保健医療分野の援助機関における優先事業決定に関する特徴

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キーワード：保健医療、援助機関、意思決定、基金、Foundation

1．はじめに

各種の援助機関はどのように援助の優先順位を決め、どのように援助政策を決めてきたのかは、時に不透明で、外側からは良くわからない部分も多い。二国間援助の場合、時にそれは政治的・外交的・経済的に国益を重視するものである場合もある。また、国連機関と聞くと、公正中立であると思われがちであるが、ここは将に政治の場であり、多種多様の利害関係者（国）がいるだけに、現場のニーズが必ずしもその意思決定に反映されるとは限らない可能性がある。一方 NGO は、個人的な繋がりや興味で動く場合も考えられ、援助への依存など開発についての深い考察もなく、また、必ずしも世界全体、国全体を見渡した結果として援助活動を決めていない可能性も否定できない。

今回、我々は、基金と呼ばれる援助機関の意思決定のプロセスを検証し、援助の開発における位置づけを考える中で、日本の援助へ提言を行うことを目的に調査を行った。

2．方法

①2007年6月－8月に、保健医療分野の代表的な国連機関である UNICEF（国連児童基金）、UNFPA（国連人口基金）、また基金による私的な援助機関である Ford Foundation と Bill & Melinda Gates Foundation（以下、Gates Foundation）について、訪問による Semi-structured interview 調査を実施した。②ウェッブサイトおよび資料、文献による調査も合わせて実施した。

3．結果

（1）UNICEF

重点課題：子供の権利条約を基本に、すべての子供（18 歳未満）が持つ権利（保護される権利、健康である権利、教育を受ける権利）が普遍的な倫理原則、そして国際的な行動規範として確立されるようにすること。

組織：本部のほかに、地域事務所、各国事務所があり、各国事務所レベルにかなり権限委譲が行われている。

意思決定過程：最終意思決定機関は、各国代表者からなる Executive Board である。4 年ごとに本部が中心となり、各国事務所と協力して中期戦略計画（MTSP：Mid-term Strategic Plan）を策定し、Executive Board の承認を得る。各国レベルでは、この MTSP を中心に国毎の Multi Indicators Cluster Survey（MICS）や USAID の Demographic Health Survey（DHS）を基に問題点を整理し、各国の事情を考慮して Results Based Planning という手法で先方政府と Logical Framework を策定する。さらに、One UN approach という考え方から、すべての UN 機関と共同で、CCA（Common Country Assessment）や UNDAF（United Nations Development Assistance

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Framework）を基に、CPAP（Country Programme Action Plan）を先方政府と作成する。

（2）UNFPA

重点課題：①人口と開発（Population and Development）、②リプロダクティブ・ヘルス/ライツ（Reproductive Health/Rights）、③ジェンダーの平等（Gender Equality）

組織：本部の他に各国事務所がある。

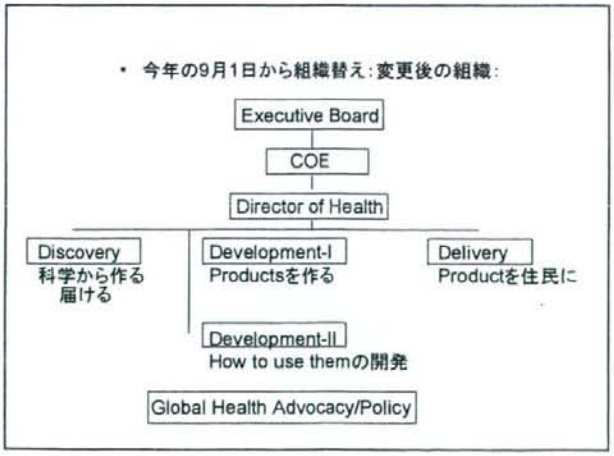
決定過程：最終的な意思決定機関は、各国代表者からなる Executive Board である。WHO などで検討された問題（例えば、「妊産婦死亡率の減少」とか）を尊重して、Executive Board で優先順位を決める。本部では、Priority Area を設定して Global agenda に反映させたり、あるいは本部の Technical Support Division が予め Program Committee（Deputy level）に提出して承認を受けた Guideline や Tool を作成し、それを基に各国事務所でその国に合った活動を考える。このとき、仮に提示された Guideline や Tool に入っていなくても、各国事務所はそこでよいと判断したものは活動に入れ込んでも良い。本部では Country Support Group を形成するとともに、世界を 4 つの Regional に分け、その Regional の定例会議に、本部からの Geographical Division（Management に関わる部署）の担当者たちと各国事務所代表者が集まって検討し、Regional な Strategy を作る。その結果を本部に持ち帰って、大きな方針に反映させる。

特徴：情報共有のために Docu Share（Documents Share Software）を使用。①内部文書の共有システム（Intra-net）。世界のどこからでもアクセス可能。②各種報告書、公式文書、Circular、スピーチ、印刷物、マンガや写真などを使った広報物、内部の事務的な文書、など、すべての書類を共有する。③キーワード、単語、国名、年号、などで検索可能。リストが出て、それをクリックするとさらに本文が出てくる。④XEROX 社の Docu-share という基本ソフト（knowledge sharing network application）を基に、UNFPA 用にカスタマイズされている。このカスタマイズ化は、コンサルタント会社と共に行う。⑤各国事務所に、Focal point を置いて、その人たちに対して Training を行った。このソフトでは Documents を放り込む、投入口（Document depository）を作る必要がある。

（3）Gates Foundation

重要課題：ワクチン開発や薬剤開発の焦点を絞ってきた。しかし、2007 年 9 月から方針転換を行い、これまでものに追加して、開発した薬品やワクチンを「どのように使うか」や「どのように住民に届けるか」といった内容も含めることになった。

組織：昔は、感染症（HIV/AIDS・結核など）や Reproductive health などと、病気毎の縦割りであった。また、これまで右記のうち Development が中心で、Discovery と Delivery が弱いので、組織変更する（図）。



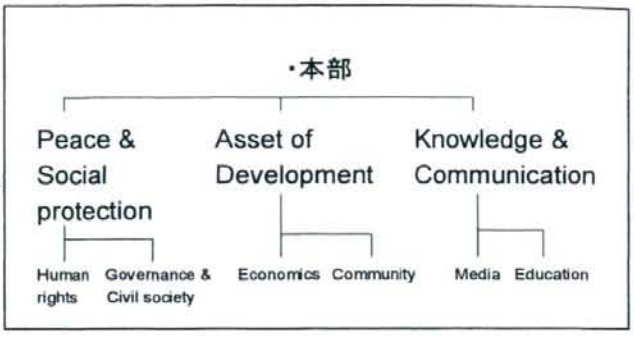
これによりバランスが取れた動きができる。 変更理由は、製品を作るだけでは、世界の保健状況が変わらないと自覚したから。

決定機関と決定過程：最高の決定機関は、私的な機関なので Founder の 3 人（Gates 夫妻、ウォーレン・バフェット）の会議が最終決定する。この下に CEO がおり、その下の Global Health President と、その下の Discovery、Development-I、Development-II、Delivery、GH Advocacy/Policy の各 Department の長が集まって、Priority や戦略を決める。GH President には Senior Advisor が付くが、この President にはまた GH Advisory Panel がついて、アドバイスを行う。

実際の動きとしては、Gates Foundation が委託する NGO が、製品になりそうなシーズを各大学や製薬会社から探し出してきて、その製品化を支援する、という形をとる。

（4）Ford Foundation、

重要課題：アメリカ国内が 80%、全世界向けが 20%の配分。現在は Health に対する支援は行っていないが、家族計画なども、Population から Human rights にアプローチを変えた。（Health は他のドナーが対象としているので、他がやっていなかった Human rights にシフトした）



組織：本部に Board があり。他は（右図）参照。

他に、Field offices（Program offices）：中国やインドのほかは、Region をカバーする。

①Latin America：3 箇所（メキシコシティー、チリのサンチアゴ、リオデジャネイロ）

②Africa：3 箇所（ケニアのナイロビ、カイロ、ヨハネスバーグ）

③Asia：4 箇所（ニューデリー、ジャカルタ、ベトナムのハノイ、北京、ラオス）

④ほか：モスクワ

これらの事務所も Funding agencies として活動。

パートナーシップは、ソフィア、エルサレムにある。

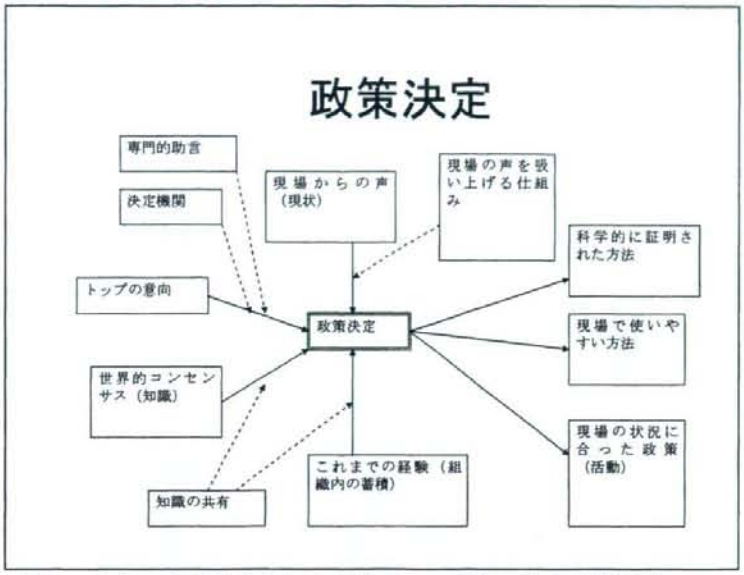
決定過程：①Field Office の長が集まって、話し合って優先順位などを決め、それを本部の Board に諮って、Foundation としての優先順位を決める。②200,000US$以下は、Program office のイニシアティブに任され、それ以上では、Board の承認が必要である。③戦略的に予算を配分するために、コンサルタントを使っている。④非常に Local にしか影響のないものは Grant の対象とならず、むしろ Regional に影響を及ぼすようなものを対象にしている。⑤Private sector 中心で、Public sector は対象ではない。

特徴：①Continuous invest で、Long-term な Commitment：短期的に結果を求めず、量的な指標よりも質的な指標で、Modest な達成目標を期待する。②Learning foundation：Grant craft network（www.grantcraft.org）というものと作り、なぜ成功したのか、なぜ失敗したのかを評価して、評価結果は組織内だけでなく広くこのフィールドの関係者に Feedback する。というのは、分野全体が良くなれば良いと考えているからであった。

4．考察

結果からいくつかの特徴が浮かび上がってきた。

- 各基金はそれぞれ特徴あるアプローチを取りながらも、Gates Foundation も含めて、途上国のシステム強化の重要性を認識し始めている。
- しかしながらこれだけでは不十分で、長期的開発の視点が必要で、Gates がやっと取り組み始めた、「物→システム」というだけではなくて、その先の「意識改革」まで踏み込む必要がある。つまり、これは UNICEF の言うように、研修や施設建設だけでは動かない話で、別のアプローチが必要と思われる。
- このためには政策や戦略決定に、現場の声を吸い上げる仕組みが必要であり、そのために Region 毎に集まって討論しあう制度は日本も利用可能と思われる。
- また、中央で Framework を組織として決定し、地域・各国レベルでは個々の事情にあったプログラムや活動を決定できるように組み合わせているのも参考になる。
- このように、援助政策決定には様々は要因が関係していることが判明した（図）。



- さらに、その評価のためには、Ford Foundation の例からもわかるように、現在、日本でも導入されている「量的な指標」だけでなく、特に、日本の援助のように相手の成長を促すようなアプローチの場合、「質的な評価」方法も考慮する必要があろう。
- そのためには、情報の内部共有化と、外部との共有化の二つの視点を持たなければならない。この場合、UNFPA の Docu Share での内部情報の共有のあり方や、Ford Foundation の Grant craft network のような、オープンで、長期的展望に立っての評価のやり方は、興味深い事例である。

5．結語

保健医療サービス提供のためのシステムの構築・強化に支援するという開発の視点を、援助側が認識し始めたこと、また、そのための援助の意思決定や方法論の構築が開発援助をより効果的に行うために必要であること、などが今回の調査から判明し、日本の援助を考える上で、参考になったと思われる。ただ、今回の調査では援助団体の一部の職員からの聞き取り調査に過ぎず、今後、さらに系統的な調査が必要となろう。

6．謝辞

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Reconstruction of health service systems in the post-conflict Northern Province in Sri Lanka

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Abstract

Public health problems in armed conflicts have been well documented, however, effective national health policies and international assistance strategies in transition periods from conflict to peace have not been well established. After the long lasted conflicts in Sri Lanka, the Government and the rebel LTTE signed a cease-fire agreement in February 2002. As the peace negotiation has been disrupted since April 2003, a long-term prospect for peace is yet uncertain at present.

The objective of this research is to detect unmet needs in health services in Northern Province in Sri Lanka, and to recommend fair and effective health strategies for post-conflict reconstruction. First, we compared a 20-year trend of health services and health status between the post-conflict Northern Province and other areas not directly affected by conflict in Sri Lanka by analyzing data published by Sri Lankan government and other agencies. Then, we conducted open-ended self-administered questionnaires to health care providers and inhabitants in Northern Province, and key informant interviews in Northern Province and other areas.

The major health problems in Northern Province were high maternal mortality, significant shortage of human resources for health (HRH), and inadequate water and sanitation systems. Poor access to health facilities, lack of basic health knowledge, insufficient health awareness programs for inhabitants, and mental health problems among communities were pointed by the questionnaire respondents. Shortage of HRH and people's negligence for health were perceived as the major obstacles to improving the current health situation in Northern Province. The key informant interviews revealed that Sri Lankan HRH outside Northern Province had only limited information about the health issues in Northern Province.

It is required to develop and allocate HRH strategically for the effective reconstruction of health service systems in Northern Province. The empowerment of inhabitants and communities through health awareness programs and the development of a systematic mental health strategy at the state level are also important. It is necessary to provide with the objective information of gaps in health indicators by region for promoting mutual understanding between Tamil and Sinhalese. International assistance should be provided not only for the post-conflict area but also for other underprivileged areas to avoid unnecessary grievance.

Keywords: Post-conflict; Reconstruction; Health systems; Human resources for health; Sri Lanka

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1. Introduction

Regional conflicts are increasing throughout the world since the end of the Cold War. Public health problems in armed conflicts have been well documented [1,2], and health service strategies during the complex humanitarian emergencies were substantially established [3,4]. However, strategies for effective international assistance in transition periods from conflict to peace have not been well established. While a risk of resumption of conflict is still high, any international assistance in the health sector in this period should contribute to enhance peace-building efforts.

Since 1983, Sri Lanka had been in armed conflicts between the pro-independent militant Tamil group, named "Liberation Tigers of Tamil Eelam (LTTE)" and the Sinhalese dominant Sri Lankan government force. During the conflict, Northern and Eastern Provinces had been the main battlefield. The country has divided into two areas by the changing conflict front lines: the area mainly under the control of LTTE and the area under the control of government. United Nations High Commissioner for Refugees (UNHCR) reported that over 60,000 people lost their lives, 200,000 had fled abroad and nearly 80,000 were displaced within Sri Lanka [5]. In February 2002, the Government of Sri Lanka and the LTTE finally signed a cease-fire agreement. Although both sides have kept the cease-fire for more than 3 years, the peace negotiation has been disrupted since April 2003, thus a long-term prospect for peace is uncertain at present.

Sri Lanka is famous for its relatively sufficient basic health and educational indicators in comparison with other similar economical-level countries [6]. Even during the prolonged conflict, Sri Lankan people enjoyed the benefits of social services such as health and education. However, the degree of benefits was not equal between Northern and Eastern Provinces where the main inhabitants were Tamil, and other areas where the main inhabitants were Sinhalese [7]. After the cease-fire agreement, international donors have mainly focused their support on the former main battlefield, Northern and Eastern Provinces. This may cause the sense of inequality among Sinhalese, which may cause the stagnation of the peace process.

This paper aims to: (1) review the demographic health information of Northern Province in comparison with those of other areas in Sri Lanka, especially underprivileged areas not directly affected by the conflict; (2) detect unmet needs among health care providers and inhabitants in Northern Province; and (3) recommend a fair and effective health strategy for post-conflict reconstruction.

2. Methods

Demographic, health and health facility data of pre-conflict, in-conflict and post-conflict periods published by the Sri Lankan government and international agencies were collected and reviewed. Northern Province was selected as a representative of a directly conflict-affected area. This Province includes five districts: Jaffna, Kilinochchi, Mullaitivu, Vavuniya and Mannar. Kilinochchi district was administratively separated from Jaffna district in 1983, and its health data was bracketed into Jaffna district until 1991. Data of the national average and Badulla district in Uva Province was also collected for objective comparison. Badulla district was recognized as an underprivileged district by Sri Lankan people, although it was not a battlefield during the conflict.

Open-ended, self-administered questionnaires were administered among health care providers and inhabitants in Northern Province in October 2004 to detect unmet needs. We used purposeful sampling method, in which inhabitants and health care providers were selected to be representative of the variety of circumstances among those exposed to the conflicts. The main inclusion criteria of respondents were those living in or working for: (1) longstanding Tamil communities mostly controlled by LTTE during conflict; (2) the government-run "Welfare Centers" where registered internally displaced persons (IDPs) live; or (3) relocation/resettlement sites where former IDPs live.

The five-paged questionnaire was dispensed through the Sri Lankan government health sectors in Northern Province as well as several non-governmental organizations (NGOs) active in the health field in Northern Province. These organizations were instructed to deliver the questionnaires to health care providers and inhabitants who fulfill criteria mentioned above. A total of 71 questionnaires, 35 health care providers and 36 inhabitants, out of 120 disseminated (59%) were returned.

Among the 35 health care providers, 15 were qualified public health midwives, 19 were medical staff and/or health volunteers of NGOs who complement the roles of public health midwife, and one was a physician. One was male and the rest were females. Six respondents were Sinhalese and the rest were Tamil. Sixteen respondents worked for governmental health facilities located in longstanding Tamil communities, and the rest worked for the "Welfare Centers" and/or relocation/resettlement sites. As for 36 inhabitants, all were Tamil and 33 of them were female. Twenty-three of them were the inhabitant in the longstanding Tamil communities. The rest of them lived in "Welfare Centers" as registered IDPs or in relocation/resettlement sites as former IDPs.

All subjects were administered a written, Tamil or Sinhalese language questionnaire according to their mother language and given unlimited time to complete it. Four illiterate inhabitants were individually interviewed following the same questionnaire in private settings. The questionnaire, originally written in English, was translated into Tamil or Sinhalese then subsequently re-translated into English by another person to verify. Written informed consents were obtained from all participants. Subjects did not receive any compensation. All data was kept anonymous. Completed questionnaires were collected from participants in person, translated into English, coded, and analyzed. More than one response was coded per subject when applicable. Duplicated answers by the same respondent were coded only once. Blank, off-subject and illegible answers were coded as missing. Data was analyzed using Excel 2002 for Windows.

Information from the demographic health data and the questionnaire was supplemented with key informant interviews to the officials of the Sri Lankan government health sector, as well as international agencies, bilateral aid agencies and several NGOs active in the health field in Northern Province and other areas in Sri Lanka. Health facilities, such as district and rural hospitals, central dispensaries and maternity homes, as well as schools, "Welfare Centers" for IDPs and resettled residents throughout Northern Province, Badulla district and the capital territory, were visited by authors to observe the situation for validation of the data.

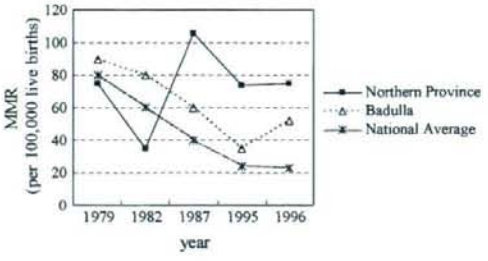

Fig. 1. Maternal mortality ratio, by district, Sri Lanka, 1979–1996. *Sources*: Department of Health Services Sri Lanka, Annual Health Bulletin, 2001. Deputy Provincial Director of Health Services Jaffna, Annual District Health Plan 2005, 2004. Deputy Provincial Director of Health Services Kilinochchi, Provincial database for Provincial Health Profile, 2004. Ministry of Health Sri Lanka, Annual Health Bulletin, 1981, 1986, 1991, 1996. Statistics Branch, Kachcheri, Mullaitivu, Statistical Hand Book, 2004. Office of the DPDHS Vavuniya, Statistical Handbook & Health Sector Development Plan, 2004.

3. Results

3.1. Comparison of a 20-year trend of health services and health status between Northern Province and other areas

The trend of maternal mortality ratio (MMR) is shown in Fig. 1 as an indicator of the health status in a region. The national average MMR reduced from 80 to 20 in the past 20 years. The data from Badulla district followed the same trend. However, the MMR in Northern Province increased during the conflict, in spite of the fact that it was lower than that of the national average or Badulla district before the conflict. The MMR in the year 2003 were available only in Jaffna district and Kilinochchi district, which were 50 and 136, respectively [8,9]. In general, most deliveries in Sri Lanka are taken place in health facilities [10].

The significant shortage of human resources for health (HRH) is detected as the specific problem in Northern Province. Fig. 2 shows the number of physicians per population. That number has increased dramatically throughout the whole country since 1991. The increasing rate of physicians per population in Badulla district traces that of the national average, though the number of physicians per population was always lower than that of the national average. On the other hand, the physicians per population in Northern

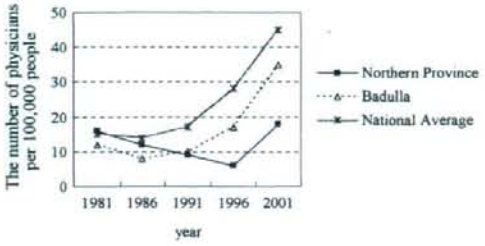

Fig. 2. Physicians per population, by district, Sri Lanka, 1981–2001. *Sources*: Consortium of Humanitarian Agencies, District Profile-Mannar, 2004. Department of Health Services Sri Lanka, Annual Health Bulletin, 2001. Deputy Provincial Director of Health Services Jaffna, Annual District Health Plan 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.

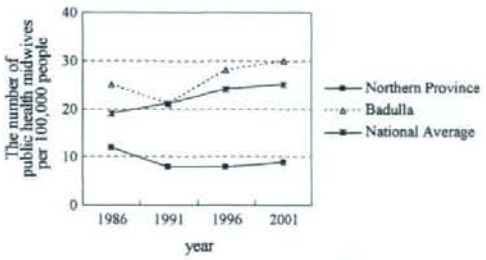

Fig. 3. Public health midwives per population, by district, Sri Lanka, 1986–2001. *Sources*: Consortium of Humanitarian Agencies, District Profile-Mannar, 2004. Department of Health Services Sri Lanka, Annual Health Bulletin, 2001. Deputy Provincial Director of Health Services Jaffna, Annual District 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