

**COMMUNITY BASED REHABILITATION:  
ITS ROLE IN REGIONS OF CONFLICT AND AS A  
CONTRIBUTOR TO PEACE**

by

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BMR(OT), University of Manitoba 2004

PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF  
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF PUBLIC HEALTH

In the  
Faculty of Health Sciences

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SIMON FRASER UNIVERSITY  
Summer Term 2010

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## **ABSTRACT**

Within the past few decades, health initiatives inspired by the emerging Peace through Health field have been implemented in regions of armed conflict with varying success. This paper, based on a literature review, examines Community-based Rehabilitation (CBR) within conflict situations and as a Peace through Health initiative. An exploration of the potential role of CBR in regions of conflict and as a contribution to peace, as well as a depiction of what this role may look like, is undertaken.

The process of the WHO/AIFO proposed guidelines for initiating and sustaining CBR among urban poor populations is considered as a template for how the field of CBR in regions of conflict as a Peace through Health initiative can be furthered.

The paper concludes that CBR embodies elements that suggest success in both goals of improving health status in conflict situations & contributing to peace. Drawing together both strategies of implementing CBR in regions of conflict and as a peace-building initiative in a formal way is essential to achieving these goals. Development of specific guidelines for CBR in regions of conflict as a Peace through Health initiative, use of the emerging CBR global database, and collaboration with the WHO Disability and Rehabilitation Team are vital to the further development of this field.

**Keywords:** community based rehabilitation; peace through health; peace-building; armed conflict

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# **1. INTRODUCTION**

## **1.1 War & Violent Conflict: A Public Health Issue**

An estimated 310,000 people died from war related injuries in 2000, according to the 2002 WHO World Report on Violence and Health. War is a major cause of death and disability, with over half the mortality and morbidity in current wars occurring in civilian populations (Santa Barbara & MacQueen, 2004). But the cost of war and the impact on human health reaches far beyond the direct impact of bombs and bullets. The recent Global Burden of Armed Violence Report indicates that up to 3 to 15 times as many people die from indirect causes, for every person who dies due to direct violent conflict (Hagopian et al., 2009). Disruption and destruction of health-sustaining economic and social systems, the famine and epidemics that follow, and the resources diverted to military and conflict instead of health goals, account for far more suffering (MacQueen & Santa Barbara, 2000).

It has only been in relatively recent years that war has been considered a public health issue. And more recent still is the idea that health professionals have an active role in protecting health through the prevention, mitigation, and termination of war. The field of health and peace is emerging. This field suggests health workers can contribute to peace, along with working to improve health outcomes. (Santa Barbara & MacQueen, 2004).



This paper will focus specifically on Community-based Rehabilitation and its role in war, in contributing to peace, and in addressing health of populations in regions of conflict.

## **2: PURPOSE OF THE PAPER**

The purpose of this paper is the following:

1. To explore the foundational basis of Community-based Rehabilitation (CBR) and the Peace through Health field
2. To determine whether there is a role for CBR in war and as a contribution to peace in regions of conflict, and
3. To suggest what this role might look like.

A critical analysis is provided, based on a literature review, of Community-based Rehabilitation and Peace through Health initiatives. From here, a look at previous CBR initiatives in regions of conflict, the peace-building properties of CBR, and the theoretical fit within the Peace through Health and public health paradigms, will help determine whether a role exists for CBR in regions of conflict.

Finally, a suggestion of how CBR might look in regions of conflict is explored. While CBR has been gaining momentum globally, to date, CBR initiatives have been primarily implemented in rural areas in developing countries. One exception is CBR within the context of the urban poor population. Guidelines for initiating and sustaining CBR in urban slums and low-income groups have been proposed. Therefore, this paper will examine these proposed guidelines and suggest how they may apply to the field of CBR in regions of conflict.

Consideration of how CBR may be applied in regions of conflict to improve health outcomes and also how CBR can contribute to peace-building will be considered throughout the literature analysis and discussion.

### **3: BACKGROUND**

Before an examination of the potential role of CBR in regions of conflict and what this would look like, it is valuable to situate CBR within the context of previous work. Therefore, the following two areas will be highlighted in the next sections: the history and development of past health work within war (a Peace through Health perspective) and an overview of the background and key elements of CBR.

#### **3.1.1 Peace through Health**

The Ottawa Charter for Health Promotion, developed in 1986, states that the essential prerequisites for health are: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity (WHO, 1986). Noticeably, peace is the first stated requirement for health. In addition, war and violent conflict have the potential to negatively affect all of the other prerequisites for health (Arya & Santa Barbara, 2008). This Charter suggests that health professionals and specialists have therefore determined that improvement of health cannot be achieved without the reduction or elimination of violence and the promotion of peace.

The term peace, within the context of this analysis, will encompass “not merely the absence of war or violence (direct, indirect, structural or cultural), or harm to others, but in a systemic way as engendering a state of integration and

positive, nurturing, respectful, and co-operative relationships” (Arya, pp.243, 2004). The definition of health will be that of the World Health Organization (WHO) as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 2003). Using these definitions, health-peace initiatives are those in which there are concurrent goals of improving the health of a population as well as improving the population’s level of peace and security (MacQueen & Santa Barbara, 2000).

Groups within the health sector are currently exploring potential ways in which health work can contribute to peace. A few different approaches have emerged in the literature under different names: Peace through Health, Health as a Bridge to Peace, and Medical Peace Work. The WHO’s program ‘Health as a Bridge for Peace’ (HBP) is similar to the ‘Peace through Health’ (PtH) framework, developed by McMaster University Centre for Peace Studies in Canada (Santa Barbara, 2004). A comparable framework is used by the U.S. based Institute for Resource and Security Studies. For consistency, Peace through Health will be the term generally used in this text, except when referring to specific initiatives.

Health work and peace work, although linked, have not always been compatriots. In the past, health professionals have been associated with some of the world’s most horrific events. The Nuremberg trial of German doctors who conducted medical trials on inmates of concentration camps provides one such high-profile example (Arya & Santa Barbara, 2008).

Despite these exceptions, there is a definite history of the two fields of peace and health converging with common goals. Organizations such as the

International Committee of the Red Cross, The Association Medicale Internationale Contre la Guerre (1905), Medical Peace Campaign (1930s), Medical Association for the Prevention of War (1950s), and International Physicians for the Prevention of Nuclear War (1980s) have intervened in conflict situations over the past century, and recognize peace as an important determinant of health. (Arya & Santa Barbara, 2008).

For example, the International Committee of the Red Cross (ICRC) was founded in 1864 to treat battlefield casualties. This practice of traditional military medicine eventually evolved into the development of international treaties. These treaties set standards of treatment in order to reduce the impact of violent conflict. (Santa Barbara, 2004). While the work of the ICRC was initially not intended as a peace-health initiative as the goal was to improve solely the health outcomes of those injured in war, it changed to include efforts to prevent and curb some of the destructiveness of war.

Within the past few decades, 'Humanitarian Ceasefires' and 'Days of Tranquillity' have emerged as Health as a Bridge for Peace initiatives within regions of the world in violent conflict as part of the global campaign to eradicate polio (Buhmann, 2005). The Pan American Health Organization (PAHO, a regional office of the WHO for the Western hemisphere) paved the way for the use of health as a peace-building tool in Central America in the 1980s (Rushton & McInnes, 2006; A de Quadros & Epstein, 2002). Temporary ceasefires within multiple war zones allowed for immunization of children. This is said to have

contributed to the work for peace and also to have provided a template for permanent ceasefire in these regions (Santa Barbara, 2004).

The WHO has also gradually adopted the use of health as a peace-building tool approach in providing post-conflict health assistance. The WHO's involvement in missions in Angola, Bosnia-Herzegovina, Croatia, Haiti and Mozambique in the 1990s had the concurrent goals of impacting both health and peace (Buhmann, 2005). It was in the mid 1990s when the WHO explicitly incorporated its 'Health as a Bridge for Peace' (HBP) framework into its approach to providing health assistance within complex humanitarian emergencies.

The acceptance of HBP as an integral part of the 'Health for All in the 21<sup>st</sup> Century' strategy by the World Health Assembly occurred in 1998. (Rushton & McInnes, 2006). Other independent clusters of thinkers, besides the WHO, had started working on projects looking at health and peace in a systematic manner at this time. A number of UN organizations, in coordination with governmental and non-governmental players, have since initiated field projects under the 'Health as Bridge for Peace' umbrella. (Buhmann, 2005).

Ongoing criticism of Peace through Health initiatives in general include lack of focus on outcomes and evaluation, lack of appropriate peace-building skills of the health workers involved, and the use of an ideological versus evidence-based approach. There is current international research in progress addressing evaluation of Peace through Health initiatives (Buhmann, 2005).

### **3.1.1.1 Peace through Health within a Prevention Framework**

For the purposes of this paper, Peace through Health activities were categorized within the public health framework of primordial, primary, secondary, and tertiary prevention. Primordial prevention addresses the underlying causes of war, such as poverty and social, cultural, and class inequities. Primary prevention activities (occurring before direct conflict) include weapon limitation advocacy, such as that of the International Physicians for the Prevention of Nuclear War, peace education efforts, and advocacy for human rights. Secondary prevention efforts (those during violent conflict) may include humanitarian ceasefires, measuring the damages of war, such as the Iraq Body Count Project, or providing medical journals as neutral forums for discussion and debate. Tertiary prevention activities (rebuilding and preventing further conflict) may include psychosocial healing, rebuilding of health systems, and CBR. (Arya & Santa Barbara, 2008).

The following reviews CBR, one such contributor to tertiary prevention activities.

### **3.1.2 Community Based Rehabilitation: What is it?**

Community-based rehabilitation (CBR) is an approach to addressing disability developed in the 1980s that “promotes collaboration among community leaders, people with disabilities, their families, and other concerned citizens to provide equal opportunities for all people with disabilities in the community” (WHO, pp.1, 2004). CBR is a multi-sectoral approach, ensuring the active



involvement and participation of people with disabilities and families within community settings, using primarily local resources.

Originally based on the medical model, CBR has since expanded to include the social and political aspects of disability and rehabilitation. (Hartley et al., 2009). The concepts that have undergone revision are those of disability and rehabilitation, the human rights aspect of CBR, the correlation of poverty and disability, the concept of inclusive community, and the role of Organizations of Persons with Disabilities (DPOs).

The 2004 joint position paper by ILO, UNESCO, and WHO states that the two major goals of CBR are to ensure the Convention on Rights of Persons with Disabilities by:

1. "Supporting people with disabilities to maximize their physical and mental abilities, to access regular services and opportunities, and to become active contributors to the community and society at large" (WHO, pp.2, 2004).

2. "Activating communities to promote and protect the human rights of people with disabilities, for example by removing barriers to participation, facilitating capacity building, empowerment and community mobilization of people with disabilities and their families" (WHO, pp.2, 2004).

WHO has developed the following matrix which illustrates the multi-sectoral approach of CBR, highlighting the 5 integral components of CBR: health, education, livelihood, social, and empowerment. These sectors can help form a CBR strategy. The matrix is not sequential, nor is every component intended to

all apply to every CBR programme. CBR strategies may choose to address a collection, but not the exhaustive list of components. However, if this is the case, consideration needs to be made with regard to who will address the remaining components within the community. (WHO, website, 2010).

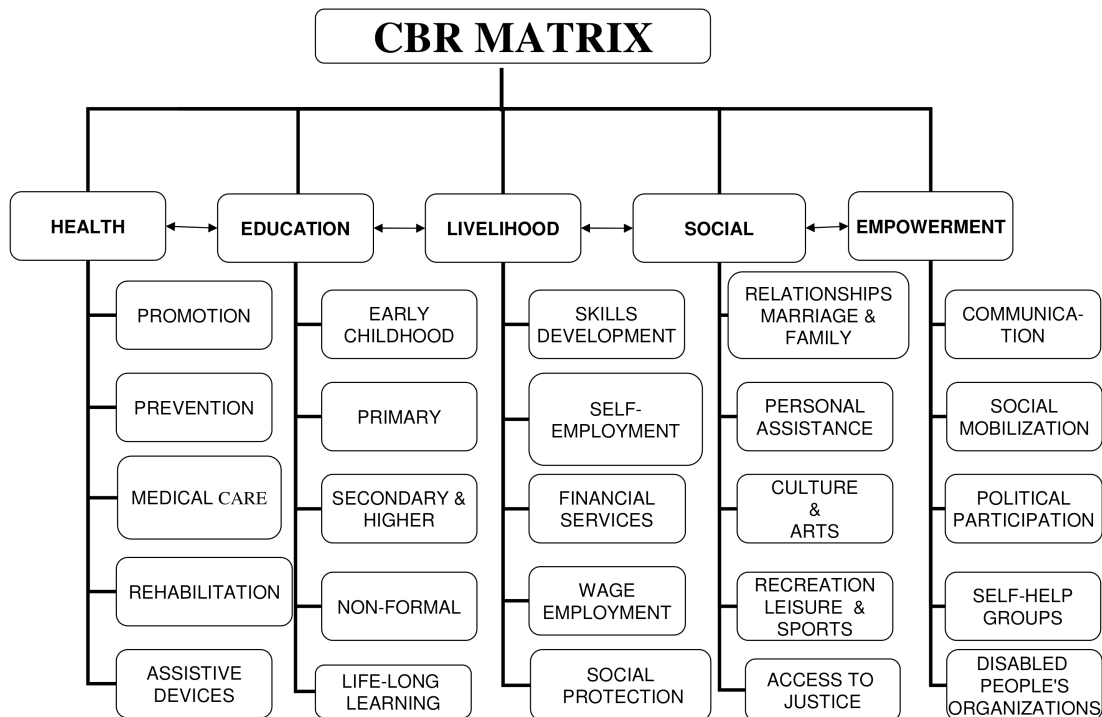


Figure 1  
(WHO, 2010)

CBR is gaining momentum, and becoming more widely used in many countries of the world. The WHO is in the process of developing a global database to track activities and advance the field. Currently CBR, with the integral involvement of people with disabilities, families, communities, and other organizations, is employed in 90 countries of the world. CBR networks have

already emerged in Asia, Africa, and South America. In Africa, half of the 280 registered CBR programmes are run by NGOs, and the other half have been implemented by government. (Hartley et al., 2009).

### **3.1.2.1 Evaluation of CBR**

The relationship of CBR to rehabilitation has been compared to that of primary health care to medicine. CBR was proposed as a way to increase rehabilitation coverage for those regions of the world with little access to institutional rehabilitation services. Just as primary health care attempts to provide universally accessible services at an affordable cost to the community, so does CBR. Presently in the developing world, one to three percent of persons with disabilities requiring rehabilitation actually receive these services (Boyce, 2000). With increasing health costs, an inadequate rehabilitation workforce, service and resource inequities, and heightening demands on health and social systems in the developing world, it has become increasingly difficult to meet the rehabilitation needs of this population. The movement away from institution-based care and into the community has helped in improving health outcomes of persons with disabilities in the developing world who have limited access to rehabilitation. (Boyce et al., 2002).

CBR is a field with limited standardized outcomes for limited standardized procedures, creating difficulties in evaluation. According to a summary evaluation of all CBR related initiatives within the past decade, most CBR programs were considered effective or highly effective. The benefits of CBR programming included: increased independence, increased mobility, and

enhanced communication skills for people with disabilities (Hartley et al., 2009). Increased self-esteem, increased social inclusion, and increased income are some of the other positive outcomes linked with CBR (Hartley et al., 2009).

Critiques of CBR included: lack of research and systematic outcomes, lack of ability of CBR to maximize functional potential and participation of those with disabilities, and lack of attention to psychosocial needs. Other critiques include overburdening women with the care of those with disabilities, and increasing, rather than decreasing, stigma and discrimination. These critiques are to be considered with the development of the new joint WHO, UNESCO, ILO, and IDDC Guidelines and Matrix for CBR which is to be released in 2010. (Hartley et al., 2009).

## **4: METHODS**

The research for the project was based on a comprehensive, systematic literature review. The central argument was formed by first examining background evidence for Peace through Health initiatives and CBR. From there, literature was sub-divided by 1) past CBR initiatives in conflict regions, and 2) those adapted to increase peace-building impact. Next, the link between CBR and theory: Peace through Health and public health, was explored by examining the relevant literature, taking into consideration titles of literature as well as abstracts to determine relevance. Finally, the evidence of how CBR had been adopted in other settings was tabulated, specifically within urban poor and slum settings. Using this information, the argument for how to use CBR in regions of conflict and as a contribution to peace was formed.

Both published, peer reviewed literature were accessed, as well as 'grey literature' from websites of key contributors to the field. Using PubMed, academic published literature was identified. The exact phrase 'Health as a Bridge for Peace' yielded 29 results; 'Peace through Health' yielded 0 results; 'Community Based Rehabilitation' yielded 274 results; 'Community Based Rehabilitation' and 'Conflict' yielded 21 results; and 'Community Based Rehabilitation' and 'Peace' combined yielded one result. Based on abstracts, 44 articles were selected based on relevance to the research question. MEDLINE was also searched using identical search phrases. The number of relevant

results was less, and the majority of articles had been previously identified in the PubMed search. Although MEDLINE did produce 12 results with the phrase 'Peace through Health'. Results for both searches were limited to those published from the years 2000 to 2010.

The search engine Google Scholar was used to identify alternate relevant literature. Identical search phrases were used. Approximately 6956 total hits were identified. Many were results which already had been identified through the database searches, and most cross-referenced to the few main actors in the field, such as the World Health Organization (WHO), McMaster University, Institute for Resource and Security Studies, and a small number of authors. Google was then used to access home pages of the main actors. Most home pages cross-referenced, providing links to one another. In addition to the above literature obtained online, one book "Peace through Health: How health professionals can work for a less violent world" by Neil Arya and Joanna Santa Barbara was acquired, as only short excerpts of the book appeared in the literature searches.

## **5: RESULTS & FINDINGS**

### **5.1 Is there a Role for CBR in Regions of Conflict?**

Past experience implementing CBR in regions of conflict, along with theoretical congruency, suggest a role for CBR in war. To support this claim, the following analysis will look at: past CBR initiatives in conflict regions, how the peace impact of CBR has been enhanced, as well as the theoretical fit for CBR within both the Peace through Health and Public Health frameworks in both improving health outcomes and contributing to peace.

#### **5.1.1 CBR in Regions of Conflict in the Past**

CBR has been implemented in regions of armed conflict in recent decades: Palestine, Bosnia, Afghanistan, Sri Lanka, and Central America (Boyce, 2000). Within these regions, different CBR context-specific approaches have been employed. For instance, Bosnia had a developed pre-war rehabilitation infrastructure, and therefore CBR goals included restoring and incorporating CBR into the system. Alternatively, Afghanistan had limited rehabilitation infrastructure in place pre-Soviet invasion and in following years, therefore the CBR focus in this region has been on training of personnel. (Boyce, 2000).

According to Boyce (2000), the typical focus of CBR programmes in regions of conflict include “clinical services in remote areas; personnel training;

promotion of Disabled Peoples' Organisations; planning, management and co-ordination; and appropriate technology" (Boyce, pp.5, 2000). CBR initiatives in conflict settings often seek to build capacity within existing agencies and institutions in the region to, in turn, work closely with the emergency aid and reconstruction organizations (Boyce, 2000).

### **5.1.2 How can the Peace Impact of CBR be Enhanced?**

Boyce, Koros, and Hodgson suggest in order to increase the peace impact and decrease the negative consequences of CBR programs in regions of conflict, some adaptation is necessary. The following, suggested by Boyce et. al., are the essential elements of CBR. The examples that follow each element are how these CBR elements have been, and could be, altered to increase the peace impact. (Boyce et al., 2002).

*Promotion of Positive Community Attitudes and Behaviours towards Disability:* Palestinian CBR programs have helped reduce inequities between combatants and civilians by not giving preferential treatment to those in the Infitada. Also, Sri Lanka refugee children with disabilities have been integrated into schools as a component of CBR. (Boyce et al., 2002).

*Empowerment of Persons with Disabilities enabling Integration within Society:* International Disabled Peoples Organizations (DPOs) may unite those from opposing groups, as was the case in both Afghanistan and El Salvador. A common goal, such as International Disability Day, served to link both sides. (Boyce et al., 2002).



*Knowledge and Skills Transfer to Promote Self-Help Skills:* Sri Lankan training of CBR skills included both the Sinhalese military and Tamil community groups, which are opposing factions. This type of joint training needs to occur before separate silos of rehabilitation services are formed for the groups in opposition. (Boyce et al., 2002).

*Development of Rehabilitation Services Resources Based upon Needs Identified by Persons with Disabilities and their Families:* In order to have a greater peace-building impact in areas of conflict, the planning and assessment process must be expedited. There must be quick action and implementation of CBR. (Boyce et al., 2002).

*Community Decision-Making, Implementation, and Accountability to the Community:* As it is common for communities to be divided in situations of conflict, sensitivity to these tensions must be accounted for in CBR interventions. (Boyce et al., 2002).

*Partnership and Cooperation among Persons with Disabilities, their Families, the Community, and Rehabilitation Personnel:* An example from southern Africa includes building disability networks across opposing factions, bringing these groups together for policy, sport, and cultural exchanges. (Boyce et al., 2002).

*Development of Rehabilitation Technology Utilizing Local Skills and Materials:* DPOs in Angola have used local technicians for orthopaedic supplies, in turn supporting community economic development and building capacity. (Boyce et al., 2002).

*Co-ordination with, and Referral to, a Network of Specialized Interventions, Including Institutions, to Provide Professional and Technical Support and Training which may be Unavailable within the Community:* This is occurring in Afghanistan, where DPOs are connected with, and collaborating with other sectors in the national reconstruction planning process. (Boyce et al., 2002).

All of the above have enhanced the peace impact of CBR initiatives. Below the link between CBR and Peace through Health theory will be explored in more detail.

### **5.1.3 The ‘Fit’ between CBR and the Peace through Health Framework**

While the initiatives using CBR within Peace through Health are limited, interestingly enough, the focus of many peace through health efforts in the past few decades has been on disability. The ceasefire agreements successfully negotiated by UNICEF, the International Committee of the Red Cross, the WHO, and other organizations, had the goal of preventing childhood disability caused by polio. Opposing factions united with a common concern for limiting the potential for disability in children. Boyce et al. suggests that disability proves to be a “powerful emotive lever” and can be used to bridge the gap between opposing factions in a conflict. (Boyce, et al., pp. 5, 2002).

CBR has many integral values that encourage and promote peace. CBR values community involvement, diversity, multi-sectoral involvement and universal access to the means to a fulfilling life. All of the above support dialogue and cooperation, and encourage conflict mediation and resolution. As well, CBR

focuses on inclusivity, bringing parties together for solutions, rather than focusing on divisive issues. Boyce et al do stress that depending solely on CBR to create these cooperative relationships is likely unreasonable, but CBR can be an active proponent and contributor for peace in this regard. (Boyce, et al., 2002).

According to Boyce, Koros, and Hodgson, there are four key benefits to integrating CBR and peace-building. The first benefit is the timely and significant impact of a CBR initiative within a vulnerable group in society. A humanitarian response such as CBR may prove to be 'cathartic' in nature between factions in conflict. As well, CBR's commitment to using local capacity and resources enhances visibility of the initiative within the community. Finally, the potential for alleviating financial and social costs within families with a member with a disability is promising with CBR. (Boyce, et al., 2002).

The second benefit of a CBR strategy is to decrease or eliminate perceived gender, cultural, social, religious, and political divisions between groups. CBR focuses on disability which attempts to transcend these divisions. This, in turn, calls into question the legitimacy of conflict based on these divisive and other exclusionist ideas. (Boyce, et al., 2002).

Thirdly, CBR promotes using a multi-sectoral approach in practice, and also in complex emergencies. Therefore, CBR supports cooperative, non-hierarchical action as an effective management style. (Boyce, et al., 2002).

Finally, CBR has the potential to create a neutral and impartial space. Health, social, and economic reform may thrive in this space. Often conflict creates opportunities for reform and to redefine underlying philosophies. With

CBR's focus on personal change, social adaptation, and community based strategies, it may be possible to redefine poverty and disability for various sectors. (Boyce, et al., 2002).

Many aspects of CBR appear to fit naturally within a Peace through Health framework. Below is a look at how congruent CBR is with current Public Health thought.

#### **5.1.4 How good is the 'Fit' Between CBR & the Public Health Framework?**

The essential concepts and elements of CBR closely reflect that of public health thinking, the idea that war is a public health issue, and the shift toward primary health care as declared at the first Primary Health Care conference, Alma Ata in 1978 (WHO, 1978) and reaffirmed in the Health for All Policy for the 21<sup>st</sup> Century (WHA, 1998). The following outlines the principles of 'Health for All' embodied in CBR.

Alma Ata, an ambitious declaration for its time, states that health is a fundamental human right. One of CBR's core concepts is the promotion of the rights of people with disabilities, in order to ensure equal opportunity for health and participation in social, cultural, religious, economic, and political activities. The *UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities* guides and governs all CBR programs and activities (WHO, 2004). The affirmation of the dignity and worth of people, declared in the 'Health for All' document mirrors what is highly regarded in CBR, namely ensuring the dignity of those with disabilities.

The 'Health for All' strategy outlines the importance of reducing social and economic inequities in improving health for the entire population. CBR recognizes the strong correlation between poverty and disability. The relationship is two-fold: poverty leads to increased disability, and disability leads to an increase in poverty. Those with disabilities have higher rates of unemployment and underemployment, in both the developed and developing world. CBR initiatives at a community level can model the inclusion and participation of those with disabilities in education and employment for national strategies and development policies. CBR also advocates for inclusion of people with disabilities in all poverty reduction and development programs. (WHO, 2004).

The use of the 'Health for All' health systems approach, strengthening, adapting, and reforming health systems, is evident in CBR. CBR programming requires national policies, managerial structure, support of various governmental sectors, NGOs, and other stakeholders. CBR requires action and involvement at the national, intermediate, and local levels. There is recognition that linking smaller projects with the health system will increase impact and sustainability. (WHO, 2004).

Finally, the "Health for All" concept that nations, communities, families, and individuals are interdependent in the promotion and achievement of universal health and well-being is also integral to CBR theory. CBR "promotes collaboration among community leaders, people with disabilities, their families, and other concerned citizens to provide equal opportunities for all people with

disabilities in the community” (WHO, pp.1, 2004). As well, CBR supports and strengthens international collaboration with DPOs (Disabled Persons Organisations) around the world. (WHO, 2004).

As evidenced, the fundamental elements of CBR align closely with that of public health thought. As CBR is gaining recognition, the next step is to expand and scale up CBR programming to communities with limited intermediate level support from government sectors. The CBR joint position paper indicates a void of CBR in urban slums and other informal community settings, such as refugee camps. A more in depth look at CBR initiatives in urban slum populations is below. (WHO, 2004).

#### **5.1.5 Summary**

Past CBR initiatives and theory appear to support a role for CBR in regions of conflict, although currently, no formal guidelines are in place. The following explores a potential course of action to address this.

### **5.2 What Would CBR Look Like in Regions of Conflict?**

While CBR guidelines for regions of conflict do not exist, CBR guidelines for the urban poor population have been proposed. In examining the characteristics of an urban poor community, many similarities exist between this community and one within a region of conflict. Therefore, a closer look at the CBR guidelines for the urban poor may prove beneficial and may help to direct CBR interventions within regions of conflict.

### **5.2.1 CBR in Urban Poor Populations: An Example**

Those with disabilities living in urban slum and low-income communities often have limited access to rehabilitation services. With this in mind, the WHO Disability and Rehabilitation Team and the Italian Association Amici di Raoul Follereau (AIFO) initiated a collaborative consultation process with organizations working in slum populations. Proposed general guidelines for initiating and sustaining CBR in this setting were produced; the document is titled *Equal Opportunities for All: Promoting Community-Based Rehabilitation (CBR) among Urban Poor Populations*. (AIFO, 2002).

#### **5.2.1.1 Characteristics of Urban Poor & Slum Dwelling Populations**

An increase in displacement and migration toward urban centres has increased the numbers of people living in slums, in search of work and survival. The WHO/AIFO document outlines the following characteristics of living in an informal, disordered setting such as a slum.

Population density is usually high, and housing is substandard. Shacks made of tin, plastic or mud may constitute a home, with overcrowding an issue. Along with this comes the lack of access to basic services: electricity, sanitation, drinking water, health care, and education. Poverty is inevitable, as most are unemployed, underemployed, or employed in the informal market. (AIFO, 2002).

Conditions of security in slums may constantly be changing. Threats of forced evacuation may be imminent, or slums may be long-standing, with new arrivals migrating in over the decades. Some slum inhabitants may be relatively stable, while others may migrate seasonally for work. (AIFO, 2002).

Ethnic, cultural, religious, and language differences are common. Occasionally groups may come from warring factions. Social problems such as violence, drug and substance abuse, prostitution, and infectious disease are rampant. Those living in the slums are often a vulnerable group, with great potential for exploitation and oppression. Initiating CBR in this setting involves some adaptation. (AIFO, 2002).

#### **5.2.1.2 CBR Guidelines for Urban Poor Populations**

The AIFO document of proposed guidelines for initiating and sustaining CBR in slum populations outlines some basic steps that may differ from a standard CBR programme. First, after some credibility has been established in the community, a thorough understanding of the population needs and priority groups is necessary. While this is essential for initiating CBR in all settings, in slum populations the consultation process may be slow, as previous experience with researchers may have resulted in suspicion and distrust of external agencies. Community participation is key to the process, as well as empowering individuals to access their rights and allowances as citizens, despite living in low-income areas. (AIFO, 2002).

Collaboration with existing DPOs, community committees, public authorities, and community volunteers is vital to the development of CBR in slum settings. Building on and reinforcing existing resources and organizations within the community, and in the neighboring city, is key. CBR collaborative activities may include: health and rehabilitation, education, and work and income generation. These should be approached as initiatives with set timelines, with



an exit strategy for external agencies in place to ensure sustainability. (AIFO, 2002).

The proposed guidelines stress the length of the CBR initiation process within an urban poor area or slum. With the 'community' being an informal collection in this situation, families, friends, and concerned citizens, as well as those recognized as leaders for their political, civic, or religious role, form the core of the community. Resources and the desire to help for the common good are likely present within the community, and need to be acknowledged and accessed for the success of CBR. (AIFO, 2002).

The significance between the proposed guidelines for CBR in urban poor populations and CBR within regions of conflict will be explored in more detail below.

## **6: DISCUSSION**

Evidence thus far points to CBR having a significant role to play in regions of conflict, contributing to both health and peace. For CBR to be recognized as a successful Peace through Health initiative, what remains to be done is the adaptation of CBR to adequately meet the needs of populations in conflict situations. The WHO/ILO/UNESCO joint CBR guidelines, due to be released in 2010, may provide some direction for the field. What needs to happen to move forward is two-fold: the adaptation of CBR for conflict settings, and the adaptation of CBR to incorporate maximum peace impact.

First, by examining the CBR projects in the urban poor and slum communities, proposed guidelines for how CBR can be adapted to a conflict setting are promising. Many of the characteristics of an urban poor community mirror that of a community within a conflict region. Commonalities such as lack of proper housing, changes in security levels, poverty, disruption of public services, ethnic/religious/language differences, and forced mobility are likely to be present in conflict settings, as they are in urban poor settings. Similar guidelines would be applicable to CBR in conflict regions.

Secondly, evidence suggests that CBR is in a position to contribute to peace-building. With such optimistic preliminary evidence of health as a peace-building tool, it should come as no surprise that a field such as CBR would be a

natural component. Some adaptation of traditional CBR will likely prove beneficial in enhancing the peace impact.

Within CBR lies the untapped potential to be successful in both the concurrent goals of improving health status in conflict situations & contributing to peace. Drawing together both strategies of implementing CBR in regions of conflict and as a peace-building initiative is essential to achieving these goals.

The first step to take at this point towards developing guidelines would be tapping into the information and expertise currently in the field. As was mentioned, CBR does have a history of and is currently being used in regions of conflict. Coordination of these initiatives for the purpose of information and resource sharing would be beneficial. Professional organizations, such as the World Society of Occupational Therapists (WSOT), may provide an appropriate forum for discussion. Because the field of CBR in conflict regions as a peace through health initiative is so new, information sharing is key. New research such as the peace building qualities of ongoing CBR initiatives, currently a Queens University study, could be accessed in this format. Blogs, on-line discussions, and networking services could be set up formally and informally through these organizations.

As well, key informant interviews with those currently involved in CBR initiatives in regions of conflict, as well as those involved in the development of guidelines for CBR within the urban poor population, would be warranted. Also, an examination of psychosocial rehabilitation initiatives in place in regions of

conflict may provide insight in regards to successes and challenges of initiating a rehabilitation project in a region of conflict.

At this point, a process such as that carried out by the WHO and AIFO for working in urban slum and low-income areas would be appropriate. In that case, representatives were invited to a consultation meeting in which basic guidelines on implementing CBR in urban slum and low-income areas were generated. These defined strategies were then implemented in a number of pilot projects for the next five years. Consultation, collaboration, and networking between participating sites was essential, allowing space to reflect on experiences, evaluate successes and challenges, and refine the guidelines. A final meeting was held, attended by representatives at the end of the five year pilot period to prepare a final report. (AIFO, 2002). A similar process should be initiated for developing guidelines for CBR in regions of conflict.

Throughout this process, information such as what would determine a successful CBR program would look like, and the prerequisites for initiating CBR would be accrued. From the limited research currently available for CBR as a peace through health initiative, a successful CBR initiative would include active community involvement along with collaboration with humanitarian organizations and NGOs in place for emergency relief. A likely starting point for CBR may be in addressing the injuries and disabilities in the community as a result of direct combat. To be noted is that CBR programming may in fact mirror traditional CBR programming in rural areas, if the community involved is not situated in the middle of a conflict zone.

Prerequisites of CBR initiation would be a thorough regional analysis with regards to existing rehabilitation infrastructure, local (community) and intermediate (regional) level support, and clearly defined goals based on community priority needs.

CBR within conflict regions shows a lot of promise, and the process to further its effectiveness as a peace through health initiative is not complex. Developing the guidelines is an achievable goal within the next five years, and an effort to accomplish this would be a huge step in a positive direction of advancing the field of peace through health.

## **7: IMPLICATIONS & RECOMMENDATIONS FOR PUBLIC HEALTH PRACTICE & POLICY**

### **7.1 Development of Guidelines**

What is desperately needed to advance the field of CBR in conflict regions as a Peace through Health initiative is a concise document outlining guidelines and strategies for implementing CBR in these settings.

The guidelines for CBR in conflict regions should direct action in initiating CBR within a particular context. They should include information such as how to conduct an analysis of the particular context, and how to determine whether it is appropriate to implement a CBR strategy. As well, guidance with regards to target populations should be provided. For example, is the CBR initiative targeting specific groups such as those persons with impairments, substance users, or other vulnerable groups.

Guidelines should also include guidance with regards to initiation of CBR and how to collaborate with different sectors and/or NGOs. Because of the nature of CBR in regions of conflict, coordination between sectors may prove more difficult than in times of peace. Guidelines should provide direction as to best courses of action in these contexts.

## **7.2 Use of the CBR Global Database**

While the literature is emerging on CBR in conflict situations and as a Peace through Health initiative, coordination and networking between those projects on the ground is paramount. The WHO global database of CBR may provide an appropriate avenue to begin uniting the field.

The first step would be the addition of a section on the database indicating whether or not the CBR programming is occurring in a region of conflict. In addition to this, a section indicating the peace goals of the initiative could be included. From here, forums for discussion among those projects in conflict zones could be created. On-line discussion groups could be created, along with newsletters and blogs for the purpose of sharing experiences, sharing resources, and sharing current research in the field. Professional organizations, such as the World Society for Occupational Therapists, can provide a platform to support these forums.

## **7.3 Collaboration with WHO/DAR**

The WHO Disability and Rehabilitation (WHO/DAR) Team is actively promoting CBR and the development of guidelines. Collaboration with the DAR Team would likely prove beneficial in development of guidelines for CBR in conflict regions as a Peace through Health initiative.

Professional rehabilitation organizations may be in a position to contribute and collaborate. The World Society of Occupational Therapists (WSOT) is an

example of such an organization that could be mobilized to support pilot projects of CBR in regions of conflict.



## **8: CONCLUSION**

CBR embodies elements that suggest success in both goals of improving health status in conflict situations & contributing to peace. Drawing together both strategies of implementing CBR in regions of conflict and as a peace-building initiative in a formal way is essential to achieving these goals.

Health professionals, as in the past, will continue to be actively involved in issues of peace, conflict, and justice. Only through incorporation of such health arenas, such as CBR, will the field of Peace through Health be strengthened and be able to play a greater part in creating a more peaceful world.

## **9: CRITICAL REFLECTION**

My interest in peace and health has been ongoing throughout the course of my Masters of Public Health (MPH) program at Simon Fraser University (SFU); it was without a doubt fuelled by the 'War and Global Health' themed Western Regional International Health Conference this year in Seattle. This relatively new movement to link peace and health, and the development of a field of study, is both exciting and timely. My background in Occupational Therapy fuelled my desire to investigate the link between rehabilitation and peace-building in regions of conflict.

In completing the research on community based rehabilitation and peace through health, the lack of literature indicating the efficacy of the peace-health approach, despite the World Health Organization and other organizations integrating it into their post-conflict health assistance plan, was surprising. The literature addressing CBR within the peace through health approach was even less. While addressing an emerging area of global health is fascinating, I found myself frustrated, constrained to the work of a few main authors in the field.

Throughout the course of my research, in consultation with colleagues, discussion surrounding war and global health suggested that consideration should be given to include a module or elective within SFU's MPH program. While McMaster University is the forerunner in Canada in the field, SFU may

benefit from engaging with, and potentially contributing to the advancement of the field.

*“The role of physicians and other health workers in the preservation and promotion of peace is the most significant factor for the attainment of health for all”*

*(World Health Assembly, Resolution 34.38, 1981)*

# APPENDIX

## Appendix A

### Summary Table of Included Literature

Literature	Summary	Document Purpose	Author's Conclusions	Notes
A de Quadros, C., & Epstein, D. (2002). Health as a bridge for peace: PAHO's experience. <i>The Lancet, Vol. 360</i> . Retrieved from <a href="http://www.thelancet.com">www.thelancet.com</a>	Lessons learned from PAHO in the 1980s with HBP projects	Editorial article	Lessons learned re: days of tranquillity paved way for other ceasefires globally	
Arya, N. (2004). Peace through health I: Development and use of a working model. <i>Medicine, Conflict and Survival, Vol. 20(3):242-257</i> . Doi: 10.1080/1362369042000248839	Attempt at defining scope of PtH (Peace through Health) activities with use of a model	PtH theory; Public Health theory combined for creation of working model	Model can be adapted; first step at situating within a conflict situation	Model has not been piloted.
Arya, N. & Santa Barbara, J. (2008). <i>Peace through health: How health professionals can work for a less violent world</i> . Sterling, VA: Kumarian Press.	Compilation by 30 experts in PtH field re: how health and peace can be linked	Compilation of current work in the PtH field; provide professionals with skills	Suggests ways we have contributed, & challenges ahead	Compilation resource

<p>Association Amici di Raoul Follereu &amp; World Health Organization (2002). Equal opportunities for all: Promoting community-based rehabilitation (CBR) among urban poor populations. Retrieved from <a href="http://www.aifo.it/english/resources/online/books/cbr/reviewofcbr/CBR%20in%20slums%20final%20Report-edited-1.pdf">http://www.aifo.it/english/resources/online/books/cbr/reviewofcbr/CBR%20in%20slums%20final%20Report-edited-1.pdf</a></p>	<p>Publication regarding process of initiating and sustaining CBR in slum populations</p> <p>Includes strategies &amp; process.</p>	<p>Research study Pilot programs in urban slums resulting in development of guidelines.</p>	<p>Guidelines proposed</p> <p>Valuable process</p>	<p>May apply to CBR in regions of conflict.</p>
<p>Boyce, W. (2000). Adaptation of community-based rehabilitation in areas of armed conflict. <i>Asia Pacific Disability Rehabilitation Journal</i>, Vol. 11(1):17-20. Retrieved from <a href="http://unipdcentrodirittiumani.it/en/diritti_umani_disabili/Adaptation-of-community-based-rehabilitation-in-areas-of-armed-conflict/228">http://unipdcentrodirittiumani.it/en/diritti_umani_disabili/Adaptation-of-community-based-rehabilitation-in-areas-of-armed-conflict/228</a></p>	<p>Principles of community based rehabilitation may be applied in areas of conflict, and the challenges faced in trying to do so</p>	<p>Review of CBR initiatives</p>	<p>Areas where CBR has not addressed challenges yet.</p>	

<p>Boyce, W., Koros, M., &amp; Hodgson, J. (2002). Community based rehabilitation: a strategy for peace-building. <i>BMC International Health and Human Rights</i>, Vol. 2(6). Retrieved from <a href="http://www.biomedcentral.com/1472-698X/2/6">http://www.biomedcentral.com/1472-698X/2/6</a></p>	<p>Civil society has a valuable role to play in peace-building</p>	<p>Explores examples of peace-building attributes to comm.-based initiatives</p>	<p>Benefits &amp; challenges to using CBR as a peace-builder</p>	
<p>Buhmann, C. (2005). The role of health professionals in preventing and mediating conflict. <i>Medicine, Conflict and Survival</i>, Vol. 21(4): 299-311. Doi: 10.1080/13623690500268865</p>	<p>Compares existing Peace through Health evidence with theoretical framework</p>	<p>Literature Review</p>	<p>Lack of systematic evaluation of PtH</p>	
<p>Hagopian, A., Ratevosian, J., &amp; DeRiel, E. (2009). Gathering in groups: Peace advocacy in health professional associations. <i>Academic Medicine</i>, Vol. 84(11):1485. Retrieved from <a href="http://journals.lww.com/academicmedicine/Citation/2009/11000/Gathering_in_Groups__Peace_Advocacy_in_Health.13.aspx">http://journals.lww.com/academicmedicine/Citation/2009/11000/Gathering_in_Groups__Peace_Advocacy_in_Health.13.aspx</a></p>	<p>Call to mobilize health associations to play a role in PtH</p>	<p>Letter in response to journal's 'Question of the Year'</p>	<p>Health associations can contribute to PtH field</p>	

Hartley, S., Finkenflugel, H., Kuipers, P., & Thomas, M. (2009). Community based rehabilitation: Opportunity and challenge. <i>The Lancet</i> . Vol. 374: 1803-1804	Opportunities and challenges to using CBR	Editorial	Need to include best practices, networks, and policy strategies	
MacQueen, G., & Santa Barbara, J. (2000). Peace building through health initiatives. <i>BMJ</i> , Vol. 321: 293-297. Retrieved from <a href="http://www.bmj.com/cgi/content/extract/323/7320/1020">http://www.bmj.com/cgi/content/extract/323/7320/1020</a>	Health work can help restrict destructiveness of war. Evaluation tools need refinement.	Public forum article	Health work can help restrict destructiveness of war. Evaluation tools need refinement.	Highlights bases of health-peace mechanisms.
Rushton, S., & McInnes, C. (2006). The UK, health and peace-building: the mysterious disappearance of Health as a Bridge for Peace. <i>Medicine, Conflict and Survival</i> , Vol. 22(2):94-109. Doi: 10.1080/13623690600620940	Involvement of UK development community in the creation of the WHO's Health as a Bridge for Peace Programme	Policy review of UK	Suggests 4 explanations as to why the policy failed to take root	Context specific
Santa Barbara, J. (2004). Medicine as a bridge to peace. <i>Croatian Medical Journal</i> , Vol 45(1):109-110. Retrieved from <a href="http://www.cmj.hr">www.cmj.hr</a>	Medicine as Bridge to Peace – new concept	Background info re: peace, peace through health theory	Too soon to tell if link between health and peace is possible	Introduction of new column in journal



Santa Barbara, J., & MacQueen, G. (2004). Peace through health: key concepts. <i>The Lancet</i> , Vol. 264: 384-386. Retrieved from <a href="http://www.thelancet.com">http://www.thelancet.com</a>	Reviews 10 Health through Peace mechanisms	Not a theory, but steps towards one.	Health sciences needs to give more attention to violent conflict and the complexities.	
Vass, A. (2001). Peace through health. <i>BMJ</i> , Vol. 323: 1020. Retrieved from <a href="http://www.bmj.com/cgi/content/full/323/7320/1020">http://www.bmj.com/cgi/content/full/323/7320/1020</a>	Peace through Health needs evidence, not ideology	Editorial	Sense of urgency with initiating Pth projects, but need evidence!	
World Health Assembly (1998). Health for All Policy for the Twenty-first Century. <i>Fifty-first World Health Assembly</i> . Retrieved from <a href="http://www.emro.who.int/mei/pdf/topic/phc/healthforall_resolution.pdf">http://www.emro.who.int/mei/pdf/topic/phc/healthforall_resolution.pdf</a>	Statement of Health for All Policy in the 21 <sup>st</sup> Century	Policy declaration	N/A	
World Health Organization (1978). Declaration of Alma-Ata. <i>International Conference on Primary Health Care</i> . Retrieved from <a href="http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf">http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf</a>	Declaration of Alma-Ata	Declaration from International Conference	N/A	

World Health Organization (1986). The Ottawa Charter for Health Promotion. Retrieved from <a href="http://www.who.int/healthpromotion/conferences/previous/Ottawa/en">www.who.int/healthpromotion/conferences/previous/Ottawa/en</a>	Document: Ottawa Charter for Health Promotion	Charter	N/A	
World Health Organization (2003). WHO definition of health. Retrieved from <a href="http://www.who.int/about/definition/en/print.html/">http://www.who.int/about/definition/en/print.html/</a>	WHO definition for 'Health'	Term definition	N/A	
World Health Organization (2004). CBR: A strategy for rehabilitation, equalization of opportunities, poverty reduction, and social inclusion of people with disabilities: Joint position paper. Retrieved from <a href="http://whqlibdoc.who.int/publications/2004/9241592389_eng.pdf">http://whqlibdoc.who.int/publications/2004/9241592389_eng.pdf</a>	CBR position paper with ILO and UNESCO	Document to describe & support CBR	CBR is an effective strategy; provides recommendations to move forward	Precursor to CBR guidelines
World Health Organization (2010). Retrieved from <a href="http://www.who.int/disabilities/publications/cbr/en/index.html">http://www.who.int/disabilities/publications/cbr/en/index.html</a>	WHO CBR webpage	Website information for organization	N/A	Grey literature

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