BETWEEN TRAUMA AND TRANSFORMATION

A Needs Based Approach

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Traumas inflicted by war and armed conflicts, natural disasters and other large-scale catastrophes have a profound effect. Be they physical or psychological, traumas invariably affect both individuals' well-being and their social and political context (family, relatives, community, state). In a move towards peace-building and a post-conflict situation, understanding and treating traumas and their consequences, both at individual and community level, are crucial.

In recent decades, policymakers and scientists have shown an increasing interest in the processes of peace-building, particularly in conflict areas. Diplomatic solutions are no longer the sole point of focus, giving way to an increased interest in the way conflict-related traumas can be treated and transformations to a post-conflict situation can be brought about bottom-up, i.e. starting from individuals and their direct environment.

Trauma as a corollary of war, conflict, organised violence or catastrophes can be defined as the profound and lasting impact on all 'biopsychosocial' dimensions of health, both at micro level (the individual and his/her environment) and macro level (the community). Transformation refers to the evident multidisciplinary contribution to the reconstruction of societies which went through periods of intense conflict. In practice this implies the immediate use of our economic, legal, administrative and social capacity, among other things, for the profound reorientation of these societies.

In an attempt to enhance societal recognition of scientific research, the seminar "Between Trauma and Transformation: A Needs Based Approach" will give special attention to the way in which scientific expertise can contribute to trauma therapy and peace-building during and in the aftermath of war, armed conflict or catastrophe. During the seminar, three aspects of these will be addressed: government and policies of communities or states, psychosocial and educational interventions, medical care and health care. For each of these aspects, a speaker from a (post-)conflict area will explain the needs of his community or country, during and after the conflict, in terms of trauma treatment with a view to its transformation into a peaceful society. A Flemish expert will next go on to illustrate in what way scientific research may provide answers to these needs. This will result in an indispensable interplay between theory and actual practice.

The seminar will also provide an impetus to the identification and assembling of existing Flemish scientific expertise in the field of trauma and transformation. The visible assembly of this expertise in a network will allow the Government of Flanders to harness this expertise with due flexibility, purpose and speed in the event of demands from abroad or at its own initiative, as a form of emergency aid based on scientific research. ■

De impact van trauma's die worden veroorzaakt door oorlog en gewapende conflicten, natuurrampen en andere grootschalige catastrofen is zeer groot. Fysieke en psychische trauma's beïnvloeden zowel het welzijn van individuen als de sociale en politieke context (gezin, familie, gemeenschap, staat) waarin die individuen samenleven. Het begrijpen en behandelen van trauma's en de gevolgen ervan, zowel op individueel als op gemeenschapsniveau, is essentieel voor de transformatie van een conflict in een post-conflictsituatie, en voor de vredesopbouw die daarmee samenhangt.

De laatste decennia is er een stijgende interesse van beleidsmakers en wetenschappers voor de processen van vredesopbouw, in het bijzonder in conflictgebieden. Daarbij wordt niet langer enkel gefocust op diplomatieke oplossingen, maar in toenemende mate wordt aandacht besteed aan de manier waarop van onderuit, d.i. vertrekkend van individuen en hun directe omgeving, conflictgerelateerde trauma's kunnen worden behandeld en de transformatie naar een post-conflictsituatie kan worden bewerkstelligd.

Trauma als gevolg van oorlog, conflict, georganiseerd geweld of catastrofen kan in deze context worden gedefinieerd als de diepgaande en blijvende impact op alle "biopsychosociale" dimensies van gezondheid, zowel op microniveau (het individu en zijn/haar omgeving) als op macroniveau (de gemeenschap). Transformatie verwijst naar de multidisciplinaire bijdrage tot de wederopbouw van samenlevingen die door periodes van intens conflict zijn gegaan. Concreet gaat het om de directe inzet van onder meer economische, juridische, administratieve en maatschappelijke capaciteit voor de grondige heroriëntering van deze samenlevingen.

Vanuit de invalshoek van maatschappelijke valorisatie van wetenschappelijk onderzoek onderzoeken we in het seminarie "Tussen trauma en transformatie: noden (h)erkennen" de manier waarop wetenschappelijke expertise kan bijdragen aan traumabehandeling en vredesopbouw tijdens en na een situatie van oorlog, conflict of catastrofe. Het seminarie gaat in op drie aspecten daarvan: het bestuur en beleid van gemeenschappen of staten, psychosociale en educatieve interventies, medische zorg en gezondheidszorg. Voor elk van die aspecten zal een spreker uit een (post-)conflictgebied toelichten waaraan in zijn gemeenschap of land, tijdens en na het conflict behoefte was op het gebied van traumabehandeling met het oog op de transformatie naar een vreedzame samenleving. Vervolgens zal een Vlaamse expert illustreren op welke manier zijn wetenschappelijk onderzoek daarop een antwoord kan bieden. Hierdoor wordt de noodzakelijke wisselwerking tussen theorie en praktijk belicht.

Het seminarie beoogt de aanzet te geven tot het in kaart brengen van de bestaande Vlaamse wetenschappelijke expertise op het vlak van trauma en transformatie. De zichtbare bundeling van deze expertise in een netwerk moet de Vlaamse Regering op termijn in staat stellen om ze flexibel, gericht en snel in te zetten in geval van een buitenlandse vraag of op eigen initiatief, als een vorm van op wetenschappelijk onderzoek gesteunde noodhulp. ■

CONTENTS

Trauma en de behoefte aan iets anders

Tomas Baum | directeur van het Vlaams Vredesinstituut | 5

Governance in Transition

Perspective by Prof. Majid Al-Haj | Professor of Sociology, Head of the Center for Multiculturalism, University of Haifa, Israel | 11

Reaction from the scientific field by Prof. Sami Zemni |Center of Conflict and Development Studies, Ghent University | 18

Psychological and Educational Approaches to Trauma and Transformation

Perspective by Dr. David Bolton | Initiative for Conflict-Related Trauma, representing the Northern Ireland Centre for Trauma and Transformation Trust) | 21

Reaction from the scientific field by Prof. Patrick Luyten |Faculty of Psychology and Educational Sciences, KU Leuven; Leuven Center for Irish Studies (LCIS), Leuven; Research Department of Clinical, Educational and Health Psychology, University College London | 28

Medical Support and Health Care Organization: A Bedside to Bench Approach ... (and Back)

Perspective by Dr. Bonnix Kayabu |Evidence Aid Project, The Cochrane Collaboration, Dublin; International Doctorate School in Global Health (INDIGO), Trinity College Dublin | 32

Reaction from the scientific field by Prof. Patrick Van de Voorde | Clinical Head Paediatric Intensive Care and Emergency Medicine, Ghent University Hospital | 40

Naar een trauma & transformatie netwerk

Prof. Marc Vervenne (Ere-Rector KU Leuven; voorzitter van de Vlaamse Unesco- Commissie) en prof. Rosette S'Jegers (secretaris-generaal van de VLIR) | 47

Trauma en de behoefte aan iets anders

Tomas Baum | directeur van het Vlaams Vredesinstituut

"Jij verdient het om te sterven."

"De erkenning van mijn lijden is een opschortende voorwaarde voor elke vorm van gesprek."

"We moeten eerst van elkaar scheiden om dan beter samen te werken: die scheidingsmuur is nodig. Het is trouwens geen muur: het is een hek."

Dit zijn uitspraken die je hoort als je een groep, verscheurd door trauma, probeert samen te brengen. Ze illustreren elk op hun manier de gemoedsgesteldheid van een getraumatiseerde mens. Het zijn kreten, soms uitgespuwd, soms ingehouden gesist, die diepe indruk op mij maakten toen ik enkele jaren geleden voor de eerste keer het contact tussen groepen Israëli's en Palestijnen faciliteerde. Het was een groep van twintigers en dertigers: zij die in hun regio de belofte voor de toekomst moesten waarmaken. Die vooruitzichten waren echter gesmoord in verschillende soorten trauma's: eigen verwondingen, gestorven of gevangen dierbaren, diepe angst en de schande van onderdrukking. Het feit dat deze jonge mensen samenkwamen, op neutraal terrein in Amsterdam, was een betekenisvolle stap.

Hun interactie diende te worden ondersteund door een betrokken derde – een facilitator – en het is in die hoedanigheid dat ik hierbij werd betrokken. Het komt erop aan de groep ertoe te brengen het trauma in de ogen te kijken, het bij zichzelf en bij elkaar niet alleen te herkennen, maar ook te erkennen. Dergelijke confrontaties maken duidelijk hoe ver de impact van trauma reikt: schijnbaar eindeloos in tijd en onpeilbaar in diepte. Daarom zwijgen getraumatiseerde mensen ook vaak, hoewel hun ogen spreken en lichaamstaal bijzonder hardnekkig is. Het onuitspreekbare eist onverbiddelijk zijn plaats op. In deze context vormt een gesprek over het conflict de aanzet om gebeurtenissen stapsgewijs een plaats te geven en het eigenaarschap van het trauma – dat zeer sterk is ontwikkeld– te transformeren naar iets anders. Niet om wat is gebeurd zomaar te vergeten, maar om het te verwerken.

De belangrijkste rol van een facilitator, een derde betrokken partij, is de noden van de individuen én de groepen te herkennen en in het middelpunt te plaatsen, om een vorm van transformatie in gang te zetten. Op die

aspecten wil ik in deze paper dieper ingaan. Eerst zal ik stilstaan bij de terreur van trauma, vervolgens zal ik het belang van herstel en transformatie bepleiten. Ten slotte sta ik ook stil bij de rol van betrokken 'buitenstaanders'.

De terreur van trauma werd treffend verwoord door Judith Herman:

"Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning."[1]

Bijna honderd jaar geleden sloeg trauma door conflict genadeloos toe in grote delen van de wereld. De Eerste Wereldoorlog zette op ongeziene schaal mensen tegenover elkaar in een gewelddadige clash. Het was in het militaire apparaat dat toen voor het eerst bijzondere aandacht werd besteed aan het psychologische effect van dat bloedvergieten. De fysieke ravage was gekend, en ironisch genoeg kreeg de geneeskunde zevenmijlslaarzen aangemeten in de vele militaire hospitalen. In de loop van de oorlog bleken echter ook minder zichtbare kwetsuren het functioneren van de soldaten te hinderen. 'Shell shock' beschreef een waaier aan symptomen van depressie, hysterie, verlamdheid tot regelrechte waanzin. Eerst dacht men aan een fysieke impact van bominslagen op het brein. Tot ook mensen die nooit van dichtbij het front hadden gezien, eraan bleken te lijden. In een eerste fase werden fysieke behandelingen ingezet: massage, diëten, elektroshocks. Later ook psychologische behandelingen als *gesprekstherapie of hypnose. De aanpak was echter niet gericht op de* noden van de slachtoffers: behandeling diende ertoe de soldaten zo snel mogelijk opnieuw gevechtsklaar te maken. De rol van de psychologische aanpak was daarvoor overigens bijzonder instrumenteel: zwakkelingen moesten zich vermannen. Ze konden hun zogenaamde lafheid enkel wegwassen door de wapens opnieuw op te nemen. In de militaire context is de aandacht en behandeling van trauma verder ontwikkeld in de bloedige twintigste eeuw, onder meer met de erkenning van post-traumatic stress disorder na de Vietnamoorlog.

De voorbije decennia is stilaan ook aandacht gegroeid voor het trauma van vluchtelingen, van burgers onder bezetting, van familie van slachtoffers, van verscheurde gemeenschappen en van een gekwetste samenleving.

Ook vandaag grijpt trauma niet minder wild om zich heen. Enkele jaren geleden klikte ik door een presentatie die we doorgestuurd kregen over het werk van Synergie des Femmes contre les Violences Sexuelles in Kivu, Oost-Congo. Na enkele inleidende slides met organisatorische informatie, kwam de confrontatie met de rauwe en expliciete impact van conflict in een van zijn meest extreme vormen: verkrachting als oorlogswapen. Het ging om

(1) Judith Herman (1997), Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror, Basic Books, p. 33.

foto's van compleet verwoeste moederschoten, afschuwelijk verminkte kinderen, ... Huiveringwekkende beelden. Men is dan geneigd om weg te kijken: de rechtstreekse confrontatie met trauma is schokkend en het onbehagen wordt heel erg groot .... Het werk van Synergie des Femmes contre les Violences Sexuelles toont evenwel aan hoe fundamenteel medische zorg kan zijn alvorens over transformatie te kunnen spreken. Verder in de presentatie werden de beelden wat zachter: foto’s van gesprekssessies met slachtoffers, beelden uit opleidingslokalen, naaiateliers vol kleurrijke stoffen. Na de medische zorg is die psychosociale aanpak een tweede cruciale lijn in het herstel na trauma en het inzetten van een veranderingsproces. Deze indringende confrontatie met de situatie in Oost-Congo toont hoe belangrijk lokaal traumawerk is – in soms extreme omstandigheden.

Enige tijd later ontving dokter Denis Mukwege de Vredesprijs van de Stad Ieper en had ik de eer de laudatio uit te spreken. Zijn werk vertoont grote gelijkenissen met dat van Synergie des Femmes contre les Violences Sexuelles, maar tijdens onze ontmoeting hamerde dokter Mukwege nog op een bijkomend aspect. Hij hamert daar overigens op in elk internationaal forum dat hij krijgt. Er is ook een institutionele en structurele oplossing nodig om verandering en transitie mogelijk te maken. De politieke verantwoordelijkheid van de Congolese leiders, maar ook van de buurlanden en de internationale gemeenschap is in zijn ogen immens. Om niet met de kraan open te dweilen, om bijkomend trauma te voorkomen en om een werkelijke transformatie op te zetten is ook een transitie op politiek en institutioneel vlak noodzakelijk. Politieke instellingen staan in principe ten dienste van de samenleving, maar ze kunnen de samenleving jammer genoeg ook ontwrichten.

Trauma vraagt herstel, een vorm van transformatie. We moeten het in de ogen kijken. Recent grootschalig trauma door gewelddadig conflict kennen wij zelf gelukkig niet, maar het ontslaat ons niet van de verantwoordelijkheid om ons af te vragen hoe we als betrokken derden iets kunnen doen. Iets kunnen betekenen voor anderen. Behoedzaamheid en het herkennen en erkennen van noden moeten daarbij onze sherpa’s zijn. Een zogenoemde ‘needs based approach’ wijst ons er op dat vragen en noden van individuen en groepen in een door gewelddadig conflict en trauma getroffen samenleving divers zijn en vaak complex verweven. Hoe kan zo’n benadering gebaseerd op noden vorm krijgen?

“Het is een verschrikkelijk conflict, maar het is wel het onze.” Ook dat is een memorabele uitspraak uit een transformatieproces van een groep jonge Israëli’s en Palestijnen. Hoe verschrikkelijk en verscheurend ook, onderschat nooit het ownership van een conflict. En van slachtofferschap en trauma als dat conflict gewelddadig is. Dat betekent dat ook een oplossing of een transitie hetzelfde ownership moet verwerven. Om dat te bereiken moeten we diep graven, moeten we onder de waterlijn naar de

voet van de ijsberg duiken. Daar vinden we 'basic human needs'. De invulling daarvan verschilt weleens, maar ze zijn in vier kernbegrippen samen te vatten: welzijn, veiligheid, identiteit en vrijheid. Die begrippen klinken vanzelfsprekend, maar de hiërarchie in die noden is in elke context anders. Soms kunnen ze op gespannen voet staan met elkaar. Zich laten gijzelen door één aspect gaat ten koste van de andere die ook essentieel zijn. Het erkennen en onderhandelen van elkaars welzijn, veiligheid, identiteit en vrijheid, is de voortdurende opdracht van een samenleving. Het is ook de sleutel tot transformatie in gewelddadige conflict- en post-conflictsituaties.

Wil traumabehandeling en transformatie echt een verschil maken, dan dient ze zich rekenschap te geven van drie dimensies: het medische, het psychosociale en het institutionele. Ik haalde die dimensies hiervoor al aan in verband met de aanpak van seksueel geweld in Oost-Congo. Ik wil hierna bekijken hoe die drieledige aanpak kan worden gebaseerd op vragen en noden van betrokkenen.

Welzijn herstellen is als een conditio sine qua non om een proces van trauma naar transformatie in te zetten. Het gaat om fysieke en psychische kwetsuren van individuen verzorgen. Het werk van Synergie des Femmes contre les Violences Sexuelles en van Dr. Mukwege vertrekt vanuit welzijn en stelt herstel centraal: eerst medische hulp en dan herstel van verbinding met de sociale omgeving.

Zoals gezegd, kan de hiërarchie in het adresseren van noden verschillen naargelang de context. In Noord-Ierland bijvoorbeeld is bijzonder veel ingezet op institutionele transitie en op veiligheid. De inwoners van Derry/Londonderry, katholieken én protestanten, hebben de vrijheid om over de nieuwe 'Peace Bridge' te wandelen over de rivier die vroeger hun stad letterlijk verdeelde als een ijzeren gordijn. De Noord-Ierse samenleving ademt echter nog steeds trauma en om een diepgaande transformatie in te zetten, is nog veel fundamenteel werk nodig. Dat situeert zich eerder op het vlak van identiteit. Laatst zag ik een indrukwekkend uittreksel uit een theaterproject 'Theatre of wittness' waarin traumatische ervaringen publiek werden uitgesproken: ze werden op de bühne onder ogen gezien. De weigering om dader- of slachtofferschap je identiteit te laten bepalen, de worsteling met de rol van je vader of moeder, het afvragen of je afkomst en geloof zozeer je leven determineert. Dergelijk werk is vooral indrukwekkend omdat het niet alleen voor de hoofdrolspelers – acteurs die uit het leven werden gegrepen – maar ook voor het aanwezige publiek een transformatieproces in gang zet.

Wat de nood aan veiligheid en vrijheid betreft, en het trauma van het ontbreken ervan, is vaak institutionele transitie aan de orde. In een conflict staat de nood aan veiligheid van de ene partij vaak diametraal tegenover de nood aan vrijheid van de andere. Elkaars trauma erkennen, begint bij

elkaars noden erkennen. In het Israëlisch-Palestijns conflict wordt dit erg duidelijk. Op psychosociaal vlak werden veel pogingen gedaan om te verzoenen en transformatieprocessen op gang te brengen. Ik denk bijvoorbeeld aan de ontmoetingen die ik zelf heb begeleid en andere 'people to people'-projecten. Die pogingen zijn vaak succesvol op korte termijn. Op langere termijn worden die resultaten echter teruggeslagen door het uitblijven van een transitie op institutioneel vlak die een evenwicht vindt in de nood aan veiligheid en vrijheid van de verschillende betrokkenen.

De impact en ernst van trauma is duidelijk en ik heb gewezen op onze verantwoordelijkheid om daar als betrokken derden niet van weg te kijken. Ik hoop dat wat vooraf ging twee zaken onder de aandacht brengt. Ten eerste zijn de noden van de betrokkenen, die ze delen met ander mensen, de enige maatstaf voor interventies. Het gaat om welzijn, veiligheid, identiteit en vrijheid. Ten tweede is een integrale aanpak nodig. Een aanpak die die basisnoden herkent en erkent. Die de juiste balans vindt, en de aanpak van trauma en transformatie op drie niveaus ernstig neemt: het medische, het psychosociale en het institutionele. Alleen zo bereiken we een duurzame weerbaarheid bij hen die door trauma getroffen zijn.

Duurzaam. Het begrip brengt me bij een laatste belangrijk aspect van omgaan met trauma en transformatie waarop ik de aandacht wil vestigen. En dat is tijd. Er is tijd, volgehouden aandacht en inspanning nodig om een transformatieproces kans op slagen te geven. Zuid-Afrika wordt vaak genoemd als een 'best practice' voor maatschappelijke en politieke transformatie. Na het Apartheidsregime waren waarheids- en verzoeningscommissies daarbij cruciaal. We kennen allemaal de erkenning die onder meer bisschop Desmond Tutu daarvoor heeft gekregen. Toch was er ook kritiek bij Zuid-Afrikaanse slachtoffergroepen, vooral op het afgebakende tijdspad, inclusief deadline, waarop de waarheid moest worden gesproken en het traumatische verleden verwerkt. Zij menen dat het te vroeg en te veel gevraagd is om van slachtoffers closure te verwachten binnen een vooraf bepaalde termijn.

Tijd speelt ook nog een andere belangrijke rol die daarbij aansluit. Een trauma is opgelopen door een gebeurtenis in het verleden. Dat verleden is dan ook onlosmakelijk verbonden met trauma en transformatie. En een verleden vaag je nooit weg. Het verstrijken van de tijd begraaft op zich het verleden niet. Wat is gebeurd, moet aandacht en respect krijgen. John Paul Lederach vertelt in zijn boek The Moral Imagination (2005) hoe een Afrikaanse collega hem vertelt: "In Africa people say that the past lies before me and the future lies behind me. They point ahead of them when they talk about the past. They point back when they refer to the future." Daarna, vertelt Lederach, stond ze op en begon achteruit te stappen: "The past we see before us, but we walk backwards into the future."

Hoe kunnen interventies in het veld van trauma en transformatie concreet rekening houden met de aandachtspunten die ik hier aanreikte? Hoe werk je op basis van specifieke noden en vragen? Wat behelst een integrale aanpak op verschillende niveaus? En, hoe verhouden we ons tot de dimensie 'tijd'? Die vragen leg ik u voor. Een receptenboek voor transformatie zullen we niet kunnen opstellen. Wat we wel kunnen verkennen is wat een expertisenetwerk kan bijdragen. Een dergelijk netwerk kan wetenschappers, mensen uit het veld en beleidsmakers met elkaar in verbinding brengen om elkaar te informeren en te versterken over de grenzen heen. In samenspraak met lokale partners, die het meest vertrouwd zijn met de plaatselijke behoeften, verzuchtingen en spanningen, kan een dergelijk netwerk bijdragen aan de ontwikkeling van duurzame weerbaarheid voor getraumatiseerde individuen en gemeenschappen. Zo verkleint de kans op nieuw geweld en nieuwe trauma's in de toekomst. Onverwerkt trauma bestendigt immers vicieuze cirkels van geweld.

Tot slot, als epiloog, wil ik de nadruk leggen op het belang van de ondersteuning door de Vlaamse overheid. Overheden zijn vaak geïnteresseerd in wetenschap, zeker als ze bruikbaar is voor beleid. Dat Vlaanderen er hier voor kiest om wetenschap in te zetten voor transformatie en vredesopbouw is een goede zaak. Ik ga ervan uit dat dit geen eenmalige opstoot is, maar een duurzaam en gedragen initiatief wordt. Het Vlaams Vredesinstituut is bijzonder opgezet met dit initiatief en zal hier graag verder toe bijdragen. Het zou bijzonder mooi zijn als wij samen kunnen werken aan een voldragen omgang met traumatische ervaringen. Dat is immers een belangrijke voorwaarde voor duurzame vredesopbouw.

Governance in Transition

Perspective by Prof. Majid Al-Haj | Professor of Sociology, Head of the Center for Multiculturalism, University of Haifa, Israel

Trauma and trauma transformation are far from my fields of expertise. But it is very close to my reality as both a Palestinian and Israeli, which is in itself a 'Traumatic Identity'. The organizers of this seminar have perfectly formulated the structure and the goals of this seminar, and have also put in detail what every speaker is expected to deliver. According to the seminar's guidelines: "a speaker from a (post-) conflict area will explain the needs of his community or country, during and after the conflict, in terms of trauma treatment, with a view to its transformation into a peaceful society". Such mission is too complicated in my case. Because I am both a Palestinian in terms of nationality and Israeli in terms of citizenship. This gives me an advantage to have been able to speak about the two communities simultaneously. But it is very complex, in the sense that I have to suffer twice, as I am feeling the pain of the two peoples. Indeed, the two peoples have been going through a severe continuing conflict for 120 years now, making this conflict among the longest and most painful in the modern history.

In what follows, I will try to take this challenge and speak about both the Palestinians and Israelis. First I'll talk about the Palestinians, with a focus on the West Bank and Gaza, and then about Israelis. But let me just say a few words about the main expressions in this seminar: trauma and peacebuilding.

1. Dealing with Trauma is dealing with the past in order to build the future – with the recognition that the past is crucial in the life of people. In case of conflict, it is of major importance to heal the trauma at the individual and community levels, in order to be able to build a sustainable peace and development. According to new theories, trauma is seen not only as the consequence but also one of the causes of war, since it might perpetuate the cycle of violence. Therefore it is of crucial importance to deal with this issue, not only for peacebuilding, but in order to ensure political and social stability.

2. Peacemaking and peacebuilding: According to the literature, in order to deal with any conflict we have to differentiate between some basic expressions that are usually confused, namely peacebuilding, peacemaking and peacekeeping. Peacemaking is the first step in conflict resolution, since it involves stopping an ongoing conflict. On the other hand, peacebuilding happens before a conflict starts or once

> it ends, while peacekeeping prevents the resumption of fighting following a peaceful settlement of a conflict. In the case of the Israel-Palestinian conflict, we are still in the phase of conflict resolution and hopefully peacemaking. We have not reached as yet the phase of peacebuilding. However, taking into consideration that the relationships of the Palestinians and Israel have been fluctuating between peace and conflict since the Oslo agreements in 1993, I will speak about peacebuilding as suggested by the organizers, with the hope that this wishful thinking would become a fact.

I will shift to the situation among the parties involved in the conflict, and will start with the situation and needs of the Palestinians.

Today there are nearly 12 million Palestinians in the World. Among them:

- 4.5 million live in the West Bank and Gaza;
- 1.5 million in Israel;
- 5 million in Arab countries, mostly in refugee camps;
- 1 million in foreign countries, basically in Western countries.

When we speak about trauma, the needs of the Palestinians and type of treatment, we should first decide what is our target group among these Palestinians. Despite the fact that these groups belong to the same people, they have different experiences, needs, and sometimes even a different orientation. I will deal here with two main subgroups, who together form more than one third of the Palestinian people, but in any peaceful resolution, they are expected to be the driving force, namely the Palestinians in the West Bank and Gaza.

The Palestinians in the West Bank and Gaza

The Palestinians in the West Bank and Gaza are considered under Israeli occupation, or semi-occupation since 1967, and they live in the pre-1967 territories, which are the basis for any peaceful solution between Israel and the Palestinians, based on the principle of the 'two-state-solution’.

As indicated earlier, there are about 4.5 million people in the West Bank and Gaza, who form over one third of the Palestinians. The Palestinians in Gaza were under the Israeli occupation until 2005, when former Prime Minister Ariel Sharon implemented the disengagement plan – which placed the Palestinians in Gaza in a 'nowhere situation', since they are seemingly free, but they are tightly dependent on Israel, economically and in their day-to-day life.

The Palestinians in the West Bank are under the rule of the Palestinian Authority. But a large part of the West Bank is still marked as ‘C area’, which is under a total control of Israeli army. The rest of the West Bank is under the administration of the Palestinian Authority – partially or fully – but it is tightly dependent on Israel. The needs of the Palestinians in the

West Bank and Gaza can be divided into three main parts: the collective needs, the community needs and the individual needs.

A. The collective needs: healing a multidimensional trauma

The most significant landmark in the Palestinians' collective memory is, undoubtedly, the disaster which happened in the wake of the 1948 Arab-Israel war, where the Arab side was defeated. This war has resulted in the establishment of the State of Israel and the total destruction of the Palestinian people, where the vast majority became refugees in the neighboring Arab countries, in the West Bank, Gaza, and within Israel itself. The UNRWA (United Nations Relief and Works Agency for Palestinian Refugees) estimated that about 700.000 Palestinians (more than 50% of the Palestinian people at that time) were displaced during or right after the war.

Most of the refugees moved as separate families, as groups from the same village, and sometimes entire villages. Refugees left behind families, kin, homes and property; the Palestinian economy was destroyed, and the vast majority of the Palestinian elite, political and social leadership became refugees in Arab countries. The Palestinian cities and the mixed Jewish-Arab cities, located in the area that constituted the territories of the State of Israel were almost evacuated of the Palestinian inhabitants.

The events of the departure and uprooting are indelible among Palestinians. Those who witnessed and experienced these events still remember them in detail, and they pass them on to the new generations. The Palestinians call the 1948 and its catastrophic consequences the Nakab (meaning Catastrope). Therefore, the Palestinians all over the world commemorate the Nakba Day (Yawm an-Nakba, Day of Catastrophe) every year on 15th of May, which is the same day in the Gregorian calendar when Israel celebrates its independence day.

B. Community needs

There are a number of problems at the community level among the Palestinians in the West Bank and Gaza, including employment, education, infrastructure, transportation, and day-to-day life. Part of these problems is connected with Israel and is directly affected by Israeli occupation and policy, and the other part is connected with the Palestinians themselves. Hereafter, I will relate to these problems briefly.

Economy. The economy of the Palestinian territories experienced a setback since the 2000 Intifada. Israel's punitive closure of the Gaza Strip, was tightened after Hamas's takeover of Gaza in June 2007, continued to have severe humanitarian and economic consequences for the civilian population. Egypt shared responsibility for the closure of Gaza by

restricting the movement of goods and people at the Rafah crossing on Gaza's southern border.

This has resulted in a high unemployment rate among the Palestinians. According to Palestinian official statistics, in 2013 the unemployment rate in Gaza Strip was 31% compared to 20,3% in the West Bank, and the unemployment rate for males in Palestine was 21,2% compared to 35,3% for females (Palestinian Central Bureau of Statistics,16/05/2013).

Economic distress is reflected, among other things, in a high percentage of poverty among the Palestinians. It was estimated that in 2012, 40% of the Palestinians in the West Bank and 50% in Gaza were living below the poverty line.

C. Individual needs: psychological healing of the trauma

At the individual level there is an overriding need to deal with the trauma caused by the life under occupation and under the continuing threat of settlers. More in particular, there is a need to address the complex emotional problem, which is a mix of pain, anger and fear. Life under occupation is not easy for any group over the globe, of course not for the Palestinians, who have been living under Israeli occupation for 46 years now. The trauma under occupation is evident at all levels and among all age groups, but is mainly painful among children. It is caused by violation of human rights, by continuing closure, humiliation by the army on the military barriers, and hostile acts from the part of the Jewish settlers in the West Bank. According the 2012 World Report of Human Watch:

"Israel maintained onerous restrictions on the movement of Palestinians in the West Bank, especially in 'Area C', which is under exclusive Israeli control. It maintained more than 520 checkpoints and other closure obstacles as of July 2011. Also Israel continued construction of the wall or separation barrier around East Jerusalem. Some 85 percent of the barrier's route falls within the West Bank, placing many settlements on the Israeli side of the barrier. The barrier led to the confiscation of private land and separated many Palestinian farmers and pastoralists from their lands. The Israeli government generally almost took no action against Israeli settlers who destroyed or damaged mosques, homes, olive trees, cars, and other Palestinian property, or physically assaulted Palestinians."

Steps which are connected to the Palestinians

Democratization and institutional building. After the Oslo agreement and the formation of the Palestinian Authority, Palestinians have taken responsibility over important aspects of their life, despite the tight dependence on Israel. One of the central steps initiated by the Palestinians has been the building of their institutions, including Parliament,

Presidential office and other basic characters of a future independent state. While elections conducted for the Parliament, the President and municipal elections were free and democratic by all means, there have been strong traditional clan and tribal elements involved in these elections. Also, after the Parliamentary elections in 2006, in which Hamas got the majority of votes, a severe conflict started between Hamas and Fatah and resulted in the formation of two Palestinian governments, one chaired by Hamas in Gaza and the second chaired by Fatah in the West Bank. This has had deep negative effects on the Palestinians themselves and on the chances to achieve a peaceful resolution for the conflict.

A basic condition for nation-building and political stability among the Palestinians should be the internalization of a democratic political culture at all government levels and the institutionalization of political and social diversity, regardless of the ideological affiliation. In this sense, there is a need for modernization and democratization of public institutes, including the strengthening of civil society organizations.

Reconstruction of education. Except for East Jerusalem, the education system in the West Bank and Gaza is under the direct control of the Palestinian Authority. This fact should be utilized in order to build a deep reform in the education system, including transformation of education from a traditional- closed system, into a modern-open system. For this to happen there is an immediate need to reconstruct educational administration, rebuild educational contents, and introduce a serious reform to teacher training. Also, there is a need to make a transition in teaching methods, from the existing traditional methods into alternative methods, based on creativity, critical thinking and scientific orientation. These steps would enable formal education to play a central role in social and economic development, and turn education into a productive human capital, which is most important for the Palestinians' future.

In addition, there is a need to fostering a multicultural and peace education in Palestinian schools. Multiculturalism and education for diversity are of crucial importance for the rebuilding of the Palestinian society, including the empowerment of women and disadvantaged groups. Unlike the existing misconception, these issue cannot wait until the achievement of national liberation, independence and nation-building. On the contrary, the institutionalization of such norms and values would be a stimulus for both peacemaking and nation-state building.

Israeli Jews

There has been a misconception regarding Israel in the Arab world according to which Arabs have dealt with the “imagined Israel” rather than with the “real Israel”. As a matter fact, such misconception has prevented

the Arab world from building any successful strategy vis-à-vis Israel. Naturally, I do hope that a strategy for peace would prevail.

In my opinion, it is of major importance to understand that Israel, like other societies on the globe, has its strength and its weaknesses. However, it is also important to know that Israel is usually described by Israeli sociologists as an “overburdened society”. In this sense, it is forced to deal simultaneously with two major conflicts: the external Israel-Arab-Palestinian conflict, and the internal conflicts stemming from the deep divisions within Israeli society, based on nationality, ethnicity and religion.

Trauma at the collective and individual levels. Naturally, as a result of wars, violence, and the very fact that civilians are becoming more and more 'involuntary participants' in wars, many Israelis have experienced trauma at various levels. But I am not going to deal with trauma at the individual level, since it is dealt with by the Israeli formal authorities and the well-organized system of civil society in Israel. I would like to briefly address the collective trauma, which should be taken into consideration in any peace negotiation or any confidence building measure. The major trauma which has deeply affected the identity and orientation of the Jewish people is, undoubtedly, the Holocaust and the fears connected with it and with the close Jewish history. Based on my experience at both the personal and the academic levels (as an expert of Israel studies), I can tell that the major problem for peace between Israel and the Arab world is psychological-resulted from fear and mistrust.

A central part of this psychological complex is originated in the fact that the Jewish population in Israel is demographically and in terms of power, a majority – but they are with a mentality of minority.

This paradoxical situation inflames the continuing fear among the Jewish population in Israel of becoming once again a minority. These fears and the ‘minority mentality’ which accompanies them, are the factors behind the continuing concern of Jewish Israelis of the so-called ‘demographic danger’. This is reflected in the argument that due to their high natural increase, the Palestinians in the West Bank, Gaza and Israel will outnumber the Jewish population in the near future, and Israel will eventually become a bi-national state and loose its Jewish character.

The concept of the ‘demographic danger’ has served both the Israeli Right and the Israeli Left as an excuse to their arguments. The Israeli Right built on this concept the ‘transfer ideology’, which has been translated politically by forming a number of parties that called to expel the Palestinians to Arab countries in order to secure the Jewish character of Israel. On the other hand, the concept of the ‘demographic danger’ has served Yitzhak Rabin, Shimon Peres and the Israeli Left to justify the need for a peaceful solution with the Palestinians, based on the principle of “ two states for two people”.

This has been eventually the driving force of the Oslo agreement between Israel and the Palestinians. In this sense, the 'minority mentality' and the development of the concept of the 'demographic danger' have accelerated the desire of the Israeli Right to get rid of the Palestinians (through transfer) and of the Israeli Left to get rid of the Palestinian territories, through territorial compromise.

Therefore, in any plan for peacemaking, peacebuilding or peacekeeping between Israel and the Palestinians there is a need to understand these fears and address them through 'confidence building measures'. In this regard, there is a crucial importance for the involvement of the academia, the civil society and the intellectuals in order to create a 'peace culture' and establish trust and cultural bridges between both sides at the level of the ordinary people. There is a saying, "as war should not be left only for Generals also peace should not be left only for Politicians".

The importance of education. As we are dealing with Israel, like the Palestinians, there is a need for a radical change in the Israeli education system. Several studies have shown that like other countries involved in continuing conflicts, typically defined as 'intractable conflicts', also in Israel education has been used as an important tool for ideological and national recruitment (Bar-Tal, 1996). Under this conflict, the school curriculum has been used to create social beliefs and values that together form a national ethos used by nation-states to consolidate the nation and raise its morale, while forming a catalyst for the continuation of the conflict. Therefore, the education system in Israel has failed to establish peace education or education for multiculturalism and diversity.

Having said that, there is an immediate need to introducing new contents to the Israeli education system with the aim of paving the way for genuine peace education and diversity.

Role of the world community

The world community, in particular Europe, can play a major role in promoting peace in the Middle East, in particular between Israel and the Palestinians. There is a consensus in the world, and among Arab countries, that the Palestinian issue forms the core of the Arab-Israel conflict and that the resolution of this issue would establish the basis for a comprehensive peace between Israel and its Arab neighbours, and with the Muslim world. Needless to say the peace in the Middle East is not only important for the people of this region but for the whole world community. Such peace would contribute to the world's political and economic stability and prosperity. Despite the chaos that we see today in the Middle East, and probably because of what we see, there is a need for immediate initiatives in order to foster the hope for Israel-Palestinian peace and in order to prevent a total deterioration in this sensitive part of the world.

Reaction from the scientific field by Prof. Sami Zemni | Center of Conflict and Development Studies, Ghent University

Although I am not an expert on trauma, my work at the Center of Conflict and Development studies, has seen a growing attention to the issue of trauma in conflict situations. My short reflection is thus based on a political and social science reading of the concept and the ways it is deployed.

Professor Al-Haj's paper addresses head-on the themes of this seminar and this within the context of one of the most long standing and difficult conflicts or our age, i.e. the Palestinian-Israeli conflict. He provides us with a brief but insightful overview of some of the major difficulties and hardships that Palestinians are facing in the West Bank and Gaza but also within the state of Israel itself. He does not forget, however, to include a short reflection on trauma on the Israeli side thus trying to encompass a more inclusive and general approach to the problematique.

Some issues I want to raise to engage in a discussion are based on Professor Al-Haj's remarks but are not necessarily tied to the Palestinian or Israeli context. They are rather more general comments on the interactions between conflict, trauma, transformation and peace-building.

A first reflection I want to make is the question of timing. From a logical point of view, the ideal chronology would be that after a conflict is ended through peacemaking, that traumas inflicted by war, conflict or violence would be treated both at the individual as society level so that a comprehensive transformation and reconstruction of society becomes feasible and durable. Alas, the political reality is often much more complicated so that this ideal scenario is rarely possible. Looking at the Palestinian-Israeli conflict, it is obvious that the massive scale of trauma that citizens of both communities endure, need to be attended to. Today, numerous local civil society organizations, health centers and international NGOs already deal with conflict related traumas. The question remains however, if these laudable efforts can, in any way, influence the agenda of peacebuilding. As we all know, today the Oslo agreements of the 1990s seem a far-away dream and even the long assumed two-state solution seems less viable day after day due to the changing facts on the ground. Unfortunately, I am afraid that while no comprehensive political settlement is made between Palestinians and Israelis, local and international actors will be confronted with many more years of trauma as corollary of the conflict.

With this remark I come to a second point. The attention given to trauma as a consequence of conflicts or even natural disasters, is a rather new phenomenon within the humanitarian sector. "Trauma is not only a clinical description of a psychological status but also the political expression of a

state of the world".[1] What I mean by that (largely inspired by Fassin's work) is that it's not just mental health specialists that have discovered new nosologies to describe the consequences of conflicts, but rather that these specialists propose, through the usage of new medical jargon within conflicts, new ways of interpreting contemporary conflicts. Trauma is part of a more general trend in humanitarianism of re-interpreting conflicts in terms of subjectivities. To talk about the suffering of victims in order to address issues of domination and violence is indeed a new way of doing morals and politics with a new vocabulary.[2]

When the International Committee of the Red Cross was founded in the 1870s, this was done on the principle of neutrality. This meant that the Red Cross agrees to remain silent on what goes on, on the battlefield or within conflicts. It is only a century later, in the 1970s, that a second age of humanitarianism emerged. The creation of Médecins sans Frontières and later Médecins du Monde, were the direct consequence of humanitarian workers not wanting to remain silent. The former was created during the war in Biafra, while the latter spoke out against the communist regime in Vietnam as the main responsible for the boat-people crisis. Indeed, since then, humanitarian intervention is revolving more and more around testifying, about speaking out, about giving a voice to the victims.

Lemia Moghnieh points out well that conflicts like the Lebanese civil war and the Israeli invasion of Lebanon in 1982 helped to standardize post-traumatic stress disorder (PTSD), a psychiatric disorder that was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association in 1980. Later on, trauma was "universalized as the frame of suffering in violent-related situations (...) (and) placed trauma at the center of humanitarian emergency aid in sites of conflict and war".[3]

Didier Fassin, a professor in Princeton, who has done extensive research on the politics of victimhood, compassion and trauma and on the Palestinian-Israeli case summarizes this turn very well.

Whereas, not so long ago, that is until the 1960s, volunteers went off to fight alongside peoples in their liberation struggles, it is now humanitarian workers who go to take care of victims of conflict. Where previously the language evoked in defending oppressed peoples was that of revolution, current usage favors the vocabulary of psychology to sensitize the world to their misfortune. Yesterday we denounced imperialist domination; today we reveal its psychic traces. Not so long ago we glorified the resistance of populations; we henceforth scrutinize the resilience of individuals. Of course, traditional criticism of oppression has not disappeared, and in fact it is often reformulated in terms of human rights. Similarly, geostrategic analysis has not merely been replaced by psychotherapeutic intervention.

(1) David Fassin, (2008), The Humanitarian Politics of Testimony: Subjectification through Trauma in the Israeli–Palestinian Conflict, Cultural Anthropology, 23: 3, p. 533.
(2) Fassin, op.cit., p. 532.
(3) Lemia Moghnieh (2011), Humanitarian and Humane Subjects in Lebanon: The Problem of Social Change, Jadaliyya;

But it is clear that a new language is being used to promote causes more effectively.[4]

A third point I want to raise flows from the prior comments. The testifying of humanitarian organizations of the suffering of victims fall back on emotions in order to mobilize more efficiently for a specific cause. The suffering of the victims, indeed, justifies the appeal to the affects and emotions of the addressees. Humanitarian organizations have been criticized on different occasions of 'choosing their victims'. Why speak about the Palestinians all the time and not mention the genocide in Darfour, for example, was a common argument during the 2009 Cast Lead operation of the Israeli Army in Gaza. But even lesser emotional conflicts have resulted in criticism: from Indonesia over Myanmar to Afghanistan. And today, we ask ourselves the question why we were so quick to assist the Libyan people against Kaddafi but not the Syrian people against Bachar al-Assad. This has led many organizations to re-evaluate their positions and ways of testifying on the horrors of conflict, violence and war. Today, there is clear tendency to a bigger focus on the individual body with its physical and psychological problems and a tendency to make an equivalence between victims. As there are always at least two (if not more) sides to a conflict, there is a tendency to treat all victims alike. Thus the Iraqi mother that cries over the loss of her son's death by American bullets is assumed to share her pain with the American mother whose son was killed by a road bomb. The same is obviously at work within the Palestinian-Israeli conflict. Some of the campaigns for peacebuilding are actually built around the idea of drawing together the traumatic experiences of victims. The problem with this approach is that it completely obliterates the politics of a conflict. The issue of asymmetry of power, of who is occupier and who is occupied, who is living as a refugee and who is a citizen, who is living in a camp or in a gated compound, is rendered invisible in an attempt to construct 'a supposedly shared "lived experience"' of pain attested by clinical evidence or merely commonsense. It remains an open question, off course, whether this de-politicization of conflicts could be any more efficient in addressing conflict resolution.

My critical assessment of the use of trauma as a tool to read and assess conflicts should not be misread. The suffering of victims all over the world is too big, too overwhelmingly present so that we cannot but act and try to help as much as we can. The point I wanted to make, and that was central to the three issues I raised, is the question of politics. Without genuine political settlements of conflicts, it will be hard – or even impossible – to rebuild societies that have gone through traumatic experiences. A humanitarian approach that overemphasizes the suffering of victims and thereby negates the politics of a conflict, necessarily will fall short of enabling a successful transformation of a conflict-ridden society to a more resilient and peace-minded society.

(4) Fassin, op.cit., p. 532.

Psychological and Educational Approaches to Trauma and Transformation

Perspective by Dr. David Bolton | Initiative for Conflict-Related Trauma, representing the Northern Ireland Centre for Trauma and Transformation Trust)

In April 1998 in Northern Ireland after thirty years of violent conflict and following a lengthy political process the British and Irish Governments signed the Belfast Agreement (otherwise known as the Good Friday Agreement). The Agreement was and remains an elegant agreed formula for bringing violence to an end. It put in place arrangements that would address many of the drivers for conflict, reduce the sense of threat, open opportunities for realizing political aspirations by consent, and bring comfort to political and community anxieties.

Elegant though it was, the Agreement was but the start of a longer journey. Four months after the Agreement the most deadliest incident associated with our conflict happened when a bomb exploded in Omagh killing 31 people, injuring hundreds and exposing thousands to terrible scenes and experiences. It was a time when we had reason to be hopeful, yet much to be sorrowful about.

On a morning misty and mild and fair.
The mist-drops hung on the fragrant trees,
And in the blossoms hung the bees.
We rode in sadness above Lough Lean,
For our best were dead on Gavra's green.[1]

Since then others have died, been injured or been threatened by violence. And at times there has been instability on the streets. Local communities remain divided in places, sometime separated by peace walls. Some parts of our community feel that they have not benefited from the progress; others continue to resist the changes.

In spite of these setbacks and challenges, the situation is transformed. Most feel a sense of progress. Overall the levels of violence have reduced enormously; daily life for most people in Northern Ireland is what we might

(1) W.B. Yeats, The Wanderings of Oisin (1889).

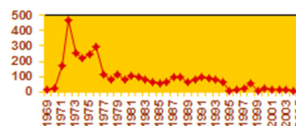
regard as normal for a Western democratic society, and we have a local Legislative Assembly at Stormont, near Belfast. International support from in particular the European Union, has been instrumental in facilitating the development of relationships and the creation of initiatives to support the peace process. There are imperfections and things have not unfolded as was anticipated. But something that was considered impossible twenty years ago has come into being, has taken shape, is progressing, sometimes haltingly, creating a new reality. Just two weeks ago, about 15 kilometres from where I live, the G8 met – something that would have been unimaginable even ten years ago.

The Agreement is of its time and place. This has become clearer as others living in places affected by war and conflict have examined the Northern Ireland peace process to see if there are lessons that could be learned for their own context. Perhaps the big lesson is that conflict can be ended – through political will and imagination – but the details are for local people, politicians and institutions to address. The impossible was imagined, and in time made real. The political lion does and can, in time, lie down with the political lamb. Political and cultural trauma began to be transformed.

The Northern Ireland conflict has been profoundly traumatic. In a series of studies undertaken with our colleagues at the Bamford Centre for Health and Wellbeing at the University of Ulster (Northern Ireland) we found that four out of ten adults have had one or more traumatic experiences linked to the conflict – a striking figure revealing how extensively the violence was experienced.[2]

The Northern Ireland Conflict

- Population 1.7 million
- 34,000 shootings
- 14,000 bombings
- 3,737 deaths
- 44-55,000 injured
- 50,000 currently with serious mental health needs linked to violence



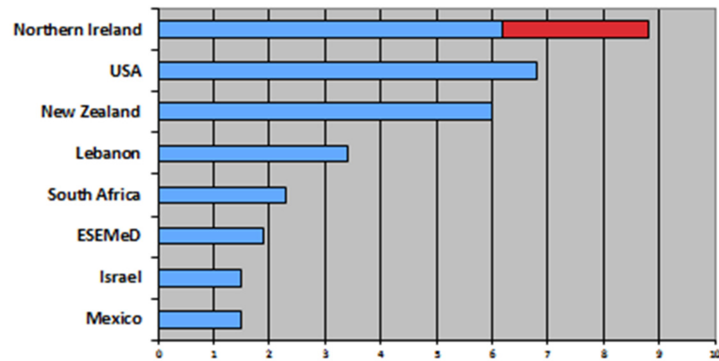
4th Jul 2013 www.icrt.org.uk 9

Since 1968, when the most recent period of political conflict in Ireland started – up until the turn of the century – it is estimated that, out of a population of 1.7 million, there were 3.737 deaths, approximately 48.000 persons were injured, and there were 34.000 shootings and 14.000 bombings. An unknown number of people were exposed to events and circumstances that were a major risk to their psychological wellbeing and

(2) B.P. Bunting, F.R. Ferry, S.D. Murphy, S. O'Neill and D. Bolton (2013), Trauma Associated With Civil Conflict and Posttraumatic Stress Disorder: Evidence From the Northern Ireland Study of Health and Stress, The Journal of Traumatic Stress, February, 26, pp.134-141.

mental health. The breadth of the impact of conflict was revealed in a 2010 study commissioned by the Commission for Victims & Survivors NI, which found that 30% of respondents had been directly affected through bereavement, physical injury, or experience of trauma.[3] The Commission in its recently published Comprehensive Needs Assessment[4] identified health, and specifically mental health, as the first priority across seven areas[5] of concern for victims and survivors.

In our study undertaken in 2006-08 it was found that over 5% (one in twenty) of the adult population met the criteria for PTSD – post-traumatic stress disorder (the 12-month figure). [6]



This is a high level of PTSD compared to other Western societies, including Belgium. It is estimated that over 25% of PTSD caseness is linked to experiences of the Northern Ireland conflict. And, as we found in our health economic study, it is costing Northern Ireland many millions of pounds sterling each year to manage the unresolved trauma in the lives of its citizens who suffer PTSD.

(3) Report for the Northern Ireland Commission for Victims and Survivors by The Northern Ireland Statistics & Research Agency (2010). Northern Ireland Omnibus Survey, Belfast, Ireland: The Northern Ireland Statistics & Research Agency.
(4) The Commission for Victims and Survivors (Northern Ireland) (2012), Comprehensive Needs Assessment, Belfast, Ireland: The Commission for Victims and Survivors. Available at: www.cvsni.org.
(5) The areas identified by the Commission for Victims and Survivors are: (1) Health and Wellbeing; (2) Social Support; (3) Individual Financial Needs; (4) Truth, Justice and Acknowledgement; (5) Welfare Support; (6) Trans-generational Issues and Young People, and (7) Personal and Professional Development.
(6) B.P. Bunting et al., op.cit.

REPORT
ECONOMIC IMPACT OF POST TRAUMATIC STRESS IN NORTHERN IRELAND

Table 7:
The total direct and indirect costs among individuals with 12-month PTSD in 2008

Cost category	Cost sub-category	Costs among all individuals with 12-month PTSD (£)
Direct costs	Service visits	27,317,184
	Medication costs	5,658,406
Indirect costs	Productivity losses	113,564,751
	Presenteeism	26,215,721
		172,756,062

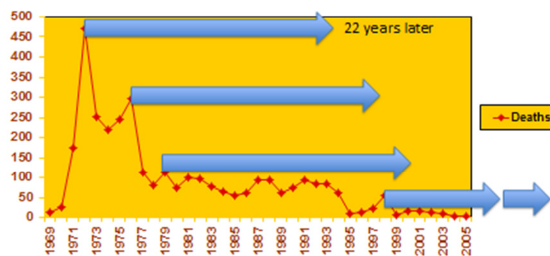
Figure 4:
Proportional breakdown of the total direct and indirect cost (£172.8 million) among individuals with PTSD in 2008

- Presenteeism (15%)
- Service Visits (16%)
- Medication (3%)
- Productivity Losses (66%)

4th Jul 2013 www.icrt.org.uk 12

We also discovered that it takes on average 22 years for people with PTSD to seek help – meaning we will need to ensure there are services in place for some time to come, so that people with chronic trauma related problems can access help.

Northern Ireland conflict related deaths

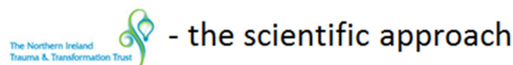


4th Jul 2013 www.icrt.org.uk 13

It is extraordinary therefore that it was only in April 2012 that a new regional and comprehensive service for victims and survivors was established to address the mental health impact of the conflict. This is in spite of the fact that in the Belfast Agreement the impact of the violence on people and on future generations was recognised as something to be addressed. Why has it taken so long? Partly, perhaps, the problem has been that – in moving things forward and addressing crises in the peace and political processes – the political system has been focused on other more immediate and politically more pressing issues. Also, there are considerable discomforts amongst our political class on the issue of victimhood in the

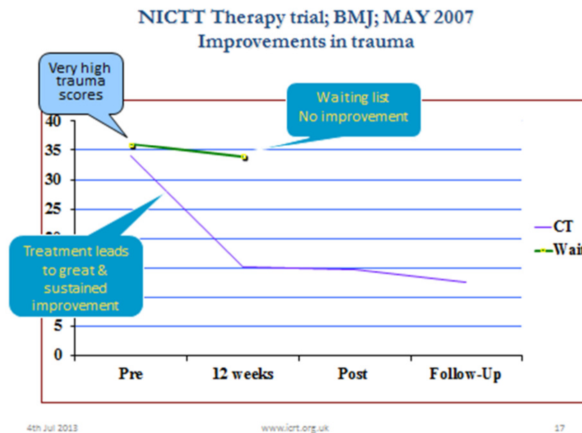
context of what was a civil conflict. You created my victims – and I created yours. In relation to this issue and to others, it is possible to see that in spite of the progress that has been made we are still deeply divided on certain issues – and to use a metaphor from Belgium: we are still in the trenches on some issues. Victims and victimhood can be a very uncomfortable legacy of violent conflict, and victims of the war can also become victims of the peace. For some, as W.B. Yeats said: … *peace comes dropping slow*.[7] Also, it was due to the fact that the mental health legacy of the conflict never really got to the political top table for reasons which we will have to leave for another occasion.

It was in an effort to contribute to finding a pathway through this issue that the NICTT Trust (Northern Ireland Centre for Trauma and Transformation Trust) set out to describe the mental health impact – in terms of the impact on the individuals and on the whole population – in economic and social impact terms,[8] and in terms of approaching mental health as an essential part of the peacebuilding project. Our argument is that attending to the mental health impact of conflict and war is necessary on humanitarian, economic, political and sustainability grounds, and is an essential task in the process of conflict transformation.[9]



We also developed and delivered a specialist evidence-based trauma therapy programme which, apart from the obvious benefit to trauma sufferers, demonstrated that the provision of effective services could address at least part of the adverse human legacy of the violence.[10]

(7) W.B. Yeats, The Lake Isle of Innisfree (1888).
(8) F. Ferry, D. Bolton, B. Bunting, S. O'Neill, S. Murphy and B. Devine (2011), The Health Economic Impact of Post-Traumatic Stress Disorder in Northern Ireland, NICTT & UU, with the support of the Lupina Foundation, Canada.
(9) www.icrt.org.uk
(10) M. Duffy, K. Gillespie and D.M. Clark (2007), Post-traumatic stress disorder in the context of terrorismand other civil conflict in Northern Ireland: randomised controlled trial, British Medical Journal BMJ, 334: 1147. Also, doi:10.1136/bmj.39021.846852.BE (published 11 May 2007).



In the face of political difficulties and discomfort we sought to bring a scientific approach to understanding needs and addressing post conflict problems that would facilitate progress. We also attempted to support practitioners working in other areas of conflict, including Nepal, Sri Lanka, Bosnia and New York, from which we also learned much that helped us back in Northern Ireland. The approach was, and remains, an exercise of science in the service of peacebuilding and conflict transformation, and an example of the valorisation,[11] whereby the outcomes of research, development and innovation were used to help develop policy and service solutions to address the needs of populations.

In treating people suffering post-traumatic stress disorder, a number of areas need to be considered and addressed.[12] First there is the issue of the memory of traumatic events – often fragmented, disjointed, incomplete, highly nuanced. Then there is the changed and unhelpful conclusions we have of the world, of others and of ourselves – as a consequence of our experiences. It is here in particular that we find how trauma impacts on relationships. Further, there are the unhelpful ways we find of coping with our distress and fear – which although they seem to help at the time, are often counterproductive and again often have adverse implications for relationships. And then there is the challenge of trying to understand why we have uncontrolled catastrophic re-experiences of the traumatic event – in the form of flashbacks and nightmares. Success in overcoming trauma depends on how well people work through these areas – which usually takes a lot of courage. All the same, with such help people do make recoveries – remarkable recoveries – and often go on to experience post-traumatic growth where their outlook on life, their priorities and their sense of direction are transformed for the good. Understanding PTSD in this way has come a long way from the pitiful grainy black and white film of shell-shock sufferers from the war that swept over this land a hundred years ago. The developing understanding of trauma through scientific enquiry is an example of science in the service of humanity.

(11) "Valorization" is the process of disseminating and exploiting project outcomes to meet user needs, with the ultimate aim of integrating and using them in training systems and practices at local, regional, national and European level.
(12) A. Ehlers and D.M. Clark (2000). A cognitive model of posttraumatic stress disorder, Behaviour Research and Therapy, 38, pp. 319-345.

Wars and conflicts make brutes of us – and often wars and conflicts end when we realise that we do not want to be brutes anymore – or that we do not want our children to be so. The road from the trauma of war and conflict to the transformation of peacemaking and of progressive and mature political agreement is, as we have glimpsed, not an easy one. Whether we are a sufferer seeking to overcome trauma or a politician seeking to bring conflict to an end, it takes courage – but again as we have seen, successfully engaging with the causes and drivers of conflict and the components of trauma brings people to better places, where the future is not founded on distress and fear – but on hope for better things, on the prospect of a progressive outlook on life, on new priorities and a transformed sense of direction for the good. Where beauty and ordinariness are once again commonplace.

From out of the trauma of the Great War, felt deeply in this place and in others such as Ireland and Britain, came a novel, which removes any enchantment with war. It urges us to find other ways of addressing our conflicts. Looking forward to the time when peace would come, Erich Maria Remarque draws to our attention the necessity of addressing the turmoil and human consequences of war. He says, through the voice of one of his characters:

And this I know: all these things that now, while we are still in the war, sink down in us like a stone, after the war shall waken again, and then shall begin the disentanglement of life and death.[13]

(13) Erich Maria Remarque, All Quiet on the Western Front (1929).

Reaction from the scientific field by Prof. Patrick Luyten | Faculty of Psychology and Educational Sciences, KU Leuven; Leuven Center for Irish Studies (LCIS), Leuven; Research Department of Clinical, Educational and Health Psychology, University College London

In my response to David Bolton's eloquent and moving presentation, I want to highlight three issues concerning trauma and its impact, informed by research in the psychological sciences, as this is the perspective I am coming from. Further, linked to each of these issues, I will discuss three specific policy implications.

First, trauma is everywhere and influences us all in negative ways, and it will continue to do so unless we intervene.

The prevalence of trauma at both the societal and the personal level is high. David Bolton reminded us of the trauma suffered by so many in Ireland, and the continuing struggle of the people of Ireland with their traumatic past. The case of Ireland also illustrates how closely intertwined trauma at the societal and personal level are, and how trauma is transmitted across the generations if we don't intervene.

Unfortunately, we have many examples that provide further support for these assumptions. Several wars continue to determine who we are, how we think and feel: the Great War, World War II, the Korean War, the Vietnam War, the war in ex-Yugoslavia, Afghanistan, Iraq, several countries in Africa. The list is very long, extremely long.

Moreover, the threat of terror has forever changed our world, with attacks and bombings in New York, Madrid, London, to name just a few, as have the many instances of large scale trauma, including natural disasters, plane, bus and train crashes (who doesn't remember hurricane Sandy, or the bus crash in Sierre that killed many Belgian children and their teachers?), and instances of sexual and physical abuse in the Catholic Church.

And then there is personal trauma, children growing up in social deprivation and chronic stress situations, children and adults that suffer from physical, sexual and emotional abuse and neglect, that undergo experiences of bullying at school and at the workplace, the traumatic loss of loved ones. Trauma is everywhere, and these examples are more telling than statistics showing that between 20 and 50% of adults experience severe (early) adversities during their life time.

Just to illustrate the influence of trauma, consider the population attributable fractions associated with trauma: these are the percentage of psychiatric disorders such as depression, post-traumatic stress disorder, and other anxiety disorders that are due to adverse events such as abuse and neglect: these range from 30 to 60% and more. Stated otherwise, if we

could prevent these adversities, the decrease in psychiatric disorders would range from 30 to 60%, which is massive. Similar figures have been found for the association between trauma and problematic behaviors, such as drug abuse and partner violence. There is no intervention in the world with such potentially powerful effects.

What is perhaps the worst about trauma is, as David Bolton so persuasively demonstrated, that it tends to affect the next generation and thus it tends to perpetuate itself. Did you know that the number of deaths in the United States due to suicide is greater than the number of military that die in combat? Think about the partners of these individuals, their children, their families and friends, the communities they live in. They have been changed forever. Trauma thus runs across the generations; the oppressed often become the oppressor, the next generation often has to suffer for the sins of the previous generation.

And here is an important insight from the psychological sciences that sheds light not only on the massively negative consequences of trauma, but also on what we might do to prevent these negative consequences: trauma typically leads us to de-humanize the other; which prevents forgiveness and reconciliation. The case of Ireland is a prime example: as long as both parties succeeded in de-humanizing the other, the conflict remained and both parties remained convinced of their truth, their cause.

However, the case of Ireland also shows that this tendency to de-humanize the other in the wake of trauma can be overcome, precisely by humanizing the other again. Realizing that others – the enemy, the perpetrator – are also human beings with emotions, feelings, wishes, values, interests, just like us, is the first step in stopping the vicious cycle associated with trauma, and paves the way for forgiveness, reconciliation and peace. Mentalizing – our ability to understand both the self and others in terms of feelings, wishes, motives, and values – fosters forgiveness, reconciliation and peace.

This often is a slow and painstaking process – we can all think of examples from our own personal life, I'm sure. But psychological science also demonstrates that trauma may lead to so-called post-traumatic growth, that is: positive psychological experiences as a result of the struggle with trauma and adversity. Individuals showing post-traumatic growth typically report a greater appreciation of life, changes in priorities, and a greater sense of relatedness and strength. Human beings thus have a remarkable capacity to overcome trauma and even thrive after trauma. This capacity, also known as resilience reflects our ability to cope with trauma, to overcome trauma and even to thrive and become a better human being after trauma. Society, and politicians in particular, have an important responsibility in this respect, as they can either foster resilience, forgiveness and reconciliation, or they can hamper these processes, by the

language that they use, by the stories they tell, or fail to tell, by the narratives they create.

Hence, to summarize, psychological science shows that trauma is everywhere – a grim reality that we often deny because of the intense feelings associated with trauma. But psychological science also demonstrates that individuals and societies can show resilience in the face of trauma, and even learn from trauma. Finally, psychological science also demonstrates that wishing won't make the negative consequences of trauma go away. We have to intervene and we have developed effective intervention methods in this respect, both aimed at individuals as well as groups. We simply need to use them.

The policy implications are clear: we need initiatives to remember trauma, but we also need to provide citizens with the tools to work through trauma and to keep it from determining their lives. We need to humanize the other thus fostering resilience. Personally, I believe the school level is the ideal context to foster resilience, forgiveness and reconciliation and to stop the potential intergenerational transmission of trauma.

Second, trauma is associated not only with high personal costs, but also with extremely high socio-economic costs.

As David Bolton pointed out, there is an increasing awareness of the vast economic costs associated with trauma. From a psychological perspective, economic costs should be broadly interpreted: trauma impairs individuals' capacities to work, to do something meaningful in life – a major source of self-esteem and self-worth that is often lost by those faced with trauma.

The policy implications, again, are very clear. The economic point of view should be routinely taken into consideration in trauma prevention and intervention. This might also increase its visibility on the political agenda. We constantly underestimate the cost of trauma, particularly as trauma influences the next generation, also from an economic perspective.

Third, and finally, despite considerable progress in the psychological sciences, the factors involved in trauma and transformation are insufficiently understood and evidence based treatments and interventions are poorly implemented in this country, in Europe and the world.

Despite the high prevalence of trauma, and its major impact on individuals and societies, we still know too little about the processes involved in trauma and resilience, in reconciliation and in peacebuilding. As David Bolton illustrated with regard to Ireland, we continue to underestimate the consequences of trauma for individuals and societies and the mental health perspective is often the last one to emerge on the political agenda, which is at odds with scientific knowledge.

Similarly, although we have developed effective intervention strategies, the implementation of these evidence based intervention strategies has far lagged behind.

From a policy perspective, it is therefore important to emphasize the urgent need for funding of at least three types of research:

1. Research regarding the factors – both biological and psychosocial – that are involved in explaining the response to trauma. It is clear that both biological and psychosocial factors are implicated in explaining vulnerability as well as resilience in the face of trauma – we need to better understand these factors to develop more effective intervention strategies promoting resilience.
2. Research concerning the psychosocial and economic cost of trauma.
3. Research concerning the development and implementation of more effective intervention strategies.

Currently, we are involved with several partner universities in Ireland, Israel, the United Kingdom, Lebanon, ex-Yugoslavia, and the United States in setting up these studies, and other research groups around the world are involved in similar studies, but more is needed.

I would like to end, in this respect, by focusing your attention on two quotes illustrating that we can do something about the negative consequences of trauma, and that we have an important responsibility to do so:

"While the content of an individual's life history or a society cannot change, it can be reconstructed and told in a different way" (Mary Main)
"Those who cannot learn from history are doomed to repeat it."

Medical Support and Health Care Organization: A Bedside to Bench Approach … (and Back)

Perspective by Dr. Bonnix Kayabu | Evidence Aid Project, The Cochrane Collaboration, Dublin; International Doctorate School in Global Health (INDIGO), Trinity College Dublin

I was born in Bukavu in 1973. For those who are familiar with the Congolese political history during the Mobutu era, this period coincided with the announcement of expropriation of foreign assets and the expulsion of foreign traders. The Congolese people are still paying a high price today for the consequences of bad political choices. The word 'Zairianisation' was used to describe Mobutu's policy. During that time, although there were signs of the decline of Congolese politics and the country's socio-economic development, there wasn't war and we lived in a state of what we call in French 'paix armee' (armed peace) – which means a state of no war and no peace. It was something in between.

I remember children born after 1962, a period characterized by civil war and rebellion in Zaire, called 'Mwavita'. 'Vita' in Swahili means war and the name 'Mwavita' was given to children born during the civil war. When I grew up this name was rare – reflecting some relative peace that existed before 1990. Today the name Mwavita has disappeared because it no longer has any meaning. Everybody living in the eastern Congo should logically be called Mwavita because everybody has been traumatised by the on-going war.

For reasons that many of you may know, the DR Congo is now in its 15th year of war and subsequent complex humanitarian emergencies. The damage caused by these recurrent wars since 1996 has been very destructive for both people who live in the areas affected by disasters and for people who provide humanitarian aid.

On a personal note, I would like to tell you an anecdote about my mother to illustrate just one experience of millions that have taken place during the conflict. My mother was visited one day by rebels in our family compound. Six well-armed men asked her where my young brother was. My young brother was 14. They said to my mother: "He would make a good soldier". They threatened her and forced her to say where my brother was. She physically blocked them from entering the house where my brother was hiding. After about fifteen minutes of threats and discussion the militias left the family compound and promised to come back. My family started

living in a permanent fear. There was no place to go as the entire region was under rebel control. One day my mother was at a local market and she felt faint and lost consciousness. There was no ambulance to take her to the hospital, no paramedical staff to resuscitate her. Miraculously she survived and she was escorted home by family friends who knew her. No medical or mental health tests were carried out in the aftermath of this incident. Two weeks later she was brought to the hospital where no mental health service existed

My brother was not taken by the militias. He is now a lawyer working for a local human right organisation helping victims of war-related atrocities to access justice. He lives in the same town where the six well-armed men who wanted to recruit him into the rebellion by force also lived.

In this paper I will try to cover the needs, barriers and current reality of medical support and health care organisation in disaster situations and all these will be in the context of trauma and transformation of societies. I will also highlight the need for evidence-based practice in medical practice. Finally I will highlight the importance of a multidisciplinary approach and opportunity for collaboration.

Let's first understand how health care is organized. Let's go back where it all started. The Declaration of Alma-Ata was adopted at the international conference on Primary Health Care in 1978. The aim of this declaration was for all participants to the conference to protect health for all people including health for people living in war zones and victims of other disasters. Primary Health Care is a concept which means "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination". According to the Alma-Ata Declaration, Primary Heath Care is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work.

Margaret Chan, the Director-General of the World Health Organisation (WHO) reaffirmed that the primary health care approach is the most efficient and cost-effective way to organize a health system. She also pointed out that international evidence overwhelmingly demonstrates that health systems oriented toward primary health care produce better outcomes, at lower costs, and with higher user satisfaction.

What is a health system? "A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as

more direct health-improving activities ....” Although there is a wide variety of health systems around the world most health system have six components including health information system, leadership and governance, health financing, essential medical products and technologies, human resources for health, and service delivery. It has been argued that interrelationships of these components should be expressed in a way that health systems include not only the institutional or supply side of the health system, but also the population; health systems must also be defined in terms of their functions, including the direct provision of services, whether they are medical or public health services. It also includes the health workforce, without which very little can be done.

In humanitarian emergency settings the situation is much more complex. There is serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope with using its own resources. For example, in Africa the post-conflict infrastructure and system is usually 10% of what it was before the war and in many cases the health care systems of countries are completely destroyed.

In many low-income and middle-income countries international aid is required during disasters as it enables the saving of lives and the rebuilding of destroyed systems. Foreign medical aid teams are one of several key initiatives which, through their activities, enable communities to rebuild basic infrastructure such as mobile hospitals, health centres, management of war-wounds, injuries after earthquakes and the provision of clean water and good sanitation. Now increasingly, in many settings mental health interventions are provided to victims of disasters.

Medical support during disasters can enable a reduction in death toll, for example through a reduction of non-violent causes of death such us malaria, diarrhoea, pneumonia and malnutrition. It can also help to reduce deaths resulted from war-wounds or injuries after an earthquake.

But the context of chronic disaster diseases such as malaria, pneumonia and conditions such as malnutrition are still claiming many lives. An example of a complex emergency is the on-going war in the DR Congo that has led to the death of about 5 million people since 1998. The majority of these have died from non-violent causes such as malaria, diarrhoea, pneumonia and malnutrition. These diseases are preventable and effective treatments exist for them.

Limb amputation is widely practiced by surgeons, mostly in the aftermath of earthquakes. Limb amputation can prevent injured victims of earthquakes from dying from haemorrhages and/or infection, but people who undergo limb amputation may suffer psychological problems years

after amputation. For example, a study done two year after the earthquake in Haiti found that the majority of amputees would have preferred conserving their limbs. This study shows that an amputation is not a routine procedure when foreign medical aids are practicing in disasters settings.

Reduction of maternal mortality is challenging to achieve in resource-poor countries, primarily because of the lack of qualified medical staff – but for other contributing reasons as well. In recent years alternatives to using qualified medical practitioners has shown promising results. In countries where human resources for health is a big problem, people who have non-formal medical education such as Traditional Birth Attendance (TBA) could help pregnant women to access health services. Middle Level Health Providers (MLHP) can provide services that physicians normally do, such as caesarean sections. It is therefore important for academics to do more research focusing on Traditional Birth Attendance and Middle Level Health Providers, the results of which can be used to inform policy about the best way to integrate them into existing health systems.

A comprehensive approach to treat physical trauma is needed.

Medical provision alone cannot solve all problems. Research shows that stress can cause medical conditions and sometime irreversible. For example, stress during war time is associated with abortions, it can decrease the immunity system that can lead to many other health conditions. Also psychological problems can interfere with offered health care, causing difficulties in provider-patient communication, reducing patient adherence to medical regimes and long-lasting hospitalization periods. It is important that medical providers and other medical stakeholders consider the need to provide training about mental health problems and its potential effect on access and use of medical service.

Both individuals and communities are affected by war and other disasters. In the aftermath of war some of the community level changes include mistrust, suspicion, silence, brutalization, deterioration in morals and values, poor leadership, dependency, passiveness and despair. It is important to recognize the manifestations of collective trauma, so that effective interventions that are effective at the community level can be used in these complex situations.

During my work in Rwanda, post-genocide, I experienced first-hand how mistrust and suspicion can prevent people from accessing health services. I realized during consultations that some patients could have different levels of disclosure depending on the nurse in the consultation room. Although services existed most of the time, some patients couldn't access them or accessed the wrong services due to a failure to disclose their symptoms

fully. One of the reasons for this was the nurses assisting me during consultations being from a different ethnic group to the patient's.

Due to immense silence suffering, avoidance and stigma associated with mental illness, traumatized people typically avoid seeking help.

Another thing to emphasize about access and barriers to access medical service is that the availability of medical service does not always lead to use of services. Also it does not guarantee that all subgroups of communities can access them. Undeniably medical supports can help to decrease human suffering. But we should also emphasise that building hospitals or health centres does not guarantee that people will use them. For example, a location of the health centre or the well to collect clean water is important. If it is located in an insecure zone women and children are unlikely to access it because of fear of being assaulted by militias. The elderly and people with physical disabilities could have difficulties in access too. Access to medical service is also important for amputees who may need wheel chairs, accessible toilets, public transport and health buildings.

There have been cases in the DR Congo during the polio vaccine campaign of 2001 where children were not vaccinated because their mothers did not have nice clothes to wear when going to the local health centres.

Hidden costs of medical services affect the quality of and access to medical services. It is important to mention that in the aftermath of disasters when international medical teams arrive in disaster-affected areas, access to services is usually free for victims of disasters – but there are always hidden costs to accessing the totality of the service and this can sometimes prevent people from accessing services in their totality. For example, an aid agency may provide free antimalarial treatment but patients still have to pay for laboratory exams in order to diagnose malaria. Also the cost of transfer from a health centre to general referral hospital can be high. For example, transportation from a patient's home to the hospital is not covered by aid agencies' assistance, which means that the patient's family members have to pay for this.

We should also add that victims of disasters need protection from local authorities in countries where disasters happen. In some cases international community help is required. Unfortunately this is a very difficult task for both national security forces and UN peacekeepers. We know from experiences of the DR Congo that the number of UN peacekeepers does not reflect the level of protection that victims of disasters would expect.

Another barrier to meet the needs of disaster-affected areas occurs when medical teams are forbidden to access areas where victims are isolated. Sometimes the local government refuses to allow medical teams to evaluate

the medical needs of victims, or in other cases national authorities refuse to declare an epidemic because the country would look bad at an international level. In many cases local governments tend to lower the number of victims of war when local governments are responsible or co-responsible for the atrocities.

Training of medical and health providers should also be considered during disasters. Medical training for local medical staff is as important as it is for international medical staff so that patients can receive effective interventions. In many situations international medical staff are not familiar with the context in which they intervene. The pressure to save lives prevents them from having time to understand how local health systems works and involve local communities in the decision-making process. In these difficult conditions, international medical staff set up parallel health systems to avoid local bureaucracies and to operate very efficiently. The negative consequence of these parallel health systems – sometimes called vertical interventions or systems – is that they further weaken and undermine already weak health systems, and perhaps prioritise the treatment of certain types of diseases or health conditions above others. For example HIV or TB, whilst ignoring other diseases. Additionally, the fact that international aid agencies tend to pay high salaries to their staff, the best of local medical staff are usually recruited by these aid agencies and weaken even further the local health system.

Other needs would include access to clean water and sanitation, food and shelter. Some of these areas are poorly covered during humanitarian crises.

Need for evidence-based practice.

The question here is, how do we know medical and health personnel's actions are working? The core concept of evidence-based practice is to improve health through evidence-based interventions, i.e. interventions that have been proven using research results that are working and do not cause harm to patients. Evidence-based practice is very established in medicine and health care – increasingly promoted in rich countries. But in disasters evidence-based decision-making is very poor. Decisions are made on a basis of assumptions and intuition.

The first reason for this is that the evidence-based practice paradigm is very new in the humanitarian field; secondly, research activities are very few; thirdly, there is a lack of training on best practice among humanitarian aid workers; fourthly, many decisions about how to intervene or not are politically driven by donor countries which might have vested interest in promoting a particular type of decision; finally, there is a lack of accountability among humanitarian stakeholders.

It is recommended that medical interventions should be based on sound evidence for safety and for professionalism. This is not always the case. As an example of looking at whether decision-makers need this evidence, we can draw on information about amputations in Haiti. In one surgical team 45 amputations were carried out in 500 patients (11%), and in another surgical team, 1 amputation in 150 patients (0.007%). We don't know the circumstances of these amputations, or the populations in which the research was carried out, and we are not saying that these amputations were incorrect, but this simply shows a difference between two teams which might or might not be due to having available evidence to base decisions on.

Promotion of mental health interventions in disasters should be welcomed too. But as for other interventions which include human participation, mental health interventions should be based on evidence. For example, to prevent post-traumatic stress disorder (PTSD) after the Indian Ocean tsunami of 2004 many aid agencies used single-session individual debriefing. However, from the Cochrane reviews we know that "there is no evidence that single-session individual psychological debriefing is a useful treatment for the prevention of PTSD after traumatic incidents". The review recommends that compulsory debriefing of victims of trauma should cease.

Children's health is an important issue to address in disasters but little evidence exists to show that guidelines to solve children's health issues are working, and do not harm children who receive treatment. A Cochrane review of 2010 did not identify any evidence-based guidelines for perinatal and child health care in disaster settings.

We acknowledge that disasters and their consequences are caused by a mixture of many factors, often taking place in challenging political environments. Still, healthcare providers need reliable, up-to-date information on interventions that might be considered in the context of natural disasters, conflict, or major healthcare emergencies regardless of their origin and type.

What are the opportunities?

First of all there is a big opportunity for collaboration. Trauma and transformation of societies is a broad area. No discipline alone can claim to be able to address this issue. It needs a multidisciplinary approach, which should consider individual trauma or community trauma. We need treatment approaches that are methodologically sound, culturally acceptable, and which can be disseminated successfully applied by local trained people.

We need people with proven expertise to work together to identify the needs of victims of war-related consequences and victims of other disasters and the best ways to invest in policies and activities that can transform individuals and communities.

Although scientific research is not the only solution to trauma, it can help policy-makers to make informed decisions. It can also help to learn from other settings by collecting all studies done in different countries and languages in a very systematic way. This method is called systematic review. Systematic reviews are key to make informed decisions. They provide high quality evidence and allow policymaker to know which interventions work, which do not work and which have the potential to do more harm than good.

We also have to remember that many policy analyses occur behind closed doors and a political need for speed, or defence against opportunistic adversaries, often drive decisions. In addition, research evidence is just one of many factors that decision-makers consider before making decisions. But the good news is that good evidence can ameliorate or neutralise political obstacles.

Medical care and health care are for the public good. Of course health is a human right, which means that people, especially the most marginalised in society, must be able to access health services when they need them. On the other side of the coin is that someone has to pay for it. In many places in the world where the majority of people live on less than one dollar a day and where disasters claim many lives, humanitarian medical aid is needed to ensure this health right is met.

Reaction from the scientific field by Prof. Patrick Van de Voorde | Clinical Head Paediatric Intensive Care and Emergency Medicine, Ghent University Hospital

'Trauma' as a result of conflict or disaster thoroughly affects all 'biopsychosocial' dimensions of health, both for individual patients, their surroundings, and the whole community. It completely disrupts the functioning of a society, thus further aggravating the already existing health impacts. Once started it's rarely a story of weeks but leads to ongoing repetitive 'injury and loss' for years on.

These disasters urge us to help, even more so if the reality of the society in disaster makes it impossible for that society to recover by itself. However, as Dr. Kayabu also described, humanitarian aid providers often prefer 'action above evidence' in the aftermath of disaster. Although the needs are huge, we need a more knowledge-based approach to ensure that the interventions done are informed by the best available objective evidence, alongside the experience of local and international key stakeholders.

In this paper, I first want to draw your attention towards the recently published Alnap Report: the State of the Humanitarian System 2012. This report shows how the humanitarian aid system is maturing, how it's moving forward in a more informed way. It might be easy but not correct to be overly self-critical towards such a maturing system and to only report the downsides and shortcomings. While the demands are still growing, so are the expectations of what can be achieved. There are more actors, more money available, more technological innovation and advances in communication, better timeliness, ... and this all has led to more humanitarian aid to more people in often very difficult operating conditions and confronted with the ongoing challenges of urbanization, climate change, highly politicized and/or religious contexts and complex security environments.

The report identifies five areas for action to improve accountability and performance (two key determinants) in humanitarian actions. They can provide guidance for our own way ahead.

Relevance: providing contextual analysis and meaningful determination of needs and programme design. To do this there is a clear need for data collection and risk assessment, especially in the context of slow-onset cyclical disasters.

Connectedness: with an aim to strengthen national systems and the local response architecture.

Effectiveness: based upon strong leadership; active preparedness and surge capacity to facilitate a rapid response with an appropriately skilled team and adequate methods of monitoring and evaluation.

Coherence: documenting good practice and achievements in collective coordinated approaches in crisis contexts.

Coverage: long term financing is needed to sustain the broader agenda of non-relief interventions including disaster-risk reduction, preparedness, resilience, infrastructure rehabilitation and indefinite provision of basic services.

Humanitarian aid thus has its focus on ‘trauma’ but even more on the subsequent ‘transformation’, the trajectory of individuals and a society towards recovery and reconstruction.

Individual health care and health system development are crucial to this process of transformation. By and if providing a low-barrier – politically or religiously ‘neutral’ – entrance to physical, psychological and social support, it strengthens the social tissue of a society in transition and adds to the necessary sense of ‘security’. This need for health care support goes far beyond the initial acute care, although the latter remains a necessary starting point for subsequent societal restoration. A transforming society will be confronted with all sorts of ‘biopsychosocial’ health problems that are directly or indirectly the consequence of the conflict or disaster (e.g. PTSD, injuries, substance abuse) but also it might be expected that other health problems (e.g. cardiac, traffic injuries, diabetes, infections) will be more frequent or less easily treated. A recovering health system might not have the capacity or means to deal with these (e.g. accessibility of care, absence of preventive measures, legislation, medications).

Good health care and health care systems do not need to implicate enormous costs and economic growth is not a necessary prerequisite. Balabanova et al. described in The Lancet of this year how lessons can be learned from different countries in terms of the future strengthening of health systems in low-income countries. They subsequently defined specific factors for success that are identifiable across different healthcare systems.

These include:

- good governance and political commitment: with effective leadership and long-term vision; clear priorities and realistic policy goals; responsiveness to diverse population needs; careful sequencing and continuity of reform; seizing windows of opportunity and enhancing accountability;
- effective bureaucracies and institutions: with strong regulatory and managerial capacity, provision of intelligence and evidence; stability of bureaucracy; sufficient autonomy and flexibility; engagement with many stakeholders (incl. non-state actors and local communities); in synergy with donors to formulate and implement policy; and using of media as a catalyst;
- innovation: with novel health workforce strategies, new approaches to financing and financial protection; and pragmatism in service delivery;
- health system resilience.

Non-health system contributors to health care improvement further included, apart from the obvious economic and political ones, better education, better infrastructure and communication tools, and female empowerment and gender equity.

Balabanova et al. then provided among other the example of Ethiopia, during the eighties one of the poorest least developed countries across the world, at that moment emerging from a bitter civil war. Now, twenty years later, 'transformation' is a fact. The country is still very poor but shows sustained economic growth. There is a relative peace and stability, induced by a multi-ethnic coalition and a decentralised system of governance. Internal leadership of certain key persons as well as investment by foreign donors were imperative to this change.

This all has led to a marked improvement in population health (in terms of under 5 mortality, malaria deaths, immunisation rates; access to essential services in isolated areas, ...). Ethiopia implemented a district health extension programme training local women with a certain level of education; instituting new medical schools for nurses and mid-level health officers; and providing regional and national primary care infrastructure and essential drugs supplies. The financial burden of seeking health care carries a risk of affecting vulnerable households disproportionally. Ethiopia developed a system of social insurance for employees in formal sectors and community insurance for others. Health care systems are, especially when being build a new, extremely vulnerable to unexpected shocks like large scale natural disasters. Introducing steps to improve the resilience of such a system is both difficult and very important. Ethiopia has put a system in place to prepare for future events, although its capacity remains limited.

On the other hand, Smith et al. published in Anaesthesia and Intensive Care outcomes data of 370 intensive care admissions at the Ethiopian Jimma University Hospital, between August 2011 and 2012. The overall mortality rate was 50.4%. The main cause for surgical admission was trauma, with head injury carrying a mortality of 52.1%. The principal cause for medical admission was cardiac disease. In children, trauma, upper airway obstruction and communicable diseases were most common. These mortality rates reflect the challenges facing critical care delivery in the developing world. Delayed presentation to hospital secondary to poor access to healthcare plays a predominant role. This is confounded by inadequate staffing, training, diagnostic and interventional limitations.

Above I described the variety of needs for a society in transformation, its complex multidisciplinary character and timeliness. I also pointed out the amount of efforts already done in humanitarian aid and the complexity of it. As transformation is a long and dynamic process, humanitarian aid in itself is also in a state of continuous transformation, part of a broad strategy with specific niches defined for specific partners. If now Flemish academic institutions and individuals want to collaborate in this story, it is imperative that we make strategic choices and identify areas in which we can have a clear added value. For the medical track, I could suggest the following.

My first focus would be maternal health (UN Millennium goal nr 5). Reproductive health not only leads to lives saved, but also strong family structures and female empowerment have clearly been identified as key issues in transformation. The International Centre for Reproductive Health (ICRH), founded in Ghent in 1994, has a unique expertise in the fight to improve sexual and reproductive health through research, training and adapted interventions.

My second focus would be mental health. Severe trauma has a long lasting impact, among others in the form of post-traumatic stress disorder symptoms. Exposure to chronic (multiple and/or prolonged) childhood trauma can however have a far more pervasive influence on the development of the brain and is associated with dysfunctional interpersonal relationships, dissociation, affect dysregulation, impulse control and attention problems in childhood and adulthood. In view of this and in the light of the new DSM-V (Diagnostic and Statistical Manual of Mental Disorders), an international expert team recently proposed consensus criteria for a new diagnosis, 'developmental trauma disorder' (DTD). Both etiological study of diagnostic criteria and epidemiological research on prevalence, risk and protective factors is needed. This focus is closely linked to the track 'Psychological and Educational Approaches to Trauma and Transformation' and the departments of Child & Adolescent psychiatry of the four Flemish Universities have all build up a lot of expertise and are already working together in various projects.

Further, in relation to this, Prof. Chris Van Geet, head of the Department of Paediatrics at the University Hospital of Leuven, is doing interesting research on epigenetics. To illustrate this field of research, I refer to the pilot study of Mulligan et al. who showed a significant correlation between culturally relevant measures of maternal prenatal stress, as observed in the DR Congo, new-born birth weight and new-born methylation in the promoter of the glucocorticoid receptor NR3C1. They hypothesised that increased methylation may constrain plasticity in subsequent gene expression and restrict the range of stress adaptation responses possible in affected individuals, thus increasing their risk for adult-onset diseases.

Finally and maybe most importantly in both inducing and sustaining transformation, my third focus would be emergency and disaster medicine. Again there is a lot of knowledge and facilities with Flemish academics. Disaster response teams have worked in different areas of the world and, although still on a preliminary basis, data from these interventions are collected and analysed by Dr. Van Berlaer from the University of Brussels. Such data and analysis could be informative in view of decision-making about human and logistic resources needed. For instance, the needs after the Haiti earthquake in terms of physicians is clearly different week one versus week six, yet this was not really reflected in the team composition as it was. Teams most often use the WHO Emergency Health kits but these are not always appropriate for the health conditions encountered and the local situation, especially for children. Systems of data collection were not uniform and data that went further than crude mortality were very scarce. Crude mortality rates are often used to inform humanitarian policy and define the needs for humanitarian aid. They however have the tendency to be very variable depending on their source, and are falsely considered to be constant in time and across geographic regions. Prof. Olivier De Gomme, current director of the International Centre for Reproductive Health in Ghent, studied death rates by causes and regions in the conflict region of Darfur and found that not so much violence but overcrowding and unsanitary conditions led to mortality and that there was a marked increase in deaths once there was a decline in number of aid workers relative to the population.

Disaster medicine goes beyond flying over response teams and more importantly should focus on improving the resilience and preparedness of the local health system, which has everything to do with knowledge, skills and facilities. Faculty of the University of Brussels were central in the founding of the European Master in Disaster Medicine, and could be of great value for local capacity building.

Most importantly, to be able to build up resilience and preparedness it is imperative that countries or regions first start with developing or strengthening a low-barrier system of first aid and emergency medicine, currently often the weakest link. Such a system, integrated into existing

programmes of primary care, has proven to be cost-efficient in resource limited settings and can go a long way towards improving individual mortality and morbidity and the overall performance of a healthcare system.

Baker et al., in Paediatric Anesthesia in 2009, described several low cost interventions that can make big differences, namely: introduction of effective triage and emergency treatments; concentrating on ABC and developing guidelines for common medical procedures; ensuring reliable oxygen delivery; establishing hospital systems that prioritise critically ill; and integrating obstetrics, paediatric and adult medicine and surgery in a combined emergency and critical care service.

Ralston et al., in a recent article in The Lancet further support this, argumenting that most (under five) deaths worldwide are still related to pneumonia and diarrhoea; approximately 2 million deaths yearly. A lot of this mortality is avoidable with simple inexpensive measures. Improved access to oxygen for instance could reduce pneumonia mortality with up to 35%. Oral Rehydration Solution and Zinc cost 0.30$ but can reduce the risk of death from diarrhoea to close to 0%. At the moment acute (paediatric) life support, especially for time-sensitive critical conditions (hypoxia, hypovolemia, sepsis, injury..), is too often incomplete and of low quality due to a lack of resources in terms of referral and transport modalities; emergency care centres and triage systems; trained (paediatric) emergency and critical care health care providers; hospital infrastructure and resources for critically ill patients. First level responders should be empowered and equipped to start time sensitive appropriate potentially life-saving management; existing life support guidelines, adapted to the local situation, should be integrated into the primary health care framework, and both pre- and in hospital emergency care should be improved. Academics from Flemish universities are very much involved in life support training, as member of among other the European Resuscitation Council, The European Society of Emergency Medicine and the WHO GIEESC (Global Initiative for Emergency & Essential Surgical Care) and could provide much added value.

As I did in my own PhD, I'll end with words of Jim Butcher, who happens to be a fantasy author:

"If the beginning of wisdom is in realizing that one knows nothing, then the beginning of understanding is in realizing that all things exist in accord with a single truth: large things are made of smaller things.

Drops of ink are shaped in letters, letters form words, words form sentences, and sentences combine to express thought. So it is with the growth of plants that spring from seeds, as well as with walls build of many stones. So it is with mankind, as customs and traditions of our progenitors

blend together to form the foundation of our own cities, history, and way of life. Be they dead stone, living flesh, or rolling sea; be they idle times or events of world-shattering proportion, market days, or desperate battles, to this law, all things hold:

Large things are made from small things. Significance is cumulative – but not always obvious."

Naar een trauma & transformatie netwerk

Prof. Marc Vervenne (Ere-Rector KU Leuven, voorzitter van de Vlaamse Unesco-Commissie)

Prof. Rosette S'Jegers (secretaris-generaal van de VLIR)

Relatie VLIR - Universiteiten in de Midden-Oosterse regio

- Juni 2009: verkennend bezoek van de rectoren van de Vlaamse universiteiten aan drie universiteiten in de Palestijnse Gebieden (Al Quds, Bethlehem, Birzeit).

  Vaststelling van de paradox dat de aanwezige know-how en het wetenschappelijk potentieel binnen de Midden-Oosterse regio geïsoleerd zijn in een escalerende conflictzone.

  Conclusie voor internationaal beleid van de Vlaamse Interuniversitaire Raad (VLIR): communicatie en uitwisseling van kennis als uitdaging om de Palestijnse instellingen uit het isolement te halen en hun natuurlijke functie in de eigen omgeving te verbreden op een internationaal forum. Identificatie van specifieke themalijnen voor samenwerking: 1) trauma; 2) conflictbeheersing; 3) onderwijs en vredesopbouw; 4) milieu.

- Mei 2010: verkennend bezoek van de rectoren aan vijf universiteiten in Israël (Hebrew University, Tel Aviv, Haifa University, Haifa Technion, Weizmann Institute of Science Rehovot).

  Verkenning van onderzoeksdomeinen gerelateerd aan de themalijnen afgebakend tijdens de Palestijnse missie.

- Juni 2012: Bezoek Minister-president Kris Peeters aan Israël en de Palestijnse Gebieden, met overlegsessies met Israëlische en Palestijnse universiteiten.

  Bepaling van de focus van de VLIR op samenwerking met Palestijnse wetenschappers rond het thema "Trauma en maatschappelijke transformatie", met betrekken van individuele wetenschappers

verbonden aan universiteiten en onderzoeksinstellingen in de Midden-Oosterse regio (onder meer Israël, Jordanië, Libanon).

Vormgeving en dynamisering van het wetenschappelijke potentieel en van de interuniversitaire samenwerking

- In de opeenvolgende missies is binnen de VLIR een engagement gegroeid om naar samenwerking te streven met wetenschappers in de Midden-Oosterse regio, en in het bijzonder uit universiteiten en wetenschappelijke instellingen in de Palestijnse Gebieden en in Israël, voortbouwend op bestaande bilaterale samenwerkingsverbanden van Vlaamse onderzoekers. Er is vastgesteld dat in deze regio met respect en belangstelling naar de wetenschappelijke activiteiten van Vlaamse universiteiten en hun onderzoekers wordt gekeken. Onze instellingen hebben de reputatie van excellentie en in maatschappelijke context ook de naam van bereidheid tot bemiddelend optreden en conflictbeheersing.

- Op basis van de intense contacten van de afgelopen vier jaar en de inzichten die daarbij zijn ontstaan, heeft het VLIR-bureau van rectoren een 'mission statement' geformuleerd waarin een aantal belangrijke krachtlijnen zijn uitgezet. Een vertegenwoordiging van de universiteiten heeft in 2012 Minister-president Kris Peeters bij zijn bezoek aan Israël en de Palestijnse Gebieden overtuigd van het nut van de component 'academische diplomatie' in het internationale beleid van de Vlaamse Regering.

- Minister-president Kris Peeters heeft de rectoren verzocht het wetenschappelijk potentieel in kaart te brengen dat rond de problematiek van trauma en maatschappelijke transformatie vanuit de Vlaamse universiteiten en hogescholen kan worden ingezet in het kader van het opbouwen van een internationaal gericht netwerk dat op wetenschappelijk onderbouwde wijze noodhulp kan bieden aan door structurele conflicten geteisterde regio's.

- Ere-rector Marc Vervenne kreeg in het verlengde van zijn Unesco-opdracht de specifieke vraag om een wetenschappelijk netwerk te identificeren in nauwe samenwerking met de VLIR. De eerste oplijsting richtte zich op de brede waaier van disciplines die remediërend kunnen worden ingezet voor traumatische ervaringen die in de conflictzones onder verschillende vormen optreden en de gezondheid, de opvoeding en de rechtszekerheid van kinderen en jonge burgers in het gedrang brengen.

- Het Departement internationaal Vlaanderen heeft het initiatief genomen een seminarie te organiseren rond het thema "Tussen

trauma en transformatie", in samenwerking met de VLIR, VLIR-UOS, het Vlaams Vredesinstituut en de Vlaamse Unesco-Commissie (VUC).

VLIR-UOS, met zijn rijke ervaring en engagement van wetenschappers die zich inzetten in Zuidlanden, vormt een natuurlijke partner voor dit initiatief. Verder is een beroep gedaan op het Vlaams Vredesinstituut, dat heel wat expertise heeft opgebouwd rond conflictbeheersing.

Ten slotte is de VUC betrokken bij de ontwikkeling van het initiatief in het ruime kader van de Unesco-programma's rond vredesopbouw. De algemene missie van Unesco, als organisatie binnen de VN, is de bevordering van wereldwijde vredesopbouw, door het mobiliseren en samenbrengen van actoren in de domeinen van onderwijs (vorming), wetenschap (sociale en natuurwetenschappen), cultuur (erfgoed in zijn diverse vormen) en communicatie (media), met een gerichtheid op specifieke vredesopbouwende acties.

Enige achtergrond bij de keuze voor het thema 'Trauma en Transformatie'

- De VUC heeft in haar beleids- en werkprogramma het thema van 'Trauma en Transformatie' uitdrukkelijk ingeschreven. Aanzet daartoe is het initiatief dat het Departement internationaal Vlaanderen in 2010 heeft genomen om de herdenking van WO I in 2014-2018 te verbinden met het 'Peace Village' in Mesen (West-Vlaanderen). De oorsprong van die locatie ligt in de Ierse Republiek en in Noord-Ierland en is nauw verbonden met de deelname van twee Ierse divisies aan 'The Battle of Messines Ridge' van 7 juni 1917. Het ontbrak de Ieren aan een monument om die slag en hun aanwezigheid in de Westhoek tijdens de 'Groote Oorlog' te herdenken. Dat veranderde op 11 november 1998 met de officiële inhuldiging van het Ierse Vredespark en de Ierse Vredestoren in Mesen. De site met opvallende ronde toren is een project van de Ierse en Noord-Ierse organisatie 'A Journey of Reconciliation' en is opgericht voor de bijna 70.000 Ierse soldaten die sneuvelden, gewond raakten of als vermist zijn opgegeven tijdens WO I. Die slag is beter bekend als de 'The Battle of Messines Ridge', de heuvelrug waarop zowel Mesen als Wijtschate (Heuvelland) liggen. Die slag zorgde enigszins voor een doorbraak in een loopgravenoorlog die al jarenlang was vastgelopen.

  De 'Mijnenslag' heeft tot vandaag een belangrijke symbolische waarde voor de Ieren. In de vallei tussen Kemmel en Wijtschate hebben duizenden Ierse katholieken en protestanten – nationalisten én loyalisten – voor het laatst zij aan zij gevochten. Die symboolwaarde was in 2001 ook aanleiding voor de oprichting van een internationale vredesschool in Mesen.

Het initiatief wilde in eerste instantie sektarische groepen uit Ierland en Noord-Ierland bijeenbrengen op ‘neutraal’ en gemeenschappelijk terrein om verzoening en samenwerking tussen de verschillende groepen (Ieren en Noord-Ieren; nationalisten en unionisten; katholieken en protestanten) te bewerkstelligen. In een latere fase zou de werking worden uitgebreid naar andere conflicthaarden in Europa en de wereld. De vredesschool als dé plaats om zich te bezinnen over de waanzin van oorlog en werk te maken van vrede.

- Vanuit de hier geschetste benadering is een partnerschap gevormd met de bovengenoemde instellingen. De insteek is verbreed naar de ontwikkeling van de dimensie van valorisatie enerzijds van onderzoek en praktijk rond trauma in de context van hedendaagse conflictgebieden en anderzijds wetenschappelijke expertise inzake maatschappelijke transformatie, onder meer met betrekking tot conflictpreventie, onderwijs en opvoeding, vredesopbouw.

  Het streefdoel is het ontwikkelen van een internationaal georiënteerd expertisenetwerk dat de universiteiten, wetenschappelijke instellingen en hogescholen in de Vlaamse Gemeenschap overspant en fungeert als een plaats waar wetenschappers, clinici en hulpverleners expertise samenvoegen. Het is geen onderzoekscentrum, omdat die taak behoort tot de universiteiten, universitaire ziekenhuizen en andere onderzoeks- en klinische instellingen, maar zoals gezegd opgevat als een netwerk van expertise, een soort van ‘levende databank’, waaruit ad hoc deskundige inzet kan worden geput.

Conclusie en perspectief

- Het mag duidelijk zijn dat we pas aan het begin staan van de opbouw van het genoemde expertisenetwerk. Tot nu toe zijn we samen met enkele academische ‘trekkers’, aangeduid door de rectoren, bezig met de identificatie en dynamisering van wetenschappers, onderzoeksgroepen en praktijkmensen van wie het onderzoek / de praxis aansluit bij het omgaan met traumatische ervaringen en bij de maatschappelijke transformatieprocessen die kenmerkend zijn voor conflictgebieden.

- Dit zijn de eerste stappen naar het opbouwen van een effectief netwerk waarop de Vlaamse Regering kan terugvallen om de expertise en de ervaring in instellingen in Vlaanderen op coherente wijze in te zetten voor tussenkomsten in regio’s die zijn getroffen door conflicten of catastrofes.

- Om dit netwerk operationeel te maken is inventarisatie en permanente actualisering van het aanwezige potentieel van wezenlijk belang. Dat is een noodzakelijke, maar zeker niet voldoende voorwaarde. Het onderkende virtuele trauma & transformatie-netwerk zal maar effectief kunnen optreden als er daarenboven verbindingen worden gemaakt tussen de respectieve actoren. Meer bepaald is het nodig win-winsituatie te laten ontstaan, waardoor de wetenschappers en praktijkmensen in het netwerk de reële meerwaarde ervaren van samenwerking over hun onderzoeks- en instellingsgrenzen heen.

- Het bindweefsel kan bestaan uit de aantrekkingskracht van financiering en fondsen voor multidisciplinair onderzoek op de gerelateerde gebieden van trauma en maatschappelijke transformatie. Volgens ons kan en moet het tevens gaan om vorming die leidt tot specifieke certificatie (labels) voor de deelnemers en hun erkenning bezorgt als specialisten in traumaverwerking en in het genereren van maatschappelijke veranderingsprocessen met het oog op vredeopbouw en conflictpreventie.

- Een inspirerend voorbeeld/format in dat verband is de internationale master in Disaster Medicine (coördinatie VUB). Deze opleiding slaagt erin wijd verspreide kenniscentra rond medische interventie bij rampen te verenigen rond een gemeenschappelijk programma, dat op een virtueel platform wordt aangeboden. Eenmaal per academiejaar komen organisatoren en deelnemers samen rond een levensecht gesimuleerde noodsituatie, inclusief inzet van lokale hulpdiensten van politie, justitie, brandweer en hospitalen. Het is indrukwekkend om vast te stellen hoe daaruit, ondanks de ruimtelijke afstand tussen de betrokken universitaire departementen en klinische diensten, een hechte band ontstaat tussen aanbieders, lokale overheid en deelnemers.

- Tot slot drukken we de wens uit de ideeën, de creativiteit en de expertise van de organiserende partnerinstellingen te bundelen met de Vlaamse Overheid en haar diensten om samen een aangepast format te ontwikkelen dat de opbouw van een virtueel netwerk voor structurele wetenschappelijk en praxis-onderbouwde noodhulp rond trauma en transformatie effectief kan maken. De kansen op slagen hangen mee af van de middelen en mensen die we daarvoor kunnen mobiliseren. In eerste instantie moet werk worden gemaakt van het opzetten van een dynamische databank, waarvan de inhoud in wisselwerking tussen beheerder, informatieleverancier en gebruiker permanent wordt geactualiseerd. De ontwikkeling van dat instrument kan een eerst concrete stap zijn om het project van een trauma & transformatie-netwerk uit te voeren.