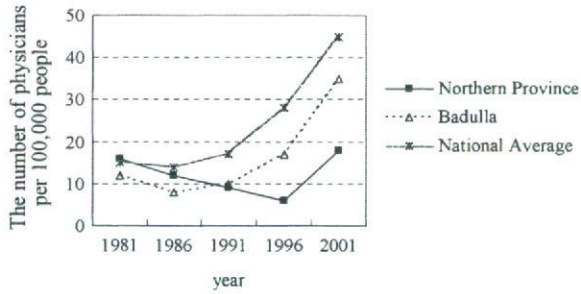

Fig. 2. Physicians per population, by district, Sri Lanka, 1981–2001. *Sources*: Consortium of Humanitarian Agencies, District Profile-Mannar, 2004. Department of Health Services Sri Lanka, Annual Health Bulletin, 2001. Deputy Provincial Director of Health Services Jaffna, Annual District Health Plan 2005, 2004. Deputy Provincial Director of Health Services Kilinochchi, Provincial database for Provincial Health Profile, 2004. Ministry of Health Sri Lanka, Annual Health Bulletin, 1981, 1986, 1991, 1996, 2003. Office of the DPDHS Vavuniya, Statistical Handbook & Health Sector Development Plan, 2004. Statistics Branch, Kachcheri, Mullaitivu, Statistical Hand Book, 2004.

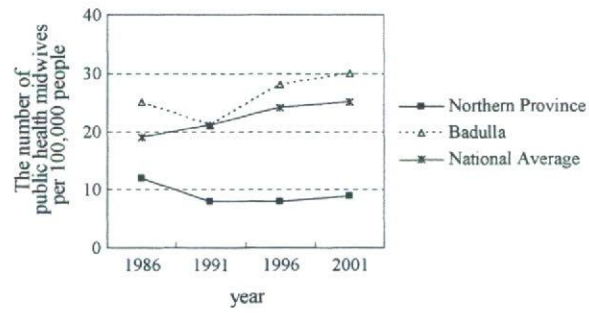

Fig. 3. Public health midwives per population, by district, Sri Lanka, 1986–2001. *Sources*: Consortium of Humanitarian Agencies, District Profile-Mannar, 2004. Department of Health Services Sri Lanka, Annual Health Bulletin, 2001. Deputy Provincial Director of Health Services Jaffna, Annual District Health Plan 2005, 2004. Deputy Provincial Director of Health Services Kilinochchi, Provincial database for Provincial Health Profile, 2004. Ministry of Health Sri Lanka, Annual Health Bulletin, 1981, 1986, 1991, 1996, 2003. Office of the DPDHS Vavuniya, Statistical Handbook & Health Sector Development Plan, 2004. Statistics Branch, Kachcheri, Mullaitivu, Statistical Hand Book, 2004.

Province was reduced by half by 1996, although it had been higher than the national average before the conflict. While once increased in 2001, the disparity between Northern Province and others expanded more after the cease-fire agreement. For example in Jaffna district, the number of physicians per 100,000 people dropped from 22 in 2001 to 15 in the year 2003 [8]. The worst district in 2003 was Mullaitivu where there were only three physicians per 100,000 people [11]. This was merely 12% of Badulla district in 2001.

The other important HRH in Sri Lanka is the qualified midwife, including the hospital midwife and the public health midwife (PHM). PHM assumes a vital role in preventive health services particularly in underprivileged areas such as Northern Province or Badulla district. The allocated cadre position for PHM is one per 3000 people [12]. PHMs are also in shortage in Northern Province (Fig. 3). The number of PHMs stayed low for 15 years in Northern Province, in spite of an upward trend of PHMs in the whole country and Badulla district, which were reaching its allocated cadre position per population. This regional disparity has increased more after the cease-fire agreement. In the year 2003, Mullaitivu district and Kilinochchi district had five and six PHMs per 100,000 people, respectively, which represents a mere 18 % of Badulla district in 2001 [11]. The number of hospital midwives per population by district showed a quite similar trend to that of PHMs. Their number per population in Northern Province was nearly half of that in Badulla district and the national average from 1991 to 2001.

Tables 1 and 2 show the coverage of safe drinking water and adequate latrine facilities, respectively. In 1981, the prevalence of housing units with safe drinking water in Jaffna district (including current Kilinochchi district) in Northern Province was much higher than that of the national average. However, the access to the safe drinking water deteriorated during the conflict and it has not recovered yet, 1 year after the cease-fire. Table 2 indicates that the development of adequate latrine facilities at home in Northern Province was

Table 1
Households with availability of safe drinking water by district

	Year (%)	
	1981	2003
National average	69.9[a]	ND
Badulla	67.5[a]	ND
Jaffna	87.8[a]	23.5[b]
Kilinochchi		39.5[c]

ND, data not available.

[a] Ministry of Health Sri Lanka, Annual Health Bulletin, 1991.

[b] Deputy Provincial Director of Health Services Jaffna, Annual District Health Plan 2005, 2004

[c] Deputy Provincial Director of Health Services Kilinochchi, Provincial database for Provincial Health Profile, 2004.

Table 2
Households with adequate latrine facilities by district

	Year (%)		
	1981	1995	2003
National average	66.5[a]	86.5[b]	ND
Badulla	66.7[a]	81.9[b]	ND
Jaffna	53.8[a]	ND	53.0[c]
Kilinochchi		ND	45.5[d]

ND, data not available.
[a] Ministry of Health Sri Lanka, Annual Health Bulletin, 1991.
[b] Ministry of Health Sri Lanka, Annual Health Bulletin, 1996.
[c] Deputy Provincial Director of Health Services Jaffna, Annual District Health Plan 2005, 2004.
[d] Deputy Provincial Health Services Kilinochchi, Provincial database for Provincial Health Profile, 2004.

delayed over 20 years comparing with that of national average.

3.2. *Questionnaire results of health care providers and inhabitants in Northern Province*

Table 3 shows the questionnaire results of health care providers and inhabitants in Northern Province. Poor access to health facilities was the most frequently reported problem in the current health service system by both health care providers and inhabitants. More than 80% of both health care providers and inhabitants mentioned difficulty to get to health facilities due to long distance, poor road conditions, or lack

Table 3
Questionnaires results of health care providers and inhabitants in Northern Province

Select questionnaire topics and responses	Positive response, *n* (%)	
	Health care providers ($n = 35$)	Inhabitants ($n = 36$)
Current problems in health service systems		
Poor access to health facilities	29 (82.9)	30 (83.3)
Lack of human resources	26 (74.3)	15 (41.7)
Inadequate relationship between health care provider and patient	9 (25.7)	0
Lack of space and/or poor physical working conditions	16 (45.7)	3 (8.3)
Inadequate wages	14 (40.0)	0
Lack of opportunity for further education/training system	13 (37.1)	0
Lack of specific medical instrument/treatment at referral hospital	10 (28.6)	8 (22.2)
Current health problems among population		
Inadequate clean water/well at village	16 (45.7)	17 (47.2)
Lack of latrine at home	11 (31.4)	16 (44.4)
Lack of basic health knowledge/awareness program	21 (60.0)	21 (58.3)
Unwanted pregnancy/artificial abortion	10 (28.6)	1 (2.8)
Mental health	12 (34.3)	12 (33.3)
Poor nutritional status among children and/or pregnant women	14 (40.0)	8 (22.2)
Poor environment	11 (31.4)	18 (50.0)
Priorities for improvement		
Access to health facilities for well-timed treatment	12 (34.3)	21 (58.3)
Health education to the population	13 (37.1)	13 (44.4)
Construct well/latrine at village	10 (28.6)	10 (58.3)
Clean environment	5 (14.3)	5 (2.8)
Provide better medical instrument/drugs to health facility	3 (8.6)	5 (33.3)
Distribute food ratio to improve nutritional status	2 (5.7)	4 (22.2)
Provide mental health care	0	4 (22.2)
Provide continuing education to the health care provider	5 (14.3)	0
Obstacles for improvement		
Lack of human resources	19 (54.3)	9 (25.0)
Lack of funds	11 (31.4)	19 (52.8)
People's unconcern for health	4 (11.4)	13 (36.1)
Lack of neighboring unity	0	5 (13.9)

Positive responses were calculated as a percentage of the number of providers that included the statement in their free response. More than one response was coded per subject when applicable.

of transportation. The improvement of the road condition and public health transportation systems to the current health facilities, as well as the set up of a communication tool at the health facilities for emergency, were mentioned as the highest priorities for improvement.

Nearly half of respondents of both health care providers and inhabitants reported poor access to safe drinking water and lack of latrine, and 30% of respondents mentioned them as one of the priority issues for improvement. Those inhabitants, without latrine at home, used the jungle as "toilet" every day and night, and reported the fear of poisonous snakebite, especially at night.

The other frequently reported problems among both health care providers and inhabitants were a lack of basic health knowledge and insufficient health awareness programs for inhabitants. Nearly 30% of health care providers pointed out the problem of unwanted pregnancy and illegal abortion. Among the inhabitants, 44% considered the health awareness programs to be the priority for improvement. The contents of a health awareness program suggested by respondents were: first aid; identification of danger signs of pregnant or post-partum women and newborn infants to make decision of visiting health facilities; nutrition; family planning; and environmental health.

Overwhelming majority of the respondents, both health care providers and inhabitants, perceived that the shortage of HRH was the most prominent obstacle to improve the above problems. Inhabitants particularly indicated the shortage of specialists, midwives, and health educators. Health care providers reported the heavy workload to cover the shortage of co-workers, and inadequate communication with patients due to lack of time.

The shortage of qualified PHM in Northern Province was supplemented by health volunteers who had been trained by various NGOs during the conflict. Some respondents mentioned that health volunteers who applied to the governmental training program of qualified PHMs were rejected because they could not meet the official criteria for selection, such as being unmarried, younger than 28 years old, or over 4.5 feet tall. This information was verified by key officials of the Sri Lankan government health sector through direct interviews.

Lack of working space, inadequate wages, as well as lack of opportunity for further training systems were other grievances regarding the current workplace among health care providers. Sinhalese health care providers mentioned the difficulty to work in Tamil communities due to language problems, however, they had no complaints about security issues.

One third of respondents reported mental health issues as priority health problems among communities. This included anxiety, depression, post-traumatic stress disorder (PTSD), domestic violence, and alcoholism.

Shortage of HRH and people's negligence for health were perceived as the major obstacles to improving the health situation. It should be noted that five inhabitants who are now newly relocated after the cease-fire reported that the lack of neighboring unity between relocated inhabitants and original inhabitants was the main obstacle.

3.3. Key informant interviews

The various problems mentioned above were recognized by the officials of Sri Lankan government health sector concerned with Northern Province. For example, to increase qualified midwives in Northern and Eastern Province, the central government started a program to educate and train 600 new midwives in October 2004. However, they admitted that there would be future challenges to allocate those 600 midwives to areas urgently in need of HRH.

On the other hand, a physician's transfer system every 4 years in whole country has been conducted in collaboration with the Sri Lankan government health sectors and the Government Medical Officers Association (GMOA), a physician's trade union in Sri Lanka. However, there have been many physicians who were appointed but refused to go for work in Northern and Eastern Provinces. GMOA accepts the refusal as there are real security threats in Northern and Eastern Provinces. As a result, Northern and Eastern Provinces are *de facto* excluded from the existing framework of the allocation system of physicians.

The key informant interview also revealed the inaccuracy of vital data. One district official suggested that the data from Kilinochchi district, including MMR, was not reliable because of the shortage of HRH.

In addition, it was identified that HRH outside Northern Province had only limited information of

health issues in Northern Province. It was also identified that the inhabitants in Northern Province and those in other areas misunderstood each other due to insufficient objective information. The road between the capital and Jaffna that located at the north end of Sri Lanka opened after the cease-fire, and increasing number of Tamil inhabitants from Northern Province visited the capital. They saw the economic development of the capital and realized the devastated state of Northern Province. However, they seldom visited other underprivileged areas such as Badulla district. Moreover, it was quite uncommon for Sinhalese inhabitants in the capital or in underprivileged areas to visit Northern Province. Some Sinhalese health providers working in the capital or Badulla district who had never visited Northern Province complained that international donor agencies focused only on Tamil dominant areas.

4. Discussion

The analysis of a 20-year trend of health service systems reveals the steady improvement of basic health indicators of the national average and underprivileged areas in Sri Lanka, in spite of the prolonged conflict. This is the distinct feature of Sri Lanka, compared to other countries experiencing long-term conflicts such as Cambodia [13] or Afghanistan [14]. Well-designed social service systems which had been established before the conflict, and continuous provision of social services during the conflict made this stable improvement possible [15].

On the other hand, the trend of health indicators in Northern Province, which had been the main battlefield, showed completely different aspects from those of the national average or other underprivileged areas. In spite of the fact that the post-conflict reconstruction depends on the health of the people who engage in social and economical activities there, the analysis reveals that there are still unmet needs in HRH, water and sanitation, health knowledge among inhabitants, and mental health in Northern Province.

Mental health care is considered one of the most important issues in post-conflict reconstruction period [16,17]. A systematic national mental health policy is still under development in Sri Lanka. First, there is an overall shortage of psychiatrists at the national level. Then, very few psychiatrists work outside the capital, and there is only one in Northern Province. Although a physician trained for mental health is supposed to be appointed to each district, no adequate number of such trained physicians are posted in districts of Northern Province. Psychological supports such as counselling for residents in Northern Province are conducted sporadically by a few NGOs with limited budgets. It is necessary to establish a systematic national health strategy for mental health, targeting those who live in conflict-affected areas as well as those who live in underprivileged areas other than Northern Province.

Among various health problems in Northern Province detected through this survey, the shortage of HRH is the most important and urgent issue. Researches from other countries show a correlation between quality of care, healthcare outcomes and the availability of HRH [18], and this is particularly relevant to re-establish the health services in conflict-affected areas [19].

The uneven distribution of HRH inside the country is a worldwide phenomenon both in industrialized countries [20] and in developing countries [21]. The shortage usually occurs in three axes: the public health sector in contrast to the private health sector; rural areas in contrast to urban areas; and primary levels of the health system in contrast to tertiary levels [21]. International migration of HRH especially physicians from the lower income countries to the higher income countries makes this problem more complex [22]. In addition, it is important to provide the insight into the fourth axis in the case of Sri Lanka; the area affected by long-term conflict in contrast to areas not directly affected by conflict.

To remedy the HRH shortage in the first three axes, different strategies have been applied in different countries: development of rural health infrastructure; recruitment of candidates from rural areas; reform of medical education from specialist to generalist oriented; compulsory public services; financial incentives; equal opportunities of rural physicians for post-graduate training and career advancement; recognition and improvement of the social status of rural physicians [23]. Each strategy is interrelated, therefore, addressing them in an ad hoc manner should result in limited effectiveness. As well, they are strongly influenced by a socio-economic and political environment. To solve the shortage of HRH in Northern Province in Sri Lanka, it is worthwhile to apply the above-

mentioned strategies comprehensively. In addition, the chance to study both Tamil and Sinhalese formally at medical educational institutes during undergraduate and post-graduate medical training should be given to reduce the hesitation of many Sinhalese HRH to work in Northern Province.

For increasing PHMs, a practical program should be considered for upgrading knowledge and skills of health volunteers, and a certification system to qualify them as PHMs under the supervision of the government. NGOs and other international agencies are the main stakeholders for human resource development in conflict areas [24]. A major problem is that those agencies often follow ad hoc strategies to fulfill immediate need and there is no official takeover to government or other responsible authorities after the cease-fire. In Northern Province, many female health volunteers were trained by various health NGOs to complement the shortage of PHM during the conflict. They still work in communities after the cease-fire without being recognized as PHMs by the government. The irrational official regulations which prevent them to enter the governmental midwife school, as described previously, should be revised as soon as possible.

The region's political stability is crucial for the fundamental solution of HRH shortage in the conflict-affected areas, although it is beyond the direct control of health intervention strategies. After the cease-fire in Bosnia, the sense of pride as a professional health worker overcame the personal hostility among antagonized ethnic groups which had grown during the conflict [25]. Likewise, carefully planned human resource strategies may lead to better communication and mutual understanding of grievances and concerns between Sinhalese and Tamil HRH, which may eventually reduce the political barrier and resume peace process. In contrast with Bosnia, Sri Lanka has so far only a bitter experience. The Sri Lankan government health sectors started to pay a monthly incentive for working in Northern and Eastern Provinces only to the physicians who were born outside Northern and Eastern Provinces. Most of such physicians are from the Sinhalese community. However, majority of the physicians who are currently working in Northern and Eastern Provinces are Tamils born in Northern and Eastern Provinces. Therefore, this incentive scheme has created grievances among these Tamil physicians who have worked in Northern and Eastern Provinces for a long time. Consequently, this strategy has to be considered as a failure as far as reconciliation is concerned.

Before the cease-fire agreement, the attention of international aid agencies was mostly focused on achieving growth in government-controlled areas. For example, Japan, which provided with approximately 54% of all donor assistance in 1999 [26], reflected that "non-economic issues such as the settlement of the civil war and the resolution of ethnic and social problems were not considered as development issues that should come under the purview of Japan's economic cooperation [27]". However, the provision of development assistance from aid agencies has dramatically changed since the cease-fire agreement. At the Tokyo Conference on the Reconstruction and Development of Sri Lanka in 2003, Japan announced to provide up to one billion US dollars over the next 3 years for promoting the peace process. In 2003 and 2004, Japan's total amount of loans and grand aids for Northern and Eastern Provinces increased to almost the same amount of those for other underprivileged areas [28]. International donors pledged approximately 4.5 billion US dollars as a whole at the Tokyo Conference as well [27]. The Asian Development Bank and the World Bank, the second and third biggest donor, started funding rehabilitation and assistance initiatives in Northern and Eastern Provinces. There were only eight international NGOs in the entire conflict-affected areas in 2000, however, at least eight international NGOs had permanent offices in Kilinochchi district alone in May 2003. The reconstruction and rehabilitation activities supported by international aid agencies in Northern and Eastern Provinces started to receive increased media coverage [29].

In this situation, it is crucial to provide objective information to Sinhalese outside Northern and Eastern Provinces and the transparency of reconstruction activities by various international and national aid agencies. Policy makers and aid agencies also should keep balance for the reconstruction and development between conflict-affected areas and other underprivileged areas in the same country. Regional imbalance in the provision of development assistance can create antagonisms.

During prolonged conflict, information about Northern and Eastern Provinces had been very limited and manipulated in government-controlled areas in Sri Lanka [30]. Even after the cease-fire, not many inhabi-

tants including HRHs living in government-controlled areas had a chance to learn the real situation in conflict-affected areas. Therefore, they misconceive that most of the international aid has targeted Northern and Eastern Provinces while bypassing other underprivileged districts. This negative feeling will increase the barrier to the promotion of peace process, or may even be a trigger to the resumption of conflict.

Lastly, it is an important subject to develop the capacity of inhabitants and communities in conflict-affected areas. The strong request of health awareness program by inhabitants themselves suggests their potential. The community-based health awareness program and the community-based construction, operation and maintenance of water and sanitation systems can contribute to this project. Those programs will empower the inhabitants and contribute greatly to rebuild the community.

5. Conclusion

The health status and public health services have deteriorated in Northern Province because of the prolonged conflict. The HRH development and allocation is one of the most crucial strategies for effective reconstruction. To promote the peace process, it is indispensable to enrich the mutual understanding between Tamil and Sinhalese by providing objective information, and keeping balance for the reconstruction and development between conflict-affected areas and other underprivileged areas.

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Building peace through participatory health training: A case from Cambodia

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Abstract
This qualitative study examines the significance and effectiveness of participatory health training as a tool for peace building. It does so by analysing a case of training for 'health promoters' run by a Cambodian government health agency. The authors observed participants during the training and interviewed those involved in the courses. A developing capacity for coexistence and reconciliation between individuals who had been on opposite sides during the years of Khmer Rouge terror and continuous internal war was observed among both participants and trainers. Factors embodied in the training that facilitated favourable changes in self and in relations with others were identified as: (1) 'space for dialogue' was created by concrete common public health interests and urgent needs; (2) training took place 'live-in' style in a rural setting; (3) course contents and methods were consistent with peace education; (4) trainers had a conscious function as role models; and (5) there was continuity of effort and consequent accumulation of experience. To build peace, as well as conducting training directly on a technical topic, these essential factors need to be incorporated in the training programmes.

Keywords: *Peace building, participatory training, health promotion, post-conflict, Cambodia*

Introduction

Over two decades of internal war and ultimate subjection from April, 1975, to January, 1979, by the radical communist Khmer Rouge regime led by Pol Pot, Cambodia experienced a tremendous loss of its population, especially intellectuals and skilled persons (including health workers), in addition to the complete

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destruction of its social infrastructure and administrative system. Only 45 doctors survived the genocidal regime at the time of the liberation in 1979, and 20 of them eventually left the country (Mysliwiec 1988). In October 1991, the four contending political parties signed the Paris Peace Accord; a 'new-born Cambodia' was to be established after a UN-supervised general election in mid-1993.

Instead, battles between the government army and the Khmer Rouge faction continued. In mid-1997, the smouldering rivalry between the two prime ministers of the new government surfaced in a military clash in the capital city. The military conflict in the country continued until 1998, when Pol Pot died and key leaders of the faction surrendered. It was only in 1999 that reconstruction and development of the whole country could begin.

This prolonged conflict deprived the Cambodian people of learning opportunities, first by the total abolition of schools and Buddhist temples during the Khmer Rouge regime and then by delayed reconstruction of the educational system in the lingering war situation and isolation from the international community. Forced to adjust to the suppressive environment for so long, people lost their motivation to take initiatives and develop autonomous leadership.

Furthermore, fundamental interpersonal relations and networks were destroyed. Forced mass migrations for labour and displacement to escape from battlefields shuffled the population. Before the conflict, people in Cambodian rural society were linked relatively loosely; close networks were observed mainly among blood-related family members rather than among geographic neighbours (Ebihara 1968, Watts 1999). The Khmer Rouge regime introduced drastic measures, including forced marriages, separation of parents and children, and the installation of secret information systems even among young children, and thus destroyed the trust relationships among people, even relatives and family, the core of the Cambodian people's social relationship (Ponchaud 1978, Ui 1991, Meas 1995, Pran 1997, Kao 1999).

As a result of such experiences, a lack of confidence and 'reluctance to trust, to plan, and to make decisions' persists among Cambodians (Downie and Kingsbury 2001). Desperate memories of losing close family members, and anger towards Khmer Rouge leaders and soldiers are engraved in people's minds.

Recovering this lost self-confidence and trust in others, in other words 'reconciliation with oneself and with others', is the key to this country's reconstruction and development. Such needs may be commonly found in war-torn societies, but may be especially high in Cambodia's case where people went through an extreme genocidal regime that sought specifically to destroy trust relations even among family members (Ui 1993, Meas 1995).

As progressively more regional and local conflicts occur in intensified modes, concrete strategies and methods are urgently needed to prevent the occurrence and recurrence of such repeated man-made tragedies. Various trials have been made, and cases of peace-building efforts through training have been reported. However, many of the reported cases are of experiences under special situations,

such as during conflict, right after conflict, or in refugee camps. Such training is specially planned and conducted, often directly on themes, such as conflict resolution, mutual understanding, human rights, and peace education (Miles 1997, World Health Organization 2006). There should be ways to integrate peace-building viewpoints and elements in regular development training activities.

In this paper we aim to examine the significance and effectiveness of participatory health training as a tool for peace building and to analyse factors that facilitate its effectiveness. The research is based on a case of community health promoters' training in Cambodia during the post-conflict reconstruction and development period.

Participatory health training in Cambodia

Participatory training is participant-centred training in which participants learn through sharing experiences with one another and working together. Contents of the training are developed based on the issues and difficulties the participants have in common. Such training intends the participants to learn not only knowledge and skills but also values, attitudes, and behaviours appropriate in a peaceful, equal, and democratic society. It emphasizes the process of individual change through group dynamics (PRIA 1987, Stephen 1989, Bhasin 1991, Johnston 1991).

The National Center for Health Promotion (NCHP) of the Ministry of Health in Cambodia has been organizing participatory training for government staff who are in charge of health promotion at provincial and district levels since 1989, supported by the Asian Health Institute, a Japanese NGO. These health promoters plan and conduct such preventive health activities as health education, special health campaigns, and training for health staff and volunteers. After a series of trials adapted to the various internal and external situational changes, in the past several years three 'step-up' courses that build successively on one another (Basic Health Education Course, Training of Trainers on Health Education, Community Health Promotion Management Course) each lasting 10 days have been offered regularly to serve the needs of health promoters at provincial and district levels. In each course, from 20 to 25 community health promoters (mainly government workers but also some workers from their counterpart support organizations) gather at a training centre in a rural area about 30 km south of the capital city, Phnom Penh. As of the end of 2003, almost 700 health workers had participated in these courses (including multiple participation in different courses). The distinct impact on NCHP training activities proved the relevance and effectiveness of the courses for health promoters (National Center for Health Promotion 2004).

After the internal armed conflict finally ceased in 1999, NCHP made a point of inviting participants from the former Khmer Rouge-controlled areas. After integration, many individuals who had served as medical orderlies for Khmer Rouge had been invited to become government health workers. From August

2000 up to August 2003, the period covered in this study, 10 former Khmer Rouge health workers joined in six NCHP courses.

Methods of study

First, participants were observed during four courses between August 2000 and August 2003. Second, individual interviews were conducted between December 2002 and August 2003 with participants, including former Khmer Rouge health workers, and trainers who had taken part in the NCHP courses. Out of the total number of 80 target persons, 20 were interviewed: 14 participants (including five former Khmer Rouge health workers) and six course trainers. Interviews were conducted in Khmer.

Semi-structured interview questions included the following: (1) informants' background (age, professional certification, years of health work experience, number of NCHP courses participated in, province currently living in, province lived in during the Khmer Rouge regime, family members that died during the Khmer Rouge regime); (2) their feelings about and their relations with participants on the 'other side' of the Khmer Rouge non-Khmer Rouge divide at the beginning of the course; (3) changes in feelings and attitudes toward and relations with the other side in the process of the course; (4) recollections of events during the course that caused or facilitated such changes. We further inquired (5) how their experiences in the course affected their work and themselves personally, and (6) their views on requirements for building a peaceful society and the relations between these training courses and efforts to build a peaceful society.

Interviews were conducted individually at the time of NCHP's follow-up visits to provinces where the former participants worked and during step-up courses attended by former participants. They were interviewed by a team of two interviewers during free time in informal settings where privacy was assured, such as under a tree or in an empty canteen after a group meal. Each interview took about an hour; participation was voluntary, and respondents were informed before the start that their names would not be revealed and that they had the right to decline to answer any question.

Results

Changes in feelings, attitudes, and relationships

All of the respondents had some tense feelings and anxieties when they first learned that there were former Khmer Rouge workers in the same course. They did not know how former Khmer Rouge would think and behave and what to talk about with them, and so they kept a distance for a while to observe how the 'other side' was. Former Khmer Rouge participants had similar anxieties but much stronger. Their worries about the feelings and reactions of other participants kept their initial behaviour rather stiff and closed.

For example, one participant was the daughter of one of the highest-ranking leaders of Khmer Rouge. At the beginning, afraid of exposing who she was, she assumed a false name and did not stay in the same place with others, saying that she was staying at a friend's house close by. Becoming more integrated into the course group after a few days, she told the trainers' team that she did not mind using her real name and wanted to stay with other participants.

In another course, three workers came from the famous last stronghold of the Khmer Rouge. From the name of the place, other participants immediately knew that the three must have been very close to Pol Pot and had accompanied him until his last moment; indeed, two of them were in-laws of a well-known commander. The three workers initially decided among themselves not to talk with the others any more than necessary, but just to observe. For the first few days they were always together, both in and out of classes. When the sessions were over, they went straight to their dormitory room and talked among themselves, having very limited interaction with other participants.

For many of the former Khmer Rouge participants, this was their first training course. However, after observing the atmosphere and interaction among the other participants and the trainers, they started to feel at home. Their comments included: 'There was no discrimination and the others were very cooperative. When we were in need, others came to us and helped us. We were very glad, and we felt we were accepted'.

While most of the participants still hesitated to talk with those from the 'other side', some, whose wooden beds were close to the former Khmer Rouge participants, started to talk to them. Their entry into dialogue was typically to ask each other about the health situation, problems, and activities in the respective areas. They asked about the difficulties they faced as health workers responding to the needs of the people, especially during the internal war. They asked about effective ways to tackle health issues. Former Khmer Rouge participants were very anxious to hear the experiences of health workers from other provinces and obtain reference documents from them. After this, they gradually started to talk about other matters.

Other participants in the same dormitory room saw that the former Khmer Rouge medical orderlies reviewed lessons very seriously every night to catch up with the non-Khmer Rouge participants, while the latter were relaxing and playing games. They were very impressed by this attitude and gradually felt like offering assistance without being asked. An experienced health promoter from the Eastern province was very happy that former Khmer Rouge participants gave him their photographs and, even after 3 years, continue to send him invitations to visit their place. Many participants mentioned that 'We would not have become close like a family if we did not live and stay together like in this course'.

In the middle of the course, when practicing a short health education session in a class, former Khmer Rouge participants seemed particularly eager to get comments for improvement and kept revising their session plans. Other participants felt stimulated by seeing the attitude of former Khmer Rouge

participants. One respondent from a province near the capital city said, 'They were working so hard under a much more difficult situation than me with various limitations. I thought I should make more effort in my work'.

As the course proceeded, more scenes of voluntary interaction and cooperation were observed. In the later part of the course, when participants were assigned to develop work plans to bring back home, former Khmer Rouge health workers asked for help from others on their own initiative; some participants offered help spontaneously before being asked. They sat side by side, discussed, and gave advice and guidance until late in the evening. We could see the change in the feelings, attitudes, and relations with others manifested by the participants from both sides.

Respondents' backgrounds (educational level, professional category, etc.) had no significant effect on their interview responses. Rather, differences in responses were associated with years of health promotion work experience and number of NCHP courses taken. The longer their work experience and the more frequent their participation in the courses, the more conscious they were about the training process, and the more effort they made to contact other participants out of session time.

Impact on their work and themselves

Most of the respondents mentioned that the course gave them self-confidence not only in health knowledge and skills but also in building good relations with strangers and even people with different backgrounds. Back on the job, many found that they made more efforts to talk with others, listen to others, and take the initiative in making plans and proposals. As a result, some were able to get more support and cooperation from other organizations and sectors. Others observed that after they tried harder to listen to others their staff became more motivated to work and villagers participated in health promotion activities more actively. Specific changes in individual, work place, and field activity levels were identified.

Requirements for peace building and relationship with the course

Aside from poverty alleviation and political agreement at higher levels, respondents listed what they thought was necessary for building a peaceful society. These were: creating opportunities to meet and understand one another, being friendly and sincere, thinking positively, building trust relationships, promoting participation, and strengthening cooperation. Respondents recognized that the participatory approach learned and experienced in the course and applied in their work could serve as a basis for building a peaceful society.

Discussion

To build peace, comprehensive and complementary approaches to various actors at all levels are indispensable (Institute for Multi-Track Diplomacy 1996, Large

1997, Lederach 1997). However, in this study, peace building is discussed in a developmental context focusing at the grassroots level rather than on military and political actions. It is about cultivating a culture of peace and care and reconciliation (Assefa 1999) to transform negative feelings, attitudes, and behaviours into positive ones, and to create new relations through mutual interaction and voluntary effort. It is about building groups of people or communities committed to making, such changes.

Both our observation of participants and interviews revealed the development of a capacity for co-existence and reconciliation in all the respondents. Further, their experiences in the training had impacts on the individuals, their work, and their community. What they identified as requirements for building a peaceful society (changes in self and relationships) were also recognized as key parts of their learning in the training. By analysing the responses, we can see that the changes did not happen automatically, just because people with various backgrounds simply spent time or participated in a training course for 10 days together. Certain factors facilitating the changes were identified, factors that are unique features of the NCHP courses.

Concrete common interests and urgent needs create 'space for dialogue'

We found that in the process of a course, health work served as an entry to dialogue. The reason why persons with different backgrounds were able to meet and work together soon after the end of armed conflict was that this was health training with clear 'technical' and concrete objectives. During the conflict period these health workers had been separated by political and military boundaries and had no chance to meet one another.

Many respondents remembered that their first dialogue with the other side was about people's health and their difficulties in responding as health workers. In Khmer Rouge-controlled areas along the Thai and Lao borders the former medical orderlies had worked with minimal training in military units to provide care for injuries and common diseases. For example, living in a forest area, the former medical orderlies and their family members had suffered from malaria for a long time. Many of them had no formal medical training or health education training, and they were well aware of their desperate need to learn how to prevent this deadly disease and how to convey prevention messages to people in an understandable way. They knew they needed training.

The World Health Organization (WHO) set up the 'Health as a Bridge for Peace' concept and has been promoting the integration of peace-building strategies into health activities and health sector development. Training is defined as a part of the 'technical space', a possible area of collaboration among health workers from conflicting parties (World Health Organization 2003). Their positions and backgrounds are different, and there are certain points on which they may not agree, but they find commonality in their interests and urgent needs as health promoters. Thus health as an area of common interests and needs served as an entry point for dialogue and a binding force to bring participants with

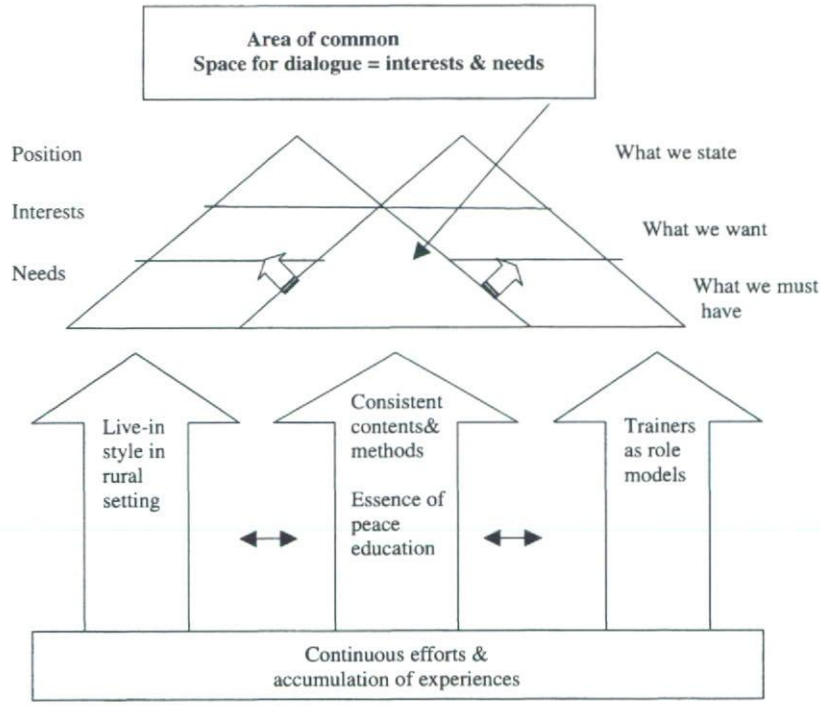

Figure 1. Facilitating factors for extending space for dialogue and process of change and reconciliation (WHO 2003, modified and added by the authors).

different backgrounds to sit and work together. Such special advantages of the health field and the values of health workers were also observed in other areas of conflict in the world and in the case of various health activities (Levy and Sidel 1997, World Health Organization 1998, Bush 2000, Hess and Pfeiffer 2000, MacQueen and Santa-Barbara 2000, Garber 2001, Krug et al. 2002, Manenti and Cassabalian 2003, Santa-Barbara 2004).

In the case of NCHP training, such factors as training venue and methods, quality of trainers, and accumulation of experience, maximize this special opportunity for health training to bring different parties together. The combination of these facilitating factors contributes to further enlarging this 'space for dialogue', as shown in Figure 1.

Live-in style training in rural setting

One of the strong facilitating factors described by many respondents in various ways was the live-in style of the training. The NCHP training team utilized the increased availability of informal time created by the dormitory life in a rural area as an integral and important part of the course design. From various responses, we established that the persons who got close to the participants from the other side were those who were physically nearer (such as in the same room, beds next to each other, etc.) in the dormitory. Much of the dialogue and changes in

interaction happened in informal out-of-session times and places, especially in the dormitory rooms.

Participants form task teams of five or six members to take roles in training management. These tasks require joint planning and work sharing. Groups are deliberately composed, mixing members of different sex and places of origins. The groups gather during breaks and after the session to work together. Furthermore, in the evening, after the session, participants and trainers join in recreational events and sports. There is no distracting entertainment, as at urban sites, and so participants gather in pairs or small groups voluntarily and discuss personal matters in a relaxed atmosphere. Some participants try to review the session or help each other with assignments.

Consistency with contents and methods of peace education

The topics of these three step-up courses have much in common with those of peace education. As conditions for building a peaceful society, respondents listed dialogue, equal treatment, mutual trust, cooperative work relationships, patience, and initiatives. Skill areas included in the courses, such as problem analysis, participatory education, communication, feedback, facilitation, collaboration with other sectors and actors, conflict management, planning and proposal skills, are core skills required for health promoters that help nurture the base for peaceful society as well. They are incorporated consistently in all three courses (see Table 1).

The consistency between the content and the process or method of training also facilitates learning. Participants and trainers eat, live, and enjoy sports and

Table 1. Contents of NCHP step-up courses.

Basic Health Education Course	Training of Trainers on Health Education	Community Health Promotion Management Course
Concept of health education	Role of training, role of trainers	Concept of PHC and health promotion
Role of health educators	Adult education and learning cycle	Health problem analysis
Health problem analysis	Participatory training	Community development and approaches
Participatory training methodology	Facilitation skill	Community participation
Facilitation skill	Communication skill	Multi-sectoral collaboration
Communication skill	Feedback	Role of managers
Feedback	Objective setting, session planning	Participatory management
Need analysis and session planning	Session practice and commenting	Communication skill, Feedback
Session practice and commenting	Field practice and reflection	Conflict management
Field practice and reflection	Training monitoring and evaluation	Project field visit and reflection
Health education activity planning	Training plan and proposal making	Monitoring and evaluation
		Project planning and proposal making

recreation together. The training team develops a tentative curriculum and schedule based on its assessment of what is needed and previous course experience. But the final plan is made only after discussing the details of content, process and methods, timetable, and the grouping of various tasks, with participants on the first day of the course. Every morning the session starts with a review of the previous day, prepared by a task group of participants. The day ends with daily feedback, while more time is allocated to evaluation in the middle and at the end of the course. Every evening, the training team discusses and reflects on the latest feedback from participants, further exchanges observations and comments, and consults on plans for the coming sessions. Through this process, values and attitudes conducive to fairness and democracy develop. Although this is nominally health promotion training rather than 'peace building training', content is consistent with peace education (Adams 2000, First Mindanao Congress for Peace Educators 2000, Smith 2005).

Role and commitment of trainers as role models

Both former Khmer Rouge and non-Khmer Rouge participants valued the trainers' role highly and tried to follow the trainers' attitudes and behaviour as role models. Trainers were very conscious of their role as good examples. They made active efforts to listen to participants, especially those who were less proactive. They gave special consideration, especially at the beginning of the courses, to grouping the participants, creating easy environments and opportunities for the quieter ones, and encouraging both sides to interact more.

Their open, fair, and flexible attitudes influenced participants to follow them. 'Because trainers came to me and helped me a lot, I also started to approach and help others'. The trainers did so not only with the participants but also among their training team, by exchanging feedback and planning together every night. Participants observed the trainers' actions throughout the course. Their influence as role models for participants is a crucial part of the course.

Continuous efforts and accumulation of experiences

The last, but basic, key point is that this course had been organized continuously for many years before the former Khmer Rouge health workers started to join. NCHP trainers and participants from other provinces had already accumulated experience in participatory health training with the unique characteristics described above. In other words, a base was prepared for accommodating new persons with very different backgrounds and positions. As some participants mentioned, previous course experience helped them to build good relationships better and faster, and attitudes and behaviours of experienced participants helped set the atmosphere of the group, which stimulated and influenced the new participants.

Especially in the course that family members and close followers of Khmer Rouge leaders joined, changes in individuals and groups could not have taken

place, or would have taken longer, without the accumulated experience of participatory training and recognition of its importance among other participants and trainers. This indicates the significance of continuous efforts in ordinary times to build a firm base to face any challenges, rather than running a one-off programme or starting efforts only after a conflict situation occurs.

Conclusion/recommendations

This study demonstrated the wider social significance of participatory health training as a tool for peace building beyond its narrow effectiveness as an educational and learning method. Participatory training itself may not be recognized as a direct peace-building activity. However, steady and continuous efforts certainly contribute not only to the improvement of health knowledge and skills but also to developing values, attitudes, and changes in personal relations that are necessary for building a peaceful society. Further, the subject of the training, health promotion, serves as an entry point for dialogue and collaboration, and provides venues for concrete collaboration. Based on these findings, we offer the following three policy recommendations and a perspective for future research.

First, in addition to planning and conducting training directly for peace building, it is important to incorporate peace-building viewpoints and elements in regular training activities in such practical and technical sectors as health. In other words, rather than separating peace building (and conflict prevention) as a special activity, it should be integrated in ordinary activities in all sectors. Like cultivating land, peace building is a conscious and continuous effort in daily lives.

Second, it is individuals who initiate and move such work forward. Therefore, it is important to develop individuals who will take active and concrete roles. We recommend that participatory training concepts and methodology be actively applied in training activities for such workers.

Third, in order to make these human development efforts bear fruit, it is equally important to prevent creating and widening unfair gaps, which may cause conflicts. There is an urgent need to improve equity in health services, promote community participation, and ensure opportunities for participation, in a general context of wider macro economic, political, and social efforts.

To further enhance research on the role of training in peace building, relevant indicators and methods should be developed that integrated the measurement of peace building into the evaluation of technical training. In this study, investigation focused on the impact of training at the health worker level, but it is also important to monitor and assess the changes at the community level which is the ultimate target of training inputs.

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