1996), which represents a reduction of 72% from the pre-war provision of drugs.

Although there was very little water in general, it was even more difficult to obtain clean water. There was no sewage management, and because solid waste collection and disposal virtually ceased, dumping sites in urban and rural areas proliferated. The impact on the water supply was detrimental in the extreme, particularly in Sarajevo. There, water supply was largely dependent on electrical supply and these were controlled by military leaders and subject to their control. Electrical supply was, therefore, dependent on changing political / military priorities and was therefore unreliable. Most families in the city treated their water for contamination (57% always and 10% more than half of the time) while 33% did not treat their water at all. Again, both the lack of money and the lack of purification means were the cause.

Drastic decreases in energy supply contributed to the destruction of infrastructure and to the decline in services. Over DM 800 million (approximately C$ 800 million) damage was done to electricity distribution networks, electric power plants, gas pipelines, coal mines, and saw mills (Smajkic 1994). Besides destroying the energy sources which supplied cities, the ability to reduce or completely cut off power supplies was used for strategic / military objectives. BiH had an average 50% cut in electricity throughout the war.

Gasoline supplies were also reduced, and coal, wood and oil were supplied only 10% of the time. Diesel fuel was a critical supply that cost US$ 36 per gallon in August 1993 (Atlanta 1994). The lack of diesel fuel, which was used to run water pumps, resulted in reduced water pressure and subsequent cross-contamination of sewage in drinking and washing water. In hospitals, this meant that surgery was performed without sterilization equipment or water (Horton 1994).

The most significant impact of the lack of energy on the general population was the loss of heating in homes. Areas of Former Yugoslavia reach very high altitudes and winter temperatures are well below freezing. The lack of heating affected all buildings, including

hospitals, where staff worked in coats and families brought in electric heaters for patients (Luhan 1995).

Post War Health Status

The principal medical problems suffered by the population were the direct result of war, such as injury and disability, and abuse in concentration camps. Secondary to these are medical problems that result from long term hostilities such as infectious disease, malnutrition, pregnancy complications and psychological instabilities due to trauma.

Determining the exact numbers of individuals who were killed, injured and displaced due to war is very difficult and the statistical data gathered during the war varies for several reasons. The principal source of variability in this data is mass migration and continuous relocation which made the collection of numerical data almost impossible. Also, data on factors affecting the general population were often collected from people in refugee camps and were not always representative of the entire population. Secondly, the method and selection of population pools used by groups and organizations to gather information yielded data that was sometimes inaccurate, and often distorted or produced to serve a purpose. Statistics collected by the different factions almost always differed.

Examples of general health problems suffered by children in refugee camps included anaemia, bronchitis, sun-stroke, pediculosis, and problems created by the under-nourishment. Adults suffered from psychological disorders, chronic rheumatic disorders, chronic cardiovascular disease, hypertension, stomach ulcers, gastritis and genito-urinary tract disorders. Diseases associated with rodents, and an outbreak of leptospirosis were also reported in the general population in internment camps.

Death, Disease, and Disablement Due to War

Bosnian government data on mortality rates differ significantly from other sources, such as international organizations. The US government estimated that 17,000 people had been killed in Bosnia - Herzegovina up until 1993, yet the Bosnian government estimated the figure to be over 150,000 (Brady et al. 1993). Although it is acknowledged that variations in information exist, the data presented in this paper were collected from sources who remained in Yugoslavia for long periods of time during the war.

<u>Mortality Statistics for the General Population</u>

The WHO recorded the death rate due to war from 1991-1994 at 200,000. It was also reported that the war left 400,000 people wounded, and 40,000 disabled and almost 3,700,000 displaced. The national death rate increased 400% in Yugoslavia from 1989 to 1994 (Horton 1994).

The government of Bosnia - Herzegovina estimates that 200,000 people were killed, 240,000 wounded, and 850,000 were displaced (BiH 1996). Croatian sources have recorded that since July 1991, 7,941 people had been killed, 28,734 wounded, and 2,764 were missing (Henigsberg et al. 1994). In December of 1993, the mortality rate in Former Yugoslavia had doubled, to an

average of 8 deaths per day. It was calculated that 68% of all deaths were directly attributable to the violence of war. Of course, many of these deaths were civilians.

Mortality, Injury and Displacement of Children in BiH

The mortality rate for children under five years of age was 20 per 1,000 in 1991, rising to 46 per 1,000 in 1992. Nearly 17,000 children died and 40, 000 were wounded in BiH throughout the period of the war. Of the 850,000 persons displaced by war within Bosnia, 40% were children.

The Elderly Population in BiH

The elderly population of BiH was particularly vulnerable during the time of the conflict, as they tended to remain in the war zones. Elderly persons were more inclined to remain stationary during the war for three reasons. The elderly were less likely than younger people to leave familiar places as they are sometimes less adaptable to new surroundings and culture. Also, escaping a war area usually requires a certain degree of stamina, strength and mobility for journeys beyond the capacities of the elderly. Many elderly people were simply abandoned.

Morbidity Rates in BiH

Yugoslavia received substantial amounts of aid from hundreds of organizations around the world. This assistance can be credited, in part, with lowering the incidence of infectious disease throughout the war. Lower rates of infectious disease in Bosnia than in other countries where civil wars have occurred recently may be attributed to: diseases being incompletely reported; displaced persons residing in private homes and therefore unaccessible to health recorders; the effectiveness of those parts of the local public health system which were still working; the amount of public health aid from NGOs effectively supplemented local programs; and, a well educated and resourceful population maintained high standards of personal hygiene (Atlanta 1994).

Epidemiological reporting was relatively regular from Sarajevo, Tuzla, and Zenica, yet was infrequent from Gorazde, Bihac and East Mostar. Although no epidemic occurred, there have been reports of a wide variety of poor health conditions that were induced by the harsh conditions of war. The average rate of morbidity from infectious diseases in BiH doubled from 1,481 cases per 100,000 people (1987 to 1991), to 2,883 cases per 100,000 people (1992 to 1994) (Smajkic 1994). Almost two thirds of all diseases reported in Yugoslavia during 1993 (the worst year in terms of the war-related conditions discussed), were enteric (Luhan 1995). The main cause of theses diseases was poor water quality: water often could not even be boiled due to lack of affordable energy.

Another large increase in incidence was recorded in parasitic diseases, which rose from 36 cases per 100,000 people before the war, to 793 cases per 100,000 people after the war . The few diseases where there was no increase in incidence were still a problem, as they became much more difficult to treat. The leading infectious disease was scabies with 16,680 reported cases in BiH during the war (Smajkic 1994).

Increased rates of diarrhea and hepatitis rates from 1990-1993 were attributed to fecal

contamination of water supplies (Atlanta 1994). A source reported that hepatitis A was twenty times higher than pre-war levels, and that over 2,700 cases of dysentery were recorded from June to September 1993 (Horton 1994). The diarrhoeal rates were highest in July and August according to a Médecins Sans Frontières survey of Sarajevo in 1993. Although higher rates were often common in children under 5 years of age, the rates were extremely high for an adult population. Since many hospitals lacked the capacity to test blood for HIV and hepatitis viruses, the incidence of these diseases was not monitored.

Vaccine preventable diseases also increased in numbers as immunization was a low priority during the war. The limited occurrence of vaccine preventable diseases in BiH may have reflected the high vaccination rates before the war (Atlanta 1994). Although there was not a significant increase in the incidences of vaccine-preventable diseases during the war, there was an increase in the number of cases of rubella and pertussis in 1994.

The prevalence of tuberculosis in Yugoslavia was always high compared to other western European countries. It had, however, been steadily declining during the years before the war (Luhan 1995). Tuberculosis became a significant problem during the war with the incidence of newly diagnosed cases in 1993 rising to four times pre-war levels (Brady et al. 1993). The WHO estimated in 1994 that there were 50 cases per 100,000 population, and about 12,000 newly diagnosed tuberculosis patients each year (Luhan 1995). The mass migration of people during the war spread the disease to large numbers of younger people who tended to reach more advanced stages of the disease more quickly. In January, 1994, treatment centres in Croatia, BiH and Serbia were unable to manage the 11,000 patients requiring treatment.

Rodent associated diseases were another threat to health during the war. Three hundred and sixty seven cases of hemorrhagic fever with renal syndrome (HFRS) were reported to the Ministry of Health of BiH from January to November 1995 with at least 5 deaths. Increased rodent populations in urban areas also caused an increase in the incidence of other diseases, such as leptospirosis (WHO 1996).

Disablement Due to the War

As can be imagined from the foregoing description of health and health care challenges faced by the people of Former Yugoslavia, war conditions led to an overwhelming need for acute care and rehabilitation services. The war wounded of Former Yugoslavia have a number of temporary and permanent disabilities. During war, the priority of health care services was to prevent death and maintain individuals in a stable condition. Post-conflict health services move toward the rehabilitation of war victims. The following definitions distinguish between impairments, disabilities and handicaps as categories of disablement related to areas of conflict (Boyce and Weera 1997):

> Impairments may include peripheral nerve injuries caused by bullet and/or shrapnel wounds; hand, foot, facial injuries and blindness caused by explosions or torture; and head, chest and orthopaedic injuries caused by explosions or by the collapse of buildings. After the cessation of hostilities, civilians may continue to suffer impairments such as amputations and

blindness caused by landmines.

Disabilities may include being weak, unable to see or protect oneself during an armed attack. Depending on the circumstances, disabilities may include problems related to the inability to respond quickly to curfew or to address activities of daily living and self care. Persons with impairments, the elderly and displaced persons are particularly vulnerable to disability.

Handicaps include not being able to safely earn a living, or stigmatization that might result from being perceived as a disabled veteran. Handicaps are overcome by increasing accessibility and the opportunities to live independently, public education, income generation projects, and peer support programs.

War Related Injuries

In Bosnia, the most common type of war related injuries are fractures causing severe movement disabilities, peripheral nerve injures and amputations. The main causes of injuries were grenades, landmines, bullets, mortar shells and bombs. Amputations were required to address injuries from landmines. Spinal cord injuries mostly resulted from mortar shells and bullets. Cranio-cerebral injuries were mostly from mortar shells, and peripheral nerve injuries and fractures were mostly caused by bullets.

From 61 municipalities in BiH in 1996, the Institute of Public Health in Sarajevo calculated that the current count was 175,258 wounded (including 34,712 children) and 76,624 seriously wounded in need of hospital treatment (WHO 1996). National health officials in Bosnia report that 80,000 persons were seriously disabled due to injury, of whom 20% were children (Smucker 1996). In Serb controlled areas of BiH, two thirds of hospital admissions were for war-related injuries. The statistics on the number and types and location of severe injuries shows that of the 17,929 severely wounded in BiH, 25% were open wounds and fractures of the lower limbs, 23% were injuries to the thoracic cage, abdomen, and pelvis, 14% open wounds and fractures of upper limbs, and the remainder in various categories including one limb amputations, skull and neck injuries, and intracranial injuries (Smajkic 1994, 42).

The Office for the Victims of War in Croatia recorded a total of 14,574 disabled individuals up to February 1994 (Croatia 1995). Of the 6,660 victims who had been wounded in captivity, 21% had disabilities with serious body impairments, 33% were disabled, and 46% were wounded but not disabled. A report of the Rehabilitation Information System of Croatia recommended rehabilitation for 6,472, or nearly 70% of patients. Amputations, spinal cord injuries and traumatic brain injuries were the priority groups which represented 1,639, or approximately 25% of the total number. The largest single category of disability was fractures causing permanent loss of mobility (2,555 persons) and the second largest category was peripheral nerve injuries (985 persons). Statistics reported that 75% of landmine survivors needed amputations.

Mental Health and the Effects of War

Civilians were bombed in their work places, shops, restaurants and their own homes. In cities such as Sarajevo and Zagreb, military attacks were designed to inflict immediate death or debilitating injury on the civilian population. Mental health is in fact the largest problem affecting war victims, more so than physical problems.

Those most vulnerable to psychological illness include children, displaced persons, disabled people, war veterans, the elderly, pregnant women, psychiatric patients, and socially alienated young people. It has not possible to determine precise statistics psycho-social problems since assessment of disorders is very time consuming. Therefore, the research-based assumption is that all refugees, displaced persons and inhabitants of war zones have experienced at least one traumatic event and of these people, an estimated 20%, urgently need professional help (Luhan 1995). Typically, during peacetime, one tenth of the population is said to experience a traumatic event, of whom 10% need professional help (Luhan 1995, 32). The number of persons requiring psycho social care in the Former Yugoslavia is, potentially, a severe drain on limited resources (Box 1).

ASSESSING THE MENTAL HEALTH PROBLEM:

Assumptions

Peace: 10 % of the population has a major traumatic event each year, of whom 10% need professional help (1% of total population).

War: Everyone in a war zone and all refugees and displaced persons have at least one major traumatic event each, of whom 20% need professional help.

War: People continue to have non-war related traumas.

ASSESSING THE MENTAL HEALTH PROBLEMS:

Calculations

a) Nonwar-affected population of former Yugoslavia	18,320,000
b) Nonwar- related trauma victims	1,832,000
c) Nonwar-related trauma victims needing help	183,200
d) Refugees, displaced and people living in war zones	3,980,000
e) Severe war trauma victims	796,000
TOTAL NUMBER OF PEOPLE IN NEED OF PROFESSIONAL HELP	**979,200**

(from Luhan 1995, p. 33)

Box 1

Impact of Conflict on Vulnerable Groups

In a zone of low intensity conflict (e.g., parts of but by no means all of Former Yugoslavia), a specific form of conflict prevalent in the world today and discussed below in detail, the needs of disabled elderly persons, the very young, refugees and migrating / internally displaced and homeless persons are similar. Negative attitudes, cultural restrictions, and ignorance disadvantage disabled women, children, and the elderly, commonly putting them last in line for food and medicine, and leaving them behind when the community is fleeing conflict (Rehabilitation International/UNICEF 1991; Godfrey and Kalache 1989). We have observed that many agencies delivering humanitarian assistance lack an awareness of the disadvantages which disabled persons face in accessing emergency relief. Furthermore, most shipments of humanitarian relief supplies contain limited basic rehabilitation supplies or equipment. It is

evident that under such circumstances, there are few opportunities for war-injured or other disabled persons to earn income.

Conflict and Disability in Children

Conflict causes disability in children through poverty (malnutrition, micro-nutrient deficiencies), social disruption and lack of parental supervision, disruption of preventive (immunization, accident prevention, malaria control) and curative health care, direct injuries, inability to escape conflict, abandonment and risk of abuse, and maternal childbirth problems. The incidence of impairment among children may rise during conflicts, but the overall prevalence may actually fall due to an increased death rate. For example, children are more likely to die or have severe injuries from landmine explosions due to their size and unawareness of landmine zones.

Post Traumatic Stress Disorder (PTSD), which is extremely debilitating, may not be the most common type of psychological disorder in children. In fact, functional psychosomatic problems may be more severe. Chronic stressors such as lack of food and unresolved bereavement are important among children in zones of LIC. Certainly, the severity of psychological distress depends on the degree of immediate threat (perceived or real), the intensity of exposure to violence to oneself or one's family, the extent of bereavement and loss, and the availability of familiar protective adults (Richman 1995).

Conflict and Disability in Women

Women are affected by conflict-related disability in multiple ways. Women are sometimes injured as combatants, but more often as support personnel. Civilian disabled women become particularly susceptible to discrimination in the provision of emergency services and are at high risk for further sexual and physical assault, both by enemy as well as 'friendly' forces. Injured women often must support the remaining family members or risk total family disintegration. Furthermore, social support organizations often do not respond to disabled women. Neither women's organizations nor disabled people's organizations are known to include them readily.

Women also have significant roles as care givers for other disabled family members. Eighty percent of all care givers for disabled persons are women, and this figure is probably higher during war (Eade and Williams 1995). Expecting women to assume community based program responsibilities may be an extra burden since they have little time available for training. Furthermore, since they earn lower incomes, female-headed households may have little money available for rehabilitation equipment.

Conflict and Disability in Elderly Persons

Common impairments of old age (hearing, vision and memory loss, arthritis, hypertension, diabetes, osteoporosis, depression) which restrict mobility and communication put elderly persons at increased risk during war. In addition, older persons may suffer from occupational hazards during displacement, such as respiratory and vision problems caused by poorly ventilated cooking facilities.

Conflict and Disability in Refugees/Displaced Persons

Refugees' greatest conflict-related difficulties, in addition to the obvious impairments caused by exposure to war, arise from secondary problems caused by lack of access to rehabilitation and other health and social services. Rehabilitation initiatives for refugees, if any, have tended to focus on emergency or crisis service which is largely medical in nature (surgery, medications, prostheses). Little attention has been given to vocational training, income generation, psychological assistance, and school integration. Generations of learned helplessness among disabled refugees has been the result.

Conflict and Persons with Existing Disabilities

It must not be forgotten that in any community there is a population already living with disabilities whose needs have often been ignored. In situations of violence, this group suffers conditions of poverty, despair, inaccessible physical surroundings, and infrastructure and community breakdown. Facilities, which are often of marginal adequacy to begin with, are taxed beyond the ability to cope (WHO Expert Committee 1981; UNICEF 1986a; Physicians for Human Rights 1988). In post-war economies, there are often few employment opportunities or retraining options. Previously disabled persons may be seen as extra burdens who do not have the status of returning war heroes. In the context of economic stress, family breakdown and social dislocation, it is not surprising that disabled persons are also at greater risk of domestic violence and child abuse (Rehabilitation International/UNICEF 1991).

Conflict and mental health in ex-combatants

There is a need to address psycho-social issues in situations of conflict. Studies of the conditions of violence must include a consideration of the psycho-social and structural influences on the perpetrators of violence, particularly soldiers and anti-government forces' personnel. While formalized conflict often occurs between these combatants and has a variety of psycho-social implications, strategic and unplanned informal violence is increasingly affecting civilians, including the families of combatants. Beyond documenting these serious post-traumatic stress and physical health problems among civilians, there may be significant value in addressing the psychological states of combatants who have participated in these actions. In particular, the peaceful demobilization and reintegration of ex-combatants may depend on the successful implementation of programs aimed at alleviating their psychological stress, guilt, and anger. Physically and mentally disabled ex-combatants may also require specific psycho-social programs which address changes in their family and community roles.

An action research agenda to address these issues must:

a) attempt to understand the dynamics of combatant participation in violence towards civilians;
b) investigate psycho-social trauma in ex-combatants; and,
c) document the psycho-social adaptation of ex-combatants with significant disabilities.

Summary

In summary, dimensions of vulnerability are present in all settings, including war. To effectively implement, or as the case may require, reconstruct, community based services which alleviate the poverty and insecurity of persons with disabilities, sensitivity to these dimensions is required. As will be discussed much later in this paper (section 5) several lessons need to kept

in mind. Perhaps most important among these: when an intervention concentrates on a specific category of people, the wider context needs to be considered in order not to exacerbate social divisions already present (Eade and Williams 1995).

CBR Implementation: The BiH Health and Social System

The overwhelming numbers of persons with disabilities in Sarajevo and other parts of the Federation made rehabilitation a priority for the governments of the Federation, its cantons, and regions. In past complex emergencies, rehabilitation has not been considered as a necessary part of humanitarian response. The siege of Sarajevo in particular has demonstrated both the need for CBR as well as its value. Communities within Sarajevo were isolated and people were not physically able to get to the health services that remained. CBR was able, in contrast, to provide the essential rehabilitation services for persons with disabilities, focusing primarily on the needs of disabled war victims. This strategy has facilitated the (re)integration of war-injured and disabled persons into economically productive activities and normal social life. CBR was aimed at reducing the burden of physical and psychological disabilities through specifically targeted and cost-effective rehabilitation services.

In 1993, the Ministry of Health for the Federation of Bosnia-Herzegovina identified the following gaps in the provision of rehabilitation services: lack of professional staff at all levels; lack of physical and occupational therapy; lack of adequate or appropriate equipment; absence of information systems and a coordinating body; and finally, a lack of understanding of the importance of rehabilitation in the community, as part of the primary health care sector.

The reform plan of the Ministry of Health envisaged the administration and responsibility for health care in the jurisdiction of the regions or cantons. National insurance schemes would finance health care, but the cantons would be responsible for the management of human and physical resources, with the Public Health Institute providing overall policy direction.

The balance of power among the political entities, and their differing political agendas had the potential to influence the outcome of the CBR initiative or bog down reforms necessary for its development. Following the war, the Ministry of Health (Federation of BiH) continues to be vulnerable to split political agendas of the two main groups known as the "Bosnian Muslims" and the "Bosnian Croats". Health authorities and the international community, particularly Canada through ICACBR and WHO, worked together to develop a strategy for both conflict and post-conflict periods that was workable, inexpensive, accessible and responsive to the critical needs. The assistance included theoretical and concrete elements, education and equipment, funding and expertise, to establish CBR services that were often incorporated into the primary health care system. The extent to which all the stakeholders were able to marshal resources and coordinate CBR development during war was linked to mobility and communications. When a more comprehensive cease fire had been achieved, the development of CBR and of community services was greatly accelerated.

Disability and Community: The BiH Experience in CBR

The severe destruction of the health care system in Bosnia together with the large numbers of disabled strongly suggested the need for a strategy based in the community. In 1993, the BiH

authorities requested external assistance in developing a program which would address the needs of war wounded and vulnerable populations, particularly the elderly and children. The lack of professional staff, rehabilitation services, equipment, information systems, and a coordinating body together with an increasing need significantly raised the profile of disability issues. At the request of the BiH Government, a Canadian team selected by the Department of Foreign Affairs went to the Former Yugoslavia in 1993 to identify specific projects that could augment Canadian support to the UNPROFOR Mission and other UN operations in this specific area of public health and humanitarian assistance.

As a result, a team from ICACBR, Queen's University, with Government of Canada support initiated the implementation of four CBR Centres in Sarajevo. This initiative effectively demonstrated the value of community programs in meeting the needs of the disabled population, their families and communities, and did so under conditions of war.

The success of this approach resulted in a wider project which brought community rehabilitation programs to other regions in BiH. This Canadian initiative was instrumental in promoting a broad multi-sectoral interest and commitment to CBR, integrating CBR within the primary health and social services sector. A major success was the demonstration that community programs could provide immediate relief and support for disabled persons under such difficult circumstances. The critical needs of the disabled were highlighted and population at large saw the value of addressing disability needs as a priority, and not deferring attention to this civilian impact of conflict to a later time.

CBR was an effective strategy in mobilizing the community around a pressing issue and one over which they could exert their own influence and control. The concept of community ownership in CBR is one of its greatest strengths and a factor in strengthening and supporting a fragile society. Implementing CBR had a major effect on morale and was seen as a simple, practical, responsive and flexible strategy addressing a major health and social need.

Following the Dayton Agreement in 1996 the Government of BiH, in conjunction with the World Bank, reviewed options regarding the (re)development and reconstruction of health and social programs. The success of the Canadian sponsored initiative in the implementation of CBR during the conflict resulted in CBR being identified as the core element in the Post War Reconstruction of Rehabilitation Services support by the World Bank.

The post-conflict development of health and social policy in the Federation has the advantage of building on the success of CBR. It is also a strategy which was of equal interest to the political and ethnic entities and was one element on which all parties could agree. Community involvement, participation by persons with disabilities and the promotion of independent living as opposed to institutional segregation was a powerful tool in creating a stable civil society.

The success of this initiative at the operational level in Bosnia-Herzegovina was of significant interest to agencies and bilateral donor governments involved in development and reconstruction. This has enhanced Canada's reputation and influence in the essential evolution

of practical and cost-effective peace building strategies.

In sum, this foreign policy research paper derives from the ICACBR/Queen's experience and success at the operational level in Bosnia in particular, drawing also upon experiences in several other countries. This impact has been possible due, at least in part, to the reputation and influence which Canada has abroad. This paper contends that further consideration of CBR as a peace building opportunity can make important contributions to CIDA's programme of development and humanitarian assistance and to the three key objectives of Canadian foreign policy.

We are of the opinion that this is an urgent issue because of the terrible forms which conflict and warfare have taken. Low intensity conflict (LIC) has in effect replaced conventional warfare. LIC (which will be described further below) is especially nefarious due to the terror it inflicts upon civilians. The siege of Sarajevo and the impact of the war in Bosnia on civilians, as an extreme case in point, has been described above. This discussion will elucidate the benefits of focusing, through policy and operations, on those vulnerable persons physically disabled during LICs.

4.0 Thesis: Community Based Rehabilitation & Canadian Foreign Policy Objectives

Government of Canada
Foreign Policy Objectives

The Government is committed to pursuing a foreign policy which will achieve three key objectives:

The promotion of prosperity and employment;
The protection of our security, within a stable global framework; and,
The projection of Canadian values and culture.

Source: Canada. *Canada in the World.* Ottawa: Queen's Printer, 1995. p. i.

Box 2

Community Based Rehabilitation (CBR) offers significant benefits to Canadian foreign policy objectives, especially to the protection of national security within a stable global framework, and this principally via the important contributions CBR can make to the effectiveness and impact of Canadian peace building activities.

As a peace building approach and process, CBR projects Canadian values and culture on social justice, equity and multicultural issues. CBR also employs Canadian capacity and expertise and contributes to the promotion of Canadian prosperity and employment.

Community Based Rehabilitation - A Definition

Community based rehabilitation (CBR) is a response, in both developed and developing countries, to the need for adequate and appropriate rehabilitation services, to be available to a greater proportion of the disabled population. Its aims are to rehabilitate and train disabled individuals, as well as to find ways to integrate them into their communities. In CBR, the disabled person, the family, the community, and health professionals collaborate to provide needed services in a non-institutional setting, and in an environment or community where services for disabled persons are seriously limited or totally absent. Its essential feature is its focus on partnership and community participation. Approaches to the implementation of CBR are many and are determined by a variety of social and demographic factors. Introducing rehabilitation services at a local or community level removes many obstacles to care which are associated with institutions. The difficulty of travel and its expense are eliminated or reduced to a minimum. The individual is not isolated from the community; family members and community volunteers are part of the rehabilitative process. All participants can see what the disabled person has achieved. This can help integrate the person into the community, a community which values the unique contribution which the person is able to make.

Source: "CBR: Development and Structure", Dr Malcolm Peat, in CBR: International Perspectives, School of Rehabilitation Therapy / ICACBR, Queen's University (1991).

Box 3

Principal Benefits of CBR to Peace Building

Several key benefits result from the integration of disability issues and CBR into the peace building process in the manner we suggest:

1. The immediate impact of CBR intervention with a critical vulnerable group, whose *immediate human security* is in jeopardy, is significant. This early humanitarian response demonstrates compassion and may be viewed as both *symbolic and tangible catharses* to warring factions, to donor agencies, and to civilian victims of conflict. Local visibility is achieved in the early stages of CBR intervention because local capacity and domestic resources must, by the very nature of the intervention, be employed to a significant degree. Furthermore, CBR can alleviate poverty in families in which a member is disabled, as well as minimize the social costs which accrue to long term disability.

2. The process of integrating a CBR focus on disability, which by definition attempts to transcend gender, cultural, social class, religious, and political divisions, contributes to de-legitimizing politics and conflict which draw their legitimacy from the exclusion of human beings on the basis of these characteristics. CBR, addressing an issue held in common, can *diminish perceived barriers between disparate groups*, thereby decreasing the legitimacy of exclusionist political rhetoric.

3. CBR, as one element of humanitarian intervention and multi-track peace building, diplomacy and conflict resolution, can provide examples of solutions to the difficulties which complex emergencies present in organizational and management terms. CBR promotes a *multi-sectoral approach to problems which require interaction and negotiations.* This example can alter the disposition of key local managers controlling the health and social service infrastructure, increasing their propensity to view local cooperative non-hierarchical action, as effective and worthwhile to support.

4. Conflict can create opportunities to re-establish the philosophy and basis for social service and economic reconstruction. CBR, due to its focus on both personal change and social adaptation through community based strategies, demonstrates *opportunities for health, social, and economic reform in a non-contentious arena.* This can create community capacity and awareness of the organizational forms and relationships required to address the interacting causes of poverty and disability. It can also heighten the expectation in local communities that they be consulted in the design of longer term social reconstruction and development projects.

CBR also contributes to the two other foreign policy objectives in Box 2. Addressing the needs of persons with disability with the community based approach requires the skills and aptitudes of a multi-disciplinary, multi-sectoral and multi-faceted team of locally engaged and external personnel. It is by definition a human resource intensive effort. Conflict and post-conflict situations provide unique opportunities to initiate community based peace building efforts which are focused on the needs of often invisible vulnerable groups. Conflict and post-conflict situations provide an opportunity to create a new foundation for, and new principles informing, the delivery of public goods generally, and health services specifically. Later in this paper we

identify Canadian CBR capacities and expertise (section 8). Also, as will become evident, CBR as an approach, with its roots in India and Africa, has benefitted, at least in part, from its assimilation of Canadian values and culture (e.g. equity, access, and multiculturalism) and the influence these have on our health care system and other issues of social justice.

4.1 The Canadian Foreign Policy Framework

The Department of Foreign Affairs and International Trade (DFAIT)
The foreign policy framework being pursued by the Department of Foreign Affairs and International Trade (DFAIT) has changed substantially since 1989. Government commitment to outreach and consultation on an ongoing basis is driving this evolution, at least in part. With the change in government in 1993 there was a commitment to consulting the public broadly on foreign policy issues for the foreign policy review (Canada 1994). These committee hearings brought forward ***Canada in the World***, the government's current foreign policy Statement (Canada 1995).

Also, the pace of change in Canada's foreign policy is accelerating. In its 1995 Statement, the government re-committed itself to broad consultation in an ongoing foreign policy process. The Canadian public, and especially NGOs, have responded positively. Large numbers of individuals and organizations commented on a foreign policy discussion paper on Haïti posted on the department's WWW home page. Participation in such events as the Bosnia Roundtables (April and October 1996), the Landmines Conference (October 1996), the Winnipeg Victim Assistance Conference (January 1997), and consultations between the government and NGOs on human rights and peace building (February 1997) has been significant.

The establishment of the John Holmes Fund and the Centre for Foreign Policy Development are also important elements of the consultative process, inviting and facilitating contributions from a broad cross-section of the Canadian public, NGOs, colleges, universities, professional associations, unions, and other organizations.

Canada's "*privileged position to influence change and to benefit from opportunities as we move toward the end of the twentieth century*" is summarized in ***Canada in the World*** (Canada 1995, i) by the five points in Box 4.

Sources of Canadian Influence and Opportunities in Foreign Relations

1. *Canada occupies a position of leadership among the open, advanced societies which are becoming increasingly influential as world power is dispersing and becoming more defined in economic terms.*
2. *Canada's geographic location gives it an important advantage as new poles of political and economic power emerge in the Pacific and Latin America.*
3. *Canada's cultural heritage gives it privileged access to the Anglophone and Francophone worlds as well as to the homelands of Canadians drawn from every part of the globe who make up its multicultural personality.*
4. *Canada can further its global interests better than any other country through its active membership in key international groupings, for example, the G-7 and APEC.*
5. *Canada's history as a non-colonizing power, champion of constructive multilateralism and effective international mediator, underpins an important and distinctive role among nations as they seek to build a new and better order.*

Box 4

As a peace building approach, CBR can contribute significantly to and benefit from the fifth source of Canadian influence in international relations.

The Canadian International Development Agency (CIDA)

It would be an oversight not to mention that foreign policy is evolving as the government reduces the fiscal deficit and takes measures to also reduce the accumulated debt. Direct expenditures on official development assistance (ODA), and on the agencies managing these expenditures and our foreign relations, have declined.

Concomitantly, the development assistance community has gone through a difficult period.[3] In their article "Paying the Piper: CIDA and Canadian NGOs," Cranford Pratt and Tim Broadhead conclude that

> *CIDA - NGO relations in the next few years will be marked by uncertainty and redefinition, CIDA will increasingly assert closer policy control over the NGOs that it assists, and a common NGO approach to CIDA and to the government may be impossible to sustain.* (1994, 87)

Phillip Rawkins, in his article for this same collection, noted that

> *In the 1990s, the whole apparatus of "foreign aid" is undergoing scrutiny on a global basis. Difficult questions are being asked about the purpose and effectiveness of aid.... the fight against the deficit takes priority ... CIDA is not immortal.... The challenge is to adapt or die and CIDA perceives itself to be embarked on a strategy through which it hopes to secure its future.* (1994, 158)

With the introduction of results-based management in 1996, CIDA is heightening its focus on

[3] This has been documented by Ian Smillie (1993, 1995), Michael Edwards and David Hulme (1996), and David Sogge (1996).

development impact. By substantially changing its contracting procedures, also in 1996, CIDA is encouraging the development of competence-based partnerships in order to achieve its programme objectives. With these developments in mind and the benefit of hindsight, Pratt, Broadhead and Rawkins appear to have been correct: CIDA has altered its relationship with NGOs and other implementing agencies and this has occurred in a time when the traditional 'development' paradigm has been challenged and complex emergencies have demanded humanitarian response from western powers.

CIDA's main focus is poverty alleviation through six programming priorities: basic human needs; the environment; the situation of women; infrastructure services; human rights, democratic development and good governance; and, private sector development. Disabled people as a group are among the poorest of the poor, however, CIDA's 1996 ***Strategy for Health*** discussion paper makes no mention of disability. This is certainly an oversight when one considers that only 1% to 3% of disabled people living in developing countries who require rehabilitation services receive them, these services being particularly inaccessible to the rural majority (WHO Expert Committee 1981; Helandar et al. 1989). The manner in which attention to persons with disabilities can alleviate poverty in development and humanitarian assistance programming is summarized in Box 5.

Disability Issues, CBR and Poverty Alleviation

CIDA Programming Priorities	Benefits of a Disability Perspective
Basic human needs.	Address the basic human needs and rights of persons with disabilities.
The environment.	Increase attention on the human cost of landmines, part of the 'environmental health landscape' in such countries as Cambodia, Afghanistan, Mozambique and Angola.
The situation of women.	Diminish the effects of poverty on women who are disabled, or who care for the disabled in their family or community.
Infrastructure services.	Assure that accessibility is considered in the reconstruction of physical infrastructure such as housing, hospitals, clinics and schools.
Human rights, democratic development and good governance.	Create formal and informal structures which treat as legitimate, and therefore include, the claims of persons with disabilities.
Private sector development.	Encourage private sector development initiatives which include technology, employment and credit facilities which increase the economic autonomy and productivity of persons with disability.

Box 5

In summary, attention to the needs of persons with disabilities can be woven through each of CIDA's six programming priorities and by so doing, additional process benefits, especially to

peace building, can be realized. A revision of CIDA's health strategy would benefit from explicit discussion of disability issues. Addressing the basic human needs of persons with disability can be achieved through CBR.

The International Development Research Centre (IDRC)

A recent and important contribution to the evolution of Canadian foreign policy comes in the form of a report, from a Task Force chaired by Maurice Strong and sponsored by the International Development Research Centre (IDRC), the International Institute for Sustainable Development (IISD), and the North-South Institute (NSI), entitled ***Connecting with the World: Priorities for Canadian Internationalism in the 21st Century***. The report contends

> *that [Canada's] historical role as international "good neighbour" can no longer be dominated by the donor-recipient exchanges of the past [. Rather,] our strategic advantage will lie in our potential to become an effective "knowledge broker"; and ... our immediate challenge is to build and strengthen the institutional arrangements required for this role.* (International Development Research and Policy Task Force 1996, iii)

Given Canadian expertise in CBR (section 8), this is certainly a field in which Canada could contribute to the 'knowledge broker' role. The Strong report clearly states that greater efforts are required to learn from countries affected by the very issues we seek to address through our policy initiatives and development assistance activities. Thus, policy options presented in this paper make a clear commitment to the ideal that we establish strong institutional links with those societies in which we seek to work, so that those efforts may be adapted and so that we too can learn from the resilient societies we often label as underdeveloped, tribal, or with another similar epithet.

4.2 DFAIT, CIDA, IDRC and Peace Building

Peace Building

Peace building, although first discussed by Johanes Galtung (1976), entered the foreign policy lexicon at a more general level in 1992. In his report ***Agenda For Peace***, the Secretary General of the United Nations defines peace building as

> *action to identify and support structures which will tend to strengthen and solidify peace in order to avoid a relapse into conflict.* (Boutros-Ghali 1992, 11)

Because this definition is extremely general, it has provoked tremendous interest and considerable discussion at numerous levels. DFAIT defines peace building as "*a set of measures that create a sustainable infrastructure for human security*" (1996). The Minister of Foreign Affairs has stated that "*the concept of human security recognizes that human rights and fundamental freedoms, the rule of law, good governance, sustainable development, and social equity*" are important elements of sustaining global peace (DFAIT 1996).

Ronald Fisher effectively distinguishes peace building from peacemaking (1993),[4] and does so in relation to two types of conflict, horizontal and vertical. By far, the most common type of conflict in the world today is vertical in nature, "*based in deep-seated racial, ethnic, and religious hatreds combined with structural cleavages and political oppression that result in the victimization of one or more groups through a denial of their fundamental needs*" (p. 247).[5]

Further, peacemaking *is practiced by a variety of third parties* (see the discussion on multi-track diplomacy below),

> *usually in a manner appropriate to horizontal conflicts, ... when applied to vertical conflicts, this approach is system preserving and does not address structural violence. It can therefore result in agreements that do not address underlying issues and that are not self-supporting.* (p. 249)

Fisher lists those features of peace building which distinguish it from peacemaking and peacekeeping, and demonstrates the appropriateness of peace building to dealing with vertical conflict (and to the very nature of LIC which will be described below):

> *... peacebuilding is essential: an associative approach that attempts to create a structure of peace both within and among nations — a structure that removes the causes of war and provides alternatives to war. This structure involves relations among a large domain of several parties that are equitable, interdependent, include a variety of people and types of exchange, and have a supportive superstructure.... Peacebuilding thus requires a process of nonviolent social change toward equality.*

In addition to the points made above, it is useful to recognize that peace building activities may be preventive or post-conflict in nature, and may occur at the in-country and international levels (Box 6).

For example, former Australian Foreign Minister, Gareth Evans, distinguishes between two broad groups of peace building strategies — 'international regimes' and 'in-country peace building':

International Post-Conflict Peace Building	International Preventive Peace Building
In-Country/Region Post-Conflict Peace Building	In-Country/Region Preventive Peace Building

Box 6

[4] Fisher refers to Galtung on these distinctions. Peacekeeping, he writes, "*is a dissociative approach in which a third party intervenes simply to keep the warring parties apart and maintain the absence of direct violence. This approach is appropriate in a horizontal conflict between equals who are relatively weak (because strong parties can be their own "peacekeepers") but is not appropriate to vertical conflicts between unequals because it freezes the status quo in a biased manner.*" (1993, 249).

[5] Vertical conflicts, he notes, "*are highly resistant to de-escalation, in part because of a host of social-psychological processes, including cognitive rigidities and distortions, self-fulfilling prophecies, and irrational commitment mechanisms [and] due to the complexities of such conflicts ... a set of interlocking ethnic, political, and economic factors in which no one issue can be resolved by itself*" (p. 248).

> *the former refers to strategies which by their nature are general in application, embracing more than one country; the latter refers to efforts — whether internationally assisted or not — to build conditions for peace within particular countries. Each group of strategies has both preventive and post-conflict dimensions.* (1993, 40)

Describing in-country preventive peace building, Evans writes that

> *preventive peace building within states, in which both the international community and individual states themselves have mutually supportive roles to play, should aim to achieve progress in reducing the gap between rich and poor, to extend basic human rights to all people (including minorities), to promote sustainable development and to advance a just and fair society which does not discriminate on grounds of gender and race. Preventive peace building at this level also seeks to promote adherence by states to the established standards of good international citizenship. Good internal government in the necessary foundation of good global governance.* (p. 52)

This distinction between international regimes and in-country peace building is useful. It acknowledges that these activities can occur simultaneously, in a manner similar to track one and track two diplomacy (Box 7). In other words, the development of international regimes which encourage or support peace building, and in-country peace building activities, can be pursued by both state and non-state actors. Indeed, the basic premise of Track Two diplomacy "*is that the expertise for dealing successfully with conflict does not reside solely within government personnel or procedures*" (Diamond and McDonald 1996, 2). These authors suggest that there are nine tracks (Box 8) one must consider in analysing the system of *peacemaking* diplomacy.

Track Two Diplomacy

The phrase "Track Two" was coined in 1982 by Joseph Montville to describe methods of diplomacy that occurred outside the formal governmental system. Its main objectives are:

- to reduce or resolve conflict between groups or nations by improving communication, understanding, and relationships;
- to decrease tension, anger, fear, or mis-understanding by humanizing the "face of the enemy" and giving people direct personal experience of one another; and
- to affect the thinking and action of Track One by addressing root causes, feelings, and needs and by exploring diplomatic options without prejudice, thereby laying the groundwork for more formal negotiations or for reframing policies.

Source: Multitrack Diplomacy: A Systems Approach to Peace, Dr. Louise Diamond, Ambassador John McDonald, Kumarian Press, 1996, p.2

Box 7

> *Each of these nine tracks represents a world unto itself, with its own philosophy and perspective, purpose, language, attitudes, activities, diversities, culture and membership ... the study of multi-track diplomacy is more than simply a view into each of the tracks individually. It looks at the interrelatedness between them as well.* (p. 5)

Multi-Track Diplomacy

1. Government: peacemaking through diplomacy.
2. Nongovernment / Professional: peacemaking through conflict resolution.
3. Business: peacemaking through commerce.
4. Private Citizen: peacemaking through personal involvement.
5. Research, Training and Education: peacemaking through learning.
6. Activism: peacemaking through advocacy.
7. Religion: peacemaking through faith in action,
8. Funding: peacemaking through providing resources.
9. Communications and Media: peacemaking through information.

Box 8

The importance of multi-track efforts to the success of formal peace agreements has been recognized by scholars such as Fen Osler Hampson whose study of five settlements (Cyprus, Namibia, Angola, El Salvador and Cambodia), led to the distillation of operational and strategic rules of the road, one of which is of particular relevance to this paper:

> ***Economic and Social Reconstruction are Crucial to the Success of the Peace Process.*** *In addition to advancing human rights, third parties have a crucial role to play in rebuilding and reconstructing civil society for long-term peace and stability. There is a vital link between sturdy civic institutions, including the norms and networks of civic engagement, and the performance of representative government. Not only is civil society important to democracy, but it also has a significant role to play in consolidating the peace process in countries making the transition from war to peace. Because third parties often provide the necessary foundations for democratic institutions, international development agencies and non-governmental organizations have a pivotal contribution to make to the task of post-conflict rebuilding.* (Crocker and Hampson 1996, 69)

In a similar vein, Nicole Ball and Tammy Halevy (1996), have provided several guideposts which should be kept in mind in support of a peace agreement (Box 9).

As we have seen, peace building and peacemaking, at a theoretical level, are not the same, but they do share some mechanisms and features, especially when

Making Peace Work

It is difficult to develop a generic list of peace building activities. However, the experiences of recent peace processes suggest that the following activities should receive early attention even when they are not specified in the peace accords:

- provide a sufficient level of internal security to enable economic activity to recover, to encourage refugees and internally displaced persons to re-establish themselves, and to persuade the business community to invest;
- strengthen the government's capacity to carry out key activities;
- assist the return of refugees and internally displaced persons;
- support the rejuvenation of household economies, especially by strengthening the smallholder agricultural sector;
- assist the recovery of communities, in part through projects that rehabilitate social and economic infrastructure;
- rehabilitate economic infrastructure of crucial importance for economic revival, such as roads, etc...
- remove land mines from major transport arteries, fields and other critical sites;
- stabilize the national currency and rehabilitate financial institutions;
- promote national reconciliation; and
- give priority to the basic needs of social groups and geographic areas most affected by the conflict.

Box 9

the benefits of multi-track diplomacy are considered. In this way, and as will be demonstrated, CBR, as a preventive and post-conflict peace building opportunity, operates on several of the abovementioned tracks and makes important contributions to economic and social reconstruction.

Peace Building, DFAIT and CIDA

In October 1996, the Minister of Foreign Affairs announced the Canadian Peace Building Initiative and CIDA announced the establishment of the Peace Building Fund, an earmarking of $10 million. This Fund is to be used for filling gaps in ongoing programmes, assuring that, where appropriate, peace building objectives are addressed. A major step in this direction is the development of peace building capacity maps — in Canada and in those countries where peace building needs to occur. This initiative is being coordinated by the Canadian Peace Building Coordinating Committee. With these announcements and consultations, momentum is gathering for concerted peace building action on the ground. For example, in an effort to broaden consensus on peace building content and action, DFAIT convened a day-long consultation (7 February 1997) with NGOs.[6] Other consultations on global issues such as victim assistance to those disabled by land mines and other effects of conflict, and more pointed regional issues, such as those held on the subject of the Dayton Accord, are also contributing to the evolution of peace building and its operational realities.

IDRC and Peace Building

IDRC is in the process of developing a framework for its Peace Building and Reconstruction Programme Initiative (PBR-PI) as part of its *"Corporate Program Framework to 2000"* (1997). IDRC has tentatively identified a focus on the critical role which applied research plays in guiding reconstruction and peace building policy. IDRC will focus on research efforts in war-torn societies which use local research capacity and which investigate reconstruction, reconciliation, and institution-building efforts and their contribution to sustaining human security.

The ICACBR has taken steps to quantify and qualify the disability dimension in zones emerging from conflict. In September 1996, the ICACBR hosted a Symposium: "Post-Conflict Integration of Persons with Disability" (see Annex I). During the day-long session, representatives of Bosnian and Eritrean authorities were present. The discussion demonstrated the importance of being open to learning from partnerships with non-Canadian organizations, fostering these and assuring that both practice and policy are informed by what works and by what is demonstrably effective, having an impact which is sustainable and owned by the target beneficiaries. Good policy must be informed by good practice.

Summary

With this set of definitions and approach as background, and with the experience of Bosnia as an introduction, it is demonstrable that the implementation of well designed and focused CBR

[6] At this meeting, the Peace building Coordinating Committee invited organizations to contribute to a "peace building capacity map". Some observations on this initiative are discussed below (4.2.1).

initiatives in countries or regions recovering from, or on the precipice of, conflict will increase Canadian peace building visibility and impact. As will become clear, CBR can effectively influence the impact of peace building efforts because, as a process, it challenges basic values, attitudes, and beliefs which are held by individuals in society. CBR can open the door to the fundamental changes in human and social behaviour required to assure human security. However, CBR as a peace building initiative must flow from the integration of disability issues where appropriate in Canadian foreign policy and development assistance programme priorities.

4.3 Low Intensity Conflict

In ***The Transformation of War***, Martin van Creveld argues that the decline of large-scale conventional war (i.e., war as understood by today's principal military powers) should not be interpreted as an end to war per se (Box 10). He also rejects the notion that war will be replaced by economic competition among trading blocks. Rather, he argues, "*we are entering an era ... of warfare between ethnic and religious groups*" (1991, ix).

Low intensity conflicts (LICs) have one or more of the following characteristics, according to Martin van Creveld:

1. They tend to unfold in less developed parts of the world; when they do take place in 'developed' regions they are known as 'terrorism' or 'police work' or (in Northern Ireland) 'troubles'.

2. They rarely involve regular armies on both sides "*though often it is a question of regulars on one side fighting guerrillas, terrorists, and even civilians, including women and children, on the other*" (p. 20).

3. Most LICs do not rely on "*high technology collective weapons*" such as aircraft, tanks, missiles and heavy artillery.[7]

4. The majority of victims, including displaced persons and refugees, are villagers or civilians "*who did not belong to any **formal** organization*" (p. 21).

[7] Michael Ignatieff (CBC Radio Interview, "Morningside", 26 March 1997) has commented that the ubiquity of LIC is fueled by the proliferation of 'junk weapons' via the international arms trade.

Low Intensity Conflict - According to Martin van Creveld

Assuming that politics is what wars are all about, then LICs have been politically by far the most significant form of war waged since 1945. Out of several dozen "conventional" conflicts waged since 1945, almost the only one which resulted in the establishment of new frontiers was the 1948 one between Israel and its neighbours, and even then the outcome was not an international border but merely an armistice line. During the same period the consequences of LICs, numerically about three times as strong, have been momentous. From South Africa to Laos, all over the Third World, LIC has been perhaps the dominant instrument for bringing about political change. Without a single conventional war being waged, colonial empires that between them used to control approximately one-half the globe, were sent down to defeat through LICs known as "wars of national liberation".

Perhaps the best indication of the political importance of LIC is that its results, unlike those of conventional wars, have usually been recognized by the international community. Often, indeed, recognition preceded victory rather than following it ... Truth to say, what we are dealing with here is neither low intensity nor some bastard offspring of war. Rather, it is WARRE in the elemental, Hobbesian sense of the word, by far the most important form of armed conflict in our time. (pp. 21 - 22)

The spread of sporadic small-scale war will cause regular armed forces themselves to change form, shrink in size and wither away.... as has already happened in Lebanon and in many other countries, the need to combat low intensity conflict will cause regular forces to degenerate into police forces or, in case the struggle lasts for very long, mere armed gangs. (p. 204)

Box 10

It is in the extreme nature of low intensity conflict that we need to demonstrate that community based approaches to the needs of persons with disability can contribute to building peace. First, we must do so if we are to recommend policy options which are relevant to the situation we find predominantly in the world, and second, if CBR can make a difference in such contexts, then it can also build peace in less extreme situations. From the discussion in section 3, it is quite clear that CBR merits serious consideration as an element of Canadian peace building activities.

Elsewhere in his book, van Creveld makes the following statement:

> *war represents perhaps the most imitative activity known to man. Strategy is interactive by definition; any attempt to defeat the enemy that involves outwitting and deceiving him must be preceded by an endeavour to understand him... the outcome of any drawn-out conflict has always been a mutual learning process. Belligerents who were originally very dissimilar will come to resemble each other first in point of the methods they use and then gradually other respects. As this happens, provided only the struggle lasts long enough, the point will come where the reasons for which they originally went to war are forgotten.... one important way by which human societies of any kind develop their internal structure has always been through fighting other societies. After all, no community illustrates this fact better than the modern nation-state itself, an organization that acquired its characteristic institutions — including specifically the armed forces and their separation from government and people — partly through the need to fight similar organizations.* (p. 195)

Here, van Creveld is certainly referring to conventional wars, and his view is essentially hopeful:

conventional wars eventually end when the reasons for war are forgotten, when we have become like 'the other'. LIC, on the other hand, because it stems from acculturated values (sometimes promoted by external agents), attitudes and beliefs which encourage hatred (recalling Fisher and vertical conflict as described above), does not contain this same element; it is not organized in the same way. As Galtung noted, it is not possible to build associative structures on attitudes of hatred. LICs therefore are not even effective conflict resolution mechanisms. They contain the seeds of their own perpetuation rather than end, feeding from the confusion they engender in regions where they occur. Building peace in such areas is therefore an extreme challenge. As Fisher points out, there is a need to "*improve the attitudes and the relationship between the parties in the direction of a structure of peace so that significant social development may begin to unfold*" (1993, 250).

Anatol Rapoport has argued that peace, as an innovation, as a viable manner of organizing our lives and interactions locally and globally, is a manifest idea whose time has come: "*ideas 'take off' when their environment ... becomes favourable for their germination and development*" (1992, 43). Peace is "*an idea that has been dormant for at least twenty-eight centuries.*"

> *In its development [peace as an idea] will enter a struggle for existence with the institution of war. The outcome of the struggle will depend on whether the political climate will enable more people possessed by the idea to come into positions of political power. If so, the world will become more peaceful, not necessarily because "people became more peaceful" (we need not invoke a change of human nature), but because the relative political weight of people concerned with power struggles and people attuned to cooperation has changed.* (p.50)

LICs present an extreme challenge to this hopeful view as they are occurring in some sense beyond time, or in the minds of the belligerents, in many different times simultaneously.[8] It would be naive in the extreme to suggest that conflict per se can be eliminated from human interaction. CBR, if employed carefully, strategically, and in an appropriate manner, can be an effective means of understanding the root of conflict and violence; to implement CBR effectively, basic attitudes, values, beliefs and behaviours must be understood and, in some if not most instances, re-cast. By building up trust between belligerents, CBR as a process does not seek to change human nature, a likely impossibility.

CBR as a process can force people to confront their own attitudes and beliefs in a manner which does not link these to thoughts of hatred and revenge, but to positive attitudes about the future, thereby rooting belligerents in time and with a common horizon. To help establish this point more concretely, some operating principles about conflict and culture are set forward in Box 11 and addressed in more detail in the section on ethics and intervention (section 5.4).

[8] Maj. Gen. Lewis MacKenzie, in response to a reporter's question as to who had violated the most recent cease-fire in Sarajevo, was heard to quip, "Someone five hundred years ago."

Conflict and Culture: Operating Principles

1. Social conflict is a natural common experience present in all relationships and cultures.
2. Conflict is a socially constructed cultural event. Conflicts do not "just happen" to people, people are active participant in creating situations and interactions they experience as conflict. This is the essential social dialectic experienced in the construction of any social reality.
3. Conflict emerges through an interactive process based on the search for and creation of shared meaning.
4. The interactive process is accomplished through and rooted in people's perceptions, interpretations, expressions, and intentions, each of which grows from and cycles back to their common sense knowledge.
5. Meaning occurs as people locate themselves and social "things" such as situations, events, and actions in their accumulated knowledge. Meaning emerges ... by an act of comparison. Thus an important working assumption from this perspective is the idea that a person's common sense and accumulated experience and knowledge are the primary basis of how they create, understand and respond to conflict.
6. Culture is rooted in the shared knowledge and schemes created and used by a set of people for perceiving, interpreting, expressing, and responding to social realities around them.
7. Understanding the connection of social conflict and culture is not merely a question of sensitivity or awareness, but a far more profound adventure of discovering and digging in the archeology of accumulated shared knowledge common to a set of people.
8. Understanding conflict and developing appropriate models of handling it will necessarily be rooted in, and must respect and draw from, the cultural knowledge of a people.

Source: John Paul Lederach, *Preparing for Peace: Conflict Transformation Across Cultures*, Syracuse University Press, 1995, p. 9.

Box 11

Conflict: Impact on Civilians

The specific case of Bosnia has been discussed. More generally, armed conflict and civil strife are widespread and have affected over 40 countries world-wide in the past decade, according to the ICRC. The majority of these conflicts are in poorer countries, and the principal victims are from poor families – those who cannot flee, and are therefore at greater risk of death and injury, and are less able to access rehabilitation services (Rehabilitation International/UNICEF 1991).

Victims of modern war, especially LICs, are largely civilians, and the most vulnerable of these are children and women. While in World War I, 5% of casualties were civilians, in World War II this figure was 50%, and, at present, 80 to 90% of war victims are civilians, according to studies undertaken for the International Symposium on Children and War, Finland, 1983 (UNICEF 1986a). Technology and tactics of armed conflict have developed such that targets are dual: in addition to the opposing fighting forces, armed forces seek to destroy the infrastructure of the enemy society. This entails bombing communication facilities, roads, bridges, and power generating plants. The concepts of total war advocate shattering the economic base and morale of the civilian population as a way of undermining the cover and strength of enemy combatants (UNICEF 1986b). Perhaps the most striking recent demonstration of these features of armed conflict is the war in Chechnya, particularly the destruction of Grozny.

Civilians are not merely indirectly affected, but are a strategic focus. Targets are even schools, hospitals, health workers, and children (Rehabilitation International/UNICEF 1991; Nixon 1990;

UNICEF 1994). LIC serves to burden the enemy with an injured and disabled population (Aston 1992; Carey 1990; Coupland and Korver 1991; Werner 1990; Lundgren and Lang 1989; Garfield 1989). In such cases, the violence is designed "*to inflict maximum damage while minimizing the risk of death*" (Physicians for Human Rights 1988). Despite the acclaim given to surgical strikes during the recent Gulf War, 20% to 40% of allied ordnance did not find the mark, and only 7.4% of the bombs dropped by the allies were precision-guided ordnance (Ruff and Ward 1991).

In 1990, it was estimated that 22 million people had died in 150 armed conflicts since the end of World War II (UNICEF 1986b). UNICEF also notes that for every child killed by war, three more are seriously or permanently disabled, resulting in 4 million children physically disabled and 10 million psychologically traumatized by war during the 1980's alone (UNICEF, 1991). Evidence from Afghanistan showed that incidence of disability nearly doubled among children living in zones of armed conflict (UNICEF, 1990).

Landmines present a particularly complex problem. In addition to the restrictions imposed by landmines on transportation, agriculture, and water supplies, deaths and injuries from landmines are commonplace in LIC and in societies trying to recover from LIC. From 1980-1988 in Angola, 10% of the population were either killed or mutilated by landmines. Fifty per cent of an estimated 50,000 amputees were women and children. In Nicaragua, 10% of all hospital admissions from 1983-1986 had war injuries. In Mozambique, there is an estimated 8,000 amputees, while Cambodia has the highest concentration of amputees in the world (1 in 240 persons) (Eade and Williams 1995).

Notwithstanding the above, little data is available regarding the extent of rehabilitation needs in many of these countries. Reasons for this include the lack of time and energy for information collection during the chaos of war, barriers imposed upon personnel which forbid travel to remote locations where civilians are under attack, and the low priority placed upon concerns of disabled individuals, especially women and children (Rehabilitation International/UNICEF 1991).

In ongoing conflict, epidemiologists face the special problems of continuous change where long term planning is virtually impossible, military sensitivities impeding data collection, and necessary compromise with respect to scientific rigour. At its worst, epidemiologists face political manipulation of their data (Armenian 1989). Armenian, reflecting upon health research in Lebanon, describes epidemiological work in the context of "endemic war", a situation in which violence has become an expected activity and, as endemic disease, is rooted in the country.

Health Effects of Conflict

LIC has direct and often disastrous effects on health. For individuals, such direct effects may be death, injury, disability, and psychological stress. In addition, health facilities may be destroyed by direct attack (Lundgren and Lang 1989; Physicians for Human Rights 1988).

Indirect effects, however, greatly out number the direct impacts on health, and claim more

victims (UNICEF 1986a; Lundgren and Lang 1989; Garfield 1989; Ruff and Ward 1991; Zwi and Ugalde 1989; Rautio and Paavolainen 1988; Black 1993; Toole, Galson and Brady 1993). These effects are listed in Box 12. Conditions of conflict introduce malnutrition, starvation, the spread of infectious and parasitic diseases, additional injury, mental illness, and despair. When it is remembered that most situations of armed conflict occur in developing nations, these risks become even more evident. Conflict exacerbates structural weaknesses inherent in health systems (in the areas of human and physical resources, management and organization, and economic support), and places great burdens on public health and health services (Macrae and Zwi 1994; Ityavyar and Ogba 1989).

Indirect Impact of Conflict on Health

- interrupted food production and distribution
- bomb damage
- lack of housing / overcrowding
- lack of water
- lack of sewage and waste disposal
- lack of transportation and communication
- lack of heating / protection from sun
- environmental hazards
- interrupted health services, such as immunization, oral rehydration and health education programs, (as well as arrest, harassment and flight of health workers)
- displacement of populations or sub-populations
- poverty (and lasting economic effects associated with high military expenditures, urban and rural

Box 12

Summary

This section has described in some detail the nature of LIC, and the impact which such conflicts have on civilians. This discussion provides further insight into the extreme conditions where peace building initiatives must be undertaken. Peace, to take hold, must change the ways in which conflict is managed, in effect creating clear interests which promote peace actively. CBR, because of its focus on immediate need and enduring changes in the system whereby health services are delivered, can increase the visibility of fundamental human rights and dignity, and in meeting these can create cross-cutting social and political interests which sustain the peace building process. With success, appeals to violence as a means of mediating conflict can become illegitimate in the eyes of key civic leaders and citizens wishing to participate in broad based reconstruction efforts.

4.4 The Continuum Convention

In the domain of conflict, peacekeeping and humanitarian assistance, much has been written about a theoretical continuum which has become a fixture of conventional wisdom. This continuum goes something like this:

peace → political instability → more overt tension → conflict → peacemaking diplomacy → peacekeeping and military intervention → peace building and elections → social reconstruction → reconciliation → stability and lasting peace.

An example of this approach can be found in Nicole Ball and Tammy Halevy's ***Making Peace***

Work (1996). Ball and Halevy identify two stages and four phases of peace processes in countries with negotiated peace settlements (Box 13):

Peace Process in Countries with Negotiated Peace Settlements

Stages	Conflict Resolution		Peace Building	
Phases	Negotiation	Cessation of Hostilities	Transition	Consolidation
Main Objectives	Agreement on key issues to enable fighting to stop.	Signature of peace accords; cease-fire; separation/ concentration of forces	Establish a government with adequate legitimacy to rule effectively; begin reforms in the areas of political institution building and post-conflict security; inaugurate economic and social revitalization efforts.	Continue and deepen reform process; continue economic and social recovery programs.

Box 13

In reality, however, such straightforward progressions are rarely observed. Ball and Halevy's model reflects this uncertainty in that overall success depends on success of the transition phase. Achieving the objective of this phase is fraught with uncertainty and this is admitted by Ball and Halevy.

Success in peace building needs to be measured in a time horizon which can assure, as we have seen, that the transition 'phase', to the extent that it can be identified, is over, and that a sustainable infrastructure for human security has been achieved. Along the way, we are likely to see violations of accords and cease-fires, difficulties with the consolidation of government legitimacy, hesitancy on the part of donors to actually deliver on assistance pledges, and difficulties in the operations of national and/or local social agencies due to fiscal budget difficulties or macro-economic imbalances.

It would be more realistic and helpful to view the process as less logical in terms of progression, recognizing that there are processes inherent in each of the elements in the diagram below which tend toward order, but which can become de-railed. In reality we are confronted with a situation where we can start at any one point and move in any direction:

peace political instability
reconciliation more overt tension
conflict
peacemaking diplomacy peacekeeping and military intervention
peace building
elections
stability and lasting peace social reconstruction

For example, in part of the country or region, peace building activities may have been initiated by local communities – even prior to a formal peace settlement informal arrangements for coexistence and tolerance may be operating. Elections may occur, and legitimacy thereby conferred by that mechanism on the winner, but that regime may then decide to launch military attacks claiming that it has the legal right to do so having been recognized as a member of the international community.

We suggest that an approach which expects confusion rather than logic seems especially appropriate to vertical conflict and LIC as discussed above. This does not deny that the intent of external assistance agencies is to support a movement from conflict to peace, but it is important not to impose a logic or a time frame which implies that only certain types of interventions are relevant at certain times in an ideal continuum. We would suggest that a more tentative approach attunes one to the precariousness of any one moment, at any one place in time, and hence to the opportunities presented. Given the state of flux and uncertainty which is the reality of humanitarian assistance in complex emergencies, there is a need to determine how and where and by whom small gains in the establishment of lasting peace can be consolidated. To do this, workers in the field and policy makers alike need to understand where to look for these gains, how to test if they are real and well-founded, and how to resource these without destroying their fragility. Sensitivity to disability issues and the implementation of well designed CBR initiatives, we suggest, can help to identify and capitalize on such peace building opportunities.

One attempt in this direction is the Peace Building Capacity Map being developed by the Peace Building Coordinating Committee. There is a danger that this effort will become a logical framework along the lines of the continuum convention. We would suggest that CBR can address problems associated with weak political institutions and with the problems of economic and social revitalization. (Ball and Halevy do include the integration of persons with disabilities as a specific issue in this regard.) CBR as a peace building technique is first and foremost a multi-disciplinary process: the objective is to create an environment of human security within which people with disability can live with dignity and respect, within and toward themselves and their community. It is in this regard that we encountered difficulty with the 'Phases and Components of Peace Building' model[9] which is used to capture information for the peace building capacity survey. The model is useful, but it does not capture the essential features of CBR for peace building: CBR is a process which must evolve and adapt as circumstances in societies change, and incorporating several aspects of the functional components of peace building presented in the capacity model, in the manner set out in Box 14.

[9] 'Phases and Components of Peace Building", Peace Building Coordinating Committee, distributed at the 'NGO Consultations on Peace Building' held at the Department of Foreign Affairs, 7 February 1997.

CBR and the Peace building Capacity Map
Emphasizing Self-Conscious and Associative Relations of Interdependence

Conflict Resolution
Communities and individuals must resolve overt conflict and potential sources of conflict to implement CBR. In fact, dealing directly with the result of war and conflict as physically manifest in an individual disabled by a mine or shrapnel can have a cathartic psychological effect on individuals other than the one disabled. The need for constructive dialogue to assure that resources are accessible requires constant resolution of conflict.

Early Warning
Increased incidence of disability, and its epidemiology more generally, can provide information on who is being targeted by conflict; if persons from gender 'X' or ethnic grouping 'B' are disproportionately disabled and not able to access the support they require to live in dignity and respect, this can be early warning of exclusionist politics and rhetoric, often a precursor to conflict or population displacement.

Humanitarian Relief
The need to include explicitly the consideration of disability in humanitarian relief has been recognized . We have observed lack of attention to this dimension in countries in, or emerging from, conflict.

Physical Security
At the Winnipeg Conference on Victim Assistance, ICACBR and other like-minded agencies such as Disabled Peoples' International assured that the landmine issue was viewed through the lens of the immense human, economic and social costs which this and other types of weaponry common to LICs precipitates. Such presentations buttress disarmament advocacy. CBR presents a problem solving and future oriented outlook for communities, families and individuals which otherwise find themselves with a dearth of resources. CBR mobilizes community resources and these become part of the formal and informal social contracts which govern behaviour and assure physical security.

Human Rights
Assuring accessibility is a measure of our commitment to human rights. Disability is an element of diversity in all societies and needs to be acknowledged as such.

Economic Reconstruction
Infrastructure needs to be rebuilt with accessibility issues in mind. Often, this can reduce the present value of reconstruction costs.

Social Reconstruction
CBR is not just a health issue. It is a vehicle for social justice. Implementing CBR means re-working the social contract and the relations of interdependence in society.

Governance and Institutional Capacity Building
ICACBR has been called upon by the World Bank in Bosnia to assist with the transformation of their medical model from one which is highly centralized to one which relies on local community capacity. Our work is also contributing to decentralization of health care in Russia, the Ukraine, and Croatia.

Policy Development and Advocacy
Where they exist, we support the work of local disabled persons organizations; where they do not exist, we attempt to identify leaders and to create an environment which can support the emergence of such groups. We could not do this without our partner organizations.

Box 14

As was pointed out by two commentators at the NGO consultations on peace building (February 1997):

1. Diversity, multiculturalism and employment equity need to be present in peace building activities. These affect both group and individual prospects for reintegration into 'normal' life.

2. Peace building needs to be viewed as a practical and pragmatic process which (re)creates dignity and respect. As much local capacity as is feasible should make up peace building efforts which involve expatriates and provide public goods alleviating one of the three key scarcities which most often exist in a post-conflict situation: health, water and/or agriculture.

Difficulties with the 'continuum convention', the Ball and Halevy model, and with the peace building capacity map are perhaps more well understood than is generally admitted. Kenneth Bush has provided a set of ten caveats (Box 15) aimed at moving *"beyond bungee cord humanitarianism and towards a developmental agenda for peace building"* via a "*critical and self-conscious approach which draws on and cultivates indigenous peace building resources*" (1996a).

Ten Caveats in Moving Towards a Developmental Agenda for Peace building

1. *Peace building requires patience and commitment.*
2. *Avoid the temptations of "bungee cord humanitarianism."*
3. *Sustainable peace building requires the identification, support and harnessing of indigenous resources. If peace building is to be sustainable, it will need to be "indigenized."*
4. *Neither technology nor information is a substitute for political will or political action.*
5. *Division of labour.*
6. *Good governance is much more than just good government and rule of law. There is a need to strengthen the democratic capacities of both state and civil society.*
7. *Seek to create opportunities, not to impose "solutions."*
8. *Development does not necessarily equal peace.*
9. *Beware of pick pockets.*
10. *Be careful not to ghettoize peace building work.*

Box 15

The CBR approach to disability is not a peace building panacea. The upcoming discussion will make clear that the processes which the CBR approach implies require numerous social, political, economic, and cultural factors to be addressed at their roots. The attitudes, behaviours and beliefs which people have about disability must be confronted, and this requires a basic re-examination of social, political, economic, cultural and even environmental factors. Such a systemic analysis occurs at the level of the individual psyche through to the macro level of society (Mooney 1995, 7). Success in the implementation of CBR initiatives can be a good indicator of the extent to which the biases in societies which support conflict can become the building blocks of lasting peace.

Once again we re-iterate, and are able to acknowledge as a result of the ICACBR's field experience, that there is much more to humanitarian response to crisis, to emergence from conflict, than the CBR of persons with disabilities. However, overlooking the disability perspective means that both an important problem and an opportunity is missed, especially for Canada.

4.5 Limitations of International Humanitarian Law and of UN Intervention

LIC, and specifically LICs which are internal to national boundaries, are a defining feature of conflict in this age. W. Hays Parks, notes that "*customary **international** law prohibits the use of any weapon against individual civilians not taking part in the hostilities, or [against] the civilian population.*" [sic] (Our emphasis.)

> *... The problem is not the indiscriminate use of all weapons of war, or necessarily one of land mine use in international armed conflicts, but primarily one of antipersonnel use [of weapons] against civilian populations in internal armed conflicts by insurgent groups or developing nations with poor human rights records.*

International Humanitarian Law and the Protection of Civilians

Protocol I (International Armed Conflicts) Article 48:
In order to ensure respect for and protection of the civilian population and civilian objects, the Parties to the conflict shall at all times distinguish between the civilian population and combatants and between civilian objects and military objectives and accordingly shall direct their operations only against military objectives.

Protocol II (Non - International Armed Conflicts) Article 13:
1. The civilian population and individual civilians shall enjoy general protection against the dangers arising from military operations. To give effect to this protection, the following rules shall be observed in all circumstances.
2. The civilian population as such, as well as individual civilians, shall not be the object of attack. Acts or threats of violence the primary purpose of which is to spread terror among the civilian population are prohibited.
3. Civilians shall enjoy the protection afforded by this Part, unless and for such time as they take a direct part in hostilities.

Source: Rémi Russbach, "Casualties of Conflicts and Mine Warfare" in *A Framework for Survival*, Kevin M. Cahill, ed., Basic Books, 1993.

Box 16

In commenting on the international framework for humanitarian law, Parks notes that there is a split in the law of war: while the law applicable in an international armed conflict is well-established, the law of war by which a nation is bound in internal armed conflict "*remains woefully undeveloped*" (Parks 1995, 47). Only one article of the 429 contained in the four 1949 Geneva Conventions for the Protection of War Victims applies to internal conflicts (Article 13; Box 16).

While current war crimes tribunals for Rwanda and the Former Yugoslavia have issued indictments, there have been difficulties in both arresting and prosecuting war criminals (Crocker and Hampson 1996, 69). Similarly, movement toward a global ban on anti-personnel land mines is important, but it cannot and should not replace efforts to deal with the inevitable injury to civilians which will occur even if an international legal regime becomes, in practice, an

effective universal deterrent.

Children and the Limited Effectiveness of International Humanitarian Law

Concern for the plight of *disabled* children in armed conflict is relatively recent, prompted by the World Summit for Children (September 1990, Box 17), and by an increased awareness of issues related to disability emerging from the United Nations Decade of Disabled Persons (1983 - 1992). In 1986, UNICEF made "Children in Especially Difficult Circumstances" a major focus (1986a, 1986b), which encompasses the "*over 20 million refugee or displaced children including those who have been physically or psychologically traumatized by armed conflict or natural disasters*" (UNICEF 1990).

World Declaration on the Survival, Protection and Development of Children (1990)

A commitment by nations to:

... work to ameliorate the plight of millions of children who live under especially difficult circumstances – as victims of apartheid and foreign occupation; orphans and street children and children of migrant workers; the displaced children and victims of natural and man-made disasters; the disabled and the abused, the socially disadvantaged and the exploited.

... work carefully to protect children from the scourge of war and to take measures to prevent further armed conflicts, in order to give children everywhere a peaceful and secure future.... The essential needs of children and families must be protected even in times of war and in violence-ridden areas. We ask that periods of tranquillity and special relief corridors be observed for the benefit of children, where war and violence are taking place.

Box 17

'Days of Tranquility', 'Corridors of Peace', and 'Peace Puddles' have been negotiated by UNICEF and other agencies such as the ICRC, the WHO, and national ministries of health, local churches and non-governmental organizations. These approaches are designed to permit immunization programs and the distribution of relief supplies to proceed unhindered during special cease-fires. In many cases, these approaches have occurred as a result of relief agencies' efforts to improve the health of children and have been used in El Salvador, Lebanon, Sudan and Iraq.

In November 1989, the U.N. General Assembly adopted the ***Convention on the Rights of the Child***. In it, Article 23 asserts the rights of mentally and physically disabled children to dignity, active participation in the community, and special care. Articles 38 and 39 outline the rights of children during armed conflicts, with respect to their recruitment, to protection, and to treatment of child victims. It is not specified, however, how these measures are to be taken, nor is a code of conduct proposed to achieve these goals.

Conclusions: Limitations of International Humanitarian Law

The conclusion at this point seems inevitable: the rule of (international) law, as a means of assuring the safety of civilians in armed conflict, especially LICs, remains an ideal solution. Until legal precedent has been established and enforced, and then universally applied and heeded, a question largely of overcoming resistance to the accession of elements of state sovereignty, there will be the enormous problem of civilians being seriously injured in LICs, whether by land mines or other weaponry.

We concur, along with Jean Bonvin and Marc Dolgin, that "*the right to protect human rights overrides that of national sovereignty ... and requires the international development assistance community to violations of humanitarian law and of the UN covenants on civil, political, and human rights and those protecting children ...*" (Mooney 1995, 7). In the meantime, CBR initiatives can work as preventive and post-conflict peace building initiatives.

United Nations Intervention and Sovereignty

Another area of international preventive and post-conflict peace building activity which has been reviewed and evaluated is UN peacekeeping operations. In January 1995, the Secretary General submitted his report on the work of the organization to the General Assembly and Security Council. Recalling his earlier report ***An Agenda for Peace*** (Boutros-Ghali 1992) where, *inter alia*, important concepts such as peace building are introduced into the lexicon for the first time, the Secretary General does not revise or update that document in 1995. Rather, the report discusses the organization's major preoccupation, namely the 28 disputes and conflicts in which the UN was actively involved in preventive diplomacy in the 12 months preceding 16 December 1994. The Secretary General echoes some of van Creveld's observations noting that

> *so many of today's conflicts are within States rather than between States. The end of the cold war removed constraints that had inhibited conflict in the former Soviet Union and elsewhere. As a result there has been a rash of wars within newly independent States often of a religious or ethnic character and often involving unusual violence and cruelty. The end of the cold war seems also to have contributed to an outbreak of such wars in Africa. In addition, some of the proxy wars fueled by the cold war within States remain unresolved. Inter-state wars, by contrast, have become infrequent.* (Boutros-Ghali 1995, 2)

These "intra-state conflicts present UN peacekeepers with challenges not encountered since the Congo operation of the early 1960s." Once again, echoing van Creveld who wrote four years earlier in 1991, the Secretary General observes that the combatants are

> *not only regular armies but also militias and armed civilians with little discipline and with ill-defined chains of command. They are often guerrilla wars without clear front lines. Civilians are the main victims and often the main targets. Humanitarian emergencies are commonplace and the combatant authorities, in so far as they can be called authorities, lack the capacity to cope with them. The number of refugees registered with the UNHCR has increased from 13 million at the end of 1987 to 26 million at the end of 1994. The number of internally displaced persons has increased even more dramatically.* (p. 5)[10]

[10] Kenneth Bush's recent paper (1996b), discusses current refugee issues at length.

United Nations Intervention and the Challenge of LIC

Characteristics of intra-state conflicts

➢ The collapse of state institutions, especially the police and judiciary, with resulting paralysis of governance, breakdown of law and order, and general banditry and chaos.

➢ Functions of government are suspended, assets are destroyed or looted, experienced officials are killed or flee the country.

➢ UN forces are used to protect humanitarian operations in instances where warring parties make access to provide civilians with succour difficult or impossible, sometimes due to the exigencies of war, but often because assistance for a particular population is contrary to the war aims of one or other of the combatants. This often accompanied by a diversion of relief supplies and humanitarian agencies undertaking their tasks under chaotic and lawless conditions.

➢ Media coverage of resulting humanitarian disasters is 'managed' by the factions in order to gain international support for their 'movement' and political pressure for UN intervention.

Implications for International Intervention

➢ Must extend beyond military and humanitarian tasks and must include the promotion of national reconciliation and the re-establishment of effective government.

➢ These are tasks which demand time and sensitivity: the UN "*can only help the hostile factions to help themselves and begin to live together again. All too often it turns out that they do not yet want to be helped or to resolve their problem quickly.*"

➢ In the cases of Somalia and Bosnia-Herzegovina the use of force is authorised, but the UN remains impartial (protecting relief operations, not bringing an end to the conflict) not having an agreement for peace-keeping in the traditional sense.

➢ The late 1980s saw the deployment of UN operations aimed at assisting parties to a conflict implement the comprehensive agreement they had negotiated. These have been deployed in Namibia, Angola, El Salvador, Cambodia and Mozambique.

➢ Peacekeeping in such contexts is more complex and expensive than when the task was mainly to monitor cease-fires and control buffer zones with the consent of the states involved.

➢ The UN operation involves military and a wide range of civilian matters such as the supervision of cease fires, demobilization of forces and their re-integration into civilian life, de-mining, return of refugees and displaced persons, provision of humanitarian assistance, supervision of existing administrative structures, establishment of new police forces, verification of respect for human rights, the design and supervision of constitutional, judicial and electoral reforms, observation, supervision and conduct of elections, coordination of support for economic rehabilitation and reconstruction.

➢ Multifunctional peace-keeping operations highlight the need for coordinated programmes over a number of years and in various fields to ensure that the original causes of war are eradicated. This involves institution-building, promoting human rights, creation of civilian police forces, and other measures to address underlying socio-economic, cultural, and humanitarian problems.

Box 18

A number of characteristics which these intra-state conflicts share and the implications for international intervention (paras. 13-22) are summarized in Box 18. The report notes that

> *The validity of the concept of post-conflict peace-building has received wide recognition. The measures it can use -- and they are many -- can also support preventive diplomacy. Demilitarization, the control of small arms, institutional reform, improved police and judicial systems, the monitoring of human rights, electoral reform, and social and economic development can be as valuable in preventing conflict as in healing the wounds after conflict has occurred.* (p. 11)

In a manner similar to that defined above where we discussed multi-track diplomacy, the report notes that peace building can occur in two kinds of situations, where the essential goal is the creation of structures for the institutionalization of peace:

➢ when a comprehensive settlement has been negotiated, with long-term political, economic and social provisions to address the root causes of the conflict and verification of its implementation is entrusted to a multi-functional peacekeeping operation; and,

➢ peace building, whether preventive or post-conflict, is undertaken in relation to a potential or past conflict without any peace-keeping operation being deployed.

The Secretary General argues that the first situation is relatively more amenable to peace-building activities. The most difficult problems are likely to be in

> *the timing and modalities of the departure of the peace-keeping operation and the transfer of its peace-building functions to others ... Most of the activities that together constitute peace-building fall within the mandates of the various programmes, funds, offices, and agencies of the UN system with responsibilities in the economic, social, humanitarian, and human rights fields. In a country ruined by war, resumption of such activities may initially have to be entrusted to, or at least coordinated by, a multifunctional peace-keeping operation, but as that operation succeeds in restoring normal conditions, the programmes, funds, offices and agencies can re-establish themselves and gradually take over responsibility from the peace-keepers, with the resident coordinator in due course assuming the coordination functions ...* (p. 12)

In sum, this transition is problematic because authority must move away from the Security Council to the General Assembly, to the regular social, economic and humanitarian activities of the UN. The report goes on to note, as much more problematic, the situation where

> *post-conflict (or preventive) peace-building activities are seen to be necessary in a country where the UN does not already have a peace-making or peace-keeping mandate. Who will then identify the need for such measures and propose them to the Government? If the measures are exclusively in the economic, social and humanitarian fields, they are likely to fall within the purview of the resident coordinator. He/she should then recommend them to the Government. Even if the resident coordinator has the capacity to monitor and analyse all the indicators of an impending political and security crisis, however, which is rarely the case, can he or she act without inviting the charge of exceeding his/her mandate by assuming political functions, especially if the proposed measures relate to areas such as security, the police or human rights?*

The obvious question to ask is "What Government?," a problem in most LIC theatres. The report admits sanguinely that there is a myriad of difficulties which can occur in implementing this progression as envisaged by the Secretary General. So, from a foreign policy perspective, we need to determine the steps which need to be taken as early as possible in any humanitarian intervention to *guarantee and sustain* continuity in the peace building effort and assure the consolidation of peace-keeping operations.

Summary

Given these difficulties or shortcomings which plague the application and enforcement of international law and the limitations which a reliance on formal government structures places on the deployment of multi-functional peacekeeping operations (including peace building

components) into zones of LIC, in terms of the peace building framework (Box 6, page 29), it would appear that we are left with working on in-country preventive and post-conflict peace building. This would appear to be a practical and immediate foreign policy niche which Canada is well placed to play an active, unique, and constructive role. While here we discuss the relative merits of one community based approach, we would also encourage more effort in policy and operations which seek to understand and promote the benefits of community based approaches across the spectrum of health, education, agriculture, etc.... The advantage of community based approaches is that the seeds for lasting peace are sewn into the fabric of the daily lives of people.

Humans who wage war have only one remaining relation of interdependence: the objective of mutual destruction, the very negation of that remaining relation. To achieve peace, this relation of interdependence must be transformed into several positive relations of interdependence on the cultural, economic, social and productive planes. While a focus only on the community based rehabilitation of persons with disabilities is clearly insufficient on its own, it is a remarkably useful starting point. CBR addresses an extreme form of vulnerability. If public services and support can reach the most vulnerable in society, especially in difficult circumstances such as LIC, then less extreme vulnerability and its social impact may be addressed. In cases where disability is the consequence of violent armed conflict, it becomes important psychologically for the traumatized society to perceive the actual human result of the conflict. A tangible and direct manner of doing this is to create the means whereby those who were engaged in or affected by violent conflict as combatants or as civilians come to grips with the need to (re-) integrate a disabled person as part of the psychological healing of the population at large.

4.6 Attention to Disability and Peace Building: An Inventory

In this section, we briefly look at the efforts of multilateral agencies to address the disability dimension in the area of reconstruction and development of war-torn societies. The gaps again indicate foreign policy opportunities for Canada in the promotion of CBR and other community based initiatives as peace building techniques.

A special report of the UN Commission on Human Rights recognizes that violations of human rights and of humanitarian law cause disability. The same report noted that suffering inflicted on non-combatants in situations of armed conflict or civil strife is of a purposive nature. Disabled Peoples' International points to the large number of disabilities that are the result of illegal military operations, ill-treatment of prisoners of war, refusal to attend to the wounded, and interference with the humanitarian action of civilians (Despouy 1991).

The action of the ICRC on behalf of the war wounded is well-known. The ICRC intervenes when local surgical structures are insufficient or access to them for certain groups of victims is denied for political or other reasons (Russbach 1993, 122). The ICRC then provides material support to local surgical structures or negotiates access to surgical care for all wounded in accordance with the principles of the Geneva Conventions. The ICRC has been active in sharing its

experience with war injury, making available booklets and films and publishing articles in medical journals.

Only where the percentage of disabled persons is exceptionally high, as in situations of conflict, do agencies incorporate specific attention to their needs or to those of their care givers. Certainly, there are numerous agencies which are engaged in mine clearance, mine awareness, as well as the provision of prosthetics and other support to those disabled by anti-personnel land mines. Indeed, CIDA supports such projects in Cambodia and Angola, to name but two countries (Axworthy 1997, 4).

However, as Rémi Russbach, MD, Chief Medical Officer and founder of the Medical Division of the ICRC has written,

> *action in favour of amputation victims should not be confined to emergency treatment, since artificial limbs, even when they are of high quality, suffer from wear and tear, and must be changed. Children's artificial limbs must be altered to accommodate body growth. It is therefore obvious that any action in favour of amputation victims must be followed up by long-term support.* (1993, 129)

The work of the ICACBR and its partners complements the activities of the ICRC and other agencies engaged in victim assistance in countries where the scourge of land mines is rampant. But what is most important about the CBR approach is that it can provide an indication of where there are opportunities in current reconstruction and peace building activities, opportunities to extend the benefits of CBR as a process and assure that peace building becomes rooted in a sustainable manner in affected communities.

In 1989, the Rehabilitation International/Unicef Technical Support Programme conducted a review of the physical rehabilitation needs of children and women victims of armed conflict, specifically in Angola, Mozambique, El Salvador, Nicaragua, and among disabled Afghan refugees in Pakistan (Rehabilitation International/UNICEF 1991). The report of this preliminary study identifies how war causes disability, discusses the magnitude of the problem, and directs attention to specific areas of concern, including the need for accurate assessments of disability, culturally based (tailored) approaches to disability, and equal participation of disabled persons. Their recommendations significantly contribute to the search for solutions and include the promotion of CBR, research on disability and on disability prevention, specific attention towards women, children and the mentally disabled, and the incorporation of disability issues into international aid programs for development, war and disaster.

The UNHCR has begun to actively address the situation of disabled refugees (Crisp 1989), providing practical guidance to their field officers and others working with refugees on steps to be taken to prevent and to provide treatment for disabling conditions, as well as rehabilitation for refugees with disabilities (UNHCR 1992) . Areas of focus include training, attitudes, support for disabled refugees acting as leaders and workers, family support, access and mobility, vocational training, education, and appropriate simplified rehabilitation technology. However, where provided, services for disabled refugees have been available only at high per capita cost,

and are limited in their coverage (Eade and Williams 1995). New UNHCR policies call for a focus on early detection and treatment, and equal access to and participation in refugee services for persons with disabilities. In general, the various international organizations that have confronted the issue of disability under conditions of political violence now advocate a community-based approach to rehabilitation (Rehabilitation International/UNICEF 1991; UNHCR 1992; UNRWA 1992; Werner 1990; ICACBR 1996).

The UN Secretariat has published ***An Inventory of Post-Conflict Peace building Activities*** (1996). However, this document fails to consider or reflect a disability perspective in the work of UN agencies which have a mandate to address this dimension. For example, under relief and humanitarian assistance, the specific needs of persons with disabilities are not addressed. In the section dealing with food aid, the need to assure that disabled persons not only have access to food but also to the means of cultivation is not discussed. While the section on health does emphasise the need to mobilize local capacity and mentions war injury, disability is not addressed beyond suggesting that prosthetic materials be distributed. In dealing with mine clearance as a peace building activity, the report does not mention the need to develop in-country capacity to organize and represent the needs of persons with disabilities in decision-making fora. In sum, the ***Inventory*** does not, unfortunately, adopt an approach to peace building recognizing that community development processes which address disability are an important, indeed vital, dimension of peace building. This presents a foreign policy opportunity to Canada, which could advocate for community based interventions in many sectors as being vital to building peace.

5.0 Disability, Conflict, and Community Interventions

In the preceding section (4) of this paper, we discussed the current foreign policy context, noting Canadian peace building priorities in dealing with the types of conflicts now occurring internationally. We also noted that peace building, and indeed development assistance policy and priorities in general, do not consider the disability perspective. At the level of UN intervention, and that of international law, and international regimes more generally, the inability to effectively address the causes and consequences of disability is also evident. We contend that this is a missed opportunity for peace building and Canadian foreign policy.

In this section of the paper, we delve further into the technical subject matter area in which the ICACBR is expert. Here we focus on the nature and scope of disability issues in conflict situations and set forward the key features of community based approaches in this area as well as issues and caveats drawn from the ICACBR experience in the more conventional 'development' environment. The ethical and moral foundations of these issues are also discussed. As the process of CBR becomes clear, its benefits, summarized early in this paper, as a conflict mediating or conflict resolution process will begin to take shape.

5.1 Community Based Rehabilitation

CBR is a response, in both developed and developing countries, to the need for adequate and appropriate rehabilitation services, to be available to a greater proportion of the disabled population. Its aims are to rehabilitate and train disabled individuals, as well as to find ways to integrate them into their communities. In CBR, the disabled person, the family, the community, and health professionals collaborate to provide needed services in a non-institutional setting, and in an environment or community where services for disabled persons are seriously limited or totally absent. Its essential feature is its focus on partnership and community participation. Approaches to the implementation of CBR are many and are determined by a variety of social and demographic factors. Introducing rehabilitation services at a local or community level removes many obstacles to care which are associated with institutions. The difficulty of travel and its expense are eliminated or reduced to a minimum. The individual is not isolated from the community; family members and community volunteers are part of the rehabilitative process. All participants can see what the disabled person has achieved. This can help integrate the person into the community, a community which values the unique contribution which the person is able to make.

Many factors have led to the development of a specific 'community oriented' perspective on disability. This evolution has paralleled the 'primary health care' response within medicine more generally. These factors include escalating health costs, inequitable distribution of resources, a limited workforce, increased consumer awareness (and resultant demands) upon health care and social systems, reassessment of the emphasis placed upon high technology and institutional based care, dissatisfaction with the hierarchical medical system, and a critical analysis of health determinants. While these factors are common, to varying degrees, among societies of differing levels of economic development, within developing nations CBR attempts to actually address the overwhelming need for rehabilitation services, reaching the tremendous number of disabled persons who have limited or no access to such resources. Estimates are that only 1 to 3% of disabled people living in developing countries who require rehabilitation services receive them, these services being particularly inaccessible to the rural majority (WHO Expert Committee 1981; Helander et al. 1989).

The principles of CBR, like the principles of many disciplines, have been the subject of much discussion. The WHO Expert Committee on Rehabilitation has defined CBR as an approach which "*involves, utilizes, and builds on existing resources in disabled persons themselves, their families, and communities*" (Rehabilitation International/UNICEF 1989-90). The WHO has contrasted CBR with institutionally-based and outreach rehabilitation services as follows: with CBR, there is a large-scale transfer of knowledge about disabilities and of rehabilitation skills to the people with disabilities, their families, and members of the community, such that resources become available at the community level and rehabilitation has been 'democratized' (Helander et al. 1989).

Einar Helander highlights the founding principles of CBR as being equality, social justice, solidarity, integration and dignity for people with disabilities (Helander 1992). His definition of CBR (Box 19) emphasises its inherent processes.

Furthermore, David Werner proposes two goals of rehabilitation at the community level:

1. To create a situation that allows each disabled person to live as fulfilling, self-reliant, and whole a life as possible, in close relation with other people.
2. To help other people – family, neighbours, school-children, members of the community – to accept, respect, feel comfortable with, assist (only where necessary), welcome into their lives, provide equal opportunities for, and appreciate the abilities and possibilities of disabled people.

CBR According to Einar Helander

CBR is a strategy for improving service delivery, for providing more equitable opportunities and for promoting and protecting the human rights of disabled people.... It calls for the full and co-ordinated involvement of all levels of society: community, intermediate and national. It seeks the integration of the interventions of all relevant sectors – educational, health, legislative, social and vocational – and aims at the full representation and empowerment of disabled people. Its goal is to bring about a change; to develop a system capable of reaching all disabled people in need and to educate and involve governments and the public, using in each country a level of resources that is realistic and maintainable.

Source: Einar Helander, "What is in a definition?" *CBR News* no. 13 (1993): 3.

Box 19

Werner stresses the importance of disabled people being leaders and workers in rehabilitation activities, of meaningful work and training for disabled people, and of local resources being used for rehabilitation equipment and aids (Werner 1990a). Both Helander's and Werner's concepts are consistent with a peace building ethic of particular relevance to the LIC context.

Rehabilitation International and the UNICEF Technical Support Programme assert that CBR is based on the community development concept of individuals with disabilities becoming empowered to take action to improve their own lives and become contributors to society (1989-90). In Canada, the ICACBR has outlined principles of a CBR program, which include change in community attitudes towards disability, empowerment of people with disabilities, participation and partnership in

CBR - The Key Elements

- Promotion of positive community attitudes and behaviours towards disability
- Empowerment of persons with disabilities, enabling integration within society
- Knowledge and skills transfer, to promote self-help skills
- Development of rehabilitation services/resources, based upon needs identified by persons with disabilities and their families
- Programs characterized by community decision-making and implementation, and accountability to the community
- Model of partnership/collaboration among persons with disabilities, their families, the community, and rehabilitation personnel
- Development of rehabilitation technology utilizing local skills and materials
- Co-ordination with, and referral to, a network of specialized interventions, including institutions, to provide professional and technical support and training which may be unavailable within the community

Box 20

program implementation and development, and education (ICACBR 1993).

Drawing upon an emerging consensus in these sources, then, a useful framework can be formed of what can be considered "key elements" of CBR. These are enumerated in Box 20. It has often been stated that there is no blueprint for a CBR project (Peat 1991a, 1991b; Helander 1993). This is because countries, regions, and communities vary enormously with respect to their administrative structures, economic and cultural conditions, populations and their distribution, and financial and workforce resources. Each of these conditions must direct the nature of the approach to rehabilitation, if the program is to be indeed 'community-based.'

However, circumstances of political violence may overlie these conditions. It has been suggested that a coordinated CBR approach to rehabilitation may contribute a great deal towards addressing the pressing issue of disability in conditions of political violence (Rehabilitation International/UNICEF 1991; UNHCR 1992; UNRWA 1992). ICACBR experience in a number of situations of armed conflict (Bosnia, Afghanistan, Sri Lanka, Cambodia, Mozambique) suggests that CBR has a constructive role to play in contributing to peace building as an element of Canadian foreign policy objectives.

5.2 Issues and Caveats in CBR Implementation

This section sets forth key issues and caveats derived from the ICACBR experience (Boyce and Lysack 1997). Those managing technical assistance projects in developing countries, those working to improve the impact of peace building activities, and those conducting research (e.g., IDRC) on the approaches communities take to improve their well being in war torn areas, would do well to consider these, and not only in relation to disability. As we have suggested throughout, CBR's impact will be enhanced as a peace building activity if it works in a complementary manner with other community based initiatives.

More research is required about the benefits to peace building associated with other types of community level public health interventions, in addition to water, sanitation, agriculture and income generating projects such as those which extend credit, implements, and other assorted benefits. All of these types of projects do have community based approaches and schools of adherents, and this knowledge base needs to be tapped so that peace building as a process, and as a Canadian foreign policy initiative, is robust and multi-sectoral, drawing on the extensive experience of our development and humanitarian assistance agencies.

Issue and Caveat 1

The first caveat which emerges from the international CBR experience derives from the issue of community diversity discussed in Box 21. The capacity of community groups to become involved in CBR implementation must be carefully assessed. When initiatives focus on the poor, the disabled, or other disadvantaged populations, utmost care must be taken so that the burden of organizing change is not placed solely on disadvantaged groups. There are important costs involved in participatory activities, including personal time expenditures. This

has real and profound implications for the health of the community, and particularly for women, the traditional care givers (Lysack and Krefting 1993). Unless participation is carefully crafted and monitored to take these issues into account, few may be prepared to be actively involved in CBR. This leaves the field open only to more advantaged community members, and this in turn can create power imbalances which undermine technical assistance projects operating in more stable environments, as well as peace building efforts operating in either preventive or post-conflict contexts.

Community Diversity

An uncritical embrace of community rhetoric assumes that "natural communities" exist and consist of harmonious collections of individuals, mutually supportive of one another, and committed to communal responsibility (Hawe 1994). Community development experience internationally, however, has clearly demonstrated that communities are diverse and often tumultuous places (Kothari and Mehta 1990; Stone 1992). For example,

➢ there are frequently vast differences within and between communities with respect to ethnicity, age, gender, and socioeconomic status which create problems in the coordination of services (Young 1990; Robertson and Minkler 1994);

➢ vested interests in communities and power structures that permit access to communal goods for some people, while systematically denying such benefits to others, also threaten community development success (de Kadt 1982; Twumasi and Freund 1985); and,

➢ because of a variety of political and developmental trends (changes in land tenure and usage, migrant labour, urbanization, wars and conflicts leading to large-scale refugee and displaced populations), the cohesive "traditional" community, may be fast disappearing (Chaudhury, Menon-Sen and Zinkin 1995).

Recent analysis of the international disability context also suggests that the positive language of community obscures inherent diversity in disability settings (Lysack 1996). Investigating community diversity is imperative for CBR, otherwise neglect of its disparate factions and their competing demands may derail attempts to mobilize community action around disability, especially under conditions of economic scarcity and/or political strife. Furthermore, ignoring community diversity risks overburdening particular segments of the population active in CBR, and risks misjudging levels of commitment to a CBR approach.

Box 21

Issue and Caveat 2

The second lesson to be learned from community diversity relates to the matter of disparate interests (Box 22). International experience has shown that powerful vested interests can control the local health agenda and *"usurp the resources of development in its own interests, rather than sharing the fruits of development with the deprived and neglected sector of local communities*" (Nanavatty 1988, 97). In such cases, the centralized control of medical professionals and governments is simply replaced by the localized control of powerful community interests (Rosenau 1994; Young 1990).

If one of the aims of CBR as a peace building and development process is to address the disability needs of individuals who are not traditionally reached by institutional rehabilitation in urban centres, then it is imperative that CBR proponents and, in their design, technical assistance projects, recognize the diversity of these communities and find ways of including

their most marginalised and disenfranchised segments (Peat and Boyce 1993).

Diversity as Disparate Interests

This is currently a major issue in Canada's northern First Nations communities where efforts to establish Aboriginal-controlled health services have come up against firmly entrenched local hierarchies of authority. If CBR projects in Canada face difficulties in negotiating the contested terrain of traditional power so that the voices of women, children, the abused, and the disabled can be heard, then it is not surprising that similar difficulties surface elsewhere. In these cases, the challenge is to implant the practice of CBR in a manner which assures that its legitimacy as community practice can be sustained. This means that it must be capable of being continued as part of the local economy, and it must also reside in and be transferred between poles of economic, social and political power. Clearly, one means of assuring this is through the creation of an environment which is favorable to the emergence of organizations of disabled persons, so that they may engage with other interests and groups in civil discourse, assuring that daily language incorporates values which are accessible to the disabled experience. Once the fundamental diversity of communities is recognized and included in the decision-making process, steps to determine the disability-related needs of communities can proceed with assurance that the breadth of community concerns are fairly represented.

Box 22

Issue and Caveat 3

The challenge of identifying real community needs can be overcome by carefully dissecting local social and cultural understandings of disability (Box 23). For CBR to have its intended impact, local meanings of disability causes, the nature of appropriate therapies, and local attitudes toward people with disabilities will also need to be examined.

Community Understanding, and Perception, of Disability

One of the first issues to be examined in the area of needs identification is the community's understanding of disability. International experience has shown that determining who is, and who is not, disabled is not at all straightforward. For example, Lysack (1995) reports how mental impairments such as mild learning disabilities are simply not recognized as problems by local people, including rehabilitation workers, in many parts of rural Indonesia. The same is true for physical impairments like limb deformities. The label "disabled" is attached in Javanese society only when people are unable to perform the social tasks common in their communities. Thus, what is considered "normal" with regard to individual functioning depends, for example, on age and gender, and is also highly dependent upon the society in which these norms are generated. Ingstad and Whyte (1995) have described a tremendous variation between countries and communities as to what constitutes disability.

Box 23

Issue and Caveat 4

As discussed in Box 24, divergent priority accorded to disability issues, whatever its root source, is ultimately reflected at the funding level: the recent CIDA ***Strategy for Health*** discussion paper fails to mention disability (1996). We contend that technical assistance, development, emergency humanitarian, as well as peace building and development research priorities must also reflect the disability dimension. CBR advocates in Canada must remember that people

in those countries we seek to assist, whether in time of peace or conflict, may not necessarily know how to participate, and many have never engaged in cooperative community initiatives. It is incumbent upon us as external agents to be pro-active in this regard. Indeed, an elucidation of the benefits of a proactive stance on disability, for peace building objectives in particular, is the central objective of this paper.

Divergence in the Level of Importance Accorded to Disability

Another major challenge to the identification of community disability needs has been the relatively low standing of disability on the list of community development priorities. A recent meeting of international CBR experts confirmed that, in many developing countries, disability issues are ranked well after food security, shelter, education, and income-generation as priority personal and community needs (PPRBM CBR Centre 1995).

The low priority of disability matters in communities is a complex phenomenon and is intricately linked to several other issues. To some extent, it is accounted for by the stigma attached to disability. Negative attitudes, lack of education, and other historical biases within dominant societies prevent people with disabilities from holding substantial personal or political power (Balcazar et al. 1994). The low priority of disability is also related to the small numbers of disabled people in any locality. Their geographic dispersion results in the lack of a "critical mass" of disablement necessary for effective programming and lobbying. The low priority of disability may also be due to the notion that disablement is a natural outcome of the aging process in all persons, and therefore not a problem that requires active intervention. Interestingly, in areas of armed conflict, disability achieves a much higher priority in communities because of both the cause, overt hostilities, and the geographic intensity of the problem (Boyce and Weera 1997; ICRC 1991).

Disability and CBR are low community priorities for other reasons as well. People with disabilities are typically isolated from mainstream political and social life in the community, including the organizational structures of the health system. Hence, they may be unaware of opportunities for participation. Even when relatively powerless groups such as disabled people do find ways to participate, there may be real problems in gaining access to necessary information in understandable forms for policy development, planning, and program implementation. Finally, poor and disadvantaged people, including people with disabilities themselves, may discount the participatory process, preferring instead to rely on professional and governmental management of community health problems (Stone 1992). Paradoxically, there are anecdotal reports of CBR projects implemented via a top-down administrative approach which would have failed with less of an authoritarian structure. This state of affairs may be expected in communities or even regions, rural and urban, developed and poor, where people had not previously been encouraged to take social development initiatives independently.

Box 24

Issue and Caveat 5

Community interest must be generated through genuine consultations with local people and material improvements in their lives. Then the issues discussed in Boxes 25 and 26 have the best chance of being addressed. In tandem with other community based efforts to address structures inimical to peaceful dispute resolution, CBR can turn conflict into growth for the community, redistributing or reallocating resources to those scarcities which can provoke conflict, and which, equally, can encourage or even force opposing groups and opposing values to recognize a common horizon.

CBR, in conjunction with other efforts at the level of community, influences collective problem

definition, the discussion of problems in civil structures, and can thereby contribute to democratic development and good government as process in a number of social, economic, and cultural areas. Evaluations of CBR at the international level suggest that the greatest success has been enjoyed when disability is incorporated into broader community development strategies (Menon 1984; PPRBM CBR Centre 1995). A community development approach integrates a disability perspective into every facet of community activity, from childhood education to nutrition, from agriculture to sanitation, from family planning to income-generating enterprises.

Community Needs are Contested

The international CBR experience clearly indicates that the nature of community need will undoubtedly be contested. For example, CBR experts often believe that disability prevention programmes will improve community conditions. Prevention programmes may be rejected by communities, however, if community members defend the adequacy of indigenous culturally-bound methods for coping with disability (Miles 1989; Stone 1992). A related difficulty is that CBR initiatives emphasizing prevention do not possess the immediate impact of quick and visible "curative" interventions. Providing dramatic proof of the benefits of a community referral system in CBR may be one way to secure community interest. For example, publicizing of the effects of surgical correction of club foot deformities is one way in which CBR can promote itself (PPRBM, CBR Centre 1995). International CBR has shown that disabled people are often interested in fragmented pieces of an entire CBR programme. A popular interest is receipt of adaptive equipment that provides immediate and tangible improvements in daily life (Menon 1984). However, "cure" and technical devices are not the principal focus of a community development style of CBR. Thus, sustaining long-term commitment to CBR as a community development practice in developing countries has been difficult to achieve (Helander, 1993; Krefting, Krefting and Tjandrakusuma 1993). This would suggest that efforts, both at the policy and operational levels, to work in tandem with other community based initiatives would be beneficial.

Box 25

Reconciling Individual and Community Interests

In the determination of community needs, there is the challenge which the reconciliation of individual and community interests presents. Who speaks for the community and how are personal interests protected? Again, the CBR experience in Indonesia has been instructive. In Central Java, where the wives of prominent local government officials often serve as CBR workers, real conflicts between the local agenda of disabled people and the policies of government have arisen (Lysack 1995). Such a reaction indicates that a fundamental problem has emerged between the participatory community based value system and one based on other distributions of power. That there is conflict means that some element of the participatory approach is threatening an interest bred of another system of values. To the extent that CBR identifies values which oppose peaceful conflict resolution, or which seek to preserve elements of the power structure contributing to conflict, CBR can illuminate the dispute resolution dynamic in a community in pre-conflict, conflict and post-conflict situations.

Box 26

A preliminary step in this direction may be to append CBR activities to already established health and education initiatives. Rather than adding a new layer of para-professionals, such as physical therapy and occupational therapy assistants with their accompanying bureaucracies, perhaps existing community health workers, public health nurses, and special education teachers should receive additional CBR education and training. In this way,

pre-existing infrastructures can be utilized efficiently to maximize the gains for people with disabilities, while searching for better opportunities and more creative solutions over the longer term.

5.3 Data and Information: Measuring Disablement in Conflict Zones

Rémi Russbach has commented that

> *it is difficult to calculate the exact number of victims of a country at war, where data gathering is hampered by chaos and the resulting isolation of remote areas ... civilian victims ... are not as easy to categorize as the military ones.* (Russbach 1993, 129)

So, what is the incidence of disability? Many statistics result from surveys conducted in order to assess the civilian impact of anti-personnel mines. But assessing the incidence, nature and scope of disability in conflict zones is complicated by numerous factors. In ongoing conflict, epidemiologists face the special problems of continuous change where long term planning is virtually impossible, military sensitivities impeding data collection, and necessary compromise with respect to scientific rigour. At its worst, epidemiologists face political manipulation of their data (Armenian 1989), and in some cases persecution. However, we are quite certain that even in the absence of land mines, the very nature of LIC, in addition to the severe economic scarcity which plagues many of the regions of the world where peace building interventions are required, means that disability is prevalent, and of sufficient scale to warrant the consideration of CBR as an approach to peace building.

To understand the nature and scope of disability in zones of LIC, it is useful to revisit some of the problems of measurement which were discussed in section 3, regarding the specific case of Bosnia. These problems relate to a variety of factors, and Box 27 provides an overview of the various types of disablement problems which occur in conflict zones. The nature of these impairments depends upon the characteristics of the conflict, and the use of various explosives, landmines, bombs, firearms, instruments of beating and torture, and tear gas. Impairments, disabilities, and handicaps also vary during different stages of conflict – from instability to conflict to reconstruction. This variability compounds data and information collection problems.

The Epidemiology of Disability: Some Definitions

Practitioners in the area of disability distinguish between impairments, disabilities, and handicaps as categories of disablement problems. Such categorization, in the experience of ICACBR, assists in measuring the nature and scope as well as the epidemiology of disablement problems. We have also found them useful in assessing disablement problems and their variations in situations where CBR as a peacebuilding technique can be beneficial.

Impairments
Impairments incurred during conflict may include peripheral nerve injuries caused by bullet and/or shrapnel wounds; hand, foot, facial injuries, and blindness caused by explosions or torture; and head, chest, and orthopaedic injuries caused by explosions or collapse of buildings. After hostilities cease, civilians may continue to suffer impairments, such as amputations and blindness caused by land mines. These impairment problems are best addressed through specific clinical programs such as surgery and prosthetics.

Disabilities
Disabilities which can occur during conflict may initially include being weak, unable to see, and unable to protect oneself during armed attack. Depending on the circumstances, being unable to rapidly respond to curfew, and to address basic hygiene and self-care may become problems. This is particularly the case for persons with impairments; in addition, elderly persons and displaced persons who are out of touch with extended family or neighbourhood networks are especially prone to disability. These problems result in needs for specific rehabilitation programs such as muscle strengthening, mobility training, vocational retraining, and provision of adaptive devices. It can also be important to assure that vulnerable groups are able to access humanitarian relief supplies as a means of preventing the possibility of increased disability and possible physical impairment.

Handicaps
In general, handicaps are overcome by increasing accessibility and opportunities for independent living. Handicaps experienced during times of active conflict often include being unable to safely earn a living. In post-conflict situations, one may also be stigmatized as a disabled veteran. These problems result in needs for specific community based programs such as public education, income generation projects, accessibility modifications, and peer support programs. In many countries where ICACBR has worked, efforts to overcome handicaps are best pursued by domestic and local disabled persons advocacy groups. In Cambodia, such groups are active participants in the human rights discourse; in Eritrea, disabled veterans have been strong advocates of generalized efforts, across society and via political means, to achieve accessibility objectives.

Source: Boyce and Weera, 1997.

Box 27

5.4 Ethics and Intervention

There are a number of relationships involved in the process of peace building. The obvious relationship, which is the primary focus of peace building, is that between the groups initially at odds during periods of conflict. The value of CBR in bridging the animosity gap between these groups, and its valuable role in the shared building of a sustainable peace with them, is obvious and undeniable.

However, the peace building process involves another set of relationships which often remain in the background. These are the relationships between the groups recovering from conflict

situations, and the external observers of the conflict who intervene to end the terror and to initiate the peace building process. Peacemakers, peacekeepers, and peace builders often have the best possible intentions in seeking to stop the terrible violence and human rights abuses that occur during these conflicts. But given the extremely compromised state of post-conflict groups, there is great risk that external intervention can have unforeseen, negative consequences. This is where the ethics of intervention must be examined.

Canada's foreign policy objectives (Box 2, page 23) include the projection of Canadian values and culture. But liberal values have also led Canadians to embrace multicultural ideals. The 5 December 1996 Halifax, Quebec and Victoria recommendations on Canadian Foreign Policy and International Peace Building include a directive that

> *The Canadian government should ensure that any peacekeeping/peace building interventions are based on promoting, protecting and reflecting Canadian values, including human rights, rule of law,* ***and multicultural tolerance****.* (CFPD 1996, 5; emphasis ours)

Although this directive is intended to stress the importance of promoting respect for multiculturalism in other societies, it also implies that we ought to respect cultural integrity when entering into international relationships.

The liberal values that underpin human rights are ensconced in international law, and have been espoused by a large number of countries, representing a vast majority of the human population. Although liberal values may be Western in origin, they rest on the fundamental value of respect for persons which is prevalent among a wide diversity of cultures. Given that widespread acceptance of respect for human rights would serve to discourage further violent conflict, and provide a stable foundation for lasting peace, it seems acceptable and beneficial to introduce these liberal values into post-conflict societies. Indeed, the 1996 Winnipeg 'Policy Options for Post-Conflict Reconstruction' suggest that

> *the democratic ideals of respect for human rights and free elections should be conceived of as a core component of Canadian reconstruction efforts and promoted regardless of a lack of local democratic traditions.* (CFPD 1996, 4)

However, Canadian liberal political theorist Will Kymlicka admits that liberal values should not be coercively imposed upon non-liberal cultures. In cases where non-liberal cultures oppress their members,

> *the initial moral judgement is clear enough. From a liberal point of view, someone's rights are being unjustly denied by their own government. But what is not clear is the proper remedy – that is, what third party (if any) has the authority to intervene in order to force the government to respect those rights?* (Kymlicka 1995, 165)

International mechanisms for protecting human rights allow us to intervene to end those terrible forms of conflict which rely upon human rights abuses, but they do not allow us to impose liberal values on non-liberal cultures which do not engage in blatant abuses. If the coercive imposition of liberal values on stable, non-liberal cultures is unjustifiable, the imposition of alien values

upon compromised groups is certainly equally unacceptable.

LICs not only destroy property and societies, they also result in immense human costs. Large numbers of persons are wounded, disabled, or killed in violent conflict. Among the survivors, the psychological costs are great as demonstrated in our discussion of the Bosnian experience. The loss of loved ones, home, security, and, above all, a normal context for everyday living, disables individuals, inhibiting their ability to interact with others. The terror that is inflicted upon innocents as part of political 'strategy' further deprives them of their humanity: rape, torture, and particularly the targeting of children, all serve to strip individuals of their confidence and their sense of self in a terrible way which lasts far longer than the conflict itself. The nature of these psychological effects is such that ending the violence will not make them go away; once an individual's own secure identity has been displaced, the process of rediscovering the self is necessarily long and difficult.

However, despite the terrible degradation of human beings which occurs during LICs, we are learning not to view these occurrences as tragedies which fully obliterate societies. Many have criticised the fatalist 'apocalyptic view' of conflict, which mistakenly assumes that post-conflict development requires rebuilding a society from nothing.

> *This approach has been criticised by those who maintain that armed violence is in practice continuous with normal social experience, suggesting that conflict does not necessarily correspond with social breakdown ... many communities are extremely practized* [sic] *at coping with adversity.... A lack of curiosity about sociological and cultural causality invites operational responses which are insensitive to local social and cultural conditions. Indeed, to intervene in an emergency ignoring indigenous coping strategies is to increase civilian jeopardy. A prime aim of humanitarian operations should be to identify patterns of social resilience and vulnerability and reinforce local capacities rather than introduce foreign perceptions and foreign responses.* (Boyden 1994, 257)

Respect for cultural integrity, then, is of the utmost importance in dealing with post-conflict situations, when cultural identity is perhaps all that is left to persons compromised by violent conflict. Throughout the series of horrors they have endured, only one part of their identity is sure to remain: they are 'other,' and it is because of this 'otherness' that they have been subjected to cruelty.

Therefore, although Canadian foreign policy objectives include the projection of Canadian values, we must be very careful in how this is implemented in post-conflict situations. The imposition of alien values upon individuals struggling to regain their own identity, independence, and confidence, not only risks causing unintended harm by inhibiting authentic cultural identities, but is also morally unacceptable. In building peace in post-conflict situations, we ought to be providing compromised groups with an opportunity to rediscover their identities and situate themselves in a context of peace, rather than imposing liberal values and alien identities upon them.

Furthermore, this opportunity for rediscovery of self is essential if any peace is to be lasting; the inhibition of self-rediscovery can be extremely deleterious. Compromised individuals cannot enter into the healthy, trusting relationships that are necessary for a society to build sustainable

peace; peace building requires confident, self-assured individuals with secure identities, if it is to result in a lasting peace.

Kymlicka also suggests that the coercive imposition of alien liberal values is likely to fail. "*Attempts to impose liberal principles by force are often perceived ... as a form of aggression or paternalistic colonialism*" (1995, 167). When attempts at liberalisation are perceived this way, members of non-liberal cultures are more likely to rebel against the perceived threat; and to reject the values that are being imposed. Kymlicka suggests that liberal values can only take hold in a society when they are internally embraced and sought by members of that society. Therefore, although the coercive imposition of alien values is unacceptable, we ought to promote liberal values, and to support internally-driven movements for liberalisation. "*Since the most enduring forms of liberalization are those that result from internal reform, the primary focus for liberals outside the group should be to provide this sort of support*" (p. 168).

Given these reflections on the morality of promoting Canadian values abroad, it is not surprising that the 5 December 1996 Canadian Foreign Policy and International Peace Building consultations yielded the following recommendation:

> *Democratization should be the primary goal of Canadian peace-building initiatives. At the centre of this lies the importance of the reconstruction of civil society as a means of fostering* ***indigenous*** *democratic elements. Strengthening the social/economic sphere can create a political space for civil society to develop, and can help democratic development that* ***reflects local values and history.*** (CFPD 1996, 5; emphasis ours)

This recommendation recognises the need to respect the cultural integrity of post-conflict groups, while at the same time supporting internal liberalisation. The question, then, is how to promote liberal values in post-conflict situations, without taking advantage of the compromised position of those groups trying to rebuild their lives.

It is unlikely that persons from other cultures will accept or embrace Canadian values if they feel that the values are alien and being imposed forcefully. In promoting Canadian values, an approach which is both respectful of other cultures, and which allows them to appreciate the benefits of incorporating liberal Canadian values in their own society, is required. In order to begin to see the value of other cultural approaches, inter-cultural dialogue must occur. Important perspectives must be shared by both sides, and each side needs to comprehend the perspectives of the other through their own cultural context of understanding. This is what Canadian philosopher and political theorist Charles Taylor refers to as a 'fusion of horizons':

> *we learn to move in a broader horizon, within which what we have formerly taken for granted as the background to valuation can be situated as one possibility alongside the different background of the formerly unfamiliar culture. The 'fusion of horizons' operates through our developing new vocabularies of comparison, by means of which we can articulate these contrasts.* (1994, 67)

In achieving this fusion of horizons, other cultures become exposed to liberal values, and are able to more truly appreciate the benefits such values offer. This allows for the internal reform sought by Kymlicka, without coercively imposing our values. It also offers the additional benefit

of exposing Canadian peace builders to the inherent value of resilient groups that have managed to survive unspeakable terror. It is only through such a fusion that we can truly begin to appreciate the value of other cultures, and they the value of ours. The ideal peace building approach will enable this fusion of horizons to occur.

John Paul Lederach attempts to achieve something like this fusion of horizons as prescribed by Taylor, by invoking a dialectical approach to mediation, which he terms an 'elicitive model' (1995, 55). Rather than imposing alien standards in resolving conflicts, the elicitive model seeks to discover and solidify the resources which exist in the situation in which we are trying to build peace. There are certainly several reasons to recommend this as an appropriate peace building approach: by empowering individuals to speak for their own cultural traditions, it allows a voice to under-represented or oppressed groups. Thus liberal values are introduced. But in seeking resources within the specific contexts in which it is applied, it also demonstrates respect for the value and integrity of other cultures.

However, Lederach's approach also has its failings. The biggest issue is in fact not so much a problem with the specific model he supports, but rather with the mediative approach as a whole. Rather than focusing on the possible future available within a context of sustainable peace, it focuses on past conflict and dredges up any central disputes which initially triggered unrest. The aim of peace building is surely to move forward, rather than to dwell on the conflicts that have brought misery and despair to so many. Further, groups who have been pitted against each other during conflict may well resent, or at least feel great unease, in being forced to sit at a table together to resolve their problems. The mediative approach is a predominantly Western creation, and may not be readily accepted in all post-conflict situations.

CBR offers many benefits that a mediation approach does not. Rather than focusing on the issues which triggered conflict initially, it forces persons in post-conflict societies to recognise the repercussions of their cruel and violent acts, in terms of the number of persons killed, wounded or disabled during conflict, as well as the poverty and suffering that subsequently result. But CBR also offers people in these societies a tangible opportunity to recreate a supportive community in an environment of peace: rather than focusing on what tore their society apart, CBR helps persons in post-conflict situations to put their society back together. It is thus a positive, forward-thinking approach that may be used in peace building.

The CBR focus on integration of persons with disabilities certainly promotes the liberal values of respect for individuals and egalitarianism. But rather than imposing these values on persons from other cultures, it introduces them in a context in which they are readily accepted and not perceived as intrusive. It is a fact that LICs cause disability in individuals, and in seeking to move forward from periods of conflict, the need to redress the harm done during this conflict is clear. Rather than preach the liberal values of individualism and egalitarianism, CBR demonstrates them by example in a clear, accessible, tangible manner. Persons from non-liberal cultures are more likely to internalise liberal values when they are embodied in social phenomena to which they are exposed every day.

Further, there is little doubt that many members of post-conflict societies will be exposed to liberal values when the CBR approach is utilised. While CBR focuses on persons with disabilities, it also recognises the need for integration within a broad, stable social context. This social context casts a wide net: persons with disabilities live in family and neighbourhood contexts, work in professional contexts, and belong to religious or spiritual groups. Thus, in providing greater mobility and allowing for greater visibility of persons with disabilities, CBR touches people in all of these contexts. In enabling all of these people to witness the growing independence of persons with disabilities, CBR exposes all of them to liberal values in a non-threatening manner. Although CBR appears to have a limited focus, its arena for the promotion of liberal values is great.

CBR promotes liberal values in a positive way because it works toward the 'fusion of horizons' which Taylor prescribes. In identifying and making use of local resources and capacities, CBR enters post-conflict situations with an implicit assumption of the value and abilities of other cultures, and a fundamental respect for persons and their cultural integrity. In working to establish self-sufficient CBR programmes, CBR brings Canadian expertise and values to a context where they are wanted and welcomed. In building effective local CBR programmes, CBR must engage in the inter-cultural dialogue that leads to Taylor's fusion of horizons. Thus, CBR offers the additional benefits of establishing open and trusting inter-cultural dialogue that can aid in resolving inter-cultural conflicts, and prevent future disagreement. CBR offers many substantial benefits when viewed as a tool for peace building.

CBR also proves to be a morally commendable method of achieving Canadian foreign policy goals of promoting Canadian values abroad. It succeeds at exposing persons from non-liberal cultures to our liberal, Canadian values, and promotes those values in a positive manner without imposing them. It employs a method which demonstrates a fundamental humility, in that it recognises that there is much value in other cultures, and that Canadians do not have a monopoly on knowledge and cultural value. It can lend confidence to many groups whose self-assurance and identity have been critically compromised during periods of terrible, violent conflict. CBR ought to be viewed as a valuable peace building opportunity, and should be pursued with vigour as an important element of Canadian foreign policy.

6.0 Addressing Disability in the Post-Conflict Context: Summary

This section is summary in nature, drawing together elements of the discussion in sections 3, 4, and 5. Constraints to CBR management and implementation are summarized, followed by a set of policy principles. Finally, the key benefits of CBR as a peace building approach, and as such to Canadian foreign policy, are summarized, and a set of implementation modalities are suggested to effectively capture these benefits.

6.1 Principal Constraints Facing CBR in War Zones

There are three principal problems in the management of a response to disability in war zones. First, there are *immediate and increasing physical and psychological needs* of injured persons which have been previously described. Furthermore, there is a similarity of needs for elderly persons, children, women, refugees and migrating persons, all of which derive from their usual exclusion from attention during wartime. There is often serious competition with other survival issues for the majority of population. Aid agency personnel are often unaware of the disadvantage of disabled persons in accessing emergency relief, since disabled persons may not be physically present to press for goods and services. Finally, there are few opportunities for war-injured or other disabled persons to earn income in competition with able bodied persons.

Second, a *lack of trained rehabilitation personnel* minimizes the response which can be mounted quickly. Especially in developing countries, there are often limited numbers of rehabilitation workers prior to the conflict. This situation is in contrast to medicine and nursing areas which often have had at least a minimal number of established training programs and graduates. The consequence for rehabilitation services is that prolonged training programs are necessary before national staff can take over responsibilities. These are also hampered by a lack of suitable training information, especially on community based approaches, in the appropriate languages. When trained staff do exist, emigration, internal displacement, and persecution of educated personnel can reduce their availability. Furthermore, a lack of salaries for rehabilitation work forces trained personnel to work elsewhere. Finally, there are usually few basic rehabilitation supplies or equipment which can be used for treatments.

Third, the *destruction of physical and political infrastructure* seriously complicates both rehabilitation service delivery and community development initiatives. There may be security risks from warring parties, opportunists, and local rivalries. Transportation is slow, especially by road, and rail systems have been destroyed . There are air transport risks regarding inoperative radar control and missiles from warring parties. Undetected and uncleared landmines restrict movement, prevent agriculture and commerce. Communication problems may prevent telephone, fax, and email. Radio networks and satellite linkages may not exist.

There may be restriction of movement, especially for women, and daily curfews which make field work impossible. Unstable political allegiances, politicization of service agencies, and lack of leadership can create distrust and an atmosphere of tension in the population. Finally, aid agencies may lack opportunities for strategic planning and networking. A lack of rapid, appropriate assessment and evaluation methods may either prevent information gathering, or produce information which exposes multiple 'divergent' problems which appear insoluble.

Thus, a number of factors, both internal and external to the war zone, restrict the ability to respond to rehabilitation needs. Internally, except for larger cities with hospitals, the geographic dispersion of disabled persons reduces the critical mass of beneficiaries which makes program delivery inefficient. The 'normal' geographic dispersion of disabled persons is somewhat overcome when refugees congregate, but often disabled persons are left behind. Disability problems, especially non-conflict related disabilities, tend to be marginalised by the general population. Priorities for survival and persistent stigma about disablement may be the cause. Often, there is limited information, on disability issues and other health concerns, or the institutional memory where such information may be stored has been depleted or destroyed.

External to the conflict zone, there is a lack of trained international personnel in rehabilitation and in community based approaches who are willing to work in these conditions. Inadequate funding, caused by donor fatigue regarding prolonged conflicts or 'unimportant' countries, limits the response. Even when funding is present, the monopolization of donor focus on humanitarian emergencies and disabilities caused by landmines results in neglect of endemic disability among more vulnerable populations. Finally, a lack of aid agency coordination results from confusion on whether disability programs should be treated as a topic for services, similar to health needs, or as a focus which requires social inclusion, similar to gender. There are convincing arguments that disablement is both a medical and social concern in war zones and that CBR is an appropriate conceptualization which allows both views to be satisfied. We touched upon this difficulty above in the discussion of the peace building capacity map and have emphasized the process benefits of CBR to peace building.

The problem of assistance agencies 'taking over' the management of domestic/national/local capacity, thereby engendering dependency, has been recognized at a general level in the international community, but it is important to check such administrative and managerial tendencies. We have noted that disability problems in general are of marginal consideration in humanitarian relief activities. This can be especially problematic for addressing disability as many humanitarian relief workers are not aware of the disability dimension, and the benefits which can come from addressing disability as soon as possible in a post-conflict context. Often this can be overcome through education aimed at changing the attitudes and beliefs of managers and officers in such organizations. Of course, there is always a need for improved aid agency coordination; because of the networks and relations of interdependence it creates, CBR can make a contribution to coordination across the spectrum of peace building processes.

6.2 Policy Principles

A number of important principles are advisable for planning CBR programs in these conditions.

Flexibility

Flexible planning and intervention models have become essential tools in emergency aid situations (Eade and Williams 1995). The uncertainty of the conflict environment is a given. Actions taken with even the best planning may create other problems which are not foreseeable. Planning mechanisms which allow incremental learning and adaptation, such as capacities and vulnerabilities analysis (Anderson 1989), and developmental evaluation (Patton 1994), are necessary. The use of development 'programs', which allow flexible mechanisms for support of local groups, may be more appropriate than development 'projects', with fixed objectives and outcomes.

Peace Building

Visions of peaceful co-existence do not come readily in conflict situations. Any opportunity must be seized to promote productive, non-exploitative contact among factions. The common concern of disability, with its powerful emotional and practical consequences, represents such an opportunity. Careful facilitation of contact between factions which are developing separate CBR initiatives can, in the right situation, promote understanding, sharing of experiences, and eventually, assistance between groups. Positive roles may be found for ex-combatants in community healing. However, these strategies must be approached with caution, so that conflict is not exacerbated by providing privileges which may expose new tensions.

Good Governance

Aid agencies can model 'good governance' practices to factions through responsible coordination activities. Such coordination systematically, and openly, uses policy instruments to achieve cohesive and effective programs. Information gathering and dissemination, planning and evaluation, mobilizing resources and establishing systems of accountability, organizing field activities, and negotiating frameworks of action with political and military authorities are important activities. Linkages to ongoing security programs, landmine awareness, and clearance projects are crucial.

Integration for Sustainability

It is advisable to link CBR with other initiatives which have potential for greater sustainability. Use of existing governance structures such as community councils, local non-government organizations, and integration with general development sectors (e.g., production, health, technology, credit, training, etc.) may allow disability concerns to be sustained once the relief crisis has passed. This approach encourages multiple actors and diverse action plans, with devolvement of responsibility to local levels. The risk, of course, is that disability concerns may not be listened to in these fora. Demonstration of this inclusionary approach by multilateral agencies such UNHCR, UNDP, and UNICEF appears to be increasing, and may serve as an

example to national actors. At the minimum, there should be an integration of disability services with mainstream Primary Health Care programs.

'Relief Development'

The problem of capacity strengthening in national NGOs, which will assist their transition to post-conflict development, is a real one. 'Relief development', or development for survival, is a concept which allows a focus on building capacity to cope with crisis (Eade and Williams 1995). Considering the crisis environment of war zones, an approach which acknowledges that organizations must undergo learning and strengthening in order to cope with their immediate environment is a useful one. Of course, the by-product of such strengthening may be sustainability, but it should not be achieved at the expense of meeting basic needs.

6.3 CBR as a Peace Building Opportunity: A Summary of Benefits

The increased visibility and incidence of disability in conflict situations creates a political necessity to address disability, especially if steps are taken to develop locally organized and managed groups which can articulate the needs of disabled persons. Often, initial impetus for such organizations comes from land mine victims and disabled combatants. This creates an opportunity to heighten the profile of disability on the humanitarian/development agenda, and concomitantly the depth and breadth of Canadian experience and exposure in this area. If action is taken to catalyse resources to address this need, disability can become an issue common to divergent groups, evoking a sense of common need, and an openness to develop a strategic vision for community based peace building initiatives. In sum, several key benefits result from the integration of disability issues and CBR into the peace building process in the manner we suggest:

1. The immediate impact of CBR intervention with a critical vulnerable group, whose *immediate human security* is in jeopardy, is significant. This early humanitarian response demonstrates compassion and may be viewed as both *symbolic and tangible catharses* to warring factions, to donor agencies, and to civilian victims of conflict. Local visibility is achieved in the early stages of CBR intervention because local capacity and domestic resources must, by the very nature of the intervention, be employed to a significant degree. Furthermore, CBR can alleviate poverty in families in which a member is disabled, as well as minimize the social costs which accrue to long term disability.

2. The process of integrating a CBR focus on disability, which by definition attempts to transcend gender, cultural, social class, religious, and political divisions, contributes to de-legitimizing politics and conflict which draw their legitimacy from the exclusion of human beings on the basis of these characteristics. CBR, addressing an issue held in common, can *diminish perceived barriers between disparate groups*, thereby decreasing the legitimacy of exclusionist political rhetoric.

3. CBR, as one element of humanitarian intervention and multi-track peace building, diplomacy and conflict resolution, can provide examples of solutions to the difficulties which complex emergencies present in organizational and management terms. CBR promotes a *multi-sectoral approach to problems which require interaction and negotiations*. This example can alter the disposition of key local managers controlling the health and social service infrastructure, increasing their propensity to view local cooperative non-hierarchical action, as effective and worthwhile to support.

4. Conflict can create opportunities to re-establish the philosophy and basis for social service and economic reconstruction. CBR, due to its focus on both personal change and social adaptation through community based strategies, demonstrates *opportunities for health, social, and economic reform in a non-contentious arena*. This can create community capacity and awareness of the organizational forms and relationships required to address the interacting causes of poverty and disability. It can also heighten the expectation in local communities that they be consulted in the design of longer term social reconstruction and development projects.

6.4 Implementation Modalities

CBR in any situation means utilizing community resources, involving disabled persons in the planning of programs, and re-educating rehabilitation personnel to address psycho social, economic, and educational integration, in addition to the usual needs for therapy, assistive devices, and home support.

CBR in post-conflict humanitarian and technical assistance programmes can contribute to peace building in numerous ways which illustrate the above benefits. Examples of peace building which have been achieved through CBR programs in areas of conflict vary depending on the specific location:

Benefit 1: Immediate human security and symbolic, tangible catharses
In the context of conflict, it is important to recognize the priority of a 'culture of peace-making' over a 'culture of development'. To achieve this first benefit, CBR programmes emphasize action over teaching and capacity-building. Rapid community-based assessment and evaluation methodologies for physical disability and psycho social trauma have been developed to assess disability needs and local response capacities. Rapid disability assessment teams are necessary for emerging war zones (Central Africa).

Psycho social and physical rehabilitation programs which emphasize peer support and income generation are valuable and have a visible impact. The latter may use labour-intensive CBR projects to gainfully and meaningfully employ disabled persons, re-directing the thoughts and energies of, for example, ex-combatants away from a return to violence (Angola).

Persons with disabilities can be mainstreamed into broader health and social development programs to avoid segregation and marginalisation. CBR initiatives can facilitate school integration of disabled refugee children and support alternatives to institutions for disabled,

displaced, and orphaned children (Afghanistan, Sri Lanka).

Available national and international media can be used to promote integration of persons with disability. Funds can be developed to receive public contributions for disabled children's assistive equipment (Palestine).

Disabled ex-combatant demobilization and re-integration support programmes (assistive devices, referrals, home ADL training, social and peer support, vocational training, income generation, leadership development) are vital to de-fuse tensions and demonstrate society's ongoing respect for injured veterans. Veterans' associations can be educated and supported to include disabled veterans and to address their needs. CBR training initiatives which are organized by disabled ex-combatants are effective self-help initiatives and should be supported. Psycho social trauma support programmes, especially for child ex-combatants, are crucial to minimize long term damage which can re-surface in future generations (Sri Lanka).

Generic CBR training modules for conflict areas are necessary since standard CBR training, with its focus on child developmental disabilities, polio, blindness, and stroke does not focus sufficiently on major traumatic musculoskeletal impairments from conflict such as head injuries, multiple fractures, peripheral nerve injuries caused by projectiles, traumatic amputations from landmines, and torture injuries (Bosnia, Croatia).

Fora can be organized for persons with disabilities and the public to discuss the needs of disabled persons. This strategy utilizes disabled persons' status and visibility as victims of war to achieve benefits for other disabled persons (Palestine).

Benefit 2: Diminish perceived barriers between disparate groups

Joint, periodic training for military and community groups in CBR practices can expose factions to commonalities of the disability experience and promote mutual assistance in the field. Such cooperative training can be only achieved during windows of opportunity and must be acted upon quickly before separate services are established for different groups (Sri Lanka).

Positive images of diverse groups can be promoted through establishing volunteer programs for disabled children utilizing disabled ex-combatants. Public education materials can emphasize the need for disabled women's independence, which may contribute to other gender-based education (Cambodia, Palestine).

Canadian ethnic groups, which may duplicate factional tensions abroad, can be organized on a volunteer basis to assist in the rehabilitation effort. Specifically, immigrants from war zones can help with cultural adaptation and translation of training materials as well as fundraising for donations of rehabilitation equipment and prosthetic/orthotic supplies. Care must be taken not to exacerbate local tensions, however (Afghanistan, Bosnia, Sri Lanka).

Development of cross-faction disabled persons' organizations is best done by persons with disabilities, preferably those with experience in politically dynamic situations. A key organization is Disabled Peoples' International which frequently consults to national disability

organizations in these areas. DPI works with groups of disabled persons to improve their organizations' abilities to develop self-help programs and conduct advocacy with the government to improve local rehabilitation efforts. Organizations from different factions can be linked in common causes – e.g., International Disability Day – December 3 (Cambodia, Afghanistan, Mozambique).

Inter-country programmes which bring together former adversaries on disability and rehabilitation concerns (e.g., for policy, sports, cultural exchanges) can demonstrate reconciliation possibilities (Bosnia/Croatia/Serbia; Angola/Mozambique/South Africa)

Former combatants with disabilities can cooperate in common tasks which promote reconciliation such as landmine awareness teams and identifying minefields with which they are familiar (Mozambique, Angola).

Charitable funds which are earmarked for disabled ex-combatants can be used to support community based programmes which benefit a wider group (Sri Lanka).

Benefit 3: Multi-sectoral approach to problems

A broad based approach to planning community services can be demonstrated through providing disability education programs for other NGOs on integration of the disability issue into development and relief activities. Common CBR training programs can be made accessible to multiple actors from NGOs, governments, and international agencies (Afghanistan).

Existing technical supports in communities for rehabilitation equipment (e.g., carpenters, welders) can be sought out prior to training new technicians or developing new orthopaedic workshops. This approach can reinforce the advantages of community participation to planners (Angola).

Training materials can be adapted for the realities of providing CBR services in a conflict environment, specifically CBR service coordination with other providers including refugee and emergency relief agencies (Bosnia, Croatia).

Organizing an annual national conference for CBR information dissemination, networking, and strategic planning can demonstrate the benefits of a multi-sectoral approach to planners as they gain insight to the complex interaction between disability, education, and employment (Palestine).

Benefit 4: Opportunities for health, social, and economic reform

In countries where there was a highly developed infrastructure for rehabilitation prior to war, it has been the aim to re-orient the re-construction of an entire system so that a CBR approach is utilized. UN and government roles can be facilitated to coordinate capacity development when the priority of disability rises on the national agenda in post-conflict societies (Bosnia).

National development programs (food & agriculture, rural & urban re-construction) can be

integrated with CBR programs so that the needs of disabled persons, including ex-combatants, are considered. International disabled persons' organizations can be linked to national planning (Afghanistan).

Legislative and bureaucratic measures which are taken to include persons with disability in public services can be symbols of equality (Palestine).

Utilization of existing NGOs, or development of new local NGOs, can advance capacity development rather than importing unfamiliar international NGOs. Integration of existing CBR structures, which may be limited in impact and coverage, in the areas of training local rehabilitation workers, developing appropriate technology, conducting needs assessment and evaluation work ('Training of Trainers' model). A local Institute for CBR in Conflict can facilitate local NGO activities, document experiences, and interact with a national CBR program (Sri Lanka).

Comparative action research can support the development of new CBR initiatives. Topics could include: the long term impact of conflict related trauma on persons with disabilities, communities, NGOs; the psychosomatic effects of trauma; completion of bereavement processes for healing; learned helplessness in disabled refugees; studies of the impact of CBR projects on communities and their gradual assimilation into local, district, and state health and social welfare programs (Bosnia, Sri Lanka, Palestine).

Community re-design during reconstruction in conflict areas includes the usual disability access issues but also re-location of public services such as transportation and recreation facilities. This has to be done with particular sensitivity to different stages of conflict or there is a risk of increasing tensions within communities (Bosnia, Sri Lanka).

Model local rehabilitation centres, community information and technology centres can be developed to demonstrate the principles of a community and information-based approach to disability (Croatia).

7.0 Identification of Canadian Capacities and Expertise

In the area of disability and CBR, Canadian capacity is extensive. The following is a list of the Canadian individuals and organizations the ICACBR has worked with in both development and post conflict contexts. The ICACBR will maintain this list on its WWW site.

(Individuals)

Alexander, J.
Occupational Therapy
Child Development Centre
Hotel Dieu Hospital
Kingston, Ontario
K7L 5G2

Arsenault, Francine
President
Council of Canadians with Disabilities
2841 Maple Leaf Drive
R.R. #1 Inverary
Perth Road Village, Ontario
K0H 2L0
Tel: (613) 353-2773
Fax: (613) 353-1859

Ballantyne, Sandra
Queen's University
School of Rehabilitation Therapy
Kingston, Ontario
K7L 3N6
OR: Health and Development Information Project,
West Bank, Palestine; e-mail:
idaibes@hdip.baraka.org

Belbin, Greg
Program Director, Applied Technologies and
Orthotic Services
Bloorview MacMillan Centre
350 Rumsey Road
Toronto, Ontario
M4G 1R8
Tel: (416) 424-3855 ex. 454
Fax: (416) 425-9332

Berry, John
Queen's University
Department of Psychology
Kingston, Ontario
K7L 3N6
Tel: (613) 545-2482
Fax: (613) 545-2499
email: berryj@post.queensu.ca

Boyce, Will
Queen's University
School of Rehabilitation Therapy
Kingston, Ontario
K7L 3N6
Tel: (613) 545-6000 ex. 5120
Fax: (613) 545-6776
email: boycew@post.queensu.ca

Caine, Jean
Vice President
Rehabilitation International
284 Church Street
Oakville, Ontario
L6K 2H1
(905) 845-2821

Christie, Nancy
International Society for Augmentative and
Alternative Communication
49 The Don Way West, Suite 308
Toronto, Ontario
M3C 3M9
Tel: (416) 385-0351
Fax: (416) 385-0352
email: nancy.christie@utoronto.ca

Cook, Philip
University of Victoria
School of Child and Youth Care
P.O. Box 1700,
Victoria, British Columbia
V8W 2Y2
Tel: (604) 721-6471
Fax: (604) 721-7067

Culham, Elsie
School of Rehabilitation Therapy
Queen's University
Kingston, Ontario
K7L 3N6

Tel: (613) 545-6727
Fax: (613) 545-6776
email: culhame@post.queensu.ca

Driedger, Diane
International Development Officer
Council of Canadians with Disabilities
926-294 Portage Avenue
Winnipeg, Manitoba
R3C 0B9
Tel: (204) 947-0303
Fax: (204) 942-4625

Edmonds, Lorna Jean
Administrative Officer
International Centre for the Advancement of
Community Based Rehabilitation
Queen's University
Kingston, Ontario
K7L 3N6
Tel: (613) 545-6881
Fax: (613) 545-6882
email: edmondlj@post.queensu.ca

Enns, Henry
Executive Director
Disabled Peoples' International
7-101 Evergreen
Winnipeg, Manitoba
R3L 2T3
Tel: (204) 287-8411
Fax: (204) 284-5343
email: ccds@escape.ca

Feika, Irene
Disabled Peoples' Association
3516 -42nd A Avenue
Edmonton, Alberta
P6L 1E5
Tel: (403) 423-2285
Fax: (403) 429-7908

Gerein, Nancy
Director of Technical Advisory Unit
Bangladesh Fourth Population and Health Project
CIDA Population and Health Monitoring and
Technical Advisory Unit
House D-2
Road 95
Gulsham, Dhaka
People's Republic of Bangladesh
Tel: (011-8802) 884740/884744/886190
Fax: (011-8802) 886190

Kaufert, Joe
University of Manitoba
Community Health Sciences
Winnipeg, Manitoba
R3T 2N2

Lele, Jayant
Queen's University
Department of Political Studies
Kingston, Ontario
K7L 3N6
Tel: (613) 545-6126
Fax: (613) 545-6848
email: lele@qsilver.queensu.ca

Loveridge, Brenda
Head, Division of Physiotherapy
University of Manitoba
School of Medical Rehabilitation
770 Bannatyne Avenue
Winnipeg, Manitoba
R3E 0W3

Lysack, Cathy
Wayne State University
Department of Occupational Therapy
Shapero Hall
Detroit, MI
48202 USA
Tel: (313) 577-1435
Fax: (313) 577-5822

Lysack, John
Queen's University
Mechanical Engineering
Kingston, Ontario
K7L 3N6

MaKrides, Lydia
Director, School of Physiotherapy
Dalhousie University
5869 University Avenue
Halifax, Nova Scotia
B3H 3J5
Tel: (902) 494-2524
Fax: (902) 494-1941
email: lydia.makrides@dal.ca

Martel, Guy
Senior Development Officer
Institute for Rehabilitation Research and Development
The Rehabilitation Centre
505 Smyth Road, Room 1401
Ottawa, Ontario
K1H 8M2

McColl, Mary Ann
Queen's University
School of Rehabilitation Therapy
Kingston, Ontario
K7L 3N6
Tel: (613) 545-6319
Fax: (613) 545-6776

Milner, Morris
Vice-President, Research and Development
Bloorview MacMillan Centre
350 Rumsey Road
Toronto, Ontario
M4G 1R8
Tel: (416) 424-3860
Fax: (416) 425-1634
email: milner@gpu.utcs.utoronto.ca

Minnes, Patricia
Queen's University
Department of Psychology
Kingston, Ontario
K7L 3N6
Tel: (613) 545-2885
Fax: (613) 545-2499
email: minnesp@post.queensu.ca

Neufeld, Vic
Director, Centre for International Health
McMaster University
1200 Main Street West, RM HSC-3N44
Hamilton, Ontario
L8N 3Z5

Neufeldt, Alfred
University of Calgary
EDT 434
Calgary, Alberta
T2N 1N4

O'Shea, Barbara J.
Director
School of Occupational Therapy
Dalhousie University
Forrest Building, Room 215
Halifax, Nova Scotia
B3H 3J5

Olney, Sandra
Queen's University
School of Rehabilitation Therapy
Kingston, Ontario
K7L 3N6
Tel: (613) 545-6102
Fax: (613) 545-6776
email: olneys@post.queensu.ca

Packer, Tanya
Queen's University
School of Rehabilitation Therapy
Kingston, Ontario
K7L 3N6
Tel: (613) 545-6280
Fax: (613) 545-6922
email: packert@post.queensu.ca

Parnes, Penny
Vice-President, Functional Programs
Bloorview MacMillan Centre
350 Rumsey Road
Toronto, Ontario
M4G 1R8
Tel: (416) 785-5468
Fax: (416) 785-0466
email: parnes@globalserve.net

Patterson, John
Queen's University
School of Rehabilitation Therapy
Kingston, Ontario
K7L 3N6

Peat, Malcolm
Executive Director
International Centre for the Advancement of Community Based Rehabilitation
Queen's University
Kingston, Ontario
K7L 3N6
Tel: (613) 545-6104
Fax: (613) 545-6882
email: peatm@post.queensu.ca

Shields, Charles A.
Executive Director
Canadian Society for International Health
170 Laurier Avenue West, Suite 902
Ottawa, Ontario
K1P 5V5

Sullivan, Michael
Dalhousie University
Department of Psychology
Halifax, Nova Scotia
B3H 4J1

Tata, Elizabeth
Queen's University
School of Rehabilitation Therapy
Kingston, Ontario
K7L 3N6
Tel: (613) 545-6595
Fax: (613) 545-6776

Thibeault, Rachel
University of Ottawa
Faculty of Health Sciences
451 Smyth
Ottawa, Ontario
K1H 8M5
Tel: (613) 562-5800 ex. 8034
Fax: (613) 562-5428

Westland, Joan
Westland Eby Consultants
133 East River Road
South Bolton, Quebec
J0E 2H0
Tel: (514) 292-3419
Fax: (514) 292-4581

(Institutions)

Bloorview MacMillan Centre
350 Rumsey Road
Toronto, Ontario
M4G 1R8
Tel: (416) 425-6220
Fax: (416) 425-6591

Canadian Association for Community Living
P.O. Box 5453
St. John's, Newfoundland
A1C 5L7

Canadian Association of Independent Living
350 Sparks Street
Suite 1004
Ottawa, Ontario
K1R 7S8
Tel: (613) 563-2581
Fax: (613) 235-4497
email: cailc@intrenet.on.ca

Canadian Association of Occupational Therapists
24 Braeside Road
Toronto, Ontario
M4N 1X7

Canadian Association of Prosthetists and Orthotists
Dental Arts Building
401-255 Vaughan Street
Winnipeg, Manitoba
R3C 1T7

Canadian Association of Occupational Therapists
110 Eglinton Avenue West, 3rd Floor
Toronto, Ontario
M4R 1A3

Canadian Paraplegic Association
201-1500 Don Mills Road
Don Mills, Ontario
M3B 3K4

Canadian Physiotherapy Association
890 Yonge Street, 9th Floor
Toronto, Ontario
M4W 3P4

Canadian Society for International Health
902-170 Laurier Avenue West
Ottawa, Ontario
K1P 5V5

Centre for International Health
McMaster University
1200 Main Street West
Hamilton, Ontario
L8N 3Z5

Centre for Refugee Studies
York University
4700 Keele Street
North York, Ontario
M3J 1P3

Community Health Sciences
University of Manitoba
Winnipeg, Manitoba
R3T 2N2

Council of Canadians with Disabilities
926-294 Portage Avenue
Winnipeg, Manitoba
R3C 0B9
Tel: (204) 947-0303
Fax: (204) 942-4625

Dalhousie University
School of Occupational Therapy
Forrest Building, Rm 215
Halifax, Nova Scotia
B3H 3J5
Tel: (902) 494-8804
Fax: (902) 494-1229

Dalhousie University
School of Physiotherapy
5869 University Avenue
Halifax, Nova Scotia
B3H 3J5
Tel: (902) 494-2616
Fax: (902) 494-1941

Disabled Peoples' Association
3516 -42nd A Avenue
Edmonton, Alberta
P6L 1E5

Disabled Peoples' International
7-101 Evergreen
Winnipeg, Manitoba
R3L 2T3

Easter Seals/March of Dimes National Council
90 Eglinton Avenue East, Suite 511
Toronto, Ontario
M4P 2Y3

International Centre for the Advancement of
Community Based Rehabilitation
Queen's University
Kingston, Ontario
K7L 3N6
Tel: (613) 545-6881
Fax: (613) 545-6882

International Society for Augmentative and Alternative
Communication
49 The Don Way West, Suite 308
Toronto, Ontario
M3C 3M9

Manitoba League of Persons with Disabilities
200-926 Portage Avenue
Winnipeg, Manitoba
R3C 0B9

McGill University
School of Physical and Occupational Therapy
3654 Drummond Street
Montreal, Quebec
H3G 1V5
Tel: (514) 398-4500
Fax: (514) 398-6360

McMaster University
School of Occupational and Physical Therapy
1280 Main Street West
Building T-16
Hamilton, Ontario
L8S 4K1
Tel: (905) 525-9140 ex. 27818 / ex 27820
Fax: (905) 524-0069

Ontario Premier's Council on Health, Well-Being, and
Social Justice
1 Dundas Street West, 25th Floor
Toronto, Ontario
M7A 1Y7
Tel: (416) 326-6754
Fax: (416) 325-4261

Physicians for Global Survival Canada
170 A Booth Street
Ottawa, Ontario
K1R 7W1

Queen's University
School of Rehabilitation Therapy
Kingston, Ontario
K7L 3N6
Tel: (613) 545-6103
Fax: (613) 545-6776

The Rehabilitation Centre
Royal Ottawa Health Care Group
505 Smyth Road
Ottawa, Ontario
K1H 8M2
Tel: (613) 737-7350

Université de Montréal
Ecole de Readaption /
Programme d'ergothérapie
C.P. 6128, succursale A
Montréal, Quebec
H3C 3J7
Tel: (514) 343-7833 / 343-7813
Fax: (514) 343-2105

Université Laval
Department de Physiotherapie /
Programme d'ergothérapie
Faculté de médécine
Pavillion Ferdinand - Vandry
Ste. Foy, Quebec
G1K 7P4
Tel: (418) 656-5689 / 656-2108
Fax:: (418) 656-5476 / 656-2535

University of Alberta
Faculty of Rehabilitation Medicine
Corbett Hall
Edmonton, Alberta
T6G 2G4
Tel: (403) 492-5983 / 492-2499
Fax: (403) 492-1626

University of British Columbia
School of Rehabilitation Sciences
T325-2211 Westbrook Mall
Vancouver, British Columbia
V6T 2B5
Tel: (604) 822-7404 / 822-7392
Fax: (604) 822-7624

University of Manitoba
School of Medical Rehabilitation
770 Bannatyne Avenue
Winnipeg, Manitoba
R3E 0W3
Tel: (204) 789-3417 / 789-3674
Fax: (204) 775-7104

University of Ottawa
Occupational Therapy Program /
Physiotherapy Program
451 Smyth Road
Ottawa, Ontario
K1H 8M5
Tel: (613) 562-5430 / 562-5429
Fax: (613) 562-5428

University of Saskatchewan
School of Physical Therapy
Saskatoon, Saskatchewan
S7N 0W0
Tel: (306) 966-6582
Fax: (306) 966-6575

University of Toronto
Department of Occupational Therapy/
Department of Physical Therapy
256 McCaul Street
Toronto, Ontario
M5T 1W5
Tel: (416) 978-2765 / 978-5935
Fax: (416) 978-4363

University of Western Ontario
Department of Occupational Therapy/
Department of Physical Therapy
Elborn College
London, Ontario
N6G 1H1
Tel: (519) 661-2124 / 661-3760
Fax: (519) 661-3894 / 661-3866

References

Development and Humanitarian Assistance

Anderson, Mary B. 1996. *Do No Harm: Supporting Local Capacities Through Aid.* Cambridge, MA: Local Capacities for Peace Project, The Collaborative for Development Action.

Anderson, Mary B., and Peter J. Woodrow. 1989. *Rising From the Ashes: Development Strategies in Times of Disaster.* Paris: Westview Press.

Atlanta. 1994. "Status of public health – Bosnia and Herzegovina, August - September 1993." *Journal of the American Medical Association* 271(12): 898-899.

Axworthy, Hon. Lloyd, Minister of Foreign Affairs. 1997. Notes for an address to the Canadian Conference on Humanitarian Demining and Landmine Victim Assistance, Winnipeg, 31 January.

Ball, Nicole, and Tammy Halevy. 1996. *Making Peace Work: The Role of the International Development Community.* Baltimore, MD: Johns Hopkins University Press.

Bertram, Eva. 1995. "Reinventing governments: The promise and perils of United Nations peace building." *Journal of Conflict Resolution* 39(Sept): 387-418.

BiH. 1996. *Federation Health Programme: Health Reform and Reconstruction Programme of the Federation of Bosnia and Herzegovina.* Bosnia and Herzegovina: Federation of Bosnia and Herzegovina Ministry of Health.

Boulding, Elise, ed. 1994. *Building Peace in the Middle East: Challenges for States and Civil Society.* Boulder, CO: Lynne Rienner Publishers.

Boutros-Ghali, Boutros. 1995. *Report of the Secretary-General on the Work of the Organization.* Document #S/1995/1. New York: United Nations.

-----. 1992. *An Agenda For Peace.* New York: United Nations.

Boyden, Jo. 1994. "Childrens experience of conflict related emergencies: Some implications for relief policy and practice." *Disasters* 18(3): 254-266.

Brady, William, Steven Galson and Michael Toole. 1993. "Are war and public health compatible?" *Lancet* 341 (May 8): 1193-1196.

Brynen, Rex Jeffrey. 1995. *The (Very) Political Economy of the West Bank and Gaza: Learning Lessons about Peace-Building and Development Assistance.* Montreal: Inter-University Consortium for Arab Studies.
Bush, Kenneth D. 1996a. "Beyond bungee cord humanitarianism: Towards a developmental agenda for peace building." *Canadian Journal of Development Studies* (Special Issue): 1-18.

-----. 1996b. "Rocks and hard places: Bad governance, human rights abuse, and population displacement." *Canadian Foreign Policy Journal* (Spring): 49-82.

-----. 1995. "Towards a balanced approach to rebuilding war-torn societies." *Canadian Foreign Policy* 3(3): 49-69.

CFPD (Canadian Centre for Foreign Policy and Development). 1996. *National Forum on Canada's International Relations: Preliminary Report – Winnipeg Forum*; and *Canadian Foreign Policy and International Peace-Building Halifax, Quebec and Victoria Policy Recommendations.*

CIDA. 1996. *Strategy for Health.*

Cahill, Kevin M. 1995. *Clearing the Fields: Solutions to the Global Land Mines Crisis.* New York: Basic Books.

-----. 1993. *A Framework for Survival: Health, Human Rights and Humanitarian Assistance in Development and Disasters.* New York: Basic Books, and the Council on Foreign Relations.

Canada. 1995. *Canada in the World.* Ottawa: Queen's Printer.

Canada. Special Joint Committee Reviewing Canadian Foreign Policy. 1994. *Canada's Foreign Policy: Principles and Priorities for the Future. Report of the Special Joint Committee of the Senate and the House of Commons Reviewing Canadian Foreign Policy.* Ottawa: Publications Service, Parliamentary Publications Directorate.

Carrington, G., and N. Procter. 1995. "Identifying and responding to the needs of refugees: A global nursing concern." *Holistic Nursing Practice* 9(2): 9-17.

Crocker, Chester, and Fen Hampson. 1996. "Making peace settlements work." *Foreign Policy* (Autumn): 54-73.

DFAIT (Department of Foreign Affairs and International Trade). 1996. *Canada to Establish New Peace building Fund.* Press release. October 30, 1996.

Diamond, Louise, and John McDonald. 1996. *Multitrack Diplomacy: A Systems Approach to Peace.* West Hartford, CT: Kumarian Press.

Edwards, Michael, and David Hulme. 1996. *Beyond the Magic Bullet: NGO Performance and Accountability in the Post-Cold War World.* West Hartford, CT: Kumarian Press.

Elias, Robert, and Jennifer Turpin, eds. 1994. *Rethinking Peace.* Boulder, CO: Lynne Rienner Publishers.

Evans, Gareth. 1993. *Cooperating for Peace.* St. Leonards, Australia: Allen and Unwin.

Fisher, Ronald J. 1993. "The potential for peace building: Forging a bridge from peacekeeping to peacemaking." *Peace and Change* 18 (July): 247-266.

Galtung, J. 1976. "Three approaches to peace: Peacekeeping, peacemaking, and peace building." In: *Peace, War and Defense: Essays in Peace Research II.* Copenhagen: Christian Ejlers. pp. 292-304.

Hampson, Fen Osler. 1996. *Nurturing Peace: Why Peace Settlements Succeed or Fail.* Washington, D.C.: United States Institute for Peace.

Han, Sonia K. 1994. "Building a peace that lasts: The United Nations and post-civil war peace-building." *New York University Journal of International Law and Politics* 26(summer): 837-892.

Henigsberg, N., B. Lagerkvist, and Z. Matek. 1994. *War Victims in Need of Physical Rehabilitation in Croatia.* Centre for Development of Disaster Management Information Systems and WHO Regional Office for Europe, Rehabilitation of War Victims Project.

Horton, Richard. 1994. "...on the brink of humanitarian disaster [letter]." *Lancet* 344 (April 30): 1053.

IDRC. 1997. *Corporate Program Framework to 2000.* Ottawa: IDRC.

International Development Research and Policy Task Force. 1996. *Connecting with the World: Priorities for Canadian Internationalism in the 21st Century.* Ottawa: International Development Research Centre (IDRC), International Institute for Sustainable Development (IISD), and the North-South Institute (NSI).

Kumar, Krishna, ed. 1997. *Rebuilding Societies after Civil War: Critical Role for International Assistance*. Boulder, CO: Lynne Rienner Publishers.

Kymlicka, Will. 1995. *Multicultural Citizenship: A Liberal Theory of Minority Rights*. Oxford: Clarendon Press.

Lederach, John Paul. 1995. *Preparing for Peace: Conflict Transformation Across Cultures*. New York: Syracuse University Press.

Lewer, Nick, and Oliver Ramsbotham. 1993. *"Something Must Be Done: Towards an Ethical Framework for Humanitarian Intervention in International Social Conflict*. West Yorkshire: University of Bradford, Department of Peace Studies.

Luhan, J. Michael. 1995. *Annual Report 1994: WHO Mission in the Former Yugoslavia*. Zagreb: WHO Regional Office for Europe/Zagreb Area Office.

Macrae, J. 1995. "Aid under fire: Redefining relief and development assistance in unstable situations, Wilton Park (UK) 7-9 April, 1995." *Disasters* 19(4): 361.

Mooney, Terrance Lome, ed. 1995. *The Challenge of Development within Conflict Zones*. Paris: Organisation for Economic Co-operation and Development (OECD).

Parks, W. Hays. 1995. "The humanitarian law outlook." In: *Clearing the Fields: Solutions to the Global land mines Crisis*, edited by Kevin M. Cahill. New York: Basic Books.

Pratt, Cranford, and Tim Broadhead. 1994. "Paying the Piper: CIDA and Canadian NGOs." In: *Canadian International Development Assistance Policies: An Appraisal*, edited by Cranford Pratt. Montreal: McGill and Queen's University Press.

Rapoport, Anatol. 1992. *Peace: An Idea Whose Time has Come*. Ann Arbor: University of Michigan Press.

-----. 1995. *The Origins of Violence: Approaches to the Study of Conflict*. New Brunswick, NJ: Transaction Publishers.

Rawkins, Phillip. 1994. "An institutional analysis of CIDA" In: *Canadian International Development Assistance Policies: An Appraisal*, edited by Cranford Pratt. Montreal: McGill and Queen's University Press. pp. 156-185.

Rigby, A. 1994. "Peace building in the occupied territories: The challenge of educational reform." *Peace and Change* 19: 349-372.

Rougemont, A. 1995. "From humanitarian action to international health." *Sozial- und Praventivmedizin* 40(1): 3-10.

Russbach, Rémi. 1993. "Casualties of conflicts and mine warfare." In: *A Framework for Survival: Health, Human Rights and Humanitarian Assistance in Development and Disasters*, edited by Kevin M. Cahill. New York: Basic Books.

Smajkić, A., ed. 1994. *Health and Social Consequences of the Aggression in Bosnia and Herzegovina*. Sarajevo: Institute of Public Health of the Republic and Federation of Bosnia and Herzegovina.

Smillie, Ian. 1995. *The Alms Bazaar: Altruism Under Fire – Non-Profit Organizations and International Development*. Ottawa: IDRC.

Smillie, Ian, and Henny Helmich, eds. 1993. *Non-Governmental Organisations and Governments: Stakeholders for Development*. Paris: Development Centre of the OECD.

Smucker, Philip. 1996. "Helping Bosnia's elderly." *Globe and Mail* May 8.

Sogge, David, ed. 1996. *Compassion and Calculation: The Business of Private Foreign Aid.* London: Pluto Press.

Stills, M. L. 1993. "The war-injured with physical disabilities are often forgotten in time [editorial]." *Prosthetics and Orthotics International* 17(2): 71-72.

Taylor, Charles. 1994. "The politics of recognition." *In: Multiculturalism: Examining the Politics of Recognition*, edited by Amy Gutman. Princeton: Princeton University Press.

United Nations. 1996. *An Inventory of Post-Conflict Peace building Activities.* New York: United Nations.

van Creveld, Martin. 1991. *The Transformation of War.* New York: Free Press.

Vesilind, Priit J. 1996. "In focus: Bosnia." *National Geographic* 189(6): 48-61.

WHO (World Health Organisation). 1996. *WHO Support to the Health Reform and Reconstruction Programme of the Federation of Bosnia and Herzegovina.* Geneva: WHO Regional Office for Europe.

Walker, John R. 1993. *Orphans of the Storm: Peace building for Children of War.* Toronto: Between the Lines.

Weiss, Thomas G., and Larry Minear. 1993. *Humanitarianism Across Borders: Sustaining Civilians in Times of War.* Boulder, CO: Lynne Rienner Publishers.

-----. 1995. *Mercy Under Fire: War and the Global Humanitarian Community.* Boulder, CO: Westview Press.

Wicker, Brian, and Fred van Iersel, eds. 1995. *Humanitarian Intervention and the Pursuit of Justice: A Pax Christe Contribution to a Contemporary Debate.* Kampen, Netherlands: Pharos.

Community and Rehabilitation Issues

Armenian, H. K. 1989. "Perceptions from epidemiologic research in an endemic war." *Social Science and Medicine* 28(7): 43-647.

Aston, D. G. 1992. *Cambodia: A Proposal for the Rehabilitation of the Disabled.* Unpublished proposal.

Balcazar, F., R. Mathews, V. Francisco, S. Fawcett, and T. Seekins. 1994. "The empowerment process in four advocacy organizations of people with disabilities." *Rehabilitation Psychology* 39: 189-203.

Ballantyne, Sandra. 1988. *Physiotherapy Fact-Finding Visit, West Bank and Gaza Strip.* Cyprus: Middle East Council of Churches.

Barghouthi, M., and I. Daibes. 1993. *Infrastructure and Health Services in the West Bank: Guidelines for Health Care Planning – The West Bank Rural PHC Survey.* Ramallah, West Bank: Health Development Information Project.

Bell, C., and H. Newby. 1971. *Community Studies: An Introduction to the Sociology of the Local Community.* London: Allen and Unwin.

Berger, B. 1988. "Disenchanting the concept of community." *Society* (Sept/Oct): 50-52.

Berry, L. 1988. "The rhetoric of consumerism and the exclusion of community." *Community Development Journal* 23: 266-272.

Black, Mary. 1993. "Collapsing health care in Serbia and Montenegro." *British Medical Journal* 307: 1135-1137.

Boschen, K. A., and N. Krane. 1992. "A history of independent living in Canada." *Canadian Journal of Rehabilitation* 6(2): 79-88.

Boyce, W. 1997. *Structural Dimensions of the Community Participation Process: The Health Promotion Contribution Program.* Unpublished PhD Thesis. Toronto: University of Toronto.

-----. 1993. "Evaluating participation in community programs: An empowerment paradigm." *Canadian Journal of Program Evaluation* 8(1): 89-102.

Boyce, W., and C. Lysack. 1997. "Understanding the Community in Canadian CBR: Critical lessons from abroad." *Canadian Journal of Rehabilitation.* In press.

Boyce, W., and S. Weera. 1997. "Measurement of disability in war zones: A new conceptual approach for CBR." International Journal of Rehabilitation Research. Submitted for publication.

Bryce, J. W., et al. 1989. "Life experiences, response styles and mental health among mothers and children in Beirut, Lebanon." *Social Science and Medicine* 28(7): 685-695.

Butchart, A., and M. Seedat. 1990. "Within and without: Images of community and implications for South African psychology." *Social Science and Medicine* 31(10): 1093-1102.

COPEDU. 1989. "The effects of torture and political repression in a sample of Chilean families." *Social Science and Medicine* 28(7): 735-740.

Carey, P. 1990. "War of the mines." *The Independent Magazine*, pp. 30-38.

Central National Committee for Rehabilitation. 1992. *Guidelines for the National Rehabilitation Policy in the West Bank and Gaza.*

Chaudhury, G., K. Menon-Sen, and P. Zinkin. 1995. "Disability programmes in the community." *Clinics in Developmental Medicine: Disabled Children and Developing Countries* no. 136: 152-182.

Chermak, G. 1990. "A global perspective on disability: A review of efforts to increase access and advance social integration for disabled persons." *International Disabilities Studies* 12(3): 123-127.

"Children of conflict." 1994. *Toronto Star*, Sunday April 10, section F.

Coupland, R., and A. Korver. 1991. "Injuries from antipersonnel mines: the experience of the International Committee of the Red Cross." *British Medical Journal* 303: 1509-1512.

Crisp, Jeff. 1989. "Disabled refugees: Coming out of the shadows." *UNHCR Refugees* 66: 19-22.

de Kadt, C. 1982. "Community participation for health: The case of Latin America." *World Development* 10: 573-584.

DeJong, G. 1979. "Independent living: From social movement to analytic paradigm." *Archives of Physical Medicine and Rehabilitation* 60: 435-446.

Despouy, Leandro. 1991. *Human Rights and Disability.* Geneva: UNESCO, Paper no. E/CN.4/Sub.2/1991/31.

Driedger, D. 1989. *The Last Civil Rights Movement: Disabled Peoples' International.* New York: St. Martin's Press.

Eade, D., and S. Williams. 1995. *The Oxfam Handbook of Development and Relief.* London, Oxfam Publishing.

Epp, J. 1986. *Achieving Health for All: A Framework for Health Promotion.* Ottawa: Health and Welfare Canada.

External Stakeholder Community Rehabilitation Working Group. 1995. *A Planning Framework for the Community Rehabilitation Program.* Edmonton: Alberta Health.

Garfield, R. 1989. "War-related changes in health and health services in Nicaragua." *Social Science and Medicine* 28(7): 669-676.

Gaza National Committee for Rehabilitation, and Diakonia. 1993. *Disability and Rehabilitation Needs in the Gaza Strip: A Survey Report on Bureij and al-Shati Refugee Camps.*

Gibson, K. 1989. "Children in political violence." *Social Science and Medicine* 28(7): 659- 667.

Godfrey, N., and A. Kalache. 1989. "Health needs of older adults displaced to Sudan by war and famine: Questioning current targeting practices in health relief." *Social Science and Medicine* 28(7): 707-713.

Haramy, Ghada. 1993. "CBR challenge in the Occupied Territories." *CBR News* no. 14: 4-5.

Hawe, P. 1994. "Capturing the meaning of 'community' in community intervention evaluation: Some contributions from community psychology." *Health Promotion International* 9(3): 199-210.

Helander, Einar. 1992. *Prejudice and Dignity: An Introduction to Community Based Rehabilitation.* New York: United Nations Development Programme, Division for Global and International Programs.

-----. 1993. "What is in a definition?" *CBR News* no. 13: 3.

Helander, Einar, Padmani Mendis, Gunnel Nelson, and Ann Goerdt. 1989. *Training in the Community for People with Disabilities.* Geneva: World Health Organization.

ICACBR (International Centre for the Advancement of Community Based Rehabilitation, Queen's University, Kingston). 1996. *Final Report: Community Based Rehabilitation Project in Bosnia-Herzegovina.* Kingston: ICACBR.

-----. 1993. "CBR – The debate." *ICACBR Update* 1(2): 2-4.

ICRC (International Committee of the Red Cross). 1992. *Blinding Weapons: Reports of the Meetings of Experts Convened by the ICRC on Battlefield Laser Weapons – 1989-1991.* Geneva: ICRC.

ILO (International Labour Organisation), UNESCO (United Nations Education and Scientific Council), and WHO (World Health Organisation). 1994. *Community Based Rehabilitation for and with People with Disabilities: Joint Position Paper.* Geneva: ILO/UNESCO/WHO.

Ingstad B., and S. Whyte, eds. 1995. *Disability and Culture.* Berkeley: University of California Press.

Ityavyar, D. A., and L. O. Ogba. 1989. "Violence, conflict and health in Africa." *Social Science and Medicine* 28(7): 649-657.

Jewkes, R., and A. Murcott. 1996. "Meanings of community." *Social Science and Medicine* 43(4): 555-563.

Jongbloed, L., and A. Crichton. 1990. "A new definition of disability: Implications for rehabilitation practice and social policy." *Canadian Journal of Occupational Therapy* 57(1): 32-38.

Kothari, M., and L. Mehta. 1990. "Violence in modern medicine." In: *Science, Hegemony and Violence*, edited by A. Nandy. Tokyo: The United Nations University. pp. 167-210.

Krefting, D., L. Krefting, and H. Tjandrakusuma. 1993. "Community based rehabilitation in Central Java." In: *Culture and Disability*. Berkeley: University of California Press.

Lalonde, M. 1974. *A New Perspective on the Health of Canadians: A Working Document*. Ottawa: Ministry of Supply and Services.

Lundgren, R. I., and R. Lang. 1989. "'There is no sea, only fish': Effects of United States policy on the health of the displaced in El Salvador." *Social Science and Medicine* 28(7): 697-706.

Lysack, C. 1996. "Critical reflections on the meaning of community." *ACTIONAID Disability News* 7(2): 43-47.

-----. 1995. "Community participation and community-based rehabilitation: An Indonesian case study." *Occupational Therapy International* 2(3): 149-165.

Lysack, C., and J. Kaufert. 1996. "Some perspectives on the disabled consumers' movement and community based rehabilitation in developing countries." *ACTIONAID Disability News* 7(1): 5-9.

Lysack, C., and J. Kaufert. 1994. "Comparing the origins and ideologies of the independent living movement and community based rehabilitation." *International Journal of Rehabilitation Research* 17(3): 231-240.

Lysack, C., and L. Krefting. 1993. "Community-based rehabilitation cadres: Their motivation for voluntarism." *International Journal of Rehabilitation Research* 16: 133-141.

Macrae, Joanna, and Anthony Zwi. 1994. "When the war is over: Speculations on the relief/development transition and its implications for the health sector – The case of Uganda." Paper submitted for presentation to the 4th International Research and Advisory Panel Conference, Refugee Studies Programme, Somerville College, Oxford, 5-9 January 1994.

Masha'l, J. 1993. *The Community Based Rehabilitation Programme of the Union of Palestinian Medical Relief Committees – West Bank and Gaza Strip*. Jerusalem: Union of Palestinian Medical Relief Committees.

McKnight, J. L. 1997. "Regenerating community." *Social Policy* (Winter): 54-58.

Menon, P. 1984. "Developing community based rehabilitation services for the disabled by the primary health care approach." *International Rehabilitation Medicine* 6: 64-66.

Miles, M. 1994. "CBR information accumulation and exchange." Presented at the Asia Regional Symposium on CBR Research and Evaluation, Bangalore, India, December 1994.

-----. 1989. "Rehabilitation development in Southwest Asia: Conflicts and potentials." In: *Disability and Dependency*, edited by L. Barton. London: Falmer Press. pp. 110-126.

-----. 1985. *Where there is no Rehab Plan: A Critique of the WHO Scheme for Community Based Rehabilitation*. Unpublished manuscript.

Nanavatty, M. 1988. "The community development movement in South East Asian countries: An Asian perspective." *Community Development Journal* 23: 94-99.

Nixon, Anne. 1990. *The Status of Palestinian Children during the Uprising in the Occupied Territories: Child Death and Injury*. Stockholm: Radda Barnen (Swedish Save the Children).

Oliver, M. 1990. *The Politics of Disablement*. London: Macmillan.

O'Toole, B. 1987. "Community-based rehabilitation (CBR): Problems and possibilities." *European Journal of Special Education* 2(3): 177-190.

PPRBM CBR Centre. 1995. "The Future of CBR: Critical Issues." A Pre-Conference Workshop on CBR at the 10th Annual Conference of the Asia-Pacific Region of Rehabilitation International (Reaching the Unreached) in Jakarta, Indonesia, September 12-16, 1995.

Patton, M. Q. 1994. "Developmental evaluation." *Evaluation Practice* 15(3), 311-319.

-----. 1990. *Qualitative Evaluation and Research Methods*, 2nd ed. Newbury Park: Sage.

Peat, M. 1991a. "Community based rehabilitation – development and structure: Part 1." *Clinical Rehabilitation* 5: 219-227.

-----. 1991b. "Community based rehabilitation – development and structure: Part 2." *Clinical Rehabilitation* 5: 231-239.

Peat, M., and W. Boyce. 1993. "Canadian community rehabilitation services: Challenges for the future." *Canadian Journal of Rehabilitation* 6(4): 281-289.

Physicians for Human Rights. 1988. *The Casualties of the Conflict: Medical Care and Human Rights in the West Bank and Gaza Strip.* Somerville, MA: Physicians for Human Rights.

Rankin, W. 1991. "Growing up in hatred." *Journal of Pediatric Nursing* 6(1): 60-61.

Rautio, J., and P. Paavolainen. 1988. "Afghan war wounded: experience with 200 cases." *Journal of Trauma* 28 (4): 523-525.

Rehabilitation International/UNICEF. 1989-90. "Community-based rehabilitation: A ten year review." *One in Ten* 8(1): 1-2.

-----. 1991. "Effects of armed conflict on women and children: relief and rehabilitation in war situations." *One in Ten* 10: 2-3.

Richman, N. 1995. "Violence and disabled children." In: *Disabled Children and Developing Countries*, edited by P. Zinkin, and H. McConachie. London: MacKeith Press. pp. 203-213.

Robertson, A., and M. Minkler. 1994. "New health promotion movement: A critical examination." *Health Education Quarterly* 21(3): 295-312.

Rosenau, P. 1994. "Health politics meets post-modernism: Its meaning and implications for community health organizing." *Journal of Health Politics, Policy and Law* 19: 303-333.

Ruff, Tilman, and John Ward. 1991. "The Middle East war – A medical perspective." *Medical Journal of Australia* 55: 39-42.

Schlaff, C. 1993. "From dependency to self-advocacy: Re-defining disability." *The American Journal of Occupational Therapy* 47(10): 943-948.

Shapiro, J. 1994. *No Pity: People with Disabilities Forging a New Civil Rights Movement.* New York: Times Books.

Stone, L. 1992. "Cultural influences in community participation in health." *Social Science and Medicine* 35(4): 409-417.

Toole, M., S. Galson, and W. Brady. 1993. "Are war and public health compatible?" *Lancet* 341: 1193-1196.

Twumasi, P., and P. Freund. 1985. "Local politicization of primary health care as an instrument for development: A case study of community health workers in Zambia." *Social Science and Medicine* 20(10): 1073-1080.

UNHCR (United Nations High Commission for Refugees). 1992. *UNHCR Guidelines on Assistance to Disabled Refugees*. Geneva: UNHCR.

UNICEF (United Nations Childrens Fund). 1994. *Anti-Personnel Land-Mines: A Scourge on Children*. New York: UNICEF House.

-----. 1991. *The State of the World's Children 1990*. New York: Oxford University Press.

-----. 1990. "Children in especially difficult circumstances." Part six in: *Children and Development in the 1990s: A UNICEF Sourcebook*. New York: Oxford University Press.

-----. 1986a. *Children in Situations of Armed Conflict*. Executive Board, 1986 Session, Paper No. E/ICEF/1986/CRP.2.

-----. 1986b. *Overview: Children in Especially Difficult Circumstances*. Executive Board, 1986 Session, Paper No. E/ICEF/1986/L.6.

UNRWA (United Nations Relief and Works Agency for Palestinian Refugees). 1992. *Community Rehabilitation Programmes for Disabled Palestine Refugees, Report and Recommendations of UNRWA/NGO Conference, Amman, 10-12 May 1992*. Geneva: UNRWA.

UNRWA/OXFAM. 1992. *Review of the Community Rehabilitation Centres in Jordan, Amman. January 1992*. Unpublished report.

UPMRC (Union of Palestinian Medical Relief Committees). 1992. *Report*. Jerusalem: UPMRC.

United Nations. 1989. *Convention on the Rights of the Child*. Ottawa: Human Rights Directorate, Department of Multiculturalism and Citizenship, Government of Canada.

-----. 1983. *World Programme of Action Concerning Disabled Persons*. New York: UN.

Valentine, F. 1994. *The Canadian Independent Living Movement: An Historical Overview*. Ottawa: Canadian Association of Independent Living Centres.

WHO (World Health Organization). 1986. "Ottawa charter for health promotion." *Canadian Journal of Public Health* 77, 425-430.

WHO Expert Committee on Disability Prevention and Rehabilitation. 1981. "Disability prevention and rehabilitation." *WHO Technical Report Series* 668: 7-37.

Werner, David. 1987. *Disabled Village Children*. Palo Alto, CA: The Hesperian Foundation.

-----. 1990a. "Starting in a village – where to begin?" *CBR News* no. 7: 6-8.

-----. 1990b. "Visit to Angola: Where civilians are disabled as a strategy of low intensity conflict." *Disability Studies Quarterly* 10(2): 36-39.

Williams, R. 1976. *Keywords: A Vocabulary of Culture and Society*. New York: Oxford University Press.

Young, I. 1990. "The ideal of community and the politics of difference." In: *Feminism/Postmodernism*, edited by L. J. Nicholson. New York: Routledge. pp. 300-323.

Zwi, A., and A. Ugalde. 1991. "Political violence in the Third World: a public health issue." *Health Policy and Planning* 6(3): 203-217.

----. 1989. "Towards an epidemiology of political violence in the Third World." *Social Science and Medicine* 28(7): 633-642.

Annex I

SYMPOSIUM: "POST CONFLICT INTEGRATION OF PERSONS WITH DISABILITIES" PRECIS AND EXECUTIVE SUMMARY

SYMPOSIUM:
Post-Conflict Integration of Persons with Disabilities

The purpose of the Symposium is to assess recent experience in addressing the needs of persons with disabilities and their families as a key element of relief and development efforts in societies emerging from conflict.

The Symposium will be held at the Queen's University Executive MBA facility (Salon A) at Constitution Square, 350 Albert Street, Ottawa on 4 September 1996.

Background

During and immediately following conflict, the needs of persons with disabilities and their communities are acute. In Bosnia-Herzegovina, target groups include those injured by shelling, sniping, land mines, and vulnerable populations including children, elderly and refugees. In Rwanda, many were disabled by machete and forced population migration. Once open hostilities cease, the population of persons with disabilities may continue to increase, particularly as a result of the ongoing and real threat of anti-personnel land mines.

Addressing the needs of persons with disabilities in society in general is in itself a major concern, particularly in those societies undergoing major economic, health sector and social change.

How agencies perceive the needs of persons with disabilities, their families, other caregivers, and their communities during a crisis affects how readily and to what extent these vulnerable groups are included in rehabilitation and development efforts.

The needs of persons with disabilities and their communities are influenced by factors such as age, gender, ethnicity, religion, nationality, and political affiliation. Increasingly, these dimensions describe significant groups of those specifically targeted and victimized during conflict.

An early focus on the needs of persons with disabilities and their communities can:

- assure that immediate relief efforts recognize degrees of vulnerability as soon as it is possible, feasible, and practical.
- result in a highly visible impact on the inclusiveness of social structures and local governance: persons with disabilities can offer a unique perspective and are acutely aware of pressing needs and priorities.
- accommodate the needs of ex-combatants disabled through injury, sometimes a source of social instability if they are not meaningfully, productively, and quickly reintegrated into society;
- ensure that adequate consideration is given to physical access issues, including home, social and work environments, as the infrastructure is rebuilt; and,
- ensure that appropriate technology such as prosthetic and orthotic devices, mobility aides, and activity of daily living tools are developed and adapted to local conditions.

The enormous economic, social and political benefits which result from preventing disability where and when possible can only be truly appreciated when society understands the full costs that disability incurs. Taking such practical steps at an early stage requires that groups of persons with disabilities participate in decision making as rehabilitation and development plans are made. Creating productive and meaningful employment opportunities means assuring a safe and secure environment free from the threat of the technology of conflict.

Communities and families emerging from conflict can rebuild faster and with greater confidence and trust if they have made a common and united effort to help the most vulnerable and have integrated the contribution of vulnerable groups into relief, rehabilitation, and development efforts.

The Policy Context

The Canadian Government has contributed significantly to conflict and post conflict areas through:

- humanitarian assistance;
- peacekeeping; and
- support of multilateral agencies.

Program priorities which have been identified include:

- primary health care;
- basic education;
- shelter;
- human rights, good governance and democracy;
- private sector development; and,
- environment.

Post conflict problems are multi-dimensional and multi-sectoral. For example, the problems associated with land mines will be compounded by lack of health and social infrastructure, appropriate technology for rehabilitation and opportunities for reintegration and re-employment.

The Canadian government declared, in January 1996, comprehensive and unilateral moratoria on the production, export and operational use of anti-personnel land mines, a measure which complements Canada's ongoing diplomatic efforts to promote universal adherence to the strengthened Convention on Certain Conventional Weapons. These initiatives move Canada to the forefront of a growing number of countries that have declared similar moratoria. It is estimated that worldwide there are 26,000 new victims of mine explosions each year. There are at least 250,000 mine-disabled peopled in the world.

Obviously, land mines are cause of disability which results from conflict, and will be for years to come.

What can be done to provide pointed and comprehensive input on the disability dimension to the October land mines strategy session being hosted by the Minister of Foreign Affairs? How can it be assured that an eventual international ban on the destructive use of technology which land mines represents combines with concrete action to address the needs of persons with disabilities in war-torn societies?

The Symposium

Conflict, like disaster, presents the opportunity to rebuild and to progress based on new principles. Canada has a wealth of experience at many levels in dealing with disability both at home, abroad and in peace and war. This experience covers a wide spectrum including:

- disability as a social justice and health issue;
- development of appropriate technology including prosthetic, orthotic, and daily living devices;
- community integration; and
- infrastructure and architectural design considerations.

There are also a number of initiatives aimed at disability identification and prevention. One example is mine clearance activities.

Queen's University (particularly the International Centre for the Advancement of Community Based Rehabilitation or ICACBR), has experience in addressing the needs of persons ahead disabilities and their families along the relief - rehabilitation - development continuum, with an emphasis on primary health care and community participation. Through its experience, and as a result of consultations with other Canadian agencies, international organizations, and health professionals in the countries where it works, Queen's University will organize a Symposium to:

- set priorities and assure that disability in countries emerging from conflict is addressed from all relevant perspectives;
- initiate or further develop mechanisms for collaboration;
- identify a set of targets and objectives; and,
- assure that policy makers are fully updated regarding existing capacity (possibilities), actual experience (needs), and the current practices of agencies and local counterparts in the field.

This one day event will have limited participation of about 25 persons able to contribute valuable perspectives and experience to the deliberations. From Sarajevo, medical doctors and rehabilitation clinicians will present their experience. It is also expected that presentations will be made by persons who have been working in this field in Sri Lanka and Afghanistan, and Angola, Mozambique, and Cambodia.

Expected Outcomes

The Symposium will:

- advance the knowledge and understanding of post conflict environments and options for linking relief assistance to long term development during post conflict periods;
- explore the extent to which community rehabilitation provides effective and sustainable strategies for the relief and integration of persons with disabilities and their families in society;
- advance the ability of persons with disabilities to achieve equal opportunity and full participation in the social and economic affairs of their family and community; and
- reinforce the value and place of rehabilitation of persons with disabilities as a peace building strategy.

The expected outcomes include:

- The development of a statement of principles and a communiqué summarizing the outcome of discussion and key recommendations. This will be made available to the government of Canada and appropriate agencies active in conflict and post conflict regions.

- The proceedings will be summarized as a set of guidelines and criteria covering the disability dimension of relief, rehabilitation and development projects. These guidelines will support Canadian foreign policy by providing additional momentum, from a disability perspective, of the eventual total global ban on anti-personnel land mines.

- The communiqué will be sent to the Minister as input for the international strategy session being held later in October. The guidelines will also integrate efforts addressing the needs of land mine victims and those whose disability results from other factors.

- A major feature will be a stated commitment to the full involvement of persons with disabilities in public policy and the design and implementation of health, social and economic strategies focusing on disability issues.

SYMPOSIUM:

Post-Conflict Integration of Persons with Disabilities Symposium Recommendations

Priority initiatives to promote greater integration of persons with disabilities in post-conflict situations:

13. Design relief interventions with explicit consideration of the disability perspective. Assure that inclusive principles inform the relief effort and carry over, providing continuity, to medium term development and reconstruction efforts. Greater attention to the prerequisites for effective post-conflict integration of persons with disabilities can begin during the relief period, but this requires a purposive effort and commitment by donors and implementors as well as a facilitating policy framework. Gaining momentum for such policy changes requires further research and consultation.

14. Needs assessments should include the identification of opportunities to improve the fit between the proposed response and the existing cultural, social and civil environment in so far as these impinge on the inclusion of disabled persons. The link between these assessments and further opportunities to consolidate peace building efforts needs to be further examined and understood.

15. Access to information on various aspects of disability during the pre-conflict, conflict and post-conflict periods in a particular country needs to be improved. Persons with disability and their local organization need to be involved in the identification and planning of relief, rehabilitation, and development initiatives as they can offer unique perspectives and insights. Disability issues need to be included in consultations with local authorities as early as possible and carry through to sustainable capacity building efforts. This can occur at diplomatic levels and via international and multilateral fora.

16. Donors would be encouraged to reward organizations which address disability issues comprehensively, especially those which make efforts to collaborate, filling gaps with skills from other organizations when this is required. For this to occur, disability needs too be on the policy **and** implementation agendas.

17. Start immediately with mental and physical rehabilitation efforts during the conflict; insist that these be included as part of a comprehensive response to the full trauma of conflict. Review and adjust, on an ongoing basis, this effort to the scale or magnitude of the problem as well as its nature and scope. Begin reintegration and resocialization with communities and individuals which have resources and the desire to develop integration programmes.

18. Educate health professionals, clinicians, and community workers, regarding the benefits which can accrue to the overall effort when persons with disability are involved in the design and implementation of relief and rehabilitation projects.

19. Assure that the appropriateness of technology is addressed in the management, selection, provision and donation of relief items, as well as being part of the assessment of community needs.

20. Organizations already engaged in emergency relief and transitional assistance need to look at their own role and assess the extent to which they are contributing to the solution or the problem of post-conflict integration of persons with disability.

The Symposium provided the following suggestions on how to assure that these priorities are addressed at the level of operations and management:

1. Funding criteria which require consideration of the disability dimension should also assure the citizens "from both sides" have been included in the assessment stage. Mechanisms to facilitate this need to be developed and promoted as part of the technology of relief and development. Quick assessment tools for the disability dimension need to be developed. Agencies should submit combined proposals when the actual problem requires skills they may not have on their own. "Lead agencies" can assure that CBR efforts are funded as part of the broader relief response by including education and participation in the design and implementation of these efforts.

2. Assessing the capacity of local health professionals in the area of disability, as well as that of organizations which are engaged socially and politically in disability issues in the affected area, can reduce the cost of meeting these needs and provide impetus to local efforts to solve this and other relief and development problems. CIDA should be encouraged to monitor and evaluate this dimension using local capacity as well as skilled professionals from the Canadian disability organizations.

3. Create a repository for Canadian experience and technology and take steps to promote these approaches internationally including via exportation through private companies. Identify characteristics which effective CBR programmes have in common and assess their applicability to the case at hand.

4. Contribute to building more effective structures and methods of information sharing. Increase the knowledge base regarding the needs and actual situation of persons with disabilities in post-conflict and reconstruction situations. Develop networks of information sharing on specific practical issues and reach out to other countries (e.g.. "Society for All" in Finland has a WWW site).

5. Consult regularly with organizations which are focused on the disability dimension domestically and which have also developed links and networks internationally. Donors need to be made aware of these organizations and need to encourage those agencies they normally fund to also become aware of these organizations. Target larger implementing organizations which have ongoing relief and development activities, the existing capacity to address this issue in the short term, and that already reach a broad Canadian and international constituency.

6. Donors may want to consider training efforts or actual programs which prepare persons working in various regions to be more sensitive to cultural issues as they affect disability, as well as related psycho-social trauma. To promote the exchange of information, donors and implementing agencies should embark on programmes of professional interchange and leadership development with agencies in the "disability movement". Agencies should demonstrate their tangible commitment to including the disability dimension in assistance efforts by paying those organizations which have this expertise to develop and deliver training programmes. Identify core skill gaps and if these include disability then create a relationship to meet this need.

7. Promote a change in attitudes by raising the issue in appropriate coordinating fora on an ongoing basis. Make conscious and clear public efforts to accept and include disable persons as equal participants and colleagues. Inform educate, lobby and exchange information. Donors need to be educated and their awareness of the benefits which come with early intervention on the disability front needs to be increased.

8. Include assistance items for disabled persons on relief convoys as soon as practicable.

9. Agencies should conduct reviews of their existing portfolios and look for opportunities to integrate consideration of the disability dimension. Implementors are not necessarily "disability focused" throughout the relief and reconstruction and development phases (recognizing that this may be neither a linear nor orderly progression) so there is a need to increase awareness and provide reminders - the donor can create this type of accountability.

10. Conflicts are specific with their own unique past, present and future: Canadian fora on each of these should be organized to collect and create a repository for a collective perspective and approach.

11. Transmit the recommendations of this symposium to Canadian policy makers at all levels, local, municipal, provincial, federal, and also assure that the private sector is made aware of these discussions, perhaps via the Business Council on National Issues.

VICE-PRINCIPAL (HEALTH SCIENCES)
DEAN, FACULTY OF MEDICINE

Queen's University
Kingston, Canada
K7L 3N6

1995 June 30

Dear Dr. and Mrs. Bader:

You will have heard, I am sure, from Dr. Keat and his colleagues. I wish to add to theirs my sincere thanks, both personally and on behalf of the Faculty of Medicine of which the School of Rehabilitation is part, for your very generous donation in support of our work in Bosnia / Herzegovina. What we have been able to help the people there, to date, to develop an effective system of community-based rehabilitation has been good. With your generous support added to that we have from government, we can do more better.

Our next project is to help the medical school there develop a primary care program modelled on what we do in family medicine. We have so much and they so little.

Thank you.

Sincerely,

Duncan Sinclair

SCHOOL OF REHABILITATION THERAPY
FACULTY OF MEDICINE
OFFICE OF THE DIRECTOR

Queen's University
Kingston, Canada
K7L 3N6
Tel 613 545-6103/4/5
Fax 613 545-6192

Dr. John S. Cowan
Vice-Principal
Operations & Finance
Richardson Hall - Room 224
Queen's University

November 30, 1995

Dear Dr. Cowan,

I have a few items of background information on Queen's initiatives in Bosnia. I thought Dr. and Mrs. Bader would be interested. If you agree, this might be forwarded to them.

Yours sincerely,

Malcolm Peat
Professor and Director

MP:lmbs

International Centre for the Advancement of Community Based Rehabilitation
A Canadian International Development Agency funded Centre of Excellence

Centre international pour l'avancement de la réadaptation à base communautaire
Un centre d'excellence subventionné par l'Agence canadienne de développement international

Queen's University Kingston, Ontario, Canada K7L 3N6 Telephone (613) 545-6881 Fax (613) 545-6882

Health and Social Services in Bosnia-Herzegovina

Comments from the Queen's Project

The following is a review of some of the current issues affecting humanitarian assistance in Bosnia-Herzegovina, particularly related to the development to the Queen's Bosnia Program. In addition they relate also to the recent memorandum of Jane Whistler to Dr. and Ms. A. Bader.

Central Coordination and Policy Development

The war effectively isolated the country from external contacts. In addition, the destruction of the transportation and communication systems forced individual cities and cantons (regions) to develop their own strategies and programs in order to deal with basic elements of survival.

The isolation of Sarajevo contributed to the extreme difficulty of the 'central' government developing the mechanisms which would permit effective implementation of policies related to essential health and social services, e.g. emergency and primary care, distribution and role of health personnel, provision of pharmaceutical products and other essential hospital supplies.

The current situation is one in which the government agencies at the central (Sarajevo) and canton level are struggling with the development of a national strategic plan in relation to reconstruction and rehabilitation of health and social services.

The major UN agencies including WHO have made valiant efforts to assist the BiH authorities in developing effective mechanisms which will identify priorities, programs and implementation strategies. In this process WHO provided the Ministry of Health with a senior policy analyst (WHO Special Representative), until recently this position was held by Ms Stephanie Simmonds (seconded from ODA - UK).

In the area of rehabilitation of the war injured WHO and the Government of BiH agreed on a strategic policy framework for CBR (Community Based Rehabilitation). This identified CBR as the preferred mechanism for providing rehabilitation services to the large number

of those disabled by the war.

The Queen's program works within a policy framework of the WHO Rehabilitation of War Victims Program. Queen's contribution is thus a component of the BiH national policy. This strategy ensures that the Queen's program works closely with city (Sarajevo, Tuzla and Zenica) and regional authorities.

Coordination of Humanitarian Relief

Humanitarian agencies range from the larger international programs such as those of CARE, UNICEF, UNHCR, MSF to small individual initiatives. The experience of the Queen's program is that it has been virtually impossible for either the UN agencies (WHO) or regional or central Government agencies to know of the range and diversity of individual humanitarian programs, even in one specific program area, e.g. distribution of drugs, community nursing, mental health and rehabilitation of war injured. Essentially the situation on the ground is close to chaos. One often finds individual groups in one region or city working without any knowledge of the other - the difficulties of communication and control are enormous. The Government of BiH and major humanitarian coordinating groups e.g. UNHCR/WHO have always been acutely aware of these difficulties but have no power or ability to bring a sense of order to the delivery of humanitarian assistance. In addition, there is a lack of effective communication between major humanitarian organizations themselves.

There is also, unfortunately, a sense of rivalry between humanitarian groups in any program area. In rehabilitation we have encountered a humanitarian organization strongly committed to the development of institutions for disabled persons. This is contrary to the established policy of BiH and UN who favour the community development (CBR) approach. We have seen several examples of non-government organizations (NGOs) agreeing informally to non-interference in each other's activity (controlling one territorial region) rather than collaborating in the sharing of resources with a common or related set of goals and objectives

Future needs in strategic planning

With the implementation of the peace agreement there will be greater control exerted by Government and major humanitarian agencies. As we have seen in other areas of conflict, when the security system becomes stabilized there is a major move towards coordination and control of communication systems and health and social agencies. It is very likely that there could be a "licencing" of humanitarian programs, either by the Government or Government in partnership with UN. This will bring some order to the current situation However, there is a number of political, commercial and national groups external to the region that will continue to attempt to influence the political and social direction of Bosnia in the phase of rehabilitation and reconstruction. Which external group(s) is going to have the greatest influence on the reconstruction of the primary health sector and for what

purpose is a critical issue.

Education of health professionals (Family Medicine)

The prewar approach to medical and health professional education prepared professional groups for institutionalized practice with significant emphasis on specialization. In recognition of the need to decentralize health services a major project currently under discussion is the implementation of a Family Medicine Program based in the Faculty of Medicine at Sarajevo University. Dr. Nedzad Mulabegovic, the Rector of the University and previous Dean of Medicine, has promoted this concept and established strong links with Italian National Public Health Institute (Istituto Superiore di Sanita). The Italian funded program under the auspices of UNICEF will establish eleven demonstration sites in Sarajevo. The purpose of the project is to evaluate the effectiveness of an enhanced service by the general practitioner at the community level.

The Faculty of Medicine, University of Sarajevo, with assistance of WHO approached Queen's University to discuss Queen's participation in:

- changes in the education of physicians at the undergraduate level to incorporate family medicine/community care principles and
- to introduce a specialist program at the post-graduate level

Dr. Mulabegovic visited Canada in May, 1995 to consult with Queen's faculty, especially with the Department of Family Medicine Head, Dr. Ruth Wilson and the Director of the Family Medicine Residency Program, Dr. Geoff Hodgetts. This was facilitated by Dr. M. Peat and the Queen's CBR Bosnia project.

Dr. Hodgetts went to Sarajevo in November 1995 on the invitation of Dr. Mulabegovic to consult on the reconstructing of the health education system and the implications of reform of the primary care system on government policy. An important task for Dr. Hodgetts was to confirm the feasibility of Queen's involvement in the National Family Medicine Program in Bosnia-Herzegovina. He worked with Dr. Mulabegovic, Dean of Faculty of Medicine and Rector of Sarajevo University, Professor Smajkic, Director of the National Public Health Institute, The Research and Operational teams for the Italian-funded Primary Health Care Reform; Dr. Tokic, Director of the Dom Zdravlja Sarajevo, officials of the Ministry of Health of BiH, UNICEF and WHO to clarify the parameters of a program that has as its goal the establishment of a National Family Medicine Program.

Dr. Mulabegovic is currently in England participating in discussions related to British assistance to the University of Sarajevo. It is possible that, in addition to an Italian component and a Canadian contribution they may also be a British element in the future design of family medicine. This will clearly require outstanding collaboration and cooperation!

Queen's and Bosnia-Herzegovina

Community Based Rehabilitation (Queen's)

The current project in community rehabilitation will continue throughout 1996.

1. CIDA's support permits the development of CBR within Central Bosnia. This initiative is currently located in Zenica region but will expand to other locations, e.g Vitez.

2. CIDA's support for national conferences on rehabilitation policies bringing together organizations working in the same area. The first of these is scheduled for Sarajevo in early 1996.

3. Dr. and Ms. A. Bader support for CBR development in Tuzla region and continuation of the CBR program in Sarajevo.

All of the above contribute towards the development of the BiH Government policy framework for rehabilitation services.

Additional CIDA funding is being requested for the expansion of the Queen's CBR program this will focus on the implementation of additional CBR units in Bosnia and the implementation an educational program for rehabilitation professionals working in community practice. Current discussion will provide some indication in January 1996 as to whether CIDA is willing to continue this humanitarian initiative.

Family Medicine (Queen's)

CIDA's support is being requested for a Queen's Family Medicine/Sarajevo Family Medicine Partnership.

The objectives of which are:

1. Strengthen the "generalist" approach to undergraduate training and introduce and assimilate Family Medicine/community care principles into the undergraduate curriculum.

2. Develop a post graduate education program for family medicine physicians with Faculty of Medicine in BiH.

3. Develop opportunities for continuing education and re-education of practicing specialist/generalist physicians making a transition to Family Medicine.

4. Collaborate with Ministry of Health of Bosnia-Herzegovina, WHO, UNICEF and the Italian Government Emergency Cooperation Department in the development of the master plan, that will guide the legislative agenda for redeveloping the health system to eliminate duplication of services and to reform the provision of primary health care.

Planning (Queen's)

Early in 1996 the following planning meetings will take place:

1. A meeting with CIDA in Ottawa in January to determine the Canadian Government's priorities in Bosnia for 1996. This will include discussions related to the continuation of Community Based Rehabilitation and implementation of the Family Medicine Program.

2. Visit by BiH Minister of Health, Dr. Bozo Ljubic to Queen's (January 20-30 1996) to review the BiH/Queen's partnership. This meeting is critical in identifying Queen's initiatives within the BiH Government policy framework. Dr Ljubic will meet with CIDA and Health Canada officials.

3. Visit by Dr. I. Pupulin, director of Rehabilitation Division WHO Geneva, to Queen's (March 1996) to review Queen's initiatives within the WHO policy framework in BiH and also Queen's other international health and social policy initiatives in 1996/97.

4. Queen's Bosnia Project CBR Management Committee meeting in Zagreb or Sarajevo (March 1996) to review the implementation schedule of activities for 1996/97 The Management Committee includes: Queen's, WHO, CIDA and BiH Government.

COMMUNITY BASED REHABILITATION

A Project of the School of Rehabilitation Therapy and
the International Centre for the Advancement of Community Based Rehabilitation (ICACBR)
QUEEN'S UNIVERSITY

Funded by the Department of Foreign Affairs and International Trade, Government of Canada

September 5, 1995

Dr. Alfred Bader
Suite 622, 924 East Juneau Avenue
Milwaukee, Wisconsin
53202

FAX: (414) 277-0709

Dear Dr. Bader:

I have just returned from Bosnia where we have been able to complete the planning for the next phase of the Queen's CBR Program. David Packer, a faculty member here at Queen's is the Program Manager for the Bosnia Project. He and I met with colleagues in Bosnia and with representatives of the WHO "Rehabilitation of War Victims Project".

The timing of our two visits this Summer coincided with the major offensive in the Krajina when the Croatian forces "reclaimed" the part of Croatia which had been occupied by the Bosnian Serbs since the beginning of the war. In addition to this, we were in Central Bosnia during the recent air strikes around Sarajevo. It was impressive to see that the humanitarian organizations continued their activities and were only occasionally prevented from entering areas in which the hostilities were so intense that it made continuation of activities impossible. There is no doubt that the events of the summer have created an even greater population of refugees and those who have become disabled as a result of the conflict.

The recent visit by David and me clearly illustrated the enormous needs within this war torn region and we and our colleagues are very grateful for the support of Queen's in permitting our contribution to the development of rehabilitation at this time. If the present peace initiatives are in any way successful in reducing the level of hostilities, there will be an even greater opportunity for rehabilitation services in the future. I believe the Queen's initiative has provided a base of experience in the development of a community approach to the implementation of services and illustrated ways in which health professionals, communities and persons with disabilities can effectively work in partnership.

With your support, development of the Queen's CBR program in Sarajevo will continue, and in addition, we will more than double our initiatives in Central Bosnia.

In Canada: Queen's University, Kingston, Ontario, Canada K7L 3N6 Tel: 613 545-2812 • Fax: 613 545-6922
In Zagreb: c/o CARE Canada, A. MEDULICA 40/2, 41000 ZAGREB, Croatia Tel/Fax: 385 41 273-998
In Sarajevo: c/o CARE Canada, TRG MERHEMICA 8 (CIGLANE), Sarajevo Tel/Fax: 387 71 664-194/5

During the month of August David and I both spent considerable time in Central Bosnia, particularly in the regions of Zenica and Tuzla. The objective was to develop the Queen's CBR program funded through your donation and also the next phase of the Canadian Government Project in Central Bosnia.

We visited the Zenica and Tuzla regions as they are major population centres which have had to assume responsibility for the refugee resettlement of thousands of people who were displaced from their homes. This has been further aggravated by the recent escalation of war and occupation of Srebrenica and Zepa by the Bosnian Serbs. The need for health and disability programs in these locations has risen dramatically. Rehabilitation programs are a high priority as there are currently few resources, and in some areas, a complete absence of any rehabilitation services. Our intention is to develop two regional community based rehabilitation programs, of which the experiences will demonstrate the value of CBR in meeting the major disability needs of the population. Your donation will support the regional initiative in Tuzla and the Canadian Government resources will support the Zenica regional initiative, thus significantly expanding the Canadian contribution to humanitarian aid and long term rehabilitation of the communities affected by the war.

In both regions we have strong support from the Canton (the municipality), Ministry of Health and other agencies involved in disability issues. The Government of Bosnia and the local municipalities are extremely supportive and appreciative of the Canadian initiative and were well aware of our activities in Sarajevo over the last two years. We were very pleased with their interest and support.

In August David also visited the Sarajevo CBR clinics. The four clinics, which have been the focus of our activities, continue to operate throughout the siege. Resources to the clinics, through your donation, have had an enormous impact on the morale of the community and clinic staff and the ability of the clinics to continue to operate.

I look forward to meeting with you and Mrs. Bader in October. This will provide us with an excellent opportunity to review the project and the impact of your donation in greater detail. In the meantime, if I can provide you with any further information please do not hesitate to contact me.

Yours very truly,

Malcolm Peat, Ph.D
Executive Director

Rehab program at Queen's helps Bosnian refugees

BY MATT McPHERSON

Refugees fleeing the war in Bosnia are trying to piece together the remnants of their lives with the help of a Queen's program.

The International Centre for the Advancement of Community-Based Rehabilitation (ICACBR), a program based at Queen's School of Rehabilitation therapy, was established in October of 1993 in collaboration with the Bosnian government and the World Health Organization.

The program was set-up in Sarajevo, and has expanded into the central Bosnian cities of Tuzla and Zenica.

And now, the community clinics — initially set up to rehabilitate those disabled by war wounds, the elderly, and people with disabilities — are also helping refugees resettle and combat disability.

Malcolm Peat, director of the School of Rehabilitation Therapy and executive director of the Bosnian undertaking, said that the sheer number of refugees and the vulnerability of the population led the program to expand its focus.

"One of the things we're trying to do is to develop teams of rehab personnel who'll visit the families, the refugee families, and try to identify the kinds of needs that they have that we could help provide through the Bosnian-Canadian program," Peat said.

in central Bosnia near Sarajevo and said the scene there left him speechless.

"The refugees had just arrived within hours, and I went into this large auditorium. There were hundreds of people there: young children, elderly people, mothers.

"The dominant impression I got was [pause] a silence. There was a stillness. There was a sense of isolation, of tragedy, of confu-

"If you can try and imagine what it would be like if you were suddenly uprooted. Everything you had is gone, and you were transported within a few hours, and you find yourself in this huge vault with a hundred other people, lying on the floor being given very basic elements of survival. The real feeling of tragedy was tangible," he said.

Peat said the teams of clinicians aim to prevent disability, and help refugees to adapt. Injured people, or anyone living in isolation, are especially vulnerable to disability, he said.

"If they lie on a mattress day after day, there's no mobility for them, there's no activity. If they're elderly, they will inevitably become weaker and suffer from problems related to their joints or mobility, and they will develop disabilities that could have been easily preventable," Peat said.

The ICACBR team, (from left) Lorna Jean Edmonds, administrative officer, David Packer, project manager, Malcom Peat, executive director, Elizabeth Tata, physiotherapist and clinical coordinator, with their new vehicle in Makarska, Croatia.

PHOTO COURTESY OF INTERNATIONAL CENTRE FOR THE ADVACENMENT OF COMMUNITY -BASED REHABILITATION

He emphasized that the program was doing more than rehabilitating people in Bosnia.

"It's not just rehabilitation, it's social support. It's visiting, it's trying to participate with the local authorities on how we can support these individuals, in the sense of dealing with what for us is the primary concern: disability," he said.

There are two clinics in central Bosnia: one in Tuzla and another in Zenica. Peat said the clinics have been established in areas where there is a very high density of refugees outside the city centres.

Unlike the Sarajevo project, the two clinics were established in areas where no clinical resources previously existed, Peat said.

He credited the expansion of the program, and the continuation of the Sarajevo program to the donation of $685,000 by Queen's alumnus, chemist Alfred Bader.

"Dr. Bader's grant now makes it possible for us to continue working in Sarajevo [and] even enhance the clinical teaching and clinical collaborative activity where you have Canadians working side by side with Sarajevo therapists," he explained.

Peat said expanding the program into Croatia and Serbia is a possibility.

"I can see a very long term involvement for Queen's in this region," he said.