

Beyond the log frame: a new tool for examining health and peacebuilding initiatives

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How do we move from identifying ethical principles to enhancing development practice? How can donors and NGOs move beyond the reporting of technical outputs to explore less tangible aspects of their health projects: contributions to rebuilding trust, promoting social cohesion, and enhancing good governance at community level? This article considers these questions in relation to health and peace-building activities in conflicted settings. It describes difficulties facing practitioners and donors seeking to undertake health and peace work, in particular focusing on the lack of appropriate tools for screening, monitoring, and evaluating projects. It critiques the logical framework, a tool commonly used in project planning, monitoring, and evaluation, and considers it alongside a new tool, the Health and Peace Building Filter, which has been designed to reflect on health programming in fragile or conflicted settings. The authors argue that such tools can help to move us beyond focusing on inputs and outputs to examining processes, relationships, and the indirect consequences of aid programmes.

KEY WORDS: Conflict and reconstruction; Social sector; Methods

Introduction

In this article we focus on an emerging body of work that theorises the links between health and conflict, and the potential for aid to the health sector to contribute to peace (or not). We briefly examine the links that are being made between health and peace, and we suggest that undertaking health and peace work requires attention to a range of issues currently at the periphery of aid delivery. These issues include trust and social cohesion; sensitivities of culture, conflict, and gender; staff dynamics and agency–government relationships; project governance; and accountability to communities. We argue that making these issues visible and providing a structure for reflecting upon them is necessary if these principles are to influence health work in conflict. The discussion draws on conceptual and practical research conducted over a two-year period, as well as fieldwork undertaken in Sri Lanka, Timor Leste, and the Solomon Islands.¹

The article has three main sections. In the first we briefly discuss the arguments for linking health and peace, and we consider some of the cautions associated with pursuing these activities, and the difficulties facing practitioners and donors seeking to undertake health and peace work. The second section presents and critiques the tool most commonly used in the management of aid programmes, the *logical framework*, and examines its strengths and limitations. We then introduce the *Health and Peace Building Filter* (hereafter referred to as the *Peacebuilding Filter*), which has been designed to assist donors and others to reflect on health projects and programmes in conflict or fragile settings. We argue that such a tool can help to move us beyond inputs and outputs to examining processes, relationships, and the indirect consequences of aid programmes. We present an example from one principle in the Peacebuilding Filter – ‘trust’ – to demonstrate how new tools can promote deeper dialogue about health projects and help to put ethical principles into practice (Griekspoor and Loretta 2001).

Peace through health

Since the early 1980s there has been growing awareness of the potential links between health and peace, and considerable advocacy regarding health initiatives as a ‘bridge to peace’. The successes of the Pan American Health Organization (PAHO) in facilitating ‘days of tranquillity’ in Central America, where ceasefires were held to allow mass child-vaccination campaigns, raised the profile of health as an entry-point to peacebuilding and conflict prevention. WHO has actively pursued ‘health as a bridge to peace’ and promoted projects in the former Yugoslavia, Angola, and Indonesia among others (WHO 1997; WHO/DFID 1998; Gutlove 1999; Griekspoor and Loretta 2001).

Advocacy work by physicians regarding the health consequences of conflict, in particular of nuclear war and landmines, furthered the argument for a ‘health–peace symbiosis’ (MacQueen *et al.* 2001) and interest in this emerging field² of practice is evidenced by the *Lancet*–McMaster Health and Peace Conference series,³ and by ongoing debate on the issues raised (see Buhmann 2005).

Early attempts at critical analysis of the underlying ethical values and principles which provide the basis for connecting health work with peace work suggest that ‘*compassion based on empathy expressed with impartiality*’ forms its foundation. A commitment to ‘do no harm’, to respect dignity and autonomy, and to act with honesty and trustworthiness is seen as being among the core ‘implementing values’ for practitioners (Santa-Barbara 2005).

The idea that sensitive application of health initiatives may provide inroads to peace in places of actual, potential, or past conflict has attracted an enthusiastic band of followers. Claims include ‘that a global health initiative can, in the right circumstances, make inroads against war’ (MacQueen *et al.* 2001), and that ‘health could be the most valuable counterterrorist measure yet to be deployed’ (Horton 2001). Other commentators are somewhat more circumspect, cautioning against the securitisation of health policy, and arguing the need to separate aid objectives from foreign-policy agendas (Duffield 2001; McInnes and Lee 2006). Many simply suggest that the potential for health to bring peace is overstated, reminding us of a comment by a nurse after the complex emergency in the former Yugoslavia: ‘*Medical workers did not close the borders, so it will not be they who open them*’ (Nurse, Baranja, quoted in Large *et al.* 1998).

While debate continues about the role that health-sector aid can or should play in fragile settings, we suggest three broad reasons for devoting attention to the links between health and peace. First, humanitarian interventions in the presence of violent political conflict typically include a major health component. Second, the health sector and health services more generally are increasingly recognised as helping to secure lives and livelihoods and demonstrating the

commitment of government to meeting the needs of its people. Third, health is seen in some situations as an entry-point for more overt and explicit efforts to build peace, and may be used instrumentally to promote these objectives. Building upon these, we consider why tools to examine the impact of donor-funded health programmes in conflicted settings are long overdue, and we argue their importance in moving from statements of ethics, principles, and values, to providing guidance for interventions on the ground.

Doing no harm? Health interventions in humanitarian emergencies

Death, disability, and disease are among the most visible and predictable effects of violent political conflict. As such, the health sector has always played an important role in the humanitarian response to complex political emergencies. Health workers are among the first to arrive on the scene, and health programming alongside interventions to promote water and sanitation, shelter, food security, and protection is a dominant component of relief and early development work during and after conflict.

The need for all aid workers to be conflict-sensitive was highlighted by Mary B. Anderson (1999) and others in the mid to late 1990s. The 'Do No Harm' catchphrase is now widely accepted. The extent to which mainstream health workers, health development agencies, and contractors have adopted these principles, however, is less clear. While the major emergency relief organisations such as the International Committee of the Red Cross (ICRC) and Médecins sans Frontières (MSF) have long reflected on issues of independence, impartiality, and neutrality in situations of violence, debate has intensified, given the wider range of actors operating in these environments, including military forces, the private sector, contractors, and a range of government-funded NGOs. There has been a concern that traditional health development agencies are often not equipped with appropriate training, preparation, or operating standards to undertake work in violent and conflicted settings.

Anderson's 'Do No Harm' framework makes explicit the contested nature of aid in conflict, the potential for aid resources to deepen divides, and the potential for the distribution of aid to reinforce, or produce, inequalities in access and outcomes. Regardless of whether health programmes are consciously or explicitly pursuing peace objectives, as with all aid their very presence affects the conflict environment (Le Billon *et al.* 2000).

Aligning health work with peace work

Health is recognised as an important sector that requires support in fragile or *pre*-conflict settings. Maintaining social services, including a functioning health system, may contribute to reducing grievances and preventing violent opposition to the state. In the *post*-conflict environment, health is increasingly seen as one of the key sectors through which governments may '(re)establish legitimacy, reduce alienation from society and crucially, be seen to visibly demonstrate that they are upholding their side of the social contract' (Rushton 2005: 442; see also Zwi and Grove 2006). However, most agencies continue to operate 'peace programmes' separately from other sector-specific activities such as reconstruction or reform of health and education systems.

So, while some advocates see health as a key sector through which broader goals of peace can be promoted and conflict prevented, those involved in the planning and delivery of these activities often do not have the training, skills, or tools to operate effectively. The gap between idealistic statements of principle and the challenge of practical application remains.

During the development of the Peacebuilding Filter, we carried out fieldwork in Solomon Islands, Sri Lanka, and Timor Leste. Health workers in these settings, while sensitive to the

conflict environment, often felt that ‘peacebuilding’ was the work of others, and that their job was to deliver the technical inputs and support to health projects. Many relief workers have attended basic conflict and development training but are unsure how best to apply this learning to their particular health activities: ‘*We’ve had a bit of training recently in peace and conflict stuff. . . and [our programme] in general is a bit more aware that this is a cross-sectoral issue . . . but even so I’m not sure I could pull it together*’ (health adviser, Solomon Islands). Difficulties arise in deciding how the results of a broad political/conflict analysis should influence projects that train midwives or provide health promotion in schools, for example. Furthermore, some informants felt overloaded by ‘special skills’ training – gender sensitivity, cultural awareness, rights-based approaches, and now peace/conflict awareness – and questioned the extent to which skilled health workers could be expected to develop expertise in each of these areas. One adviser from a donor agency asked, ‘*How many different lenses can we layer on these programmes?*’

Health as an entry point for peacebuilding

As indicated earlier, there is a growing body of work suggesting that special characteristics of health work may enable it to contribute more actively to building peace in some settings.⁴ The main arguments are covered elsewhere (Rushton 2005; Arya 2004; Buhmann 2005); they include the following:

- The status enjoyed by health workers in many communities.⁵ During times of conflict this is reflected in the fact that doctors and nurses may enjoy greater mobility, be given access to different warring parties or communities, and be able to help develop ‘corridors of peace’ to allow the delivery of health care in war zones.
- The notion that health workers are generally seen as credible and respected and may act as role models, both personally and through the principles and values of medicine – doing no harm, demonstrating commitment to impartiality, non-discrimination (treating all the sick and injured), equity (deciding on the delivery of care on the basis of need alone), and maintaining confidentiality.
- The importance of trust in relationships between patients and doctors, and the possibility of this personal trust being scaled up to include trust in health clinics, services, systems, and public institutions.
- The observation that health workers, concerned about the determinants of health, are recognising that conflict and instability are major contributors to poor health outcomes and inadequate health services; this produces a rationale for acting ‘upstream’ and for seeking to influence those factors that contribute to undermining health.
- A belief that health may be a ‘connector’, as it is an issue of common concern, with characteristics that unite people because ‘we all care about health’, and because in some very real ways (for example in relation to communicable diseases) our own health is dependent on the health of others.⁶

While each of these points is open to critical evaluation, this is not the place for it. Our purpose here is to argue that these ambitious (but in many ways well founded) arguments are ‘out there’ and underpin aspects of the rationale for regarding health work as capable of making a special contribution to building the peace.

The idea that health work can be peace work and that *doing health differently* might produce a positive impact on the conflict is attractive, but very difficult to put into action. There is little evidence of effectiveness and few case studies to support assumptions. Having completed several issues papers, background articles, and policy briefings for AusAID on health and

peace links, we were faced with guarded enthusiasm. The reaction among donor staff was often *'This is interesting, we're interested in this, but my job is to sit in Dili [or Honiara or Colombo. . .] and make decisions about which projects to fund'*. In these settings, programme managers needed a way to determine which health projects carried the least risk of harm and the greatest potential to contribute to peace, while still meeting technical objectives of improving the health system and promoting better health.

Once such projects had been funded and were operating, these aid officials also needed a way to monitor and assess these issues. This very direct challenge was one that required a response. Clearly, identifying conceptual, theoretical, or even ethical links does not necessarily bring us any closer to realising the potential of health work to contribute to peace. If the principles and values at the interface of health and peace are to take a more central place in the activity of development workers, then applied frameworks are needed: tools which relate directly and concretely to the day-to-day work of health projects.

From ideas to action: the challenge for health and peace

What might help to translate the theory and values of health and peace work into effective programming on the ground? Field research suggests that health personnel require a mechanism to help them to reflect on the effects of their activities, especially those that are indirect or unanticipated. It also points to the need to support programme managers to see health work as embedded in (rather than separate from or simply reactive to) the environment of conflict in which they work. Finally and perhaps most importantly, it highlights the importance of stimulating dialogue about the principles of peace and health among a range of stakeholders, including the parties to the conflict, funders, implementers, and communities. Observations and discussions with donors and project staff led us to believe that the tools currently being used to design, monitor, and evaluate health projects are not well suited to these tasks. In some sense they act as a barrier.

The following section describes the logical framework matrix,⁷ widely used in the development sector (Cracknell 2000; Aune 2000; Dale 2003). It discusses the role of this tool, which is used by many to plan and monitor health projects, and it draws attention to its attractions for the donor community. These features are then examined in relation to the challenges of managing health and peace work in conflict-affected settings.

When a 'log frame' is not enough

The logical framework ('log frame') is described as 'a matrix which summarises the main elements of a programme and connects them to one another' (Bakewell and Garbutt 2005). The log frame in its most basic form consists of a four-by-four matrix, with the four rows corresponding to a hierarchy of project objectives (goal, purpose, output, activities) and four columns, describing the objective, its indicators and how to measure them, and critical assumptions⁸ (see Figure 1).

The matrix is intended to reflect a 'vertical logic'. The first column, starting from the bottom, should tell a 'feasible means-to-ends narrative' about a project or programme. It describes how a set of *activities* such as training technicians and building wells produces an *output* – increased quantity of water – which is related to a defined *purpose* – providing access to more clean drinking water for a village – which in turn contributes to a *goal* of reduced morbidity and mortality from water-related diseases. At the same time, the log frame provides a 'horizontal logic' which sets out how progress towards each objective can be measured and verified; it also

Objective (narrative summary)	Indicators	Sources of verification	Assumption
Goal (overall objective)			
Purpose (outcome)			
Outputs (results)			
Activities			

Figure 1: Logical framework matrix

identifies any external factors which may affect or impede the ability of the project to reach its objectives.

The log frame has considerable merits. It breaks down a complex set of activities and enables a snapshot view of what a project or programme is hoping to accomplish, how it will do so, and why it is being done at all. It obliges managers to think about their objectives and how they will know if they have achieved what they set out to do: it encourages identification and use of measurable indicators. It points staff or evaluators to where data on the indicators can be found and allows efficient assessment (in terms of time, logistics, and money) of project progress. The log frame provides a focus for people involved in different activities to see how what they do fits into a bigger picture. It also attempts to identify important issues that pose risks to the project – so that those that can be managed are addressed, and others are identified as assumptions upon which project success may rest. For donors and others, the matrix provides a valuable overview of the project, often distilled down to a single page, and is typically used also as the basis for monitoring and evaluation. A small industry involving consultants and their clients has emerged around the modification and improvement of this planning and management tool. The log frame is not without its problems, however, and thorough critiques of the logical framework exist.⁹

While health and peace initiatives comprise a series of technical inputs, it is clear from the earlier description that the dual purpose of improving health and supporting peace increases the complexity of projects that seek to combine the two aims. Planning must take account of the need for health aid to be delivered efficiently and effectively, while contributing to the achievement of other objectives such as promoting social justice and equity, encouraging trust in relationships, and supporting greater community cohesion and non-violent resolution of conflicts. Doing no harm is a prerequisite; making a contribution to peacebuilding is a bonus. Relying only on the log frame to plan and manage such objectives is problematic: the core concern is that the matrix encourages a technical rather than a social appraisal of the project. Indeed, the log frame tends to hide precisely the issues that require the greatest attention in health and peace work: relationships, processes, indirect effects, and unintended consequences.

Measuring what matters

The log frame contains a natural bias towards quantification. The matrix demands ‘objectively verifiable indicators’, forcing projects to consider how they will measure progress towards intended outcomes. While setting clear objectives and identifying ways of measuring these from the outset helps management and other stakeholders to identify where the project is succeeding or failing, this emphasis on the ‘measurable’ also represents a crucial weakness. The matrix becomes dominated by those issues that are easiest to define and measure, rather

than those that are most central to success. In particular, relationships between people (both internal and external to the project) and process issues (how the project is undertaken) are likely to be neglected, with attention focused on the most tangible outputs, such as clinics built or vaccinations administered.

Cracknell (2000: 114) acknowledges this in his critique of the log frame: '[w]here people are concerned, the most vital success factors are linked in some way to interpersonal relationships, but no performance indicators can reflect these satisfactorily'. He suggests that we may simply have to accept this limitation of the matrix, while recognising that this is a 'basic problem with any attempt to monitor and evaluate projects involving human development'.

In situations of instability, however, where the breakdown of relationships or the erosion of trust can lead quickly to the outbreak of violent conflict, relationships and responsiveness to stakeholder concerns must be at the forefront of development interventions. The difficulty in measuring relationship issues in no way obviates the need to reflect on them, continuously and systematically. Cracknell further suggests that there is a 'degree of unreality' about assuming that 'if you do A, it will lead to B'. He notes that this logic applies to some mechanical processes, such as engineering projects, but that 'once people become involved, the outcome of an intervention can not be taken for granted'. Dale (2003) argues that the log frame does not express or directly refer to the underlying 'people-related problems' and does not elucidate stakeholder concerns. How people or communities engage with and respond to any interventions, whether they are internally or externally driven, is never wholly predictable, but is vitally important to monitor.

Prioritising relationships

Without a mechanism for deeper reflection on this, health-related interventions run the risk of inadvertently doing more harm than good, and increasing community tensions or rivalry without knowing it.

A simple hypothetical example will suffice. In the aftermath of a conflict that revealed serious community and ethnic divisions, development workers have identified an impoverished peripheral community with poor access to water. A donor agency has contracted an NGO to develop and deliver water supplies. The local government authority considers the project to be valuable. The log frame reiterates the overarching goal as contributing to alleviating poverty through enhanced health, resulting from improved water supply. The 'outputs' contributing to achieving this purpose are improved access to better-quality water, the establishment of a water users' committee, and a sustainable system of maintenance by community members to support water delivery. Specific and verifiable activities include enclosing and fencing off a spring on a nearby hill; constructing two large water-storage tanks; laying pipes with taps to 50 household clusters; and employing a part-time maintenance officer to keep everything in working order.

Project funds are disbursed on time, and some community members are working hard to assist with laying pipes and taps to their homes. Community ownership seems to be present; all looks on track. But . . . problems emerge a week after the keys to the fenced-in water tanks have been handed to the village head. Some peripheral pipes have been cut, with valuable water flowing away; a few taps were opened overnight, and the tank's enclosure fence was cut with wire-clippers. Animals are celebrating better access to water. Young men from up the hill were seen milling around in the early morning. What went wrong?

The project team knew that the village was of mixed ethnicity, but they did not realise that the villagers living in the area where the tube wells had been sunk and the water tanks placed were members of the same ethnic clan as the village head. The fenced-off spring at the hill-top was in

the sub-village of the 'other' community, those of a different ethnic background from the village head. The leader of those from the hill-top now explains that his ancestors had always recognised that the water needed to be protected and revered, that it was a communal resource, and had always been available to any locals or visitors prepared to trek up the hill to get it. Community members near the spring at the hill-top and on the upper slopes now complain that they have lost access, and furthermore that their homes on the hillside are not among those chosen for receiving piped water, which is available farther down the hill. No recognition of those who had protected the source of the water for hundreds of years had been given, and the ancestors of those on the hill-top were angry.

Still further complications are identified. The person employed to do the maintenance is the nephew of the village head. The water-users' committee comprises members, mostly men, who are from the same clan as the village head, plus only one member of the other ethnic community – a local shopkeeper who had negotiated for the provision of water near his shop and small tea-room. And there are more and more problems unfolding: women from both communities have no say, now that the initial work has been done, in the ongoing management of the resource and negotiations with the NGO – these tasks are seen to be too important to share with women.

It is not difficult to see, then, how a project may complete its activities, deliver outputs, and perhaps even fulfil its purpose, while creating an impact very different from that which was intended. In fragile settings in particular, *how* projects are managed and implemented is at least as important as *what* activities are undertaken. Focusing only on inputs and outputs distracts us from what we know to be critical factors in determining the broader impact of projects. Insensitivity to community structures and to processes regarding decisions on access and employment has left a sour taste with community members. The piping laid is at risk, the shopkeeper has been disowned by his own community, accusations of nepotism and corruption abound. This fragile community has split along ethnic lines, and past grievances related to discrimination are re-surfacing. Not only has the water and health project been disrupted, perhaps permanently, but tensions are now running high throughout the district, and community members on all sides fear the renewal of violence. But, according to the log frame, all was on target.

We saw earlier that the log frame describes intended routes for achieving intended outcomes. The project team and log frame had not anticipated these issues and did not place them in the matrix; they did not devote time and resources to monitoring relationships within and between communities; they did not foresee how improving water supply for some would upset others. Des Gasper describes this as 'tunnel vision' and notes that using the log frame in monitoring concentrates attention on what the project is trying to do, and hoped to do, neglecting unintended and unforeseen effects. Gasper (2000) suggests that the users of the log frame often tend to become fixated on the 'horizontal logic'; i.e. at each level the specific objective, associated activity, indicators, and assumptions become paramount, rather than continually reflecting on the 'vertical logic' – how each of these objectives and activities ultimately contributes to achieving the project's goals and purpose.

Integrating objectives

Another concern with the reliance on log frames is that the tool has a fundamental flaw when dealing with complicated projects or programmes of activity where there is a series of objectives operating at different levels. This is especially relevant to health and peace work, which by definition is seeking to achieve multiple goals; indeed, promoting peacebuilding is routinely acknowledged as operating on 'multiple tracks' and levels. The log frame is unable to deal with this easily and may push managers to divide the goals and produce two or more matrices. Doing so, however, undermines the intention of an integrated health–peace project. Experience suggests

that where donors keep their conflict-resolution and development activities in a separate silo from their health-specific activities, it has been particularly difficult for practitioners to keep broader peace principles and objectives in mind in their day-to-day planning.

One informant in the field told us, *‘[our agency] has never really expected us to look at things like this [peacebuilding] . . . of course we have the peace council, that’s something separate’* (health programme manager, Solomon Islands). Another reflected, *‘well we do these – we do have health programmes . . . and we do have peacebuilding, we’ve just never put them together, never thought about how they go together like this’* (project worker, Sri Lanka). Much aid, including health aid delivered in fragile settings, has a meta-goal of improving stability and security, so the health and peacebuilding components are to some extent inseparable. Tools are thus required which help to integrate the aims, rather than address them each separately.

So, while the log frame may provide a snapshot of the technical aspects of a project, using a log frame alone to develop, monitor, or evaluate health and peace activities risks allowing harm to occur; critical assumptions are easily overlooked, relationships are not given due attention, and measuring ends rather than means allows the negative side-effects of projects to continue unchecked. Furthermore, opportunities to do good could be missed; the log frame is unlikely to identify entry-points or possible avenues by means of which health work can contribute actively to peacebuilding, precisely because these are difficult to plan for or measure and may arise spontaneously and unpredictably.

Beyond the log frame: the Health and Peacebuilding Filter

It was against this backdrop of increasing interest in how health work was being funded and implemented in conflict, and a realisation that traditional project-management tools were not well suited to assisting health and peacebuilding work, that the Peacebuilding Filter (Zwi *et al.* 2006) was developed. Drawing on the academic and practitioner literature, five core principles of health and peacebuilding were identified and then refined with input from donors, NGOs, field staff, and academics. These were the importance of cultural sensitivity and conflict sensitivity, and the value of promoting social cohesion, social justice, and good project governance. These broad principles covered ten individual components (Figure 2). The aim of the

Peacebuilding principles and component parts	
Cultural sensitivity	Cultural sensitivity
Conflict sensitivity	Conflict awareness Trust
[Promotion of] Social justice	Equity and non-discrimination Gender
[Promotion of] Social cohesion	Community cohesion Psychosocial well-being
[Promotion of] Good governance	Community capacity-building and empowerment Sustainability and co-ordination Transparency and accountability

Figure 2: Structure of the Health and Peacebuilding Filter

Peacebuilding Filter is to provide a structure within which to reflect on these issues and stimulate thinking about how activity might be done better. In each of these areas it asks the user to assess the performance of the project against a series of ‘indicators’ (statements with which an assessor can state his or her degree of agreement or disagreement – Figure 3), and using the Companion Manual provides prompts and questions to help to contextualise these for a health project.

In this way, the Peacebuilding Filter attempts to bring principles of conflict sensitivity into the health arena. Rather than introduce theory and principles alone, the Peacebuilding Filter relies on a series of grounded and challenging questions that can be asked of projects, whether by funders, by external evaluators, or by project managers themselves. The excerpts that follow relate to mistrust in the community, associated with health services. In order to examine this issue within a particular project, the Companion Manual provides a range of prompts about how health workers in this community are perceived, the extent to which they have been aligned with different parties to the conflict, and whether hospitals or clinics had been targets of violence (see Box 1). In addition, the Companion Manual describes how trust relates to health work, and how it may be affected by conflict. The Manual also provides some definitions of key terms (not shown), as well as listing simple ways to promote trust which emerged from discussions with experienced project staff. The Peacebuilding Filter seeks to be practical, but also provides an introduction to the underlying principles and values that guide health and peace work.

Piloting of the Peacebuilding Filter as a tool to be used by aid agencies took place in 2005 with projects in the Solomon Islands, Sri Lanka, and Timor Leste. Donor staff and NGO project managers provided insights and feedback which were used to revise both the content and format, and to deepen our understanding of the core principles associated with health and peace work. The fieldwork reinforced the importance of focusing attention on the nexus between health and peacebuilding: there appeared to be definite scope for enhanced understanding and practice. At the same time, however, the pilot study revealed major gaps between what funders and even project managers know about the texture of their projects and their operation on the ground,

SA = Strongly Agree; A = Agree; B= Both agree & disagree; D = Disagree; SD = Strongly Disagree; DK = Don't Know; NA= Not Applicable										
Principle	Indicator	Response								Comments
	Trust									
Conflict Sensitivity	The project is sensitive to health-related issues that have contributed to mistrust in this community	SA	A	N	<u>D</u>	SD	DK	<ul style="list-style-type: none"> • Clinic was periodically occupied by rebel forces, disrupting services – patients now afraid to come • Low attendance rates by Tamils, prefer to travel to a clinic further away where they feel safer • Staff refusing to do outreach in certain villages • Some intimidation of hospital staff by rebel forces reported in the past 		

Figure 3: Sample completed section from the Health and Peacebuilding Filter

Box 1: Excerpts from the section of the Health and Peacebuilding Companion Manual which deals with the issue of 'Trust'

Trust: The project is sensitive to health-related issues that have contributed to mistrust in this community

- Were health facilities a target of fighting, violence or intimidation? Were health services perceived to be aligned with any of the groups involved in the tensions/conflicts?
- How was health care delivered during the height of the armed conflict? Were military forces (local or international) involved? How was this perceived? Did local clinics and hospitals continue to operate, did staff flee during the fighting – are those who stayed perceived to be different?
- Was there, at any stage, pressure on health workers not to treat certain members of the community (based on ethnic or political affiliations)? Have there been situations where people presenting to health services have been ignored or discriminated against?
- Did any community members seek out other health services further afield, thus demonstrating a lack of trust or confidence in local services?
- Think about how fighting or tension in the community has affected health providers and health services. Remember health workers are active members of their communities. If there is a tension between two communities, health workers will be affected by them and may well bring these tensions into the workplace.

Distrust of health services

In the Palestinian territories during the *intifada* community members distrusted the official hospital services and so set up parallel structures, usually run by NGOs, to meet health-care needs.

The Kosovar Albanians also set up parallel structures to avoid going through Serb-controlled services that were considered to be discriminatory.

Distrust of the government-sponsored health services was a major issue in the Solomon Islands. During and following the conflict, many people travelled long distances to other islands to seek medical treatment from health services providers they trusted, namely those of either their same ethnic background or their religious affiliation.

Simple ways to promote trust:

- *Take time to talk to people – and especially make sure you listen*
- *Meet face to face*
- *Be honest and realistic about what you can and cannot do; be open about the limitations of the project*
- *Communicate regularly with stakeholders; keep them informed; let people know about project changes early so these are not a surprise*
- *Treat people fairly*
- *Be consistent, reliable and predictable*
- *Respect people's privacy and confidentiality; recognise that if people have told you things in confidence that these are not for sharing*

and the extent to which they can comment upon its positive or negative contributions. The tools routinely used by donor-agency staff did not allow space for reflective disclosure of project problems or challenges, despite recognition by both donor and recipient agencies of the complexity of such fragile settings and the need for flexibility and responsiveness.

Donor-agency staff were typically based in the capital city, with limited time, expertise, and resources to visit projects in the field or to work with implementers to enhance ethical practice, critique the values implicit in project activities, or focus attention on the community relationships being built. Key personnel acknowledged the importance of such issues as the cultural sensitivity with which a project is undertaken, while simultaneously admitting their inability to engage with these issues in much depth.

Project manager commenting on the Peacebuilding Filter: *'OK then cultural sensitivity . . . this is like I mentioned before, these questions [about sensitivity to local cultures and different approaches to health and illness and about contributions to health made by traditional or indigenous practitioners] sitting at our level would be difficult to determine . . .'*

Interviewer: *'yeh, OK . . . and how important are they . . .?'*

Project manager: *'Ummm . . . See potentially they could be very important . . . if you are going to do a health project, and you're thinking about local and indigenous [health] practices, it'd be pretty central to know what's going on! . . . ummm . . . yeh, I'm just not sure how you would know that, at our level for example.'*

Part of the value of the Peacebuilding Filter is that it provides a basis for a potential conversation between funders and project staff about the priority to be given to key peacebuilding principles. A tool like the Peacebuilding Filter encourages a structured discussion about some of the broader issues that affect a health and peace project and draws attention to the impacts that a project may be having in communities. Even if senior staff are unable to spend long periods of time at the grassroots level, their ability to address these issues during meetings with project implementers, rather than being confined to basic reporting of outputs, should go some way towards ensuring that health and peace principles are given due attention.

The Peacebuilding Filter does not provide a blueprint for health and peace work: it cannot be used to develop a score or grade for a project, and it should not, on its own, be used to evaluate a project's success or failure. It helps health staff to describe and reflect on what is happening within the communities in which they live and work, and it can bring concepts like 'good governance' to life, down from a national level to a local or project level.

Designed to promote discussion about principles rather than outputs, it makes explicit what is often implicit and enables issues such as trust or cultural sensitivity to take their place alongside more technical concerns that would otherwise dominate monitoring and evaluation efforts. It can help to counter-balance what Gasper (1999) calls the 'self-evident virtue of the "we deliver" approach to humanitarian relief'. The Peacebuilding Filter assessment ends with the user creating an Action Plan and enables this to be informed by the priorities of the project, rather than the ratings in the assessment.

The Health and Peacebuilding Filter: strengths and limitations

It is not possible to address all the cautions or dangers concerning how conflict might affect projects or how projects might affect conflict dynamics. Nor can every peacebuilding opportunity be realised.

The Peacebuilding Filter can be a powerful tool for reflection when used intelligently and thoughtfully. Conversely, as with most subjective or self-reporting mechanisms, it can be used on auto-pilot. Users may fail to address the issues with real depth, glossing over weaknesses, hiding difficulties, or rendering ongoing challenges invisible. This can be motivated by a desire to present an image of good 'management performance', or may occur simply

because applying the Peacebuilding Filter is seen as another administrative imposition. To get the most from it, users must apply a critical lens and devote time and energy to reflection and developing the Action Plan; or, if it is used earlier in the design and planning phase, attention to each of the principles would be required. Such a process would have uncovered many of the types of problem that we described in the water-project example presented earlier. Neither the Peacebuilding Filter nor its Companion Manual provides easy answers; indeed, one frustration may be that they uncover new levels of complexity and potential problems without necessarily solving them.¹⁰

The Peacebuilding Filter requires a depth and breadth of knowledge about a project that is likely to benefit from collective inputs. Piloting it revealed that many respondents felt they needed to refer to project documents and confer with colleagues in order to complete some sections. The difficulty of this is that the exercise becomes more time-consuming and labour-intensive, or that users may 'get stuck' in some parts and not progress. If this is overcome, however, applying it encourages people at different levels of the project to talk to one another and reflect on these important underlying principles of health and peace work. If undertaken in the planning and design phase of a health intervention, the Peacebuilding Filter will demand careful consideration of relationships, processes, the sensitivities surrounding the introduction of new resources, and the use of power, in difficult environments. These are critical issues in both relief and development work, and they deserve deep, not superficial, attention.

We suggest that the Peacebuilding Filter is more powerful when completed with inputs from different stakeholders or groups – allowing multiple perspectives to be considered simultaneously. The instrument itself was, however, not designed with teams in mind, and its effectiveness in a group setting warrants exploration. Interestingly, some health personnel who participated in the pilot recommended that different members of a project team, along with donor or government staff, complete the Peacebuilding Filter independently and then come together to discuss their findings. In this way it could provide a focal point for debate and enable different actors to voice their concerns or ideas about elements of the project's processes or relationships.

The research team has sought to explore the relationship between different principles in the Peacebuilding Filter, in particular whether some are more important than others and should therefore be given greater weight. The presentation of the principles as interrelated but non-hierarchical reflects the findings from the fieldwork. In each pilot site (six different projects across three countries), broad agreement about the principles and sub-principles was reached, but different emphases were present, depending on the conflict context (who was fighting about what) and the phase of the conflict (escalating violence vs. post-conflict stabilisation). In the Solomon Islands, where simmering ethnic tensions persist, health workers prioritised cultural sensitivity and respect. In Sri Lanka the twenty-year civil war rages on, and escalating violence has focused attention on the issue of conflict sensitivity and awareness of the history of the conflict and its effects on different communities. In Timor Leste – where efforts have focused (and recently come unstuck) on the job of building one of the world's newest nations – the issues of good governance, and especially accountability to the community, were considered central to health and peace work.

Despite the fact that the Peacebuilding Filter principles themselves were not particularly contested, and that together they were seen to form a coherent framework, it is apparent that there are some tensions between the principles. For example, the Peacebuilding Filter encourages respect for local processes of decision making and conflict resolution. However, traditional mechanisms for handling these difficult issues in the community may be neither transparent nor accountable, and they could be exclusionary or provide no avenue for the participation of women, young people, or other marginalised groups (all issues that are highlighted elsewhere

within the Peacebuilding Filter). Thus in respecting some of the principles of cultural sensitivity and social cohesion, there may be lost opportunities to promote good governance or social justice. Likewise the Peacebuilding Filter highlights issues of mistrust in fractured communities and the potential role of health services in rebuilding relationships of trust (Conflict Sensitivity), while also advocating improving transparency and accountability (under Good Governance). It has been argued by some that trust and accountability are at times competing principles, in the sense that developing and demonstrating trust in others (individually or collectively) often requires a loosening of accountability, supervision, and checking mechanisms (Wenar 2006). The Peacebuilding Filter cannot, and does not, resolve these issues; decisions about what to do when principles appear to compete with one another must be resolved by making these apparent, and consciously choosing which to prioritise or how to integrate them at some point in the project. The value of the Peacebuilding Filter value in these instances is in raising such tensions early – forcing project staff and funders to re-consider their aims in delivering health aid, and to think about how those aims intersect with broader peacebuilding objectives.

Conclusion

In presenting the Peacebuilding Filter and some of the findings from fieldwork on health and peacebuilding, we hope to contribute to debates about how principles and values in development can be better reflected in reporting, monitoring, and evaluation of projects. Health interventions, whether relief or development, are often perceived as technical projects, with accountability focused upwards and on infrastructure, human resources, or equipment (numbers of hospitals built, midwives trained, or vaccination kits supplied). This work seeks to highlight the importance of processes and relationships and to encourage greater reflection about *how* health work is carried out in fragile settings, and how the values that underpin this work may affect communities and the broader conflict environment.

This article has analysed one of the most pervasive management tools in development aid – the logical framework matrix – and argues the need for alternative or additional instruments which can reflect on the less tangible, less technical, but no less important concerns of health and peace work. We have introduced a new Health and Peacebuilding Filter not as the definitive answer to these issues, but to demonstrate the need for tools which can attend to the underlying principles of this new field; raising concerns about culture and conflict sensitivity, and promoting social justice, social cohesion, and good project governance. We believe that the Peacebuilding Filter offers opportunities for deeper consideration, in planning and design, implementation, monitoring and evaluation, and reporting, of processes and relationships which are so crucial in fragile settings. Providing a focus for such issues, which are recognised as important but are sidelined in quantitatively driven evaluations, is necessary if ethics and values are to be central to development work.

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Notes

1. For further details about the research project and activities, including background papers and policy briefings, see www.sphcm.med.unsw.edu.au/SPHCMWeb.nsf/page/AUSCAN (retrieved 10 May 2007).
2. Debate continues about whether peace-through-health can or should represent a new discipline or field of its own, or whether it ought to be considered and promoted within the mainstream of public health. See Zwi *et al.* 2001.
3. See www.humanities.mcmaster.ca/peace-health/ for information on *The Lancet*–McMasters Health through Peace Conferences in 2001 and 2005 (retrieved 10 May 2007).
4. At this point we leave aside questions about whether health should be used to influence peace and conflict, and when, how, and who ought to make this decision.
5. It is important to note that the health workers of course, are not uniformly ‘good’. The Serb physician and psychiatrist Radovan Karadzic is one of the key actors accused of war crimes involving the massacre of 8000 Muslim men and boys in Srebrenica.
6. WHO (1995) has declared that ‘Health is valued by everyone. It provides a basis for bringing people together. . . (and that) the potential for using health as a mechanism for dialogue, and even peace has been demonstrated in situations of conflict.’ This must be qualified by the obvious fact that we don’t all care about each other’s health. See Rushton (2005) for further critique.
7. While the log-frame matrix is ideally used as one component of a larger process (logical framework approach, or LFA), which includes stakeholder analysis and problem trees, the matrix is often used on its own, as this is the particular product demanded by donors.
8. The assumptions describe factors external to the project that could influence the achievement of each objective; those that can be controlled or addressed are included within the outputs and activities.
9. For critiques of the LFA in theory and in practice, readers are referred to Gasper (2001), Cracknell (2000), and Bakewell and Garbutt (2005).
10. The intent of the Companion Manual in particular is to provide some guidance to assist programme managers to think through different ways of working and to point to additional resources in each of the principal areas; it aims to ensure that users do not feel abandoned.

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