

# HEALING UNDER FIRE

THE CASE OF SOUTHERN THAILAND



**Editors**

Virasakdi Chongsuvivatwong

Louisa Chan Boegli and

Supat Hasuwannakit



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The Deep South Relief and Reconciliation Foundation  
and the Rugiagli Initiative

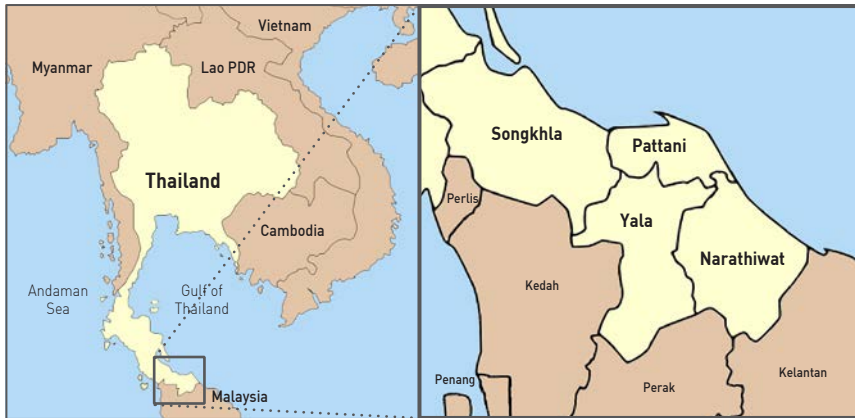
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Map of Thailand and the four southern provinces

## Healing Under Fire: The Case of Southern Thailand

### Editors

Virasakdi Chongsuvivatwong

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# FOREWORD

*Surin Pitsuwan*

The decades-long multidimensional conflict in southern Thailand is seldom reported and little understood in the international media. Increasingly, however, a body of knowledge has been accumulated by Thai and foreign scholars and is gaining more intensive scrutiny.

The scale of the conflict is by no means small. It has taken a heavy toll in lives (more than 6,000) and thousands of mentally traumatized and physically handicapped individuals, with several thousands more internally displaced people.

Having been insulated and locally contained with little or no involvement from external parties, a window of opportunity exists for people of goodwill in all segments of our society to make a collective effort to resolve the conflict by peaceful means, with active and conscientious engagement. A further delay would only invite deepening divisiveness and open doors for external parties to complicate the matter even more.

It is extremely encouraging to see the medical professionals in southern Thailand taking the challenge to heart, responding to the call for compassion and understanding from both sides of the ethnic divide, the Malay Muslims and the Buddhist communities in the southern border areas. It is a most trusted group of professionals, Buddhist and Muslims, risking their lives in the frontline of conflict, knowing that theirs is a calling that seeks to live up to the credo of 'do no harm', winning the hearts and minds of the local people.

This is indeed an asset, a 'social capital' that can be further harnessed for the larger purpose of our society. The goodwill of the people, the trust that they have placed in the medical personnel, the reverence that they have given to their doctors and nurses, whose very profession is the manifestation of 'selfless sacrifices' – all these can serve as a strong foundation of a sustained and peaceful resolution to the southern strife.

As has been recognized by the global community, violent conflicts, no matter how complicated, no matter how long, no matter how deeply rooted, always have a space for the involvement of medical professionals in the search for their lasting solutions.



It is heartening that the doctors and nurses from regional universities, provincial hospitals and local clinics have been engaging in national development and communal reconciliation for quite some time now. They have been catalysts of change, proponents of more equitable and inclusive development or even forming coalitions to forge better policies and building a more just and peaceful society for Thailand.

Mindful of the benefits of learning from and exchanging with other like-minded professional colleagues from around the world, the medical corps of southern Thailand have reached out and engaged with foreign experts, learning from their successes and failures, their best practices and their models of efficiency in fulfilling their mission as ‘agents of change’ for the betterment of our society.

***Healing Under Fire – The Case of Southern Thailand*** is a valuable collection of stories and narratives of the noble engagement of the medical professionals in southern Thailand seeking to heal the wounds in the larger context of our society, and not just the physical healing that is of their immediate concern.

In that sense, it is a set of heroic deeds that deserve our attention, not just for the sake of recognizing their selfless sacrifices but also for the larger and more noble purpose of sharing with others how a group of dedicated people, ‘with malice towards none, with charity towards all’, can indeed make a meaningful contribution to the search for a lasting resolution to the painful and costly conflict of southern Thailand.

**Surin Pitsuwan**

Former Secretary-General of ASEAN  
Nakorn Sri Thammarat,  
Southern Thailand

# PREFACE

## *Prawase Wasi*

The current era is still full of overt and 'silent' violence. It is the violence that we learn to live with. Peace therefore should be loud. The three Deep South provinces of the Thai Kingdom, predominated by a Malay Muslim population, have been occupied by a long history of conflict, the most recent of which exploded into a new level of violence a decade ago and which over these past few years has killed several thousand and injured thousands more of innocent people.

Several attempts have been made to resolve the conflict. This includes those who work for peace through the work they do, silently, in their everyday lives. In the Deep South, this includes the countless medical professionals who believe that health and peace are intertwined and that a healthy society is a peaceful society. This includes a group of local people who established the Deep South Relief and Reconciliation (DSRR) Foundation. It was first chaired by Prof. Dr Tada Yipintsoi and currently by Prof. Dr Virasakdi Chongsuvivatwong. They and the others working with them share the belief that providing assistance to victims of violence without discrimination will lead to psychological and social healing.

In Europe, the Rugiagli Initiative (tRI) was set up by another group of people who believe that medical people working in conflict areas have the potential to create peace. They believe that there can be no good health outcomes without peaceful outcomes. tRI was looking for an area where they could work, to demonstrate how medical healing can go beyond the patients and reach out to communities. They found the work already being done in Thailand's Deep South inspiring and useful for documenting and open to being enhanced. The health professionals in the South provide non-discriminating health services with devotion, patience and courage. DSRR and tRI became partners in providing further skills and knowledge to complement what the Thai health professionals have been doing in their everyday work to promote peace. Dr Supat Hasuwannakit, the Director of Chana Hospital in Songkla province coordinated this mission.





This book emerged from a workshop co-hosted by the DSRR Foundation and tRI in Krabi, Thailand in late 2013. The publication is financially supported by the Swiss Embassy in Thailand. The workshop brought international specialists to exchange with the Thai health personnel on their experiences. This workshop became an interactive learning through action, which is the most powerful tool to overcome any difficulty eventually. The contributions collected here reflect many of the presentations made during that workshop.

Based on a consensus in twinning peace with health, the participants in the workshop agreed that they should propose a curriculum inside medical education to create peace negotiation skills. This needs to be proved by practice. If it is really workable, the impact would not be limited to the conflict area but also would be useful in clinical practice. Because peace involves relationships that are based on equity and mutual respect, a doctor or a nurse who embodies these principles in their work will be even more helpful to all parties in the conflict.

I admire the people with devotion to serve humankind, both in this conflict zone and in the international arena, who came together here in Thailand to learn from one another. I believe that the good things that human beings give to one another and their shared wisdom will lead to the healing of the world and to a peaceful era. Such admirable attempts are the beauty that loudly decorates the world.

**Prawase Wasi**

Professor Emeritus of Medicine

Chairman, National Health Foundation

# I. BACKGROUND – CONTEXT OF SOUTHERN THAILAND

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## Chapter 1

### Introduction

*Louisa Chan Boegli, Virasakdi Chongsuvivatwong and Supat Hasuwannakit*

## Chapter 2

### The Deep South of Thailand: Neither War Nor Peace? Trajectories for a peaceful settlement of the conflict

*Norbert Ropers*

## Chapter 3

### The Southern Medical Community's First Forays Into Peace Work

*Virasakdi Chongsuvivatwong, Metta Kuning, Vorasith Sornsrivichai and Wallapa Thakan*

## Chapter 4

### By the Numbers: Major Health Problems in the Deep South

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## Chapter 5

### Epidemiology of the Violence in the Deep South

*Metta Kuning, Mayuening Eso, Vorasith Sornsrivichai and Virasakdi Chongsuvivatwong*

# Chapter 1

## Introduction

*Louisa Chan Boegli, Supat Hasuwannakit  
and Virasakdi Chongsuvivatwong*

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This book explores the links between health and peace, using ongoing situation of violent conflict in the Deep South of Thailand<sup>1</sup> as a case study. Drawing on discussions from a workshop in December 2013, the papers here reflect the experiences of national health professionals working in southern Thailand's conflict areas and an international collaboration to share ideas and approaches for linking health work with peace work.

The contributions were written by a range of medical professionals, researchers and academics. The book is divided into three parts: I) introductions to the conflict in southern Thailand and background information on the local situation; II) examples of adapting and delivering health care under fire and the collaborative initiative in southern Thailand; and III) essential knowledge and skills required for peace work as well as for coping in an violent conflict situation.

The papers and case studies are intended for health professionals working in areas of violent conflict in Thailand and globally. The contributions aim to inspire readers to learn from the highlighted approaches and, if applicable, adapt them to their context.

This collection of insights was made possible by a generous grant from the Embassy of Switzerland in Thailand. The Editors dedicate this book to the women and men who deliver health care to those in need in war zones throughout the world. In particular, it honours those who work for peace while exercising their medical profession.

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<sup>1</sup> The Deep South of Thailand, or 'Deep South' in short, includes Pattani, Yala and Narathiwat provinces and four districts of Songkhla province (Chana, Thepha, Na Thawi and Saba Yoi). The area is 'deep' in the sense that it is farthest from the centre of Thailand in both geographical and socio-cultural sense.

### **The collaborative initiative**

*Healing Under Fire – The Case of Southern Thailand* is a product of the Deep South Relief and Reconciliation (DSRR) Foundation, an organization based in southern Thailand, and the Rugiagli Initiative (tRI), based in Italy and Switzerland. The two organizations share a vision that physicians and health professionals have the potential to contribute towards achieving peace and reducing violence in conflicts.

In early 2013, the Executive Director and founding member of the DSRR Foundation, Dr Virasakdi Chongsuivatwong, and his team initiated a project to encourage doctors to go beyond their traditional roles and embrace peace work. The Rugiagli Initiative, whose focus is building peace through health care, was invited to collaborate.

The objective of the collaboration was to reach out to health professionals and enhance their capacity to play substantive roles in support of peace building, mutual understanding and violence reduction. Representatives of each health specialty from the Deep South were invited to participate: physicians, nurses, psychologists, dentists, physical therapists, pharmacists, hospital administrators, epidemiologists and forensics experts. The initiative took place in close proximity to the conflict zone, with emphasis on the safety of everyone involved.

The collaborative initiative took shape in July 2013, when the DSRR Foundation invited a group of Thai doctors and other health workers from the conflict areas in southern Thailand for a roundtable discussion on the role of health professionals in peace building. It was the first time for these professionals to sit together and talk about health and peace. Enthusiasm to know more was the first outcome.

Specifically, the participants wanted to know what they could learn as health professionals to contribute towards peace building. They recommended a workshop through which they could acquire skills and knowledge to i) cope with difficult issues in their work in conflict areas and in a way that would not exacerbate the conflict and ii) build the foundation for mutual understanding and reducing violence among conflicting communities.

The ensuing workshop took place in December 2013, with the participation of both Thai and international experts in peace and conflict studies, medical peace work, human rights, ethics, negotiation and conflict analysis. With funding from the private Swiss foundation, Peace Nexus, the Rugiagli Initiative provided expert resources and guidance to the proceedings. The details of that workshop are described in chapter 9.

## Why southern Thailand?

Doctors and other health workers are the most respected professionals in the conflict-affected areas in southern Thailand. Owing to a strategy adopted collectively among them to maintain a position of impartiality as the violence flared a decade ago, to integrate their teams (in terms of gender, religion, culture and technical specialties) and to stay 'low profile', the doctors and other health workers have managed to escape as direct targets in the conflict. Additionally, the access that many health professionals have to communities and villages that are otherwise closed to outsiders places them in a unique position to take on the role of 'connectors' for peace.

In several ways, although to a limited extent, the health professionals in southern Thailand were already engaged in health and peace work. Confronted with challenges and dilemmas over the ten years since the escalation of the violent conflict, they had been working at the frontlines and had devised ways to cope and to continue providing health care. In doing so, some found ways to cooperate with health professionals from the other side of the conflict. Their stories are documented in chapter 6. The background of the conflict in the provinces of Narathiwat, Pattani, Yala and parts of Songkhla is introduced in chapter 2.

## The link between health and peace

Much has been written about the theory and practice behind the concept of the health sector contributing towards peace building. Those who advocate and promote a strong and natural link between health and peace include the World Health Organization (WHO), the United States Institute of Peace and such individuals as peace and conflict expert Johann Galtung.<sup>2</sup>

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<sup>2</sup> See chapter 24 in Webel, C. and Galtung, J., eds., *Handbook of Peace and Conflict Studies*, London and New York, Routledge, <http://guessoumiss.files.wordpress.com/2011/08/handbook-of-peace-and-conflict-studies.pdf> and United States Institute of Peace, [www.usip.org/issue-areas/health](http://www.usip.org/issue-areas/health)

Several terms have been used to represent the concept, such as: health as a bridge for peace (WHO), peace through health (Neil Arya and Joanna Santa Barbara, McMaster University, Canada) and medical peace work (Medical Peace Work, Norway).<sup>3</sup> For practical purposes, the Editors of this volume use ‘health and peace nexus’.

The concept first emerged in 1980 when introduced by the Pan American Health Organization (PAHO) as a multicountry, multiagency programme that health ministers in that region supported and was based on the principle that “shared health concerns can transcend political, economic, social and ethnic divisions among people and between nations.”<sup>4</sup> At about the same time, a group of physicians from the United States and the Soviet Union (both sides of the Cold War) started the International Physicians for the Prevention of Nuclear War, based on the belief that physicians’ responsibilities include a commitment to the prevention of nuclear war.

Further endorsement of the concept came in 1981 when the World Health Assembly, the governing body of the WHO, confirmed in Resolution 34.38 that “the role of physicians and other health workers in the preservation of peace is the most significant factor for the attainment of health for all”.

Perhaps the most convincing argument for the health and peace nexus concept is the menace of arms and war to public health. In 1996, the WHO and the World Bank predicted that wars would be the eighth-leading cause of mortality and disability by 2020.<sup>5</sup> Certainly, direct violence from guns and other tools of conflict contribute heavily to mortality and morbidity; but millions of people have lived and still live in precarious conditions due to the destruction that war inflicts and the displacement of populations that it causes. In such situations, access to essential services becomes limited, facilitating the transmission of preventable diseases. Modern warfare also has scarred millions mentally and psychologically, thus increasing substance abuse and delaying the return to productive livelihoods.

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<sup>3</sup> For McMaster University, see [www.humanities.mcmaster.ca/peace-health/about.html](http://www.humanities.mcmaster.ca/peace-health/about.html); for Arya, N. and Barbara, J.S., see [www.amazon.com/Peace-through-Health-Professionals-Violent/dp/1565492587#reader\\_1565492587](http://www.amazon.com/Peace-through-Health-Professionals-Violent/dp/1565492587#reader_1565492587); for Medical Peace Work, see [www.medicalpeacework.org/about-us.html](http://www.medicalpeacework.org/about-us.html)

<sup>4</sup> World Health Organization, *Health as a Bridge for Peace: Report on the First World Health Organization Consultative Meeting*, 1997. Available at [www.who.int/hac/techguidance/hbp/strategies\\_/en/index2.html](http://www.who.int/hac/techguidance/hbp/strategies_/en/index2.html)

<sup>5</sup> Murray, C. and Lopez, A., *Global Burden of Disease*, published by the Harvard School of Public Health on behalf of the WHO and World Bank, 1996.

The proponents of the health and peace nexus make the point that working for peace is part and parcel of a sound public health approach. They emphasize the intrinsic values of medicine – altruism and the reliance on scientific evidence to draw conclusions – which give physicians and other health professionals legitimacy across cultures and societies. It is assumed that the rigorous training and empathy inherent in the profession also bestow the qualities needed for peacemakers.

To further clarify the concept, ‘peace’ is defined as a state of harmonious relationships, in which individuals and communities have unimpeded, secure and equitable access to the basic needs of life for their well-being. This is ‘positive’ peace. Just as health does not mean the absence of disease, peace is not the mere absence of war or violence.

Using this interpretation, the practical link between health and peace becomes more diverse. It includes, for example, *advocacy* against deadly weapons, injustice, prejudice and human rights abuses; *education* in ethics, human rights and peace through health; the *collection* and *dissemination* of epidemiological and forensic data on the consequences of violent conflict; and *ensuring* equal access for all communities to development opportunities and humanitarian health assistance. Worldwide, hundreds of health workers are engaged in mitigating the effects of violent conflict and providing humanitarian health assistance, including mental health services, to ease the long-term psychological and social impact of violence. All of these actions contribute in one way or another to sustainable peace.

Brokering that peace typically requires a series of talks or negotiations between two conflicting sides, usually mediated by a third party. This is the so-called ‘track I’, or the main diplomatic track for reconciliation and a resolution to a violent conflict. Less universally understood across cultures are the tracks II and III peace processes, which involve civil society and community-based organizations engaging in informal dialogue, which can inform and support the official track I diplomacy. Tracks II and III peace processes are concerned with building relationships of trust and confidence among groups or communities in conflict and can involve medical professionals in several contexts.

These and other types of health and peace initiatives have been documented in a variety of conflicts. For example, in the Middle East, Afghanistan, the former Yugoslavia and Sri Lanka, doctors from opposing camps have collaborated to plan health services and post-conflict health systems or to provide mental health care. What has not been systematically researched is whether physicians and other medical professionals have been instrumental in bringing about the cessation of violence and lasting peace. The effectiveness of track II and III processes deploying the medical profession directly in conflict transformation requires closer scrutiny and documentation.

### **Lessons from southern Thailand**

Both track I diplomacy and track II informal dialogue processes were in place in southern Thailand when the DSRR Foundation and the Rugiagli Initiative first discussed collaboration. At that time, it was the policy of the Thai Government to engage in formal dialogue with the insurgency groups, with facilitation by the Government of Malaysia. With that policy in practice, civil society and community-based groups were encouraged to participate in activities in support of peace.

Involving civil society in general, and health professionals in particular in peace work was a rather new concept in southern Thailand. Most physicians and nurses were more comfortable with joint cooperation to improve health services or access rather than for the purpose of peace-building or conflict transformation. The most pressing priority for them had been exploring new options to enhance coping mechanisms for staying safe and delivering the highest quality of health care in the conflict areas. For this reason, the majority of professionals found that building relationships and mutual understanding with counterparts from the 'opposing' side was largely sufficient. Engaging directly in a peace process was seen as political and risky. Yet, as the collaborative initiative came together, there were notable exceptions of health professionals who saw the potential of using their position and assets to contribute to the peace process.

Even though exploring the role of the health professionals in peace work is sensitive in the context of southern Thailand, many were ready to participate in some way. In the course of the collaborative activities, the pressing priorities to find options to deal with daily security risks, challenges and ethical dilemmas tended to dominate. However, quietly but substantively, courageous initiatives directly contributing to peaceful co-existence and reduction of violence also emerged.



This experience points to a few issues that should be further researched. Can the health and peace nexus concept be applied universally across all cultures and in all conflicts? Is it even feasible for national health professionals, who are more prone to be caught in a conflict? Is it feasible to systematically introduce peace-building knowledge and skills to health professionals in the midst of conflict? During which phase of a conflict would this best be applied? Which topics would be universally essential, and should tailor-made courses be designed? Which initiatives can be linked directly to sustainable peace? Alternatively, would using the health sector as a tool for peace prove to be ultimately harmful to the provision of health care in times of conflict?

The Editors believe there is a need for a concerted effort to document existing activities of national health professionals in their efforts to prevent and mitigate the impact of violent conflicts and to rehabilitate broken communities in ways that can bring about lasting peace. This book endeavours to contribute to that body of knowledge.

## Chapter 2

# The Deep South of Thailand: Neither War Nor Peace?

## Trajectories for a peaceful settlement of the conflict

*Norbert Ropers*

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The conflict in the Deep South of Thailand clearly belongs among the world's violent but less known internal disputes. Although the escalation of this conflict has led to more than 6,000 deaths and the injury of nearly 11,000 people since 2004, it rarely appears as an issue in the international media. A peace effort initiated by the Government in February 2013 generated hope that a settlement might be possible; but it became stuck after six months due to half-hearted and non-inclusive engagement on both sides. More recently, the effort was overshadowed and sidelined by the political conflict in Bangkok, from November 2013 onwards. The National Council for Peace and Order (NCPO), which took over power in May 2014, declared they wanted to move the peace talks forward. It is not yet clear what format these talks will take.

Some conflict analysts presume that for some time to come the Pattani<sup>1</sup> region will resemble what in other parts of the world is known as a situation of 'neither war nor peace': a region controlled by the Thai State and security agencies but with a protracted incidence of low-level violence and occasional manifestations of political protest and discontent. They argue that as long as there is no serious commitment by all stakeholders to redress the drivers of the conflict and to agree on a genuine compromise, this stalemate will endure.

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<sup>1</sup> There are two spellings of this historical word: The Thai 'Pattani' is the version used for the name of one of the three southernmost provinces and its main city. The Malay 'Patani' relates to the former Sultanate of Patani and is used by supporters of the Patani movement. We use both spellings according to the context. Some peace activists use the term 'Pat(t)ani' to acknowledge the differences.

Other conflict analysts are more optimistic. Their main argument is that in the past five years, weighty changes have taken place in the region. Civil society actors, alternative and local media, academic institutions and, not least, the health and peace nexus initiative reflected in this book have created a remarkable public sphere for promoting a culture of peace and for exploring innovative ways to transform the underlying conflict. They mention the official peace dialogue initiative of 2013 and claim that some of its parameters are difficult to accept and some are difficult to revert, from the perspective of the Thai State, such as the acknowledgement that the southern situation is a political conflict that needs a political solution, the recognition of the militant movement as an official partner in peace talks and the acceptance of Malaysia in some kind of third-party role. Conversely, the preparedness of the team representing the militant movement to work on a solution within the Thai Constitution is interpreted as a significant concession.

As in most other subnational protracted conflicts, the root causes and history of the southern situation are contested among the parties. The fairest way to engage with this is to acknowledge that the thinking and acting on both sides is very much influenced by their different historical narratives and discourses. Without going into a detailed discussion of the contested historiography, it might be sufficient in the context of this publication to mention that the region had been shaped since the first century by the ancient Kingdom of Langkasuka and influenced by Hinduism and Buddhism before the arrival of Islam in the region. From the thirteenth century onwards, the region came increasingly under the influence of Islam, and the Malay Kingdom/Sultanate of Patani experienced a 'golden age' of commercial outreach and political control, particularly in the sixteenth and seventeenth centuries. At the same time, the peninsula – like the rest of Indochina – was in an ongoing struggle concerning political dominance, changing alliances and different levels of vassalage. The decline of the Malay Kingdom in the eighteenth century finally ended with the defeat of Patani in 1785. Since then, the region was obliged to pay tribute to the Kingdom of Siam but kept a certain level of self-rule. This period lasted until the formal integration of the region into Siam in the context of the Anglo-Siamese Agreement of 1909.

During the nineteenth century, the level of self-rule was increasingly reduced by the Siam government, a development much driven by the threatening spread of European powers in Indochina during the high time of colonial expansion and the need to emphasize the country's own nation-building. One of the most influential educationalists during the reign of Siam King Chulalongkorn, Prince Damrong Rajanubhab, captured the official understanding in the often-quoted sentence: "Pattani has belonged to the Thai

[kingdom] since time immemorial". In contrast to this perspective, the educated class of Malay Muslims emphasized the history of the Kingdom/Sultanate of Patani before their final defeat in 1785 and the persistent loyalty of the Malay-Patani people to their distinct culture, language and religion.

The twentieth century as the peak period of nation-building affected the relations between the Siamese/Thai State and the majority of the Malay Muslims in the Deep South, not only substantially but also symbolically. The State used the concept of unified 'Thainess' (Thai nation, Buddhist religion and king) as the symbolic marker of the nation and pursued various strategies to incorporate minority identity groups into the national realm. Influenced by the dramatic changes in the international arena from WW I to WW II, the Cold War and its aftermath, the political leadership in Bangkok shifted between strategies of assimilation and accommodation through the most southern provinces. Accordingly, the Deep South experienced phases of heavy resistance and of adjustment by the local population. The vast majority of the younger Malay Muslim generation are now conversant with the Thai language, culture and political system, but it has not changed the deeply ingrained Malay Muslim linguistic, cultural and religious orientation among the approximately 80 per cent majority population in the region.

On the political level, the competing discourses between the Thai State and the Malay Muslim movement became more distinct after the change of the country to a Constitutional Monarchy in 1932, particularly in the context of the power struggle in Bangkok in the 1930s and 1940s between a more authoritarian and a more liberal wing of the ruling political class. While the state leadership was interested to consolidate Thailand's centralized statehood and borders after the dramatic events during and after WW II, the Patani movement was interested to explore alternative governance structures.

Duncan McCargo, a British professor of political science and South-East Asian Studies, describes the essence of the conflict as one of "competing legitimacy". State agencies are reluctant to use the term 'armed conflict' to define the ongoing violence, though it seems that aversion is changing. They emphasize that the violence not only comprises 'terrorist' activities by 'insurgents' but also organized crime and incidents related to personal disputes.

Undisputed is that since the 1960s, the character of the resistance movement changed from the traditional aristocratic elites to more ideologically driven militant organizations during the peak of the Cold War. The most important ones that are still active, though all organizations have gone through various splits, mergers and other forms

of restructuring, are: the National Patani Liberation Front (BNPP), the Patani United Liberation Organization (PULO) and the National Revolutions Front (BRN). Most observers have assessed PULO as the more active organization before the end of the century and BRN as the one that became the main driver of the armed struggle after 2000. The BNPP no longer has an armed wing, and its main break-out group has changed its name to Islamic Liberation Front of Patani (BIPP).

At the beginning of the twenty-first century, a new generation of militant activists took over the Patani-Malay movement, at least on the ground, though it is widely assumed that the leadership remains dominated by the decision-making bodies of BRN and PULO. Why the latest wave of violence started at the beginning of this century and is still ongoing is a matter of debate. In the public realm, 2004 is typically mentioned as the starting year because of a series of particularly dramatic violent events. But de facto the escalation had emerged in late 2001. The first publicized awareness of change underfoot appeared in January 2004 after a large group of insurgents raided an Army depot in Narathiwat province, shooting four soldiers and escaping with a large amount of weapons and munitions. In parallel, 20 schools were torched as well as a few other state-related targets.

A generally agreed upon explanation is that a shift in the southern policy by the then Prime Minister Thaksin Shinawatra (in office from 2001 to 2006) had substantially contributed to this escalation. He abolished the Southern Border Provinces Administrative Centre, which had been created as a problem-solving and confidence-building mechanism between Bangkok and influential leaders in the region (it was later reinstated). Instead, he mandated the police to pursue a ruthless 'law and order' policy based on the argument that the majority of the militants were 'bandits' involved in various types of organized crime.

But there are also competing complementary explanations. One is that some members of the movement had been preparing for a new wave of violence since the 1990s in the context of the post-Cold War discourse on the 'conflict of civilizations' and in response to measures by Thai and Malay security agencies to curb the insurgent activities. Another explanation emphasizes the response to the US-led War on Terror since 2001, which had triggered the radicalization of several subnational conflicts involving Muslim participation. And we cannot overlook the brittle truth that one of the strongest drivers of violence is violence: After the raid on the Army depot in January 2004, two violent incidents occurred that have generated long-lasting traumatic memories among the Malay Muslim population in the region: the Krue Se Mosque episode in April 2004 and the Tak Bai tragedy in October 2004.

In the first case, a violent escalation around a highly revered mosque led to a heavy-handed siege of the location and a shoot-to-kill approach that left 31 militants dead. In the second case, a protest rally in front of a police station led to the intervention of the military that ended with the arrest of hundreds of young men who were then stacked on top of each other, face down with their hands tied behind them, in army trucks for a long drive to the main army detention facility in the region. On the way, 78 men died, most of them due to suffocation. Although the State has since accepted responsibility for these atrocities and has paid compensation to affected families, no official has been called to account.

Since 2004, the region has experienced an ongoing series of violence and counter-violence. Combatants and civilians on both sides have been killed, maimed, lost family members, sometimes their homes, had to flee the region or have been left traumatized, likely for the rest of their lives. Tragically, each act of violence creates not only victims but often the impulse to take revenge and feed the vicious circle of protracted violence.

The response of the Thai State after 2006 has focused primarily on four types of measures: improving security, development, education and the rule of law, including restorative justice. In all these sectors, some kind of progress has been achieved, although it is internally disputed how effective and efficient some of these measures have been. The massive securitization of the region in terms of the number of personnel serving in the military, paramilitary and other armed forces has indeed reduced the level of violence since 2007. But it has also demonstrated that the current level of violence has become a protracted feature of the conflict.

Similarly expensive has been the financial investment into various development projects, which were justified with the argument that this would effectively integrate the majority population into the national economy. But the impact has been limited due to the main investment into the government sector – instead of promoting agriculture and industry – and due to the high level of corruption and mismanagement of funds. With respect to education, the rule of law and restorative justice, some progress has been achieved but the key stumbling block has not been addressed: The need for governance reform that responds to the issue of the legitimacy conflict.

The political situation changed in 2013, after the Pheu Thai-led government of former Prime Minister Yingluck Shinawatra (the younger sister of Thaksin Shinawatra) announced that they would engage in a peace dialogue process with BRN representatives. It was not the first initiative of direct talks between both sides. Several discreet efforts had

been undertaken before, sometimes with the help of third parties, but none had achieved any substantial result. This 2013 initiative marked a decisive step towards the promising peace process: It was the first official acknowledgement by a Thai Government that the unrest was driven by a political conflict that requires a political solution. And, the Malaysian Government was invited to facilitate the talks.

The Malaysian involvement was criticized by some people as not being sufficiently neutral. This criticism came from members of the Thai security agencies as well as from within the Patani-Malay movement and some outside observers. But others argued that Malaysia as well as Thailand have a common interest to stabilize the situation at the joint border in view of the upcoming ASEAN Community and that the chances for a political settlement to be implemented later would be enhanced if the country had been part of its creation.

By agreeing to participate in the peace dialogue process, the BRN delegation conceded to work towards a solution within the framework of the Thai Constitution. This concession became highly contested when the BRN delegation later issued a set of five demands that were perceived by some government representatives as harsh and unacceptable. The first demand related to the acknowledgement of the Patani-Malay people in the region as having the right to self-determination in light of the colonization by the former Siamese State. The request did not formally violate the reference to the Thai Constitution. Other demands related to acknowledgement of the BRN as the legitimate representative of the Patani-Malays, the acceptance of Malaysia as a mediator (and not only as facilitator), the involvement of international actors and civil society as observers and the release of 'political prisoners'.

The demands were not unusual in comparison with the requests of other insurgent movements in similar cases of subnational conflict that ultimately led to some form of autonomy as the basis of a peace agreement. What made the BRN demands difficult was that the leaders insisted on their acknowledgement 'in principle', while the State's dialogue team neither had the power to grant any political concessions nor the capacity to engage in an in-depth dialogue to develop a joint process of trust-building and incremental substantive mutual agreement.

As in many other peace processes, this experience led to mutual disappointment, which was exacerbated by contrasting understandings of 'peace' between the two sides. For the Thai Government, mainstream society and the media, peace primarily meant to end the violence. For the Patani-Malay movement and many supporters, it *also* meant to

address the injustices of the past, to improve equality and dignity and to acknowledge their right to (internal) self-determination. These differing expectations concerning 'negative peace' and 'positive peace' constitute a common hitch for subnational conflict settlement efforts. To overcome this hitch, it is necessary that parties learn to see the conflict from the other side's perspective.

This capacity is particularly needed when it comes to the outcomes of a peace effort, such as a ceasefire agreement. In most cases, insurgents are willing to agree to a formal truce only when they are sufficiently convinced that the other side is seriously committed to tangible political concessions. A lack of trust and a sound series of negotiations were the two main reasons why the time-limited Ramadan ceasefire in the summer of 2013 did not succeed, although the prospects appeared promising at the outset.

The NCPO has repeatedly stated that they would like to take forward the peace talks and has in the meantime already established a supervisory and administrative structure for this purpose. At the same time, they have also stated that a reform of the governance structure in the region would not be on the agenda. More recently, they stated that the five demands of the BRN should not be put on the agenda but that they would like to listen to the 'people on the ground' to learn about their requests.

An open question though is in how far the new arrangement will refer explicitly or implicitly to the Peace Dialogue document from 28 February 2013. This might be an important issue for the Malaysian Government, which needs some kind of mandate to go on with their third-party role, which has not been challenged in principle by the NCPO. Also unclear is how the militant movements will respond to the new set-up and how the BRN can find a creative solution to their former statement that some kind of acknowledgement of the five demands would be required for the resumption of the talks.

To settle protracted subnational conflicts is a long-term task. It might take many years or even decades. Most peace processes go through various ups and downs. One of the key insights of successful cases over the past 30 years, such as in Northern Ireland or more recently in Mindanao, Philippines, is that civil society actors and organizations do have important and sometimes critical roles in the process. Without their persistent support and their efforts to broaden, deepen and sometimes revitalize stalled processes, the achievements in Northern Ireland and Mindanao would not have been possible.



In one of these initiatives from early 2014, a local network, the Insider Peacebuilders Platform, issued a policy paper entitled, *How Can the Peace Process Be Taken Forward?* The peace activists identified a couple of shortcomings of the 2013 process but also highlighted its assets and proposed a series of recommendations to make the next peace effort more effective. They argued particularly in favour of a sound infrastructure to be established by all dialoguing and negotiating parties to enhance the chances for trust- and confidence-building and professional support while working on the contentious issues of the conflict. They also made a series of proposals to improve the active multi-track participation of people from all walks of life to give the peace process a broader basis and resilience to cope with the various challenges that all protracted peace efforts go through.

The medical profession represents another important community for the proactive transformation of the conflict in the Deep South. With their solid presence on the ground, with their deep roots within the Malay Muslim, Thai Buddhist and Thai Chinese communities, and with their professional and ethical standards, they have a profound understanding of the urgent need for a peaceful transformation and significant potential to be part of this transformation.

## Chapter 3

# The Southern Medical Community's First Forays Into Peace Work

*Virasakdi Chongsuvivatwong, Metta Kuning,  
Vorasith Sornsrivichai and Wallapa Thakan*

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In 1962, in the depth of the ethno-political conflict in Thailand's Deep South, the military Government, under advice from the National Economic Development Board, began planning for the first university in the southern region. It was a strategic move to correct the opportunity inequality in higher education. At that time, nearly all southern Muslim youth were educated in religious schools (*pondok*), making it difficult for them to compete for admission to universities elsewhere. It would take decades but eventually the enrolment gap in higher education would narrow between the southerners and the central population.

The first hurdle was the physical construction of a southern institution. It took three years before a budget was available (in 1965) to begin building the Faculty of Engineering in a coastal section of Pattani city (now the Pattani campus). But then closer inspection revealed the land was too soft and too near the sea to accommodate the planned-for engineering equipment. The engineering college blueprint shifted to what is now the Hat Yai campus for Science and Technology.

In 1967, the King named the institution Prince of Songkla University (PSU). Since then, half of all first-year students are recruited under exclusive competition among high school students from all 14 southern provinces; the other half are from the nationwide competition.

Given that providing education to students was a high priority, PSU (like most other Thai universities) conducted little research in its first two decades. Additionally and owing to its remoteness and history of unrest, the Deep South seemed a 'no-go land' for research until 1986 when the Ford Foundation agreed to finance an Epidemiology Unit at the PSU Faculty of Medicine to conduct health research.

The Epidemiology Unit focused on attending to poverty-related health problems in the southern provinces. The approach was local immersion. The medical staff ventured deep into the field to study the health issues and systems and to meet villagers. Under an affirmative action policy, local youth were recruited to assist in the fieldwork and in the Unit's office and eventually mentored by the staff in their academic careers. The research findings were published and became the basis for planning and evaluation in the prevention and control of various health problems, such as maternal and infant mortality, diarrhoeal disease, pneumonia and parasitic infections.

In 1992, the World Health Organization granted the Epidemiology Unit funds to set up an International Graduate Study Programme in Epidemiology. Up to 2014, the programme has awarded PhD or master's degrees to nearly 150 students from 17 countries in Asia and Africa. The Unit's research work in southern Thailand and even internationally led to a series of research grants to increase its capacity in tackling the health problems of southern Thailand. In 2003, based on the success of the Unit, the Thai Health Promotion Foundation, along with support from the Thailand Research Fund and PSU, set up the Institute of Research and Development for Health of Southern Thailand (RDH). The opening of the RDH in 2004 coincided with the eruption of violence in the region.

### **Treating violent conflict as a disease**

The extreme violence of 2004 set off a feeling of doom and darkness among the local people and even the nation. Along with the rupture of security across the South came an overwhelming emergence of prejudice and anger between the two ethnic groups. RDH treated that animosity as another challenging disease. Its board of directors even advised the doctors not to confine themselves to conventional health matters. Their interests quickly covered many dimensions of well-being, including the restoration of social and political peace. RDH committed itself to long-term activities that would promote peace in the Deep South.

Through stakeholder analysis, RDH next identified academic institutes and faculty members and alumni who would be willing to join a peace and development alliance. Their interest was not only to help surrounding communities survive the turmoil but to use the troubling situation as an opportunity to strengthen their capacity in research and development. A 'community R&D mission' evolved with faculty from the PSU Pattani campus (which eventually turned into the stronghold of subsequent peace-building activities), the Princess of Narathiwat University and the Yala Rajabhat University, the Boromarajonani College of Nursing Yala and the Sirindhorn College of Public Health in Yala province.

Workshops were organized on proposal development, data analysis and research translation. These activities helped uplift morale and unify the medical community. Subsequently, the participating institutes independently engaged in research for peace and development, with support from the central Government and the Southern Border Provinces Administrative Centre, which was the frontline agency of the Government.

### **The health sector as a pillar of peace**

To further strengthen the peace and development work of the participating academic institutes, the Epidemiology Unit offered scholarships to local health scholars for the PhD course of the International Graduate Study Programme. These fellows were eventually recruited as teachers within the institutes. At the end of the first decade of the renewed violence, the programme had six alumni teaching in Pattani and Narathiwat provinces. Two of them are now assistant professors. The other four received international and national grants for peace and health development in the Deep South.

The Government set up the National Reconciliation Commission in 2005, tasked with recommending resolutions for a long-term solution to the violent-conflict problem. The Commission's deputy chairman, Dr Prawase Wasi, met with faculty members and local NGOs in Pattani province. He suggested that PSU should conduct a study to document the proportion of the conflict-related victims who had been compensated by the Government.

RDH members on the Pattani campus took on the study, leading to two important by-products. The first was a database of victims and their families created from case reports kept by the police and the army and which continues to be updated regularly. The database was expanded by the Ministry of Public Health as the Violence Injury Surveillance System, a registry for any victim of violence who presents at a public hospital in the region.

The second outcome was the consolidation of the PSU mission with the mission of a local NGO working to assist victims of the violence. An office representing these two missions was set up at the Faculty of Science and Technology on the Pattani campus under the name Deep South Coordination Center (DSCC) in 2005. Over the following two years, relief activities were expanded by the Faculty of Nursing at the Princess of Narathiwat University and Boromarajonani College of Nursing Yala to cover three provinces. Thus, the consolidation of the two missions established a strong link between the database and the relief activities.

Widows of men killed by the violence were the main targets of the relief assistance. The DSCC approached them one by one. After time spent making acquaintances and the provision of financial and medical assistance, the widows were invited to join a support group, which brought together women from both sides of the conflict. The DSCC arranged workshops on coping with difficulties that built up moral support among the women. Additionally, the DSCC arranged for livelihood training, including the production of food items and handicrafts that would give them work and income to feed their children.

Despite their differences in religion and mother tongue, the women shared the same difficulties in providing for their families after the death of their husbands. In solidarity, they all agreed that peaceful co-existence must prevail. The widows' group eventually became the Woman Volunteer Group, whose members help each other and reach out to new victims' families to bring them into the group for psychological, social and financial relief and rehabilitation (skills training). The group has become an instrumental agent for peace.

### **When health workers were targeted**

Thailand has a strong record in health system development; service delivery is accessible in all rural areas, including the Deep South. Each district maintains at least a 30-bed community hospital (for an average population of 50,000). In the two decades preceding the 2004 eruption of violence, health personnel (including doctors) from both religious groups in the Deep South worked together harmoniously. They certainly had their challenges, with above-country-average incidence of disease attributed to low levels of education, poverty and maladaptation, all of which are related (see chapter 4). Prior to the 2004 renewal of violence, impressive progress was achieved in service utilization. Birth attendance, for instance, shifted from 80 per cent of births in the 1980s delivered by a traditional birth attendant to 80 per cent hospital births in the early 2000s.

PSU, especially the Epidemiology Unit, has a long history of collaboration with the local and central public health offices. In response to the new era of violence, the PSU researchers and the government officers conducted a series of meetings to devise strategies for their future work. Dilemmas were identified and discussed: On one hand, the health system was under the Government, which was the target of the violence by insurgency groups. On the other hand, most hospitals were surrounded by areas of insurgency. The hospitals were not in a position to disarm the policemen and the

soldiers who visited their premises. In some places even, soldiers set up a temporary camp next door to a hospital. Doctors also were providing forensic services, sometimes under confrontation between the police and protesters, who were the relatives of conflict-related victims.

To better cope with the situation, the health sector orientated itself as neutral territory, reaffirming it would not discriminate against anyone needing medical care. Hospital security was strengthened, with fencing, adequate lighting and improved telecommunication capacity, especially for the ambulances operating at night.

Still, medical personnel were targeted. A number of health centres were torched in 2006, for instance, increasing to eight in 2007. One of them was attacked by an insurgent group during operating hours; two Buddhist health personnel were killed while their Muslim colleagues were spared. Those attacks triggered an exodus by many Buddhist health workers away from the conflict area.

In response, the Government increased the salaries of health workers to encourage them to stay. Additionally, the PSU Faculty of Medicine allocated one third of its local openings for medical students to high school graduates from the Deep South provinces who were given a special tutorial by the Faculty of Education before the entrance examination. A new medical school was set up in Narathiwat province. The Government also established a special programme to recruit 3,000 high school graduates from the southern provinces to be trained in nursing at various nursing colleges around the country before returning to work in their home province. At the same time, the regional hospital in Yala province was upgraded to a teaching hospital for medical students recruited locally, after their preclinical years at PSU. These measures eventually remedied the health personnel shortage.

### **Volunteers as a bridge to communities**

After the initial outbreak of violence in 2004, all field research was forced to halt for security reasons. That interruption in fieldwork lasted a few years and disrupted the link between the researchers and the communities. To reconnect, RDH realized the potential bridge that the large proportion of PSU students and alumni who came from local communities could become. With assistance from community development experts from southern Thailand as well as other regions in the country, RDH set up a training programme for young southern Thailand university graduates that centred on conceptual and management skills in community development. Through these

full-time 'volunteers' (they received a stipend), PSU re-established its link with communities. While carrying on their health and development activities, the volunteers could operate as agents of change, which would prepare them for leadership roles in the near future.

The programme remains running, with 20–30 recent graduates recruited from various universities in southern Thailand each year. After an intensive training in a camp-like environment, they are posted to communities with a mission to organize a small group of activists and assist them in developing a project that benefits the community in terms of health, the environment or livelihoods. During the field work, a trainer and an external expert (mostly from universities in the South) visit the communities and the volunteers for guidance. The training period takes one year. Since its inception nine years ago, a total of 194 volunteers have completed the training and most have remained working in the South in the development field. They easily have found employment in development agencies, for example, because they are equipped with skills and a predisposition for community work. In the long term, they are expected to have a pivotal role in development work, which in turn can lead to peace.

### **Learning from a ceasefire in Aceh, Indonesia**

In a completely different type of collaboration, health professionals from southern Thailand looked out of the country and into Indonesia, where a 30-year insurgency (in which tens of thousands of people died) had recently ended in Aceh province, for ideas. Aceh province and southern Thailand have many things in common. Although the two territories are separated by Malaysia and the Strait of Malacca, they have a history of cultural exchanges and communication. The language, culture, lifestyles and terrain are very similar. As well, both populations have suffered from natural disasters and the 2004 tsunami in particular. In fact, it was the massive destruction caused by the earthquake and tsunami that led to a ceasefire and peace process in Aceh between the pro-independence Free Aceh Movement and the Indonesian Government.

In December 2005, Dr Virasakdi with Mazlan, Deputy Rector of Yala Islamic University, and Dr Urai Hattakit, Associate Professor of the PSU Nursing Faculty, flew to Aceh to discuss a potential collaboration with counterparts there. Amid the still-devastated condition of Banda Aceh, the provincial capital, a proposal was developed and submitted to the Rockefeller Foundation, which agreed to support the Southern Thailand Aceh Collaboration, formed by the two groups of medical professionals. The Robert Wood Johnson Foundation (a health-focused American philanthropy) joined soon after.

The collaboration consists of three activities: i) PSU worked with Syiah Kuala University (SKU) in Aceh province to set up the Faculty of Nursing; ii) exchange visits of personnel at various levels and iii) community development through a series of workshops in both countries covering community diagnosis, disaster preparedness, health research methodology and hands-on laboratory work on plant-disease control.

More than 20 Indonesian teachers from SKU have studied at the PSU nursing school and other faculties. The exchange personnel has involved university rectors, faculty members, a vice governor, government officers, senior health officers, students, volunteers, villagers and ex-combatants, all of whom have focused on problem-solving issues related to peace and development. The community health development programme eventually merged into the curriculum of the SKU nursing school.

### **The foundation for peace work**

Despite the depressing atmosphere of violence in the Deep South, the crisis has become an opportunity of the academic and health networks to take on an important role in peace and development in the troubled region. There is now a heightened level of enthusiasm and interest to work together, to encourage each other and to strengthen each other's capacities as well as the process for building lasting peace across all of southern Thailand. A spectrum of health professionals, from doctors and nurses to academic professors to researchers, now see how they can better work with and for the southern communities. Through that work, they are seeing glimmers of hope.



# Chapter 4

## By the Numbers: Major Health Problems in the Deep South

*Rohani Jeharsae and Virasakdi Chongsuvivatwong*

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Amid the impact of stunted development as well as the violence in the Deep South, local health professionals have been working hard to combat disease and improve communities' well-being. Despite their hard work, however, disparities in health indicators remain between the South and other non-conflict areas of Thailand, as the following analysis on the successes and challenges in health care in the Deep South illustrate. Although the geographical areas that are off-limits to government staff because they are insurgent-controlled have reduced over the past decade, as pointed out in chapter 6 on the challenges and dilemmas in delivering health care, certainly the lack of access to health professionals has had an impact on health outcomes. But the socio-economic conditions of the Deep South likely heavily influence the health situation as well, if not more so.

While the so-called Deep South and its high level of conflict and violence refers to Pattani, Yala and Narathiwat provinces and the four districts of Songkhla province (Chana, Thepha, Na Thawi and Saba Yoi), many of the statistics cited in this chapter refer to all five provinces covered by the Southern Border Provinces Administrative Office, which includes the whole of Songkhla and Satun. In certain surveys, however, data collection was done exclusively in the conflict area and the non-conflict areas of Songkhla and all of Satun province were not included.

### Population demographics for the Deep South

The majority of the population in the Deep South is Muslim, with approximate proportions at 82 per cent in Pattani, Narathiwat and Yala provinces and 46 per cent in Satun and Songkhla provinces. The percentage of households living under the national poverty line in 2009 was 15 per cent, 12 per cent and 4 per cent in Yala, Narathiwat and Pattani, respectively.<sup>1</sup> Among all 76 provinces of Thailand, the three southern provinces rank 32nd, 49th and 52nd in terms of per capita income.<sup>2</sup>

The total population in the southern provinces of Songkhla, Satun, Pattani, Narathiwat and Yala in 2013 was slightly more than 3.6 million. The population pyramid (figure 1) reflects slightly declining fertility and longer life expectancy, indicated by a high dependency ratio.<sup>3</sup> In 2012, the life expectancy at birth of the population in Pattani Province was 60.6 years among males and 67.3 years among females,<sup>4</sup> lower than the life expectancy at birth for the overall Thai population, at 71.9 years for males and 78.8 years for females in the same year.<sup>5</sup>

The population growth was constant from 2008 to 2012, at 1.2 per cent per year.<sup>6</sup> The crude birth rate has been stable since 2008, ranging between 17.5 and 19 per 1,000 population. The crude mortality rate was 5.5 per 1,000 population, slightly below the national average, in 2012.<sup>7</sup>

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1 Thailand National Statistical Office, *Poverty Rates 2009: Provincial statistical report*, Bangkok: Government of Thailand, 2009.

2 Ibid.

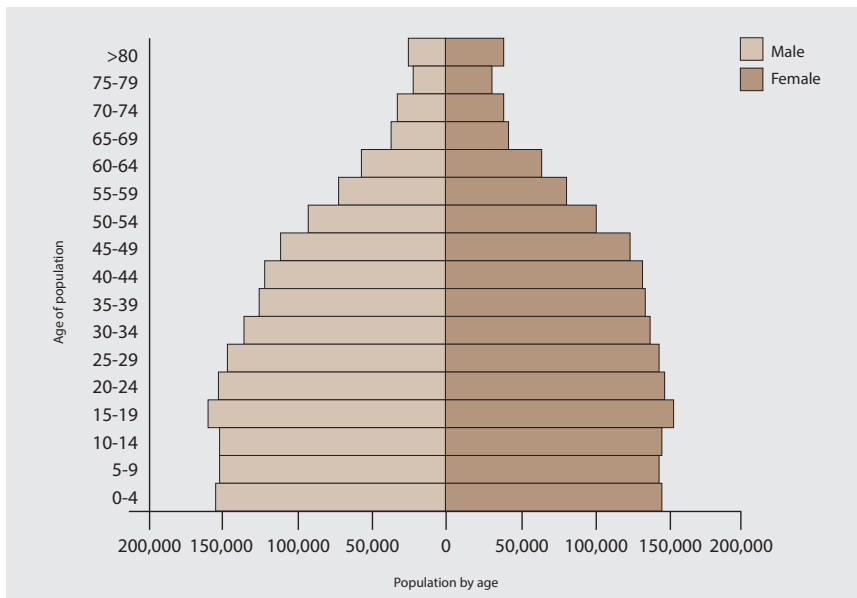
3 Thailand National Statistical Office, *Number of population by province and age 2012*, Bangkok: Thailand National Statistical Office, 2012.

4 Pattani Provincial Public Health Office, *Annual Report 2011*, Pattani, Thailand: Pattani Provincial Office, 2012.

5 Bureau of Policy and Strategy, *Health statistics*, Nonthaburi: Ministry of Public Health, 2011.

6 Thailand National Statistical Office, *Number of population from registration record, percent change and density by district: 2007–2011*, Bangkok: Government of Thailand.

7 Thailand National Statistical Office, *Number of birth and death, crude birth rate, crude mortality rates 2007–2011*, Bangkok: Government of Thailand.

**Figure 1. Population pyramid of the Southern Provinces, Thailand, 2012**

Source: National Statistical Office, 2012.

## Maternal and child health

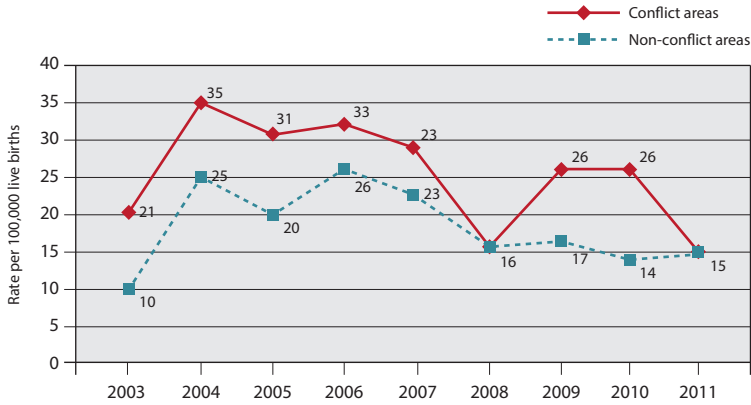
### Maternal and infant mortality

As illustrated in figure 2, the maternal mortality rate (MMR) fluctuated between 2003 and 2011, remaining higher than the national indicator (at fewer than 18 per 100,000 live births). In 2012, the recorded MMR in the southern provinces was 30.5 per 100,000 live births.<sup>8</sup> The MMR was higher in Pattani, Yala and Narathiwat (also known as the Deep South, the conflict-affected areas) than in Songkhla and Satun (non-conflict areas). Intra-partum and post-partum haemorrhaging were the major causes of maternal deaths.<sup>9</sup>

<sup>8</sup> Center of Health Promotion Region 12, *The Statistical Report 2006–2012: Maternal mortality rates*. Yala: Center of Health Promotion Region 12.

<sup>9</sup> Department of Health Promotion, *Causes of Maternal Deaths: Reported from Saiyairak Project*. Available at [www.saiyairakhospital.com/newdemo/admin/user\\_department\\_report.html](http://www.saiyairakhospital.com/newdemo/admin/user_department_report.html) [accessed on 30 May 2013].

**Figure 2. Maternal mortality rate, by conflict or non-conflict areas**



Source: Center of Health Promotion Region 12, 2013.

In 2010, the United Nations Statistics Division estimated that the infant mortality rate (IMR) in Thailand was 11.4 per 1,000 live births.<sup>10</sup> The IMR in the Deep South ranged between 8.5 and 10.9 per 1,000 live births in 2011, which were better than the national indicator. [From the Editors: Underreporting may be more common in these conflict provinces.] Within the subregion, the IMR in the conflict-affected areas has been higher than in the non-conflict areas. The rise in IMR has been observed in Pattani Province since 2005, following the resurgence of violence. The major causes of early infant death (occurring within the first 28 days of life) in 2011 were congenital abnormalities and obstetric complications, including velamentous umbilical cord, antepartum haemorrhaging and intrauterine asphyxia, while infectious diseases are the most common causes of late infancy death.

<sup>10</sup> United Nations Statistics Division, Country profile. Available from <http://data.un.org/CountryProfile.aspx?crName=Thailand#Summary> [accessed 20 July 2013].

### ***Mortality and morbidity among children younger than 5 years***

The mortality rate for children younger than 5 years (U5MR) in Thailand has declined as a result of better health care and improvement in socio-economic status.<sup>11</sup> In contrast, the U5MR in the Deep South was overall 13.7 per 1,000 live births in 2009, higher than the national and regional averages. The online registration during 2007–2009 showed the U5MR in Pattani, Narathiwat, Yala, Songkhla and Satun provinces at 15, 19.4, 13.4, 12.2 and 8.2 per 1,000 live births, respectively. Again, the U5MR has been higher in the conflict areas.

The pneumonia incidence rate was estimated at 1,541 per 100,000 population. The morbidity rates of measles ranged between 20 and 40 per 100,000 population from 2009 to 2012; two cases of pertussis have been reported; one in Yala in 2010 and one in Songkhla in 2011, while 97 cases of diphtheria, with 27 per cent fatality rate, were recorded from 2007 to 2012.<sup>12</sup> Of all provinces in Thailand, the Deep South has the worst situation of vaccine-preventable diseases.

### ***Nutritional status***

The nutritional problems among children younger than 5 years require special attention. The prevalence of undernutrition in 2011 was 1.5–2 times higher than that on the national level<sup>13</sup> and above the World Health Organization's threshold for public health concern (underweight  $\geq 10$  per cent, stunting  $\geq 20$  per cent, wasting  $\geq 5$  per cent).<sup>14</sup> The rates of underweight, stunting and wasting among children younger than 5 years in the three southernmost provinces in 2010 were 19.3 per cent, 27.6 per cent and 7.4 per cent, respectively. The prevalence of obesity was 3.6 per cent, slightly lower than the national level. Satun (at 11 per cent) and Songkhla (at 10 per cent) provinces have higher rates of obesity than Pattani (at 5 per cent), Yala (at 5 per cent) and Narathiwat (at 5 per cent) provinces.

11 Office of National Economic and Social Development Board, *Thailand Millennium Development Goals Report 2009*. Available from [www.un.org/millenniumgoals/pdf/MDG\\_Report\\_2009\\_ENG.pdf](http://www.un.org/millenniumgoals/pdf/MDG_Report_2009_ENG.pdf) [accessed 30 April 2013].

12 Department of Disease Control, *Annual Epidemiological Surveillance Report*, Nonthaburi: Ministry of Public Health, 2007–2012.

13 R. Jeharsae et al., 'Dual Dietary Intake Problems Among Under-Five Year Olds Children Living in the Armed Conflict Area of Southern Thailand', *J Med Assoc Thai*, 2011, 94:8.

14 De Onis, M. and Blössner, M., *WHO Global Database on Child Growth and Malnutrition*, Geneva: World Health Organization, 1997.

Inadequate intake of energy (at 27 per cent) and protein (at 7 per cent) among children younger than 5 years was documented in 2011. Intake of sodium and sugar in 2011 was two times higher than the Thai recommended daily intake,<sup>15</sup> which implies the high risk of future chronic disease, such as cardiovascular disease, diabetes mellitus and renal dysfunction.

The prevalence of iron deficiency anaemia among women in the Deep South, based on a screening of haematocrit of less than 33 per cent in the first antenatal care visit, was constantly high, ranging between 15 and 20 per cent in 2012, which was 1.5–2 times higher than the national indicator (at 10 per cent).<sup>16</sup> Among those pregnant women, 18 per cent had a soil-transmitted helminth infection. Pregnant women living in areas with a high intensity of violence had a higher risk of macro- and micronutrient deficiencies.<sup>17</sup>

### HIV and AIDS

The annual incidence of AIDS in Thailand has declined, from 55.4 per 100,000 population in 2004 to 0.4 per 100,000 population in 2012.<sup>18</sup> The incidence of AIDS in the Deep South has been below the national estimate and steadily declining, from 31.2 per 100,000 population in 2004 to 0.06 per 100,000 population in 2012 (figure 3).<sup>19</sup> The cumulative number of AIDS cases in Songkhla, Satun, Pattani, Yala and Narathiwat was reported as 12,484 in 2012, with 2,822 deaths.<sup>20</sup>

Among the AIDS cases, the ratio of males to females was 2.6 to 1 in 2012; with labourers (at 42 per cent), farmers (at 18 per cent) and fishermen (at 7 per cent) the most common occupations. Around 47 per cent of the AIDS patients were aged 25–35 years in 2012. The infection rate among housewives tended to increase during 2007–2011. The prevalence of HIV among children younger than 20 years in the Deep South was 4.8 per cent in 2012.<sup>18</sup>

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15 Department of Health Promotion, 'Thai Recommended Daily Intake', Nonthaburi: Ministry of Public Health, 1989.

16 Center of Health Promotion Region 12, *Iron Deficiency Anemia Among Pregnant Women: Official report 2007–2012*. Yala, Thailand, 2013.

17 Sukchan, P. et al., 'Inadequacy of Nutrient Intake Among Pregnant Women in the Deep South of Thailand', in *Conflict and Health*, Vol. 10, 2010, p. 572.

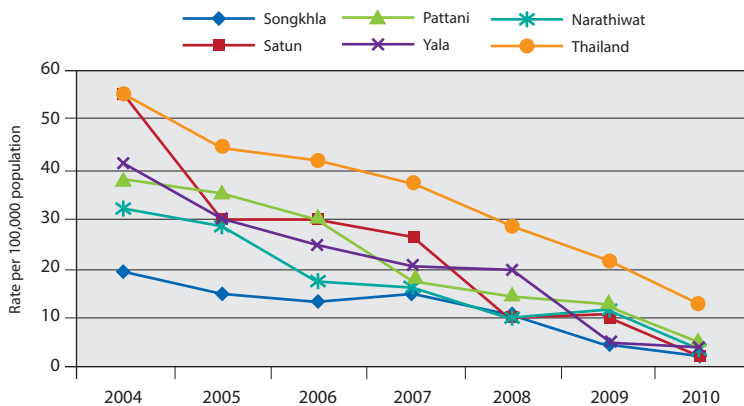
18 Bureau of Epidemiology, 'The Analysis of HIV/AIDS in Thailand', 2012. Available from [www.boe.moph.go.th/Annual/AESR2011/index.html](http://www.boe.moph.go.th/Annual/AESR2011/index.html) [accessed 15 May 2013].

19 The Office of Disease Prevention and Control Region 12, *The Situation of AIDS in Seven Southernmost Provinces: Official Report*. Yala, Thailand, 2012.

20 Bureau of Epidemiology, 'Number of HIV/AIDS cases and deaths 1984–2011'. Available at [www.boe.moph.go.th/report.php?cat=68l](http://www.boe.moph.go.th/report.php?cat=68l) [accessed 11 May 2014].

The incidence of HIV infection among pregnant women in the provinces of the Deep South in 2012 was 0.5 per cent and increased to 3.5 per cent among pregnant women who did not attend antenatal care clinics. The incidence of mother-to-child transmission was 3.6 per cent in 2012.<sup>21</sup>

**Figure 3. Incidence of AIDS, 2004–2010**



Source: Bureau of Epidemiology, 2012.

## Drug addiction

The Ministry of Social Development and Human Security reported that 5.5 per cent of children in Thailand sought treatment for drug addiction in 2012.<sup>22</sup> Estimates from a survey in southern Thailand in 2004 placed the prevalence of illicit substance use among high school students in 2002–2004 at 5–7 per cent.<sup>23</sup> The prevalence of illicit substance use among youth in the five southernmost provinces ranged from 80 to 380 per 100,000 population, two times higher than the national estimate.<sup>22</sup> Krathom cocktail, typically made by boiling the leaves of a local addictive herb (*Mitragyna speciosa* Korth.) and adding cough syrup, Coca-Cola and a sedative drug, is considered the most common illicit substance used among youth in the area. A significant upward trend for Krathom

21 National Health Security Office Region 12, PMTCT: An official statistic 2009–2012.

22 Ministry of Social Development and Human Security, 'Child Watch, 2011–2012', Bangkok: Ministry of Social Development and Human Security, 2012.

23 Assanangkornchai, S. et al., 'Substance Used Among High School Students in Southern Thailand: Trends over three years (2002–2004)', *Drug and Alcohol Dependence*, No. 86, 2007, pp. 167–174.

use was reported among the population in southern Thailand, from 2.3 per cent in 2002 to 6 per cent in 2011.<sup>24</sup> On the other hand, the rates of methamphetamine use declined, from 2.8 per cent in 2002 to 2.3 per cent in 2004<sup>22</sup> but increased to 3.4 per cent in 2011.<sup>23</sup>

## Chronic diseases

Non-communicable chronic diseases are the major causes of morbidity and death in Thailand. Among them, hypertension and diabetes mellitus were the most common health problems in 2013 (table 1).<sup>25</sup> The Bureau of Epidemiology estimated in 2013 the number of patients with non-communicable chronic diseases at 626,073. The country conducts a National Health Examination Survey every five years. However, due to the security reasons, the Deep South provinces have not been covered by the survey for the past ten years. The figures reported by the Ministry of Public Health in table 1 are based on the number of cases attending public health services.

**Table 1. Morbidity of non-communicable chronic diseases per 100,000 population, by province, 2013**

Diseases	Songkhla	Pattani	Yala	Narathiwat	Satun
<b>Hypertension</b>	442.5	345.2	326.5	442.3	456.9
<b>Diabetes mellitus</b>	202.8	138.1	121.0	143.1	215.9
<b>COPD*</b>	103.3	91.8	99.5	116.4	91.8
<b>Coronary heart disease</b>	61.6	57.9	56.6	86.1	71.1
<b>Stroke</b>	93.5	48.5	56.9	54.5	73.8

\* COPD: Chronic obstructive pulmonary disease.

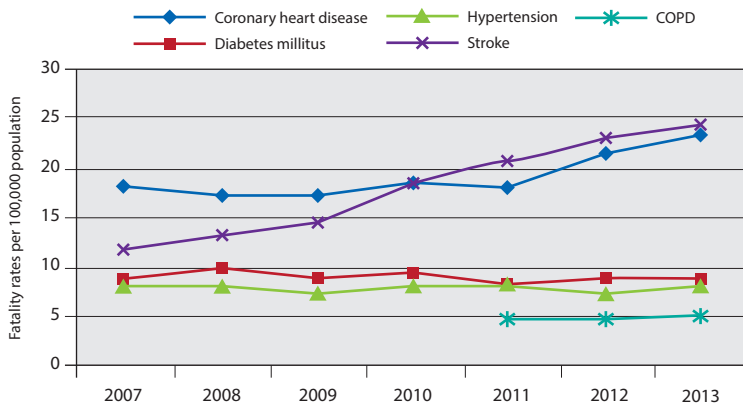
Source: Bureau of Non-Communicable Disease, 2014.

Figure 4 shows the mortality rates from coronary heart disease, stroke, diabetes mellitus and chronic obstructive pulmonary disease. There is a rising trend of deaths from coronary heart disease and stroke.

24 Assanangkornchai, S. et al., *Situation of Substance Use in Southern Thailand 2011*, Songkhla: Prince of Songkla University, 2012.

25 Bureau of Non-Communicable Disease, 'The numbers and case fatality rates of non-communicable disease 2007–2013'. Bangkok: Government of Thailand, 2014. Available from <http://thaincd.com/information-statistic/non-communicable-disease-data.php> [accessed 11 May 2014].



**Figure 4. Fatality rates, by non-communicable chronic disease and year, 2007–2014**

Source: Bureau of Non-Communicable Disease, 2014.

### Access to care and use of health services

The expansion of the Universal Health Care Scheme has improved accessibility to health services among Thais, including residents of the Deep South. The accessibility of antenatal and postnatal care of pregnant women in Thailand was 99 per cent since 2009.<sup>26</sup> In the provinces of the Deep South, the rate of early antenatal and postnatal care has improved but remains worse than the national average and has not met the Millennium Development Goal. The rates of pregnant women in the Deep South who had their first antenatal visit during the gestational stage (within the first 12 weeks) and had completed antenatal care visits during their pregnancy were less than 75 per cent and 90 per cent, respectively.<sup>27</sup> Skilled birth attendance during delivery in the Deep South provinces has increased, from 95 per cent in 2007 to 98 per cent in 2012. The rate of skilled birth assistance was lower in Pattani, Yala and Narathiwat than in Satun and Songkhla provinces.

<sup>26</sup> Thailand National Statistical Office, *National Reproductive Health Survey 2009*, Bangkok: Thailand National Statistical Office, 2010.

<sup>27</sup> Center of Health Promotion Region 12, *Maternal and Child Health: Official statistics 2007–2012*. Yala, Thailand: MOPH, 2013.

Accessibility and quality of HIV and other chronic disease treatment has improved over time.<sup>28</sup> The coverage of antiretroviral therapy among HIV-infected cases increased, from 66.8 per cent in 2010 to 82.9 per cent in 2013. The quality of care has also improved but remains below the national average. The Nationwide Prevention of Mother-to-Child Transmission programme was launched in 2000 and has reduced the incidence rate of HIV transmission among infants in Thailand from 6.4 per cent in 2001 to 0.7 per cent in 2009. However, early diagnosis of HIV among infants born to HIV-infected mothers in the Deep South has not been achieved. The coverage rate of HIV testing by the DNA Polymerase Chain Reaction test within two months was less than 70 per cent in 2012.<sup>27</sup>

The coverage of the recommended vaccine immunizations among all children in Thailand was more than 80 per cent in 2006<sup>29</sup> and 2010.<sup>30</sup> However, the accessibility of vaccine immunization among children in the Deep South has been worsening. The health surveys in 2006 and 2010 reported that the coverage was lower than 60 per cent in Pattani, Yala and Narathiwat provinces. This led to the outbreak of several vaccine-preventable diseases during 2007–2012.<sup>31</sup> The low coverage of immunization was associated with the intensity of armed violence. Residents of areas with a high intensity of violent conflict had 2.4 times higher risk to have incomplete immunization in comparison with residents in the non-conflict areas of the South.<sup>32</sup>

### Conclusion

Thanks to the dedication of the local health work force, there are certain successes in most of the indicators, although several coverage indicators are still below par. The poor health indicators can be partially explained by the fluctuating physical access that public health officers have had to certain zones controlled by the insurgents. But as well and likely more so, the long-running neglect of economic development in the region, coupled with socio-cultural barriers and inadequate education, have had adverse impact on personal unhealthy behaviours. Poor health, poor coverage of health care, the violence and the socio-economic traps have formed a vicious cycle. It is hoped that the cycle can be broken finally through peace and equitable development, both of which involve health professionals.

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28 National Health Security Office Region 12, 'PMTCT: An official statistic 2009–2012'. Yala, Thailand: MOPH, 2013.

29 National Statistical Office and UNICEF, Multiple Indicator Cluster Survey December 2005–February 2006, Bangkok: UNICEF Thailand Country Office, 2006.

30 Department of Disease Control, *National Survey of Vaccine Coverage 2010*, Nonthaburi: Ministry of Public Health, 2010.

31 Bureau of Epidemiology, Ministry of Public Health. *Annual Report of Infectious Diseases 2007–2012*. Bangkok: Government of Thailand, 2013. Available from [www.boe.moph.go.th/Annual/Total\\_Annual.html](http://www.boe.moph.go.th/Annual/Total_Annual.html) [accessed 12 July 2013].

32 Jeharsae, R., *Effects of Armed Violence on Growth and Development of 1- to 5-year-old Children in Southern Thailand*, Songkhla: Prince of Songkla University, 2011.

# Chapter 5

## Epidemiology of the Violence in the Deep South

*Metta Kuning, Mayuening Eso, Vorasith Sornsrivichai  
and Virasakdi Chongsuvivatwong*

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In 2005, National Reconciliation Commission members approached researchers from Prince of Songkla University to monitor and evaluate the incidence of violence and casualties in southern Thailand. A database system was set up at the Faculty of Science and Technology, Pattani Campus. Data were retrieved from various sources, including the army, police and newspaper reports. The office managing the database came to be known as the Deep South Coordination Centre.

In 2007, the Ministry of Public Health joined forces with the data collection and set up a violence-related injury surveillance (VIS) system in which all public hospitals in the Deep South capture basic data for all insurgency-related victims during their first admission. The VIS data is then fed into the database of the Deep South Coordination Centre. All the data is analysed each month and results distributed through public health and academic networks.

The data on victims of violence in the South have been used to guide and evaluate a rehabilitation programme for affected families that the Government and the Deep South Coordination Centre jointly manage.

Using that same information, this paper presents epidemiological analysis of i) general trends in violence (seasonality, day of the week and time of day, ii) where the violence occurred and iii) certain characteristics of victims (age, sex, occupation and religious affiliation). The data represents the four southernmost provinces of Pattani, Narathiwat, Songkhla and Yala (also referred to as the Deep South, the conflict affected areas) and largely spans incidents that occurred from 2004 through 2013.

### Limitations

The data did not preclude crime-related violence. Although the Government set up a committee to differentiate violent conflict-related victims from crime victims for financial compensation purposes, this epidemiological analysis included them equally as victims of violence. The data derive from several primary sources, of which the quality of the detail and classification could not be guaranteed. Despite these limitations, there is no strong indication for changing the conclusion of the analysis.

Additionally, the Southern Border Provinces Administration Centre had no influence on the data analysis.

### General trends

Figure 1 presents a summary of victim cases from 1993 to 2013. The chart reflects the flare up in violence in 2004, which continued to increase in 2005 before peaking in 2007. From 2004 to 2013, a total of 22,979 people were reported as physically affected by violence in the southernmost provinces, 7,567 of whom died (as noted in chapter 2, more than 6,000 deaths are directly attributed to the violent conflict). In addition to those injured, 553 were reported as disabled. A total of 55 persons went missing (disappeared) in 2004; to date, there is no information on their whereabouts. Of the 21,254 violence events reported between 2004 and end of 2013, guns (44 per cent) and bombs (21 per cent) were the most common weapons used. The other 15 per cent included arson and knives.

**Figure 1. Trends in cases of victims affected by violence in the four southern Thailand provinces, 1993–2012**

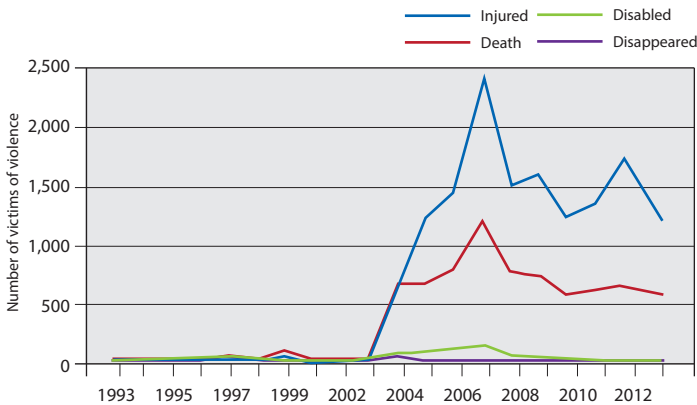


Figure 2 breaks down the number of cases (all categories) reported between 2004 and end of 2013 by the month and year in which they occurred. There is no clear seasonal variation; most years had a steady fluctuation. The exception is 2012, when the peak reached more than 700 cases, mostly due to the massive bombing of an underground car park of a hotel–department store complex in Hat Yai, Songkhla province and simultaneous attacks in other provinces.

**Figure 2. Number of victims of violence, by month and year, 2004–2013**

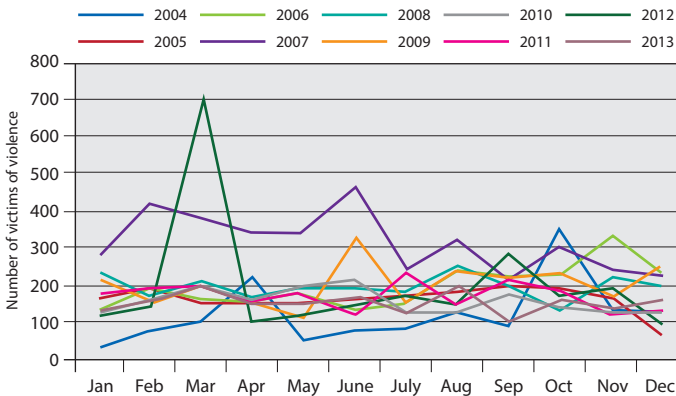


Figure 3 illustrates the number of cases by the day of the week an attack was made from 2004 through 2013. With the exception of the 2012 bombing and simultaneous attacks in Songkhla province, the attacks generally occurred during weekdays, with smaller numbers of cases occurring during the weekend.

**Figure 3. Number of victims of violence, by day of the week and year, 2004–2013**

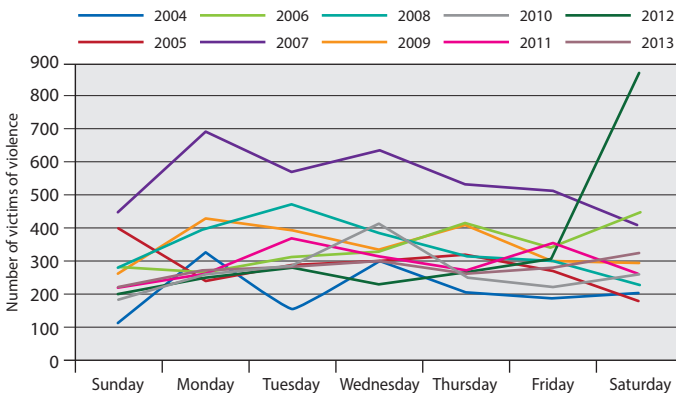


Figure 4 shows the distribution of cases according to the time of day, from 2004 to the end of 2012. The activities started mostly at daybreak, peaked around the morning rush hour, slightly declined during the day (except the unique bombing event in 2012 in Songkhla province) and rose again after dark. After midnight, however, it was relatively quiet.

**Figure 4. Number of victims of violence, by hour in the day and year, 2004–2012**

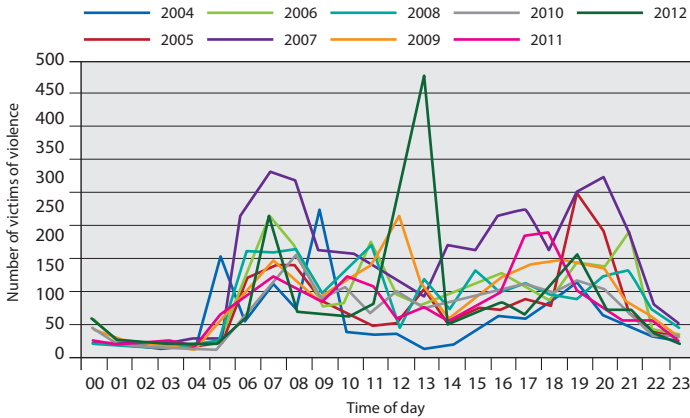


Figure 5 illustrates a comparison of the number of reported violent attacks from 2004 through 2013 in each of the four provinces analysed. The largest number of cases was reported in Narathiwat most years, while the fewest was reported in Songkhla. Narathiwat, Pattani and Yala all experienced a spike in cases in 2007. Narathiwat continued to experience a couple of spikes, while the incidence took a downward trend in Pattani until 2011; the incidence in both provinces reached the same level in 2013. With its population slightly more than half of Narathiwat and Pattani, Yala had the largest concentration of cases in the majority of years. Most of the time, it had the same trend as the other three provinces. Although overall Songkhla had the smallest number of cases, it experienced a huge spike in 2012, when two of the four provinces were experiencing a downward trend.

**Figure 5. Comparison of violence trends among the four affected provinces, by year, 2004–2013**

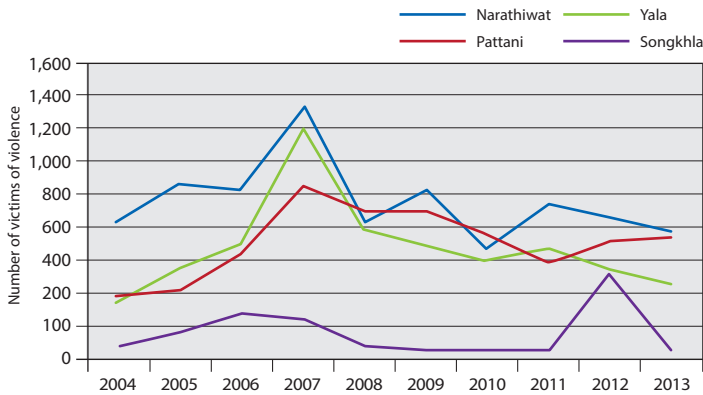


Figure 6 illustrates the summary of where violent attacks took place from 2001 through 2013. Of the 11 categories of sites, more attacks occurred on a road or highway, generally by ambush or targeted assassination. The second most common site was a shop or house. Schools were the fourth most common type of location for an attack. Of the total events that took place in that time period, 945 schools across the four provinces were attacked (by arson) – exceeding the number of attacks on government offices (593) and military barracks (525).

**Figure 6. Numbers of victims of violence, by place and year, 2001–2013**

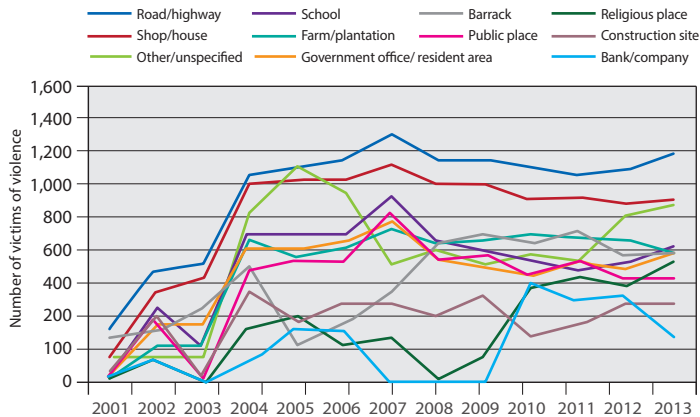


Figure 7 breaks down cases of victims by age and sex in 15-year intervals. Males clearly exceeded females in all age groups. Not surprising, the incidence was sharply high among male youth and middle-aged men.

**Figure 7. Number of victims of violence, by sex and, 2004–2013**

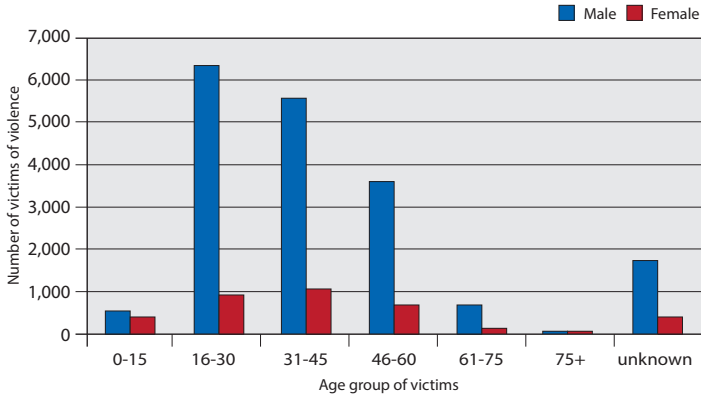


Figure 8 illustrates the number of victims by type of target from 2004 through 2013. Of the 22,377 victims in that time period, more of them were either civilians or armed force personnel. The former was two to three times greater than the latter in 2004. This ratio declined as more soldiers were deployed, beginning in 2006. In 2013, when peace talks between the Government and the insurgents began in Malaysia, the number of civilians and armed forces casualties were similar, suggesting that the discussions may have prompted a shift in attacks, from civilians (soft targets) to soldiers (hard targets).

Attacks involving community leaders, such as village heads and local politicians, were nearly equal in number to children and students. Next in number was unspecified civil service officers. Teachers, who are part of the government civil service, were counted separately, at 304 cases. The number of religious leaders, either Muslim or Buddhist, were generally fewer than ten per year. Altogether, 39 Muslim and 31 Buddhist religious leaders were attacked. Health professionals were the least targeted, at 16 cases in the ten-year period.



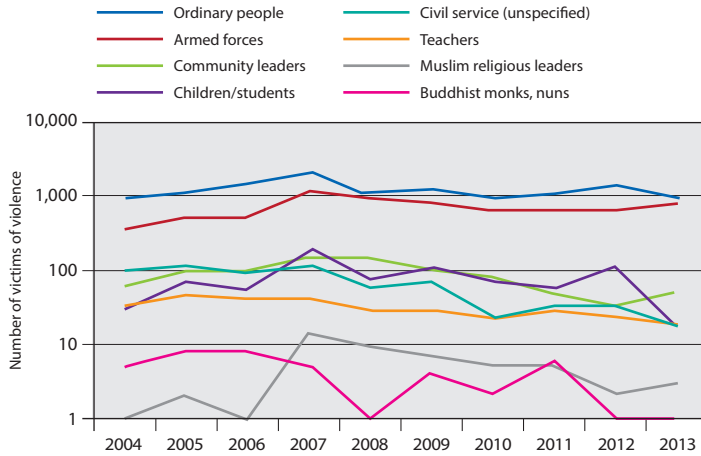
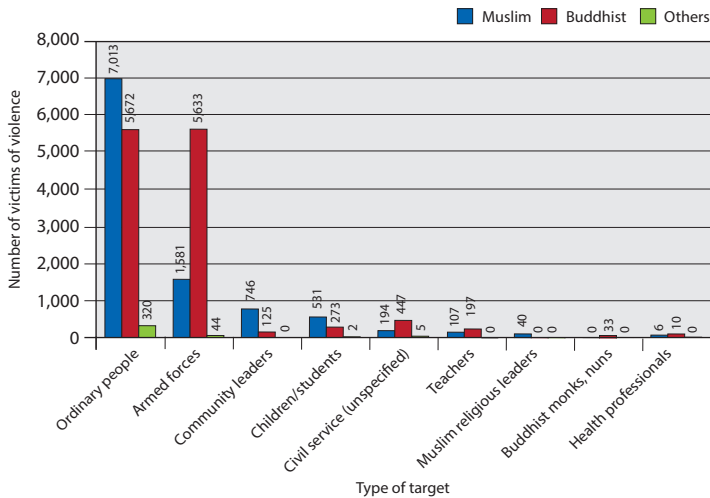
**Figure 8. Number of attacks, by target and year, 2004–2013**

Figure 9 breaks down the cases of violence by types of targets and religious affiliation that occurred from 2004 through 2013. Of those who were attacked, Muslim civilians (at 7,013) outnumbered Buddhist civilians (at 5,672). However, with the total population for the four provinces at 80 per cent Muslim, the odds of a Buddhist being attacked was approximately three times greater than a Muslim. The soldiers who are stationed in the South are largely deployed from other parts of Thailand and are mostly Buddhist; a significant portion of the locally employed or deployed police and paramilitary are Muslim. From 2004 through 2013, the number of casualties among Buddhist soldiers was more than three times the number of casualties among their Muslim comrades. Buddhist cases exceeded Muslim cases among the civil services officers and school teachers who were attacked (as with schools, school teachers were regular targets).

**Figure 9. Numbers of victims of violence, by type of target and religion, 2004–2013**



### Analytical summary

The incidence of attacks tend to occur in the daytime on weekdays. The targets of attacks have been mostly men of working age, although children and elderly people have also been injured or killed. Targeted locations and people hit by attacks have been mostly civilians. These include shops, homes and schools; school teachers and children; and, to a lesser degree, religious leaders. The increased deployment of soldiers and other security forces has not led to any reduction in casualties among civilians, especially among the local Buddhist minority whose risk is three times greater than their Muslim peers; discussions between representatives of the Government and the insurgent groups seemed to have had a short-term positive affect on the number of attacks, although the number of attacks on soliders increased. The relatively low attack rate on health professionals suggests that they have been somewhat spared by the intense conflict. The most unfortunate indication from this analysis is that the attacks will not abate any time soon.

In unexpected ways, the data that has been generated has helped communities. For example, they have learned to diminish the risk of exposure to violent attack by avoiding certain places and by only travelling during certain times. Ultimately, the data illustrates a decrease in civilian casualties during the formal peace process, which is strong advocacy for resolving the conflict through peaceful means, such as through dialogue.

# II. ADAPTING AND DELIVERING HEALTH CARE AND THE COLLABORATIVE INITIATIVE

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## Chapter 6

### Coping with Challenges and Dilemmas Amid the Conflict

*Supat Hasuwannakit and Withoo Phrueksanan*

## Chapter 7

### From Unprepared to Managing Severe Traumatic Mental Stress in the Deep South

*Pechdau Tohmeena*

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*Ananchai Thaipratan*

## Chapter 9

### Capacity Building for Health and Peace Work: A Collaborative Effort in Southern Thailand

*Gabriella Arcadu, Louisa Chan Boegli, Urs Boegli, Virasakdi Chongsuvivatwong  
and Supat Hasuwannakit*

## Chapter 6

# Coping with Challenges and Dilemmas Amid the Conflict

*Sapat Hasuwannakit and Withoo Phruksanan*

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Thailand has experienced five decades of impressive rural health development. Health infrastructure, including various levels of hospitals and health centres, are now spread out across the whole country. They are all staffed with trained health personnel, ranging from doctors, nurses, dentists and pharmacists to other types of health workers.

Community participation in health issues in Thailand also has been exemplary. In all villages, there are village health volunteers connecting people with the health system. As of 2002, the universal health coverage policy successfully covered all citizens with practically free essential care, from primary level to high-cost care, such as cancer treatment. In international forums, the country has been praised for attaining good health at low cost.

The health system in the Deep South<sup>1</sup> shares this success. Despite the poorer general health of residents there (described in chapter 4 on the health situation in the South), the health infrastructure and system have been well maintained and proven to be a foundation of social welfare capable of surviving, at times, overwhelming challenges.

Despite instability and conflict, local health care facilities managed by the Ministry of Public Health have been able to provide services to people continuously throughout the past stormy decade. It is the only public sector that is still running grassroots-level activities in the areas of unrest. According to field assessments from the Deep South Relief and Reconciliation Foundation, areas off-limits (due to insecurity or control by insurgents) to government health personnel have steadily decreased. During the peak of violence in 2007, around one third of villages were off-limits to government personnel, but that number has shrunk to less than 10 per cent today.

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1 'Deep South' refers to the conflict-affected provinces in southern Thailand of Narathiwat, Pattani, Yala and four districts in the Songkhla province.

Maintaining this level of health care amid the conflict has been challenging. Resourceful coping mechanisms, resolve and courage are required to deal with many of the difficult situations. This chapter presents some examples of how health professionals in the Deep South managed the challenges and dilemmas they confronted.

## Health care system in Deep South provinces

As table 1 indicates, the three southernmost provinces of Pattani, Narathiwat and Yala (also referred to as the Deep South) have a combined total population of around 2 million people (approximately 80 per cent of whom are Muslim); three-quarters of them reside in the two largest provinces. The four districts of Songkhla province affected by the conflict have a total population of around 300,000 people (45 per cent of whom are Buddhists), nearly half the size of the two largest provinces.

Each district has either a general hospital (with 120 beds and more than 300 staff) or a community hospital (with 30 beds and more than 100 staff) and around 10 health centres (or health promotion hospitals) staffed with at least four health personnel. Yala Hospital is the designated regional hospital of the Deep South, whereas Songkhla has one large regional hospital under the Ministry of Public Health and a teaching hospital run by Prince of Songkla University in Hat Yai. With these facilities and considering that every household in any village has a motorcycle or a car, any health problem or casualty is practically within a 15 minutes' drive from care at a health centre or within half an hour's drive from a hospital.

**Table 1. Population and health facilities in the Deep South, mid-2013**

Province	No. of districts	Population	Percentage of Muslim population	No. of general/ community hospitals	No. of subdistrict hospitals
Pattani	12	735,164	86.3	1 / 11	128
Narathiwat	13	760,783	89.1	2 / 11	111
Yala	8	493,818	76.6	(1*)+1 / 6	80
4 districts of Songkhla	4	317,715	55.4	(2*)+1 / 3	62
<b>Total</b>	<b>37</b>	<b>2,307,480</b>	<b>80.9</b>	<b>3*+5 / 31</b>	<b>381</b>

Note: \* = Regional hospitals with more than 500 beds in Yala and Songkhla provinces.

Source: Ministry of Public Health, 2014.

In terms of the distribution of health personnel in the Deep South, although there is no precise data, an estimated 30 per cent of the doctors in district hospitals are Muslims, compared with less than 10 per cent in the provincial hospitals. In general, more than 50 per cent of the nursing staff in the Deep South are Muslims. In community hospitals, especially in rural areas, more than an average of 80 per cent of nurses are Muslims, as compared to an estimated 50 per cent in the provincial hospitals.

### **Responding to the escalating conflict**

In response to the violent events, the Ministry of Public Health and the Institute for Research and Development of Southern Health conducted a series of meetings in early 2004 on security for health personnel and facilities. As noted in chapter 5 on the epidemiology of violence in the Deep South, with vigilance and careful management, certain health professionals and health facilities were still targeted, but far less frequently than other civilian government entities.

In the meetings, there was consensus that the immunity provided by communities and people is the most important factor to achieving security in a sustainable way. The strategies that emerged from these meetings involved ways to enhance trust between the government health workers and the communities. First and foremost, a firm stance on the principle of impartial and non-discriminating quality health service provision was adopted collectively.

Other strategies (described further on) included a systematic approach to integrating Malay Muslim cultural customs and practices into public health facilities; the formation and nurturing of mixed Buddhist and Muslim health teams; promotion of harmony among hospital workers of different faiths and cultures; advocacy for health and access; reaching out with holistic care to communities suffering from poverty; and measures for promoting the physical security of patients and health workers.

These strategies proved critical not only for deepening the potential for social healing in the communities but also for coping with the more immediate challenges and dilemmas.

## Challenges and dilemmas encountered by health professionals

The following examples illustrate that impartiality and the provision of non-discriminating care to all people in need are sometimes inadequate to address the dilemmas. The capacity to analyse a situation in order to take the best course of action that will 'do no harm', and the ability to negotiate are equally vital.

### 1. Conflicting loyalties

- This case illustrates some of the frequently encountered incidents faced by health care personnel. A man came to a health centre in Yala in 2005 with a serious gunshot wound in his foot. Treatment was beyond the capability of the local health personnel, and the patient was therefore referred to Yala Hospital. Following treatment, the patient was arrested on suspicion of being an insurgent. Subsequently, the worker in the health centre who had referred him was threatened by the insurgent group on suspicion that he was responsible for the arrest. The health care worker had to move out of the area for his own safety. The dilemma was that had the wounded man not been referred, he might have died from his wounds. It takes courage to put medical ethics first, taking the side of the patient's best health interest, even at the cost of personal risks.
- To gain goodwill among communities, the armed forces sometimes requested the government medical teams to join the propaganda mobile unit. As government workers, the health care providers had a certain obligation to participate in government events. But joining these units would have jeopardized the impartiality of the health professionals in question and damaged the trust with the communities. Because many of the health care workers are Malay Muslims, refusing to join may have created suspicions among the military. An alternative solution was found in which the medical team created its own mobile unit that operated independently of the military.

### 2. Protecting patient confidentiality

The military sometimes requested to see the family folders that each health centre keeps for health monitoring and preventive care service. Honouring this request would have seriously damaged the trust with the communities served by the health facility. In many cases, this request was successfully refused on the grounds that health workers needed to protect their impartiality as well as the patient's private information.

### 3. Forensic medicine, justice and culture

Forensic science is one of the most important tools medicine has to offer to serve justice and contribute to the rule of law in times of insurgency and conflict. However, there are several challenges to providing forensic evidence in a systematic way in the conflict areas of the Deep South.

- The first challenge is safety for the forensics team at the scene of the incident, most often located in a violent environment. At times, secondary bombs may be buried or hidden, undetected until it is detonated to harm the investigating military officers. Medical doctors in community hospitals typically are requested to join the military to perform this task in remote areas. Ultimately, to protect the medical personnel, a compromise was negotiated to allow post-mortem examinations to be conducted only at hospitals.
- In almost all incidents of violence in the Deep South, eye-witnesses, circumstantial witnesses and hearsay witnesses are rarely found or might not be trustworthy. This is mainly due to fear among the villagers of reprisals from either side.
- Cultural barriers are another major challenge. An example is the retrieval of bullets from gunshot wounds. By law in Thailand, bullets must be handed over to the police as forensic material. In the South, it is the custom for some villagers not to cut the body of the deceased because it is considered to be disrespectful. The doctors managed the dilemma by negotiating with the military that they would perform autopsies and hand over forensic material on a case-by-case basis. In high-risk areas, doctors honour the request of relatives of someone deceased not to carry out an autopsy.
- The local Islamic faith does not allow autopsies to be performed, even if evidence from the examination would help to establish justice. To find a definitive solution, a study tour to Malaysia and Singapore, made possible by The Asia Foundation, was organized in 2010 to learn how autopsies on Muslims were handled in those two countries. Among many useful guides they learned that a fatwa had been issued to permit the performance of autopsies, particularly for reasons of establishing justice. This finding was compatible with the Office of the Chief of Muslims in Thailand. The Forensic Medicine and Toxicology Unit and the Office of the Chief of Muslims in Thailand then organized a seminar on Forensic Medicine and Justice in the Deep South in April 2011 to disseminate the details of the study trip and news of the fatwa to other doctors working in the southern provinces. Additionally, they assembled the insights from the study trip into a booklet entitled, *Autopsy in Muslims: Experience from Malaysia and Singapore*. Little by little, autopsies have become more acceptable in the conflict areas.



- Finally, there is a shortage of forensic specialists for the whole country – there is not a single one in the three provinces. General practitioners, who receive one week of forensic medicine training during their studies, are called to ‘crime scene’ investigations or to conduct post-mortems. To address this shortage, the Forensic Medicine and Toxicology Unit, Faculty of Medicine, Prince of Songkla University and The Asia Foundation started refresher courses for general practitioners and paramedics working in the Deep South. After the first course in 2009, a workshop in crime scene investigation for physicians was conducted in 2010, with an annual training course now organized in collaboration with the Office of Regional Public Prosecution Region 9.

#### **4. Presence of armed forces at health facilities**

During the peak of violence in 2005 to 2008, the national security forces demanded to have military checkpoints in front of certain health centres across much of the Deep South. It was understood that this would breach any trust built with the community as well as the principle of impartiality, potentially leading to attacks from the insurgents. Even so, the hospital and health centres staff did not manage to refuse the presence of the government armed forces.

### **Security strategies for health professionals and facilities**

The following examples illustrate the resourceful strategies that health personnel in the Deep South used for managing security in their work in the conflict areas.

#### **1. Building trust with the communities**

The Yabi health centre in Pattani province is responsible for six villages, one of which is an isolated Buddhist village. Polarization and hatred were so intense that the road entering the village used to be well known as the ‘Buddhist killing zone’. The health centre deployed mixed teams of Buddhist and Muslim health workers to provide needed medical services within all the villages to win over the trust of the surrounding communities. One of the successful programmes targeted maternal and child health. The teams provided antenatal care and transferred the women for hospital deliveries. As follow up, they also provided postnatal visits and infant immunization. The outreach and the interest were welcomed by the villagers. According to one of the medical team members, “We need to consult our community on any new policy ordered by the Ministry of Public Health. The Imam and community leader must be first consulted in order to adapt the policy to harmonize with the local culture. By this approach, we gain much community trust and participation. Conflicts within the community are then minimized.”

### 2. Culture-oriented medical service

There is agreement among Buddhist and Muslim medical leaders in the Deep South that Malay Muslim culture can be applied to promote health services. Several community hospitals (such as Chanae Hospital in Narathiwat, Raman Hospital in Yala and Mai Kaen and Mayo Hospitals in Pattani) initiated activities, with support from the Thai Islamic Medical Association, which was established in 2003 by health professionals in the Deep South to promote health activities based on Islamic disciplines. This included adjusting the hospital kitchen to comply with the halal standard, allocating areas in the hospital wards for Salat (Islamic prayer), giving advice or accommodating the duo prayer for Muslim patients, adjusting the drug administration to Muslim patients during Ramadan, giving opportunity to family members of Muslim patients to recite the surah Yasin over the dying ones, allocating areas for azan chanting to welcome newborns, promoting birth-spacing instead of contraception and expediting the post-mortem examination to allow burials of family members within 24 hours.

Deliberate efforts were made to show respect for the cultural identity of the majority Malay Muslim population. For example, Jawi (the Kelantan-Patani Malay dialect) is now spoken for all communication with the patients and families who are Malay Muslim. Buddhist staff learned the language if they did not know it. All hospital signs are now in both Thai and Jawi. Confidence in hospital deliveries is encouraged by allowing female family members of the mother-to-be to perform maternal 'bearing-down cheering' in the labour room. To the extent possible, gynaecological examinations are conducted by female medical personnel.

Islamic traditions are also used to promote healthy practices. One example is involving the local mosque in health check-ups for people prior to their making the pilgrimage to Mecca. The Iman at the mosque now discusses the parts of the Koran that relate to health promotion. At the same time, Chanae Hospital has established an association of people who have completed the Hajj to assist others who are preparing for the pilgrimage. They are also active in contributing to community development.

### 3. Nurturing harmony among hospital personnel

It is a common tendency to carry personal discriminations and prejudices into the workplace. This is also true for the Buddhist and Muslim hospital staff in the conflict areas. At Mayo Hospital in Pattani, the loss of relatives due to the violent conflict had become common among the health personnel and was affecting their work morale as well as their relationships with staff from another culture. There was also a threat of staff leaving, which would then jeopardize the quality of services and ultimately the well-being of communities. The hospital initiated psychological healing therapy that involved all personnel, regardless of religion. This brought about a new level of mutual respect, understanding and reconciliation within the hospital. Over time, the harmonious relationships in the hospital spread over to the surrounding communities, benefitting the delivery of health care.

### 4. Providing health care to off-limits areas

There are a number of ways an area becomes off-limits to government health teams. One is if the area is controlled by insurgents; another is the recent occurrence of a security incident. For instance, if an arrest or assassination occurred near a house that was visited by a medical team, they could become suspect. In these situations, subsequent access would be denied to the health teams.

Building trust with communities and improving health services is problematic when access is interrupted by one side or the other. Home visits by hospital teams are stopped, increasing the potential for misunderstanding with the villagers. Without home visits, several health service activities, such as health education, immunization and vital follow-up care with patients, including psychological support, would decline. Several initiatives have been taken to address this challenge.

Bannang Star district of Yala province is an area that constantly shifts between 'control' by the government forces and an insurgency group. In 2007, five health care stations were set on fire in the same night. In times of such violence, it became too dangerous for the health team to carry out home visits. To cope with this challenge, the Bannang Star community hospital built a strong collaboration with a variety of community groups in the area. One such group is the Hilal-Ahmar Foundation, a Muslim charitable organization that provides ambulance services. The Bannang Star hospital supports the training of Hilal-Ahmar's paramedics and provides medical supplies and equipment for the ambulances. In return, the Foundation's paramedics transport patients to and from the hospital because they can more easily access areas that are off-limits for hospital personnel. In another district near a 'frontline', nine villages were identified as off-limits to the

government health staff. The insurgent groups would give no guarantees for the safety of any medical personnel who travelled to those villages. Unable to visit the villages, the hospital recruited and trained 'health volunteers' from the off-limit villages to promote basic health and to bring people who needed medical services out of the villages to a safe area where they could be treated.

One current initiative taken by the hospital director in this district is to informally 'pair' a village in an insurgent-controlled area with a nearby village in a government-controlled area. This approach involves enabling villagers to spread health education to another village that is not accessible to the hospital health teams, follow up on patients, especially for chronic illnesses or pregnant women or to maintain an 'eye' on the medical situation, particularly the incidence of communicable diseases like dengue. The visiting villagers assess the health conditions of the village and report back to the hospital. They encourage villagers whose condition requires medical care to go to the hospital or they take medicine from the hospital to them and monitor their adherence to the regime, and they ask parents to take their children for immunization. This arrangement intends to establish a positive relationship between the off-limit villages and the medical sector and create an environment of trust that eventually will pave the way for health staff to come in.

### **5. Engaging with communities beyond medical care**

Staff in one community hospital in Narathiwat province realized that their healing of wounds and psyches in an area prone to conflict-related violence was not alleviating suffering. Doctors and other health professionals on their own initiative were making house calls to provide physiotherapy, psychological support and other needed care to victims of the violence that sometimes occurred on a monthly basis. The director of the community hospital saw villagers in his district not only as victims of bombs and gunshots but also victims of the decades of limited economic development. The poverty was more pervasive, affecting most villages in the district. The families could not seem to escape poverty. The director used hospital funds to set up a livelihood scheme to provide families with seed money to start a business: If they could earn more income through a shop or small business, they could improve their homes and provide better care for their children. The hospital staff who routinely made the house calls for follow-up services helped the families start a business (growing vegetables, preparing food for sale in the market, rice trading and making hijabs). They made referrals to other government agencies for specific social-welfare or technical assistance as needed. The money provided, ultimately to 30 families, is regarded as a 'tool' the hospital

uses to make contact and stay engaged with families and with those communities. The hospital staff collectively participates, expanding their follow-up medical care visits to include more basic health promotion along with the continued psychological support and now extending to holistic care by checking on the health of their businesses.

## **6. Advocating access to health care for all**

Health professionals continue to engage in informal discussions with the government armed forces and, separately, with communities. These 'go-between' discussions have led to a common understanding among the different parties, and over time the off-limit zones have decreased. Consequently, health personnel have been able to visit more and more communities that had been off-limits over the past decade.

The off-limit status of these villages is not static. It is dependent on the situation, such as, which side is 'in control' of an area, and other factors, including the level of trust. In view of this, there is growing recognition that health care personnel should be able to safely enter all areas to perform their duties and serve communities. There is both a need and an opportunity to raise such an issue in the next round of negotiations between the Thai Government and the insurgents.

## **7. Physical security measures in health facilities**

Under the extraordinary circumstances when the conflict escalated so precipitously in 2004, there was an urgent concern to protect the health care providers and hospital workers. The security measures considered by hospitals posed certain dilemmas. It curtailed the openness of the hospital staff and environment, but by taking the initiative, intervention by armed security forces in the hospital was reduced, and staff morale improved substantially.

Raman Hospital in Yala province was the forerunner in implementing the measures for physical security. It is a 60-bed community hospital responsible for a population of around 84,000 people, nearly all of whom are Muslim. Buddhist doctors, nurses and other health personnel work with the majority Muslim staff. Because the hospital is situated in a frontline of tensions, the main challenge initially was to set up a reliable security system within the hospital to boost staff confidence and enable the continuation of services.

The outer surface of the hospital fence was cleared of bushes and signs to improve visibility. Considerably more lighting fixtures and closed circuit surveillance video cameras were installed. All ambulances were installed with telecommunication equipment and the necessary instruments for self-protection while retrieving or transporting patients to the regional hospital, especially at night.

In addition to modifying the physical infrastructure, security guards were given refresher training. More were recruited to enlarge the security surveillance 24 hours a day, and they were provided with necessary non-lethal defence devices. Vehicles were prepared and provided for health care workers for routine and emergency commutes between their home and the Raman district hospital. Lodgings were provided for health personnel on night shifts. More male hospital personnel were added for night duty. Food stocks were increased to meet the needs of the patients and the personnel. Drills were conducted regularly for various scenarios, including the detection of suspected explosive objects.

With these measures, designed to keep themselves from becoming a target, none of the health centres ever requested security protection from government armed forces.

### **Has the effort of the health sector made a difference?**

The violence in the South is a result of deep-rooted conflict, which the health sector alone cannot be expected to resolve. But as the examples cited here illustrate, health professionals constantly seek and test coping mechanisms to meet the challenges of their work environment. Because of these experiences, hard lessons have been learned and new thinking has emerged. The main strategy is to take opportunities for 'positive' peace as the sustainable way forward to end the violence in this conflict. The health professionals in the Deep South have become a kind of bridge in the conflict, as they show time and time again that trust – the basis of reconciliation – can be earned through applying principles in a consistent way, unflinching commitment and speaking out for local people and their health.

## Chapter 7

# From Unprepared to Managing Severe Traumatic Mental Stress in the Deep South

*Pechdau Tohmeena*

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The unrest in southernmost Thailand that has caused much loss of life and physical suffering also has disrupted the psychological well-being of the population living there. The impact is especially grave on the survivors, their families and the families of those killed and the individuals who witness the acts of violence associated with the unrest.

Chronic fear and horror can reduce the productivity of people's daily work and quality of life. Women whose husbands have been killed or are missing are particularly affected, especially when they have few income-earning skills and are suddenly forced to provide for their families. There are an estimated 3,000 widows due to violence in the Deep South, many of them struggling with psychological trauma.

Survivors of blasts and other attacks who have lost a limb and possibly their ability to work have been struggling with depression, although they are sometimes not aware they are suffering a treatable mental health disease.

Children are in an even more precarious situation. Sometimes as witness to an incident, their reaction persists long after the situation; often, no one realizes they are suffering psychological trauma. Symptoms manifest as nightmares, screams in the night, chronic paranoia, repetitive aggressive behaviours, refusing to leave their mother or go to school.

For example, a 10-year-old Muslim girl witnessed a bomb incident in front of her school in Narathiwat Province. She was not physically hurt and thus was not sent to hospital. One week after the bombing, however, her behaviour began to change. She dared not leave her mother's sight or go outside the house, including to school. She was overcome with fear at the sight of uniformed persons, such as soldiers and policemen, whom

she angrily cursed when she saw them. After a year of such behaviour, she was taken to hospital. Had her teacher known the signs of trauma, she likely would not have suffered so long or lost a year of schooling.

People directly exposed to a psychologically traumatic incident can experience various forms of acute stress disorder, or ASD. The symptoms self-remit within four weeks. However, if symptoms persist longer than four weeks, patients are diagnosed with post-traumatic stress disorder, or PTSD, which manifests as panic attacks, anxiety, addictive substance dependency, depression and/or suicide. According to a review by Galea et al., the prevalence of PTSD within the first year after a human-made or technological disaster varied from around 25 to 75 per cent in international literature.<sup>1</sup> They concluded that there is “a substantial burden of PTSD among persons who experience a disaster” and people who are direct victims “have a greater likelihood of developing PTSD than other groups”.

### **From promoting mental health to managing violent conflict trauma: Unprepared health professionals**

In 2004 when the brutal violence erupted, the mental health practitioners based in the South were in no way trained to cope with trauma associated with violent conflict. The only psychiatric hospital in the region was located in Songkhla province to serve seven provinces. Within the three provinces (Narathiwat, Pattani, Yala) where the violence was overwhelming, there was only one psychiatrist posted in Yala province.

As he read of the quickly escalating violence, the Director General of the Department of Mental Health in Bangkok expected immense numbers of mental health issues at a level beyond the capacity of local health services to cope with. Not only for the individuals suffering without even being aware that such trauma is normal and treatable but also to help the rebuilding of community trust that would be needed when peace finally returned, the Director General requested that I move from Bangkok to my native Pattani province in late 2004 to build a mental health response unit, which would be the first mental health office in the Deep South.

After hiring local staff – three psychologists, three social workers and three public health officers, I needed to understand what was needed in the communities. Initially, focus group discussions were conducted among three separate groups of people: 1) patients

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1 Galea, S., Nandi, A. and Vlahov, D. 'The Epidemiology of Post-Traumatic Stress Disorder after Disasters', in *Epidemiologic Reviews*, Vol. 27, 2005, pp. 78–91.



and victims' families; 2) government officers, soldiers and teachers; and 3) health professionals. In the discussions, everyone said, "Help me, help me". They all talked about stress and how they did not know how to deal with it. The government officers wanted to know how to protect themselves, especially the teachers, who were perceived as being targeted by the insurgents. The health workers, especially the nurses, said they understood grief or being upset, but they were not prepared to deal with violent conflict. Severe traumatic psychological stress was a new problem for many.

### **Interim volunteers provide care**

My team and I decided local bachelor graduates in psychology could best fill the many gaps but this needed at least two years of specialized training and refresher courses. During the first two years, the Ministry of Public Health deployed, on a voluntary and monthly rotation basis, psychiatrists, psychiatric nurses, psychologists and social workers along with general practitioners and other needed specialists. These volunteer professionals worked at the three provincial hospitals. However, it was hard to establish trust with patients due to the constant face-changing, especially of staff for mental health treatment.

### **Training local psychology graduates**

The local graduates who signed up for the two-year Mental Health Crisis course comprised a mix of Muslims and Buddhists. The curriculum included psychological first aid, crisis intervention, home visits, psychological resilience, counselling and cognitive behaviour therapy. The trainees were provided with an operation guideline to conduct mental health rehabilitation. Depending on the subject, individual courses varied in duration. Some parts of the training were instructed in Bangkok.

Starting from 14 trainees in the first year, 74 trained psychologists were produced by the end of the fourth year. There was no quota for any religious representation among the trainees – the only emphasis was each trainee had to be a local resident. As a whole, 80 per cent were Muslim, and the others were Buddhist.

The trainers were experts from Bangkok, but without direct experience in violent conflict. Useful articles from international journals were summarized and translated into Thai for the trainees to read. The ideas from these articles were then tested on a group of local residents, such as relaxation techniques.

In 2006, for training on dealing with trauma for children, the Government brought in foreign specialists who had direct war zone experience.

In 2008, after that training was completed, a Mental Health Rehabilitation Unit was set up in each of the 37 district hospitals across the three southernmost provinces and four districts in Songkhla province. Each unit is staffed with a general practitioner, a psychiatric nurse and at least one psychologist (depending on the population and the incidence of violence). They are technically supervised by the 12th Mental Health Centre in Pattani, which in turn, is supervised by the Department of Mental Health in Bangkok.

### Home visits

From early 2005, a mental health team from the community hospital and the Tambon Health Promotion Hospital and a village health volunteer began visiting families victimized by the unrest and the mental health patients recently discharged from hospital. The priority is to check the mental health impact; the case can be referred back to the hospital if necessary. The home visits even include a team travelling to northern and north-eastern provinces to follow up on soldiers who were originally treated in a hospital in the southern conflict area. Over the years, the home visits have been vital for detecting violence-related trauma cases that have been neglected.

This following case illustrates the importance of home visits. A woman in Pattani, mother of two, was married to a soldier. One day in 2004, after dropping the woman off at a shop, the husband was gunned down. The woman became depressed and paranoid, lost her appetite and could not sleep. The case was mentioned to the mental health rehabilitation team from the community hospital. They visited her at home and began counselling her. She eventually joined a support group for widows and is now the leader of her group.

The mental health rehabilitation team generally involves a nurse, psychologist and a health volunteer from the village. Village health volunteers and NGO staff were trained to conduct basic screenings and now assist in the mental health work by reporting undetected cases, especially among survivors of incidents who did not need to go to hospital.

It has become standard practice that immediately after a bombing or other attack, a team from the Mental Health Rehabilitation Unit visits the families of all survivors and those who died, from both sides. In the early days the focus was only on the mental health of the survivors and their families. However we often heard such complaints as, “You keep asking me if I’m sleeping, if I’m eating. But I’m hungry because I have no money. How can you help that?” At that point, we started asking about social problems to make referrals to other government agencies and NGOs that could respond to those needs. Now staff in other government agencies inform us of mental health concerns they find when visiting villages.

### **Providing desperately needed training**

In 2005 a training workshop was set up for teachers on psychological first aid and how to recognize trauma in children. One teacher from each school was trained to be trainers with the intent that they pass on knowledge to other staff in their school. It did not work as planned because the teachers were so overwhelmed with other trainings as well as their own worries. What was needed then and remains a gap is a psychologist in every school.

A specialist in negotiation from the Department Mental Health in Bangkok trained health care personal in hospitals and clinics on negotiation techniques, particularly in managing a hostage situation or an insurgent attack. They also had training on psychological first aid and what to do if they see a bomb. They were also trained on how to replicate this training with all health professionals in their district.

### **Overcoming stigma**

Thailand is a country without a tradition of seeking out psychological treatment generally. Stigma is a major obstacle. Typically, a mental health problem is translated as ‘craziness’. To begin breaking down the stigma, the psychologist teams approached people, in the hospital or in their home, to explain that they were not ‘crazy’ patients, but that what was happening to them is part of normal life – a normal reaction to abnormal situations.

People believe that if a loved one dies, it's okay to cry. But after an exposure to violence, they won't cry because they think it is a weakness. We conducted many one-day workshops for the media, religious leaders, village heads and health volunteers to tell them that it is normal to cry. We also included in our training workshops a session on burnout to tell the participants they may have a mental health problem and not realize it. We emphasized that they should encourage their friends to speak up if they notice them acting out of character.

### **Mobile clinic**

Due to the stigma, not every household was at ease with mental health practitioners visiting them. We set up a mobile clinic that made visits to villages recently affected by violence (or when a village chief called and asked for help because residents were particularly stressed) every three months. The mobile clinic included a general doctor and nurse along with a psychologist and psychiatric nurse and a community mental health specialist if there was one. The clinic set up in the middle of village to provide a mix of services. This way we masked the mental health purpose with general health care and people with stress disorders could discreetly come to the clinic.

### **Self-help groups**

Families of those left dead by the violence in the South typically struggle to carry on. Women whose husbands are killed are especially affected because they typically were previously only handling the child rearing and household work. The death of the husband leaves them immediately responsible for the family's financial burden, and they are unequipped. In the early years, women were both mentally traumatized and struggling to find ways to earn income.

In 2008 the Government provided funding for 'healing purposes' and we asked each district hospital to start a widows' support group and a children's group. They could use the funds to take members on field trips for relaxing and to teach them new skills.

In 2011, the Mental Health Rehabilitation Unit started a social rehabilitation programme for the wives of the victims of the violence. A total of 28 self-help groups in various communities have been formed and they all include a mix of Muslim and Buddhist women. By sharing their experiences of suffering and how to overcome the difficulties, the women gradually found psychological rehabilitation. Many of the self-help groups involve livelihood training, such as handicraft production, to help the women improve their financial situation.

The contribution of the group goes beyond ethnic, culture and religious boundaries – it provides a natural reconciliation process. Exchanging experiences of pain and suffering works to reduce the psychological burden. This self-help group approach has become a local success story. It could be an inspiration for similar victims elsewhere in the world.

### **Dealing with revenge: Particular concern for children**

Children's mental health remains a priority for treatment. Although the PTSD symptoms have remained similar over the past decade, we are seeing a shift in children's attitudes. Early on they spoke of having no hatred for the 'other side'. But now we are increasingly hearing of children from both sides wanting revenge. There are children who want to become soldiers to kill 'the one' who killed their father. In the villages, they want to have a gun to kill the soldier or police who killed their father.

This is a possible social fracture that we health professionals can help to heal through our work. We have found that if we go as soon as possible after an incident and talk with everyone who experienced an injury or trauma we can better deal with those feelings of revenge. But we don't have enough personnel to make all the visits we should make. And for safety reasons we can't go everywhere. Hospital directors don't allow their staff to go to insurgent-controlled areas. However, because of the trust built, if I go to those areas, usually the staff can go with me.

PTSD is known to be common among children exposed to the violence in the South. As of March 2014, a total of 5,686 children had been left orphaned due to the unrest, according to the Ministry of Social Development and Human Security. Yet, less than 10 per cent of them appear in the violence-related mental health surveillance (VMS) database that was set up by the regional psychiatric hospital. The statistics alone (such as those for children and adults receiving mental health attention highlighted in the table) suggest that the problems among children are under-recognized. PTSD sufferers are seriously under-reported in all age groups. The majority of them are left undiagnosed and thus untreated in the community.

**Time trend of patients receiving and reported to need mental health services**

Affected children and adults whose mental health is being monitored							
	2008	2009	2010	2011	2012	2013	2014 Jan-Jun
No. of affected victims recorded in the VMS database (Children/adults)	0/660	0/1,404	104/1,454	17/326	158/2,898	380/1,477	76/717
No. with risk for more mental health problems (Children/adults)	0/183	0/314	10/237	5/118	10/102	79/94	20/32
Diagnosed with PTSD (Children/adults)	0/0	0/0	0/0	1/7	0/10	0/6	0/2

A Child Trauma Centre was established in Yala Hospital in 2008 to provide special services specifically targeting children and teenagers affected by the unrest. Currently, two trained psychiatrists run the centre.

**Remaining challenges**

Mental health problems are still overwhelming in the Deep South. They are affecting the well-being of those who reside in the provinces where the violent conflict is ongoing as well as many of those from elsewhere in the country who are temporarily posted there. A new concern is the survivors of attacks that have left them with a disability; many are struggling with depression. Despite tremendous efforts by the Ministry of Public Health, too many cases of psychiatric trauma are left undetected and untreated. With what we have put in place over the past decade, we have about 70 per cent coverage in the three southernmost provinces and the four districts of the fourth province.

Most of our mental health experts are Muslim. We have found that, at least in the fragile beginning after a violent incident, the religious appearance of our therapists makes a difference. There was a case in which a monk was killed in a temple. The psychiatrist who visited the community looked Chinese (but was Muslim) but the staff with him wore headscarves. Someone in the community said, "Your Muslims killed our monk." The psychiatrist told the staff to stay back and he talked with those who were affected. After a month or two of regular visits, the community could accept talking with a Muslim therapist.

I think there is more we can do with communities and not just individuals, especially where a particular family may be stigmatized by a community because of something one person in that household did in the past. I recommend group therapy, but that is proving difficult because some of the ten families I wanted to start with were told by an insurgent not to join any group activity.

Self-healing can begin when victims receive support and treatment. The self-help group is proving to be an invaluable tool to help the healing, not only the psychological issues but also the financial and social hardships.

Self-healing begins with health care professionals who have a vital role in the healing of communities – physically, mentally and emotionally. Visits and support by mental health personnel enhance the potential for rehabilitation of the countless victims and witnesses to the violence and their families.

Clearly more mental health assistance is needed in the Deep South. But equally needed is protection for those professionals who bravely reach out to help the healing. Eventually, attention to mental health healing will contribute to understanding and reconciliation within and among these communities. Above all, this kind of healing will prevent hatred and revenge passing from one generation to the next.

## Chapter 8

# Thai Islamic Medical Professionals' Contribution to Peace

*Ananchai Thaipratan*

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Protection of life, respect for diversity and, above all, peace, are deeply rooted in Islamic teachings and culture. For Thai Muslims, it is as much a spiritual practice as a way of life and an identity.

This Muslim way of life may be jeopardized by materialism and moral degeneration as the impact of globalization spreads. In some areas in Thailand, especially the Deep South provinces, Muslims find it vital to follow Islamic teachings and to fully and freely express their culture and identity. It is perhaps the perception by the Muslims in the Deep South that their belief and way of life are threatened that there is continued unrest. This perception and the lack of efficient integration of all religious and cultural groups in the Deep South may have impaired the well-being of all people living there.

Uneasy with this reality and wanting public health care to be more acceptable to the Muslim communities, Muslim health professionals came together more than a decade ago to find ways to accommodate the Muslim way of life, beliefs and faith in the medical and public health care services.

These health professionals established the Thai Islamic Medical Association (TIMA) in May 2003. The founding group included physicians, dentists, pharmacists, nurses and other professional health care workers who reside in the Deep South. The association was founded on a commitment to professional and ethical responsibility and to society. Since its inception, TIMA has provided leadership and professional standards. It has become a role model for change, providing inspiration to preserve harmony among the southern population and making space for sustainable peace.



Using TIMA as a platform, the Muslim health professionals organized themselves to work with colleagues of other faiths in providing medical and public health care in the form of health promotion, disease prevention and curing the ill in all communities. Their work, however, involves a particular focus on serving people with attention to the need to balance the mind, the body, the spirit and social relations if the quality of life is truly to improve.

To meet the needs of communities that are difficult to access, medical and public health outreach is organized through TIMA to complement the medical services provided by the government health system. For example, mobile medical services are now available to these communities. Assessment of needs and health promotion are conducted through the mobile services in areas inaccessible to the government public health personnel. Mobile services also help victims of natural disasters, such as floods, earthquakes and tsunamis, and also victims of the unrest. This assistance has been given to all those in need without discrimination of race, nationality and religion.

There is a consensus among the Muslim health professionals that health care has much wider implications than merely responding to disease. Therefore, it has become common practice to be involved in and to support social welfare and community activities.

The process starts with community visits and analysis of community issues. Volunteer health professionals work with community members to survey the health conditions and the infrastructure and gather insight on current problems. Then together they consider solutions. Attention is paid to involving the community in problem solving. In this way, individuals are drawn together in seeing the significance of community management, learning to solve their issues as a community and learning to manage medical and public health problems quickly and with maximum efficiency.

Muslim health professionals also organize youth camps and workshops on topics all communities are struggling with: managing the drug addiction problem in villages; strengthening family relationships and cohesion; building awareness and education in health; ensuring consumer protection; securing the standard of food hygiene in Halal food; preventing infections from religious practices, such as circumcision;<sup>1</sup> and managing the environment as part of tending to the balance needed to improve the quality of life.

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1 The Joining Sunat Project involves encouraging the community to go to health facilities with good medical practice for Sunat (male circumcision) and to avoid practitioners who are not qualified.

TIMA and Muslim health professionals have also collaborated with non-Muslim colleagues in government district hospitals to adapt some of the procedures to accommodate Islamic traditions. These activities have reassured Muslim communities that all health professionals respect their culture, identity and religion. It is hoped that in time, the trust and mutual respect fostered will lead to peaceful co-existence among all the people in southern Thailand.

Many of the leaders in the Muslim medical and health community attended the workshop on Health and Peace in December 2013. Several strategies presented during the workshop are already in place in the daily practice of Muslim health professionals; they have been validated and others adapted further. Most of all, there is an acute awareness of the merit of developing more skills and knowledge for Muslim health professionals in peace work. A conference on health and peace and the role of Islam and the medical profession is next in 2015.

## Chapter 9

# Capacity Building for Health and Peace Work: A Collaborative Effort in Southern Thailand

*Gabriella Arcadu, Louisa Chan Boegli, Urs Boegli,  
Virasakdi Chongsuvivatwong and Supat Hasuwannakit*

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The collaboration between the Rugiagli Initiative (tRI),<sup>1</sup> a Swiss-Italian association of doctors and diplomats, and the Deep South Relief and Rehabilitation (DSRR) Foundation,<sup>2</sup> a southern Thailand non-government health organization, began in 2013. The two organizations share the vision that health professionals, particularly nationals working in conflict areas in their own countries, have the potential to contribute to a mutual understanding among opposing communities, violence reduction and ultimately to peace. To exercise that potential as effectively and safely as possible, many health professionals could benefit from capacity building in peace work.

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- 1 The Rugiagli Initiative:** tRI is a network of physicians, diplomats and practitioners whose goal is the prevention and abatement of violence in conflicts by working directly with local (in-country) physicians. The work of tRI is based on the widely recognized link between health and peace: No peace is possible without health and, vice versa, no health is possible without peace. A number of programmes and activities have emerged from this link, with various degrees of success. tRI follows in this tradition and aims at creating a platform for like-minded physicians and future generations of physicians who aspire to develop a fresh approach to the abatement and prevention of violence in conflicts. tRI is based in Italy and Switzerland. It was formed by four members – all former WHO and ICRC staff – and relies upon a wide network of advisors from amongst others, Harvard University Medical School, the United Nations system, the private sector, NGOs and academic institutions.
  - 2 Deep South Relief and Reconciliation (DSRR) Foundation:** DSRR was established in 2010 to coordinate and mobilize resources and activities to alleviate problems arising from the unrest in the Deep South. It grew out of earlier efforts to help academic and health professions assist victims of the Deep South violence since 2004. The activities range from awarding grants for the timely provision of relief to conducting research on relevant issues to managing public communication for policy change. Its board of directors and affiliate experts encompass individuals with long working experience in the Deep South, which allows for a good understanding of the local dynamics and the evolution of the conflict. The DSRR network operates in four main areas: relief and improvement of the quality of life of the victims and residents in the region; enabling of community-level reconciliation; development of knowledge to solve problems faced by local communities; and communication to improve the public's understanding of the situation in the Deep South. In its activities with tRI, the DSRR aims to establish strong collaboration with local partners to foster long-term sustainability of its activities; such partnerships have been established with the Deep South Coordination Centre and the Institute of Research and Development for Health of Southern Thailand.

### Collaboration in southern Thailand

The collaboration on health and peace work in southern Thailand is unique in many ways. First, capacity building on health and peace is unusual for medical professionals, particularly for those working in conflict areas. Second, capacity building on this subject is usually offered only through universities, most often in peaceful countries or as online courses.

The core assumption of tRI is that medical professionals have in common intrinsic 'peace capacities', originating from altruistic values, the Hippocratic Oath and a systematic evidence-based problem-solving approach, all of which lends credibility to their profession. Just as tRI was researching pilot projects to test its core assumptions, DSRR was simultaneously searching for a partner for its Health as a Bridge to Peace initiative. Through mutual academic contacts, the two organizations found themselves in a collaborative initiative.

From the start, the tRI's strategy has targeted national doctors for training in peace work. The strategy includes carrying out training in situ, in safe areas in the vicinity of conflict areas. The DSRR agreed with the strategy, after all the pros and cons were weighed and discussed.

A private Swiss foundation, PeaceNexus, which specializes in supporting start-up organizations working to support peace, sponsored the collaborative initiative. Organizational support and co-financing also came from DSRR's core budget. All the experts, resource persons and organizers donated their time for the project.

### Process and planning

To reach out to potential Thai partners, detailed desk research was first undertaken by the tRI team to build on the existing knowledge of the conflict, expand potential contacts for information and identify risks and opportunities. Different perspectives of the conflict and historical developments were researched.

In coordination with the DSRR and at their invitation, a field assessment mission was conducted in the summer of 2013. A specific questionnaire was developed to obtain information in a cultural- and conflict-sensitive way. The assessment was then conducted in Bangkok, Hat Yai (where DSRR is based) and in the conflict areas (in Narathiwat, Pattani, Songkhla and Yala provinces) with health professionals to further gather information, analyse risks and opportunities and to evaluate the strengths and weaknesses of the health system and the social and economic issues in the Deep South.

For tRI, the field assessment resulted in a more thorough understanding of the conflict, beyond what desk research could bring. A wide array of stakeholders was identified and new relationships were built.

During the field assessment, DSRR sponsored a roundtable discussion, inviting health professionals from all sides of the conflict, ethnic and gender groups and health sector specialities. The discussion was unexpectedly open and frank. It was the first time since the conflict escalated in 2004 that medical professionals from the conflict area sat together to talk about the conflict, the dilemmas they faced, the difficulties of delivering good health care, the risks and the opportunities for reconciliation and violence reduction in the communities where they operate. On the question of the role that the medical community could have in peace work, they wanted to know more from other contexts. Concepts such as 'peace', 'reconciliation' and 'violence reduction' were extensively discussed.

All participants at the roundtable expressed the need for a workshop to learn more about the role of health professionals in peace work; they suggested such topics as mediation, negotiation, conflict analysis, managing suspicions, human rights, international humanitarian law and the ways health professionals may contribute to peace.

## Experts resource team for the workshop

### Thai

- Dr Virasakdi Chongsuvatwong, Chair of the Deep South Relief and Reconciliation Foundation
- Dr Yongyudh, Ministry of Health, Department of Mental Health, Thailand
- Dr Uthai Dulyakasem, former President, Silpakorn University, Thailand
- Somchai Homlaor, Asian Institute for Human Rights, Thailand

### International

- Dr Louisa Chan Boegli, tRI, Switzerland
- Urs Boegli, Former Int. Committee of the Red Cross (ICRC) delegate, Switzerland
- Dr Kimberlyn Leary, Associate Professor, Harvard University Medical School, USA
- Dr Klaus Melf, Associate Chief Medical Officer, Troms, Norway and Medical Peace Work (MPW)
- Dr Gabriella Arcadu, tRI, Italy
- Dr Stephan Kolb, Nuremberg Clinic, Germany, MPW
- Victor Vavricka, Minister, Deputy Head of Mission Swiss Embassy, Thailand
- Dr Norbert Ropers, Berghof Foundation, Germany, Bangkok Liaison
- Thomas Frisbie (main facilitator), management consultant, Krabi, Thailand

In preparing for the workshop, tRI and DSRR collaborated to invite the participation of experts from Thailand and other countries. Great attention was given to the selection of resource persons in charge of conducting specific learning sessions. The main criteria were experts who either had firsthand knowledge of the situation in the Deep South or who, because of their professional background, could provide compelling insights on the subject matter. The results of this effort was an international–Thai experts resource team who could easily respond to participants’ needs and who constituted a significant network of experts that tRI, DSRR and the participants could build upon for future initiatives.

### **A three-day workshop in Krabi**

The Workshop for Medical Professionals in the Deep South: Supporting Mutual Understanding and Violence Reduction was arranged for the end of 2013 in Krabi, a town untouched by violent conflict but in close proximity to southernmost Thailand.

A total of 30 participants (health professionals, social workers, academics and hospitals managers) attended – nine of them were Muslim and the others were Buddhists; half of them were women. Thai was the working language, with simultaneous interpretation in both English and Thai.

The workshop was designed for three purposes: i) to respond to the learning needs as outlined during the roundtable discussion during the field assessment mission; ii) to create a safe space in which health professionals facing the challenges of working in conflict-affected areas could vocalize their concerns and explore possible strategies for coping; and iii) to serve as a first step of the feasibility phase aimed at assessing tRI’s main concepts and working assumptions (the last step of this feasibility phase would be an impact evaluation mission).

The workshop was also a way to strengthen the tRI partnership with national (Thai) actors as well as to build alliances with the international associates. Finally, the workshop was designed as a start-up process that would lead to the development of a national/international collaborative model for tRI and its partners.

## Methodology and content of the workshop

### Main topics covered during the workshop

- Introduction to ethno-political conflicts, the southern Thailand peace process, multi-track diplomacy and peace processes
- Health and Peace work in theory and in practice
- Ethical dilemmas health personnel can face in times of internal conflict
- Enhancing access and security and the management of suspicions
- Experiential learning on the main principles of negotiation and mediation
- Human rights issues arising from the conflict in the Deep South
- Anger and violence management

For the success of the workshop, it was crucial to have the maximum involvement of participants. It was therefore essential to create an environment in which they felt safe to share – among themselves and with the experts resource team – their professional experiences and the challenges they face. In addition, it was necessary to provide them with sound technical inputs to increase their conflict analysis competence as well as provide them with tools that would enhance their capacity to interact with the volatile situation they encounter in their everyday work. To this end, the workshop was organized in three phases.

The first phase focused on conflict and problem analysis. An analytical framework of the southern Thailand conflict was provided and a specific session was entirely devoted to participants presenting the challenges they deal with when delivering health services in conflict-affected areas. To make this session more effective, participants were advised to bring case studies prepared in a certain format.

The case studies brought the immediate reality into the workshop, describing, for example, the widespread violence in Yala and Pattani and how the rising level of mistrust among communities posed obstacles in health care delivery. With this session, participants strongly framed the activities of the workshop into the dynamics of the Deep South conflict.

The second phase focused on sharing knowledge and practical skills. Participants were exposed to conflict analysis models, negotiation and mediation skills, managing ethical dilemmas, human rights issues in southern Thailand, tools to engage stakeholders and the opportunities to develop curricula for health personnel that included peace and violence reduction topics. Each topic was approached through specific presentations followed by working groups, practical exercises or general discussions to allow maximum participation and idea sharing.

The third phase focused on operational planning for follow-up activities. Working in small groups, the participants discussed in detail what practical steps could be taken in different situations to address a particular need, challenge or issue.

The entire workshop process was facilitated by a bilingual Thai–English consultant who ensured overall coherence. He (with assistance from professional interpreters) facilitated the interaction among participants and communication with the non-Thai resource persons.

### Outcomes of the workshop

The main outcome of the workshop was four initiatives with corresponding action plans to be implemented in the following months. Brainstorming of initiatives occurred throughout the workshop among teams, facilitated by a Thai and an international mentor for each team. The action plans for the selected initiatives were elaborated during the last session of the workshop by the teams, again facilitated by the Thai and international experts. With facilitation, all working groups identified objectives, intended outcomes and step-by-step actions and then developed timelines to implement the overall plan for their initiative. Team leaders were selected for each initiative.

#### Initiatives and action plans:

##### **Initiative concerning mental health, anger and violence reduction**

The goal of this initiative is to reduce the transfer of violence from generation to generation. As post-traumatic stress disorder (PTSD) among adolescent and children sometimes manifest in compulsive acting out and aggressive behaviour, the plan is to increase mental health services that target youth and children living in families affected directly or indirectly by violence. The selected target group would normally have limited access to the health system and usually left out of standard mental health care. In addition, an outreach strategy is planned, based on mental health promotion to sensitize parents to the signs and risks of psychological trauma in their children. A prominent Muslim woman psychologist based in the conflict area leads this initiative.



### **Medical school curriculum development initiative**

This initiative plans to introduce health and peace work topics in the standard nursing and medical school curriculum of Yala University. The group developed a step-by-step approach that starts with a sensitization workshop for staff of the different academic institutions to engage them, build awareness and test an initial curriculum. Building on the feedback received from this workshop, the plan foresees developing a curriculum that then could be proposed to other nursing and medical schools. To ensure relevance of the curriculum, each step is to undergo an in-depth evaluation process. A senior lecturer and education development specialist in the medical faculty of the Prince of Songkla University, southern Thailand, leads this initiative. (see also chapter 10)

### **Supporting mutual understanding and the peace process – Track II involvement by physicians**

This action plan focuses on including health personnel in the tracks II and III processes for peace already in place in the Deep South. The main point of the plan is the establishment of the Deep South Health Profession Network. It is envisaged that the Network will provide the framework to engage in peace efforts. In addition, the Network would also serve as a framework to create a health package for southern Thailand that is more relevant to the needs of the region. A district hospital director from the conflict area leads this initiative.

### **Integrated teams for health outreach initiatives – ‘Healthy Mosques’**

This action plan focuses on increasing access to health care for communities in areas controlled by opposition forces and the off-limits areas where Government health personnel do not have access.<sup>3</sup> The strategy is based on engaging local imams and authorities to use mosques around the restricted areas as health centres that the population feels comfortable to visit. Health care and confidence building will be supported by the creation of a mobile health clinic that is able to provide primary health care. A prominent Muslim doctor and district hospital director leads this initiative.

In the months following the workshop, the international and Thai mentors (except one) kept in touch with the four team leaders to provide support for the implementation of the action plans. This contact and mentoring continued for this book project, which the Embassy of Switzerland in Bangkok has sponsored.

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3 There are a number of ways an area becomes off-limits to Government health teams. One is if the area is controlled by insurgents; another is the recent occurrence of a security incident.

In terms of capacity and network building and from participants' evaluation, the workshop was a useful learning and relations-building event. The participants were engaged and committed throughout the three days. They were open when discussing the challenges and the problems they confront when working in the conflict-affected areas. Even when sensitive topics were approached, such as issues of discrimination based on language and race in the Deep South, identity and self-determination and the lack of remedies put in place to address consequences of violence, the participants remained non-confrontational.

Bringing everybody out of the conflict zone and providing a 'safe space' proved to be a successful strategy for constructive discourse on creating mutual understanding. Further, keeping the workshop close to the conflict area proved a sound choice in terms of allowing the participation of busy health professionals coming from conflict-affected areas and, at the same time, having the conflict issues ever closely present.

During the workshop it became evident that the medical and health professionals from the conflict areas were most concerned about the daily challenges they deal with in their work. These concerns were about security for themselves, their families and their staff and colleagues; suspicions from the local military and political leadership; political pressure; and ethical dilemmas. Also of concern was the lack of access to certain communities, not only because of the military operations but also because of polarization and conflicting loyalties and ideologies from both sides. The participants admitted that the health indicators in the off-limits areas were alarmingly poor, compared with non-conflict areas of Thailand.

Remarkable coping strategies have been internalized to manage these challenges. In fact, the skills, ideas and knowledge shared during the workshop were well received in part because the participants could identify with the scenarios presented and were eager to learn different ways of coping. These coping strategies – some translated into the action plans – were possibly the most useful outcome of the workshop because they could be developed and shared with other health professionals in the Deep South and elsewhere. In several instances, the participants wanted validation of the ways they have been coping with the situation, and the inputs from the external resource experts filled that need.

In addition to the initiatives proposed by the participants, the workshop further added value by brining together health professionals, men and women, from both sides of the conflict and from all ethnic groups (Thai Buddhists, Chinese Buddhists, Christians and Malay Muslims). Open exchanges on normally taboo subjects created special bonds and relationships of trust. This workshop was the first step towards understanding the 'other' side, and not just on a professional basis but at a deeply personal level. The hope is that these relationships will go on to foster the creation of a network of like-minded professionals who provide mutual support in Thailand as well as in other conflict areas in the world.

### **Assessing the impact of the workshop**

A year after the start of the project, an evaluation team from tRI and DSRR visited southern Thailand and the conflict areas with the objective of assessing how the initiatives developed during the workshop are evolving and, in general, to understand the feasibility of the concepts and operational strategy proposed by the pilot project. The evaluation exercise was meant to be a continuation of learning for all those who have collaborated in the project. The Krabi workshop was never designed as a single event but was to begin a stream of continued contact and activities with local and international networks.

The evaluation took place just after a major political upheaval resulting in a change of government and the suspension of the official peace talks between the previous Thai Government and the representatives of the southern Malay Muslim opposition group. The evaluation revolved around a number of questions as a framework for data collection and analysis: What happened after the workshop? What problems were encountered? What assistance was – or is – needed for proceeding? What should have been done differently during the workshop? What networks were established?

The evaluation was carried out mainly through:

- an impact assessment seminar with some of the participants of the Krabi workshop;
- several field visits in the conflict-affected areas at the location of the proposed initiatives; and
- group and individual meetings that allowed the engagement of a variety of stakeholders, such as imams, village leaders, school teachers, university professors, health personnel, journalists and representatives of organizations engaged in track II diplomacy.

Of the four initiatives developed during the workshop, two had concrete follow-up activities.

### **Curriculum development**

The proposal of the health and peace course inserted into the core curriculum of the medical school was under deliberation by the Board of Directors of the Faculty of Medicine of the Yala University. It has been decided, however, to include topics relevant to health and peace in the extracurricular courses and seminars. As part of the extracurricular programme, the lectures given by the tRI and DSRR evaluation team were well received by both faculty staff and medical students. Further, the translation of Medical Peace Work online material<sup>4</sup> in Thai has started.

### **Healthy Mosques**

This is an ongoing programme in one of the conflict-affected districts in Narathiwat province, with 10 of 34 mosques now designated as 'Healthy'. These Healthy Mosques offer primary health care to restricted groups of families. After participation in the workshop, the director of the district hospital negotiated access to the Healthy Mosques for everybody, including the communities in areas where health workers have no access. In some cases, these Healthy Mosques are used to conduct outreach services for the off-limits villages.

One new initiative – not planned but inspired by the workshop – is the 'twinning of red and green villages' (red villages are insurgent controlled and green villages are Government controlled). The initiative focuses on reaching out through health promotion to selected 'green areas' located in the proximity of 'red villages'. Through these outreach activities, contacts between the red and green communities may be increased. In time, confidence in health services would also grow and eventually allow access to villages that at present are off-limits to Government personnel.

In addition, a process was discretely started to request that wise and influential elders visit and engage communities, teaching the Islamic way to reduce violence and to foster non-violent ways of resolving disputes.

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4 Medical Peace Work modular course on peace work for health professionals, available from: [www.medicalpeacework.org/courses.html](http://www.medicalpeacework.org/courses.html)

The evaluation found that not all the participants at the workshop were ready to engage in peace work. The culture of the Thai society generally involves non-interference, particularly in political affairs. Any kind of peace work is considered political. Other dimensions are fear of reprisals, loss of credibility and access to communities in need. In this light, the success of the workshop can be attributed to the fact that the knowledge and skills offered through the workshop are not only part of the peace workers' toolkit but are also powerful tools to enhance the capacity of health professionals to cope and deliver health care in complex and difficult situations.

Although not all initiatives have been followed up, several activities planned by the workshop participants or inspired by the discussions have taken place in southern Thailand. One of the participants received the Rural Doctors' Award during the tRI and DSRR evaluation mission; at the associated media event, the awardee talked about the physician's role in peace building and reducing violence as a public health priority in conflict areas.

At a minimum, the skills provided through the workshop have been used to tackle challenges in the work environment and to improve health performances. In general, peace and health messages have reached a good number of participants, and the workshop provided a framework of analysis that made engaging in peace-related activities a concrete possibility.

## Conclusion

The collaborative initiative has opened some space in terms of personal attitudes and capacity to engage in peace-related actions, at least among a select number of individuals. The overall strategy, with its focus on strong collaboration with a national partner, seems to be a sound approach to create a culture in which health and peace work-related actions may grow, creating a multiplier effect. The 'insider' knowledge of the national partner regarding the local situation, day-to-day developments, issues, networks and resources is an invaluable asset. On the other hand, the international partner contributes international expertise, a certain 'detachment' from the conflict, an external perspective, validation and inspiration from other experiences. Additionally, an international partner can sometimes more easily propose and manage sensitive activities than a national agency.

In terms of future capacity-building activities, the immediate concerns and learning needs of health professionals must be addressed first and foremost. In the case of southern Thailand, the priority has been to increase the scope of coping mechanisms to survive and to provide health care in line with professional principles. There are numerous medical professionals who face similar challenges working in conflict zones as the ones presented and discussed here.

Although donor countries provide ample resources for the training of international medical staff to work in conflict areas abroad as expatriates, national health resources are often neglected as a precious resource – not only as connectors for expatriate staff but also as connectors to non-violent solutions to conflicts. This initiative shows, in a small way, the value of national and international collaboration and how a focus on building the capacity of national health professionals adds a precious resource in internal conflicts.

# III. CURRICULUM, KNOWLEDGE AND SKILLS FOR HEALTH AND PEACE WORK

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## Chapter 10

### Peace–Health Education for Medical Professionals

*Klaus Melf and Pantip Chayakul*

## Chapter 12

### Human Rights Law in the Context of Southern Thailand

*Paisit Pusittrakul*

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# Chapter 10

## Peace–Health Education for Medical Professionals

*Klaus Melf and Pantip Chayakul*

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Over the past 25 years, there has been an international assortment of initiatives for training doctors and other health professionals in peace – from model curricula for medical schools, such as *Medicine and Nuclear War*<sup>1</sup> and *Medicine and Peace*,<sup>2</sup> to new theoretical frameworks for training and practice, such as *Health as a Bridge to Peace*,<sup>3</sup> *Peace through Health*<sup>4</sup> and *Medical Peace Work*.<sup>5</sup> If the mission of the health sector is to prevent and reduce infirmities and diseases and promote health, why is it relevant to train health workers in peace?

### Why peace–health education?

The most obvious reason is that war, violence and other forms of power abuse have an enormous negative impact on health. Direct violence kills about 1.5 million people annually, and many times more individuals are hurt, disabled and/or traumatized or suffer from indirect effects of violence, such as forced migration, hunger and the disruption of social life.<sup>6</sup> Violence is therefore a crucial health issue – and violence prevention is important public health work.

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- 1 International Physicians for the Prevention of Nuclear War, *Medicine and Nuclear War: A medical curriculum*. Cambridge, MA, 1988.
  - 2 UN Commission on Disarmament Education, International Physicians for the Prevention of Nuclear War and Physicians for Social Responsibility, *Medicine and Peace: A model curriculum for medical students*, 1993, draft.
  - 3 World Health Organization and Emergency Humanitarian Action. *Report on the First World Health Organization Consultative Meeting on Health as a Bridge for Peace*. Annecy, France: Les Pensières, 1997.
  - 4 Arya, N., 'Peace through Health II: A Framework for Medical Student Education'. In *Medicine, Conflict & Survival*, Vol. 20, No. 3, 2004, pp. 258–262.
  - 5 Melf, K., *Exploring Medical Peace Education and a Call for Peace Medicine*. Master's thesis. Tromsø, Norway: Centre for Peace Studies, University of Tromsø, 2004.
  - 6 Krug, E.G., Dahlberg, L.L. et al. *World Report on Violence and Health*. Geneva: World Health Organization, 2002.



Nonetheless, health professionals can be contributors to violence if they do not follow their ethical principles and responsibilities,<sup>7</sup> or if they are not aware of the conflict context and of unintended negative effects of their work.<sup>8</sup>

There are many ways, both implicit and explicit, that health professionals and their organizations can work for conflict transformation, social harmony, justice, health equality and sustainable development.<sup>9</sup> Because peace is not a static condition but also a capacity of constructive conflict handling,<sup>10</sup> the ‘peace capacity’ of individuals and societies can be strengthened. Peace–health curricula in medical and health-related schools make a contribution to that.

### Suggested training outcomes

To improve the peace capacity of health professionals, it is important to establish relevant exit outcomes of all related training. Consultations in Norway<sup>11</sup> and Sri Lanka<sup>12</sup> have led to the following list of relevant training outcomes:

1. Diagnose and address different forms and levels of violence.
2. Understand social determinants of health, identify vulnerable groups and address health inequalities and discrimination.
3. Recognize and apply ethical and legal principles in the existing situation.
4. Develop leadership and coordination skills, manage stress and take care of team members and self.
5. Master communication with individuals, groups, power holders and the public and respect different cultures and backgrounds.
6. Be aware of the peace potential of the health sector and exploit local opportunities.
7. Understand and apply health-related human rights and international humanitarian law.
8. Develop peace skills, analyse conflicts and identify the reasons for violence and social disruptions.
9. Understand the ‘do no harm’ framework and develop conflict sensitivity.
10. Cultivate non-violent communication, listen empathically and identify underlying basic feelings and needs.

<sup>7</sup> Miles, S.H., ‘Abu Ghraib: Its Legacy for Military Medicine’. *The Lancet*, Vol. 364, No. 9435, 2004, pp. 725–729.

<sup>8</sup> Anderson, M.B., *Do No Harm: How Aid Can Support Peace or War*. Boulder, CO: Lynne Rienner Publishers, 1999.

<sup>9</sup> Melf op. cit, 2004.

<sup>10</sup> Galtung, J., ‘What is peace studies?’ In J. Johansen and V. Vambheim, eds., *Three Papers by Johan Galtung*. Tromsø, Norway: Centre for Peace Studies, University of Tromsø, 2002.

<sup>11</sup> Melf op. cit., 2004.

<sup>12</sup> Karunathilake, I., *Outcome-based Approach in Development of a Peace Curriculum*. Presentation to the Pre-Conference Workshop on Peace and Health, 39th Conference of Asia-Pacific Academic Consortium for Public Health, Saitama, Japan, 22–25 Nov. 2007.

To achieve these outcomes, there is also a need to develop training content, learning methodology and methods of assessment.

#### **How to implement peace–health training?**

Peace and health work largely overlap. Medical curricula often address or could easily address several of the relevant training outcomes (in particular, outcomes 1–5). Medical disciplines, such as public health, mental health, psychiatry, social medicine, occupational medicine, refugee health, child health, medical ethics, medical communication, disaster medicine, forensic medicine and health administration already deal with some peace issues in an implicit way. These issues could be strengthened to increase not only the health provision but also the peace capacity. Other outcomes (6–10) are more explicit peace- and conflict-related and are traditionally not found in the medical curricula. Peace mainstreaming of medical courses, special study modules and extracurricular training offers could contribute towards covering those outcomes. Training in explicit peace issues would be the most effective for strengthening health professionals' 'peace performance'.

#### **Appropriate teaching methodology**

Few publications exist on appropriate methodologies for peace-capacity building of health professionals. Teaching experiences in the field of medical ethics and of violence prevention (domestic and interpersonal) indicate that the most successful trainings are case-oriented. It is important that theory be applied to trainees' individual life situations. Thus, existing model curricula should be tailored to the local context. The more practical and experiential the training is, the more it can contribute to acquiring relevant skills and to behaviour change. Because peace work often requires the collaboration of different sectors and disciplines and because medical scholars are seldom experienced in peace and conflict issues, the faculty of peace–health courses should be multidisciplinary.<sup>13</sup>

#### **Medical Peace Work as a training resource**

A European partnership of medical peace organizations and teaching institutions known as Medical Peace Work has developed a series of seven online courses (also known as Medical Peace Work<sup>14</sup>) that are freely available on the internet. Interested health

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<sup>13</sup> Melf op. cit., 2004.

<sup>14</sup> According to its website, Medical Peace Work is an emerging field of expertise in health work, violence prevention and peace building. It is also the partnership of medical organizations and teaching institutions committed to the development of this new field of expertise. It also includes the seven online courses and a collection of teaching resources for medical peace education.

workers can learn by self-study about the range of the health sector’s peace involvement. Some universities also combine their Medical Peace Work online courses with institution-based teaching, in which students can gain academic credit. Such combined courses are available, for instance, in the Norwegian universities of Tromsø and Bergen. Other training resources, such as model presentations and teaching papers, are available to alleviate the development of local training opportunities. Interested teaching institutions from Thailand can adapt these courses and teaching materials and add their own context-specific content and assessment forms. These online resources and training material are provided at [www.medicalpeacework.org](http://www.medicalpeacework.org).

### **Who are the stakeholders for peace-health education?**

Most often, scholars at medical, public health and nursing schools provide peace–health education. In addition, those who are responsible for the human resources at hospitals and health care institutions are important agents for implicit or explicit medical peace education. Some health workers’ associations and NGOs offer peace–health training also, targeting their staff, members or other health professionals in a violent conflict context. Non-formal training also can take place in study circles of students, colleagues and friends.

### **From theory to local practice: The Faculty of Medicine PSU**

The Faculty of Medicine of Prince of Songkla University (Faculty of Medicine PSU) is located in Hat Yai district, Songkhla province. It is the first medical school in southern Thailand. It was established in 1972 with the mission to produce highly qualified physicians, specialists and health personnel with good medical ethics to serve the needs of society. Its teachings emphasize continuing lifelong education and promoting nationally and internationally recognized research that addresses national health problems, especially those in southern Thailand. It also aims to provide outstanding medical services to support the production of health care personnel and specialists as well as maintain the Faculty’s status as a tertiary care and referral centre for southern Thailand and to lead Thai society towards promoting good community health, disease prevention and improvement of the health care system. The Faculty of Medicine PSU is now the largest medical school and referral hospital in southern Thailand and has produced 3,512 physicians (in 36 batches) to date. Most of the physicians who work in the Deep South, especially the directors of many community hospitals, graduated from the Faculty of Medicine PSU.

## **Challenging health inequalities through human resource development**

As a result of the shortage of doctors in southern Thailand in the early years of the renewed violence, the Faculty of Medicine PSU set up three additional training programmes of physicians for the region:

1. Training programme for physicians who will work in rural communities. Faculty of Medicine PSU and Hat Yai Hospital began to recruit medical students for the programme in 1999. Each year, 30 students enter the training programme. The preclinical courses are provided at the Faculty of Medicine and the Faculty of Science PSU and the clinical courses are conducted at Hat Yai Hospital.
2. The training programme for physicians who intend to work in the three Deep South provinces (Yala, Pattani and Narathiwat). This programme was established because to the violent conflict in those provinces that resumed in 2004, prompting many physicians to move away from these provinces. Since 2005, the programme has recruited 30 medical students a year. The Faculty of Medicine and the Faculty of Science PSU provide the preclinical courses and Yala Hospital conducts the clinical courses.
3. Advice and support for the newly established medical school at Princess of Narathiwat University. The preclinical courses are provided at the Faculty of Medicine and Faculty of Science PSU and the clinical courses at Songkhla Hospital. This new medical school has produced one batch of 30 physicians.

## **Implicit medical–peace curriculum**

Thailand's Deep South Relief and Reconciliation Foundation and the Switzerland-based Rugiagli Initiative brought together international experts and Thai health professionals from the Deep South in a workshop in Krabi province to exchange ideas on medical peace goals. The workshop also led to a consensus among the participants on the need for training on peace-negotiating skills in Thailand's medical education curriculum.

Prior to the Krabi workshop, the Faculty of Medicine PSU did not focus on strengthening the peace capacity of health professionals – the current medical curriculum was designed to produce highly skilled physicians. To fulfil the requirement of the Medical Council of Thailand, the skills obtained include:

- Professional habits, attitudes, morals and ethics
- Communication and interpersonal skills
- Medical knowledge, clinical and manual skills, holistic and evidence-based patient safety concern
- Critical thinking and problem solving
- Health promotion and understanding health care system: individual, community and population health
- Continuous professional development
- Information technology and innovation skills
- Leadership, teamwork and management skills
- Social and life skills

Although these requirements were designed for good medical practice, they have relevance to peace work. The medical curriculum at PSU has been covering some implicit curriculum content of Medical Peace Work, such as social determinants and reducing health inequalities, medical ethics and universal principles, leadership, coordination, self-care and stress management and communication and culture sensitivity.

During the Krabi workshop, one group of participants worked out the following action plan to strengthen the peace issues coverage within the existing medical disciplines and to develop explicit medical peace content.

### **Plan for curriculum development in Medical Peace Work**

#### **Objective**

Develop explicit peace-related subjects for health personnel in the Deep South and strengthen implicit peace capacity in the standard curriculum.

#### **Possible targets**

There are two nursing schools (Yala Nursing School and Faculty of Nursing PSU), one public health school in Yala and two medical schools (Faculty of Medicine PSU and Faculty of Medicine Narathiwat University).

#### **Approach**

1. Integrate peace-related issues into mental health teaching at Yala Nursing School and the social skills forum at the Faculty of Medicine PSU.
2. Introduce peace–health topics at the annual education meeting at the Faculty of Medicine PSU.
3. Develop a special peace–health study module:
  - a. Start-up workshop for faculty and school staff to familiarize with the inclusion of peace–related topics in the curriculum.
  - b. Introductory teaching of new topics.
  - c. Evaluation of the best methods to teach Medical Peace Work in southern Thailand and to integrate peace–health topics into the standard curriculum.

#### **Tentative content**

- Health and peace concept
- Cultural sensitivity and diversity
- ‘Do no harm’ analysis
- Negotiation and mediation
- Psychological first aid
- Forensic medicine related to violence:
  - Management of torture cases
  - Post-mortem examination
- Management of conflict and political stress
- Human rights and humanitarian law
- Risk management
- Health care for vulnerable groups (teen mothers, drug users, etc.)
- Role of health professionals in conflict and politics
- Non-violent communication
- Inner-peace work

#### **Measurement process**

- Pre-test (multiple-choice questions MCQ)
- Evaluation for each topic
- Post-test (MCQ)
- Reflection (narrative writing)
- Research

**Learning material:** Translate into Thai some teaching materials developed by Medical Peace Work and have them freely available online.

### Strategy timeline

- Step 1. Discuss ideas and explore possibilities of the teaching programme with administrators and teachers to aid decision-making and preparation of an action plan.
- Step 2. Start-up workshop to prepare the groundwork by familiarizing teachers and administrators with the approach and introduce some translated materials.
- Step 3. First step in teaching the selected topics, include pre-test and evaluation.
- Step 4. Workshop with administrators and teaching staff to look at results of the pre-test and evaluation and make decisions on next year's plan.

### Conclusion

Physicians and other health professionals have an important role in peace work. Because the field of peace and health overlap extensively, health workers quite often learn and perform medical peace work in an implicit manner. Adding explicit peace content to the curriculum will help make health professionals better agents for peace.

For more than 40 years, Prince of Songkla University has produced doctors and aligned health workers in southern Thailand. Since the outbreak of the violent conflict in the Deep South, the Faculty of Medicine PSU has particularly addressed the health workforce crises in the violence-affected areas and, in the process, challenged the health outcome inequalities and structural violence. Through implicit peace content in the existing medical curriculum, doctors in the Deep South have acquired a certain capacity in violence prevention/reduction and peace promotion.

The action plan on peace–health curriculum development, which emerged during the Krabi workshop, aims to strengthen the implicit medical peace content in medical, nursing and public health schools in the Deep South. In addition, it intends to add explicit peace–health issues in the form of a special study module and peace mainstreaming into the education curriculum.

With this action plan now moving into practice, it appears the 2013 Krabi workshop may well have a broad and long-lasting effect on peace capacity-building for health workers in the Deep South.

# Chapter 11

## Human Rights Law in the Context of Southern Thailand

### Implications for Health Professionals

*Paisit Pusittrakul\**

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The situation in the southern provinces of Thailand (insurgency) has affected the lives of people who have been living there for more than a decade. A number of studies have reported that there are human rights violations in the provinces by both sides of the conflict – the insurgents and the authorities. More than 10,000 incidents of violence, 4,766 deaths and 7,808 casualties are recorded among both Buddhists and Muslims from the insurgency for the period of 2004–2011.<sup>1</sup> The insurgency is attributed to many causes, including the fact that locals have been denied justice and do not have access to justice. There is confusion in the state policy between a peaceful approach and traditional means of solving problems with the use of force. Locals are faced with internal conflict, and cultural diversity is viewed by some as a threat.<sup>2</sup> The health professionals who work in the area are affected by the insurgency and often face difficulties due to it directly and to its consequences.

This paper considers the laws that apply to the situation in the southern provinces, especially those linked to human rights issues, how the situation affects the population and the effect of such laws on the work of health professionals.

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\* The author would like to thank Professor Vitit Muntarbhorn, Distinguished Scholar at the Law Faculty, Chulalongkorn University, Bangkok and a UN human rights expert, for his advice.

1 Amnesty International, "They took nothing but his life" The unlawful killings in Thailand's southern insurgency, Amnesty International, London, 2011.

2 The National Reconciliation Commission, *Overcoming Violence through the Power of Reconciliation, The report of National Reconciliation Commission*, Bangkok, 2006.



## Laws related to human rights in the context of southern Thailand

The laws having an impact on human rights in the southern provinces tend to be security laws, including the Martial Law Act 1914, the State of Emergency Decree 2005, the Internal Security Act 2008 and the Criminal Code and Criminal Procedure Law. They should be tested against human rights standards, particularly the human rights treaties to which Thailand is a party.<sup>3</sup> Each treaty has its own monitoring body, a Committee that was established to monitor State Parties' obligations under that treaty. Apart from the treaty bodies, there are two other international monitoring mechanisms: the Universal Periodic Review and Special Procedures, such as UN Special Rapporteurs.

### The Martial Law Act 1914

Under this law, military personnel can arrest and detain suspected persons for interrogation for up to seven days without access to court (normally, arrested persons would have access to court within 48 hours, two days, after arrest).<sup>4</sup> There is no obligation on the prompt access to medical assistance and to lawyers. However, arrested persons are to have access to family within the first three days, but this does not cover access to medical personnel.

This law transfers administration from the civilian authorities to the military authorities. A civilian who is arrested is to be taken to the military court rather than the court of justice. The fundamental legal safeguards for an arrested person are less effective under this law as compared with those of the Criminal Code.

### State of Emergency Decree 2005

This law raises a number of questions regarding human rights and continues to instil mistrust among the local population.<sup>5</sup> It allows the authorities to arrest and detain persons for seven days without access to court, and it can renew preventive detention for up to 30 days without access to court (renewable seven days at a time). It also

<sup>3</sup> Thailand is a Party to 7 out of 9 core Human Rights Treaties, namely: International Covenant on Civil and Political Rights 1966 (ICCPR), International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR), Convention on the Elimination of All Forms of Discrimination against Women 1979 (CEDAW), Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment 1984 (CAT), Convention on the Rights of the Child 1989 (CRC), International Convention on the Elimination of All Forms of Racial Discrimination 1966 (CERD), and Convention on the Rights of Persons with Disabilities 2006 (CRPD). Until 2014, Thailand signed the International Convention for the Protection of All Persons from Enforced Disappearance 2006 (CED), but has not signed the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families 1990 (CMW).

<sup>4</sup> Article 15 *bis*, the Martial Law Act 1914.

<sup>5</sup> Abuza, Z., *The ongoing insurgency in Southern Thailand: Trends in violence, counterinsurgency operations, and the impact of national politics*, Strategic Perspectives No. 6, Institute for National Strategic Studies, National Defense University Press, Washington D.C., September 2011.

allows the authorities to detain persons in an unofficial location other than a police station, official prison or official detention centre (which could be anywhere).<sup>6</sup> This may lead to human rights violations by the authorities, such as deprivation of the liberty of the arrested person and limitations on their rights to prompt access to court, medical assistance, lawyers and family.

The Government has to renew the application of this law, through the approval of the cabinet, every three months. It has been enforced in the southern provinces and has been renewed several times since 2005.

#### **Internal Security Act 2008**

The Internal Security Act (ISA) established the Internal Security Operation Command (ISOC) under the order of the prime minister with a strong presence of military authorities; the ISOC Region 4 covers the southern provinces. This Act does not pose a threat to human rights and the rule of law on the same level as the Martial Law Act 1914 and State of Emergency Decree 2005.<sup>7</sup> However, it applies only in limited areas – four districts in Songkhla province (Chana, Thepha, Na Thawi and Saba Yoi) and one district in Pattani province (Mae Lan).

ISA applies the Criminal Code and Criminal Procedure Law for arrests and investigation. However, there is a provision concerning alternative training regarding plea bargaining, under Section 21 of this Act.<sup>8</sup> Such alternative training is subject to court order and the consent of the suspects, and the period of training usually takes six months. The question raised is whether suspects consent fully/actually/wholeheartedly or not. There have been reports that some civilians received (both oral and written) ‘invitations’ to such training, and the invitation did not mention the law. In fact, the civilians did not want to go to the training but they could not reject the invitation. They were concerned that if they were to reject the invitation, it would be in violation of Section 21 of ISA.<sup>9</sup> Even if the invitees were unwilling to go to training, they could not really reject the invitation. The consent issue could thus lead to human rights violations.

#### **Criminal Code and Criminal Procedure Law**

Although the previously cited security laws are applied in the southern provinces of Thailand, the Criminal Code and Criminal Procedure are also still applicable. The normal

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<sup>6</sup> Section 12, The State of Emergency Decree 2005.

<sup>7</sup> International Commission of Jurists, Thailand's Internal Security Act: Risking the Rule of Law, Bangkok, 2010.

<sup>8</sup> Section 21, Internal Security Act 2008.

<sup>9</sup> Konkachornkiat, P. and Himeena, A., *Situation and Impact on the Population in Four Districts of Songkla Province Under the Enforcement of Security Laws*, Konrad Adenauer Stiftung Foundation, Bangkok, 2010. (IN THAI)

process of arrest and detention is that the authorities must arrest a suspect with a warrant. An arrested person shall have access to court within 48 hours, and he/she shall be detained only in the police station or other official detention centre.

Of all the laws discussed here, great concern relates to the Martial Law Act, the State of Emergency Decree and ISA. These laws pose several challenges to the issues of human rights violations:

1. The implementation of security laws in the southern provinces constrains a number of rights and freedoms in the area in order to maintain internal peace and security. It does not mention the criteria for restraining the exercise of power. However, the Government invokes such laws on the basis of necessity and proportionality.<sup>10</sup> The question concerns the notions of necessity and proportionality – What is the threshold of necessity and proportionality?
2. The implementation of such laws may lead to human rights violations, such as torture or other cruel, inhuman and ill treatment of civilians and detainees. There are a number of reports that indicate torture had been committed by the authorities during interrogation. Around 80 per cent of suspects have been tortured while in custody; most of them were punched, kicked, hit with combat boots or other hard objects; some of them were assaulted, suffocated by plastic bag and other cruel treatment.<sup>11</sup>
3. The authorities can hold any person (suspect) in custody for 30–37 days by using the powers of those special laws. This concerns the fundamental legal safeguard for detainees – the access to court, lawyers, family or medical assistance.
4. These laws have provisions that exempt the authorities from liability, which may shield the authorities who violate human rights. There are provisions of impunity in the security laws, namely:
  - Section 7 of Martial Law Act combines with its Annex to give broad scope to jurisdiction of the military court, which may be used to exclude the possibility of trying military authorities in civilian courts.<sup>12</sup>
  - Section 16 of the Martial Law Act also prevents a compensation claim against individual officials.

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<sup>10</sup> Opening Statement of the Head of Thai Delegation to the Committee on the Convention against Torture and Other Cruel, Inhuman, Degrading Treatment and Punishment, Geneva, 30 April 2014, access at [http://tbinternet.ohchr.org/Treaties/CAT/Shared%20Documents/THA/INT\\_CAT\\_LOP\\_THA\\_17127\\_E.pdf](http://tbinternet.ohchr.org/Treaties/CAT/Shared%20Documents/THA/INT_CAT_LOP_THA_17127_E.pdf) [2 July 2014].

<sup>11</sup> *Supra* note 7.

<sup>12</sup> *Supra* note 5.

- Section 16 of the State of Emergency Decree excludes the jurisdiction of the Administrative Court.
- Section 17 of the State of Emergency Decree exempts the competent authorities from civil, criminal and disciplinary liability for the acts of good faith. But those acts have to be based upon non-discrimination, necessity and reasonableness. The provision does not exclude the possibility of compensation but raises the issue concerning what is a reasonable act on the part of the authorities.
- Section 23 of ISA accepts the jurisdiction of the Court of Justice but totally excludes the jurisdiction of the Administrative Court.

These provisions exempt the authorities from responsibility and may lead to human rights violations by the authorities. On the other hand, the acts of violence committed by insurgents affecting the lives of ordinary civilians in an indiscriminate manner should also call for responsibility on their part, and not impunity. Thus, access to the courts to assess the various allegations against the authorities and the insurgents is important to ensure the rule of law for all.

The issue concerning the justice system and the implementation of security laws are part of the environment that might lead to discontent linked with insurgency and human rights violations. The National Reconciliation Commission (NRC) was established in 2005 to provide some ideas on steps to peace. According to the NRC, people in the area are affected by the insurgency, in terms of their lives and property, physically and emotionally, through direct personal experience and that of relatives. And some are professionally affected. But only a few have received redress.<sup>13</sup> The NRC regards such issues as the priority that needs to be tackled.<sup>14</sup>

The insurgency persists even with the implementation of the special laws, and it affects various rights of the people who live in the area in addition to their security. Schools have been shut down due to attacks on public schools in an area. People have to relocate because of the insurgency, causing an influx to urban areas in neighbouring provinces.<sup>15</sup> This also affects children's access to compulsory education. In addition, the insurgency causes a negative effect on the economy in the southern provinces.

Civil society is another crucial actor to heal the situation in the southern provinces. There is no legal obligation at the international or national levels for civil society to

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<sup>13</sup> Supra note 2.

<sup>14</sup> *ibid.*

<sup>15</sup> Supra note 1.

protect human rights. It is a moral responsibility. The role of civil society is a supporting role, such as to promote human rights and peace through negotiation and reconciliation processes, to publish reports or studies related to the situations and to monitor the human rights violations. Civil society can create a certain level of peer pressure on the State and the insurgents to deal with the human rights violations. However, civil society may face some difficulties in its work, for instance, such as how to be involved in the peace and reconciliation processes and how to protect the safety of the civil society network.

### Implications for health professionals

The violence in the southern provinces of Thailand creates fear and insecurity among the people in the area, including the health professionals. However, health professionals who work in the southern provinces are the least targeted by the attacks. Recently, however, the media reported that two trainees at a hospital in Yala were shot at an open market near the hospital.<sup>16</sup> This has the potential to renew insecurity among health professionals.

Apart from general responsibility relating to their profession, some health professionals may have to work with the issue of human rights violations, especially the doctors and pathologists who perform autopsies or check the health of detainees. This role of medical professionals is crucial as an impartial witness to detect, address and possibly reduce the human rights violations. Thus, the independence of the profession and safe working conditions are important for medical professionals whose work relates to the investigation process. There is an issue, though, concerning the impact of the security laws on their work. The security laws allow the holding of people in custody for a long period with insufficient fundamental legal safeguards, and they can sometimes detain people in an unofficial location, which makes it harder to access medical assistance.

At times, the authorities make an effort to provide a better standard of medical assistance. However, there is a question concerning access to prompt medical assistance for detainees. This concern was highlighted in the recommendation of the Committee on the Convention against Torture and Other Cruel, Inhumane, Degrading Treatment to Thailand. The Committee recommended to Thailand that it should respond to the basic needs of persons deprived of their liberty regarding sanitation, medical care, food and water.<sup>17</sup>

<sup>16</sup> See [www.thairath.co.th/content/435268](http://www.thairath.co.th/content/435268) [10 July 2014].

<sup>17</sup> Para. 22, Concluding Observation on the Initial Report of Thailand, Committee on the Convention against Torture and Other Cruel, Inhumane, Degrading Treatment. UN Doc. CAT/C/THA/CO/1, 20 June 2014.

As noted, there is no legal obligation for the State to provide access to medical assistance for detainees; but the authorities will provide a medical check-up on the arrival and before the release of a detained person. The check-up is conducted by military doctors. Recently, the authorities in ISOC Region 4 campaigned for the invitation of non-military medical doctors to carry out these check-ups.<sup>18</sup> Moreover, cooperation with the National Human Rights Commission of Thailand would allow trained authorities from the Commission to visit detention centres at any time upon request. Such effort would create more due diligence among the authorities (in ISOC Region 4).

## Key challenges for the health professionals

Beyond the justice system, health professionals face other challenges working and living in the southern provinces:

### Insecurity

Health professionals have to live their lives. Everyone would like to live in a safe environment. The insurgency poses a threat to security and affects health professionals in their work and daily life. Some have to stay over at the hospital, and they have less time to be with their family due to the insurgency.<sup>19</sup>

### Lack of forensic doctors

The number of forensic doctors working in the southern provinces is very limited. The Ministry of Justice and the Central Institute of Forensic Science Thailand is the only authority in charge of the forensic science. The situation in the southern provinces requires a forensic doctor to analyse the crime scene for the evidence needed to bring perpetrators to justice.

### Sophisticated techniques of torture

Techniques of torturing have been developed over time. They have become more sophisticated than earlier in the escalating violence. They now leave less evidence of physical or mental assault than initially possible. Long periods of detention under the cocktail of powers derived from the security laws may add to the difficulty in making a precise diagnosis. The report of doctors are crucial evidence in the case of torture and to bringing perpetrators to justice.

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<sup>18</sup> Phone interview with senior high ranking authority who works in the area, interviewed on 10 July 2014, Bangkok.

<sup>19</sup> Kraonual, S. et al., *The Impacts of Insurgency to Nurses Who Work in the Southern Provinces of Thailand*, Nursing Science (Adult Nursing), Prince of Songkla University, 2007. (IN THAI)

### **Access to casualties/bodies**

The southern provinces, especially the areas experiencing grave violence, are not considered a desirable place to live by people with options. Despite the efforts of the public health authorities, there are not enough qualified health professionals working in those areas. The insurgency makes it difficult to access casualties and bodies. Another problem is the consequent of lack of human resources; some medical professionals work or live far from the conflict areas and it can take a long time for them to reach the site of casualties and bodies.

### **Lack of funding**

Lack of funding is a classic challenge that leads to a low standard of medical facilities and a low standard of health services. The Committee on the Convention against Torture and Other Cruel, Inhumane, Degrading Treatment is also concerned with the lack of a training programme, mentioned in the Concluding Observation on its Initial report of Thailand: "... The Committee regrets the insufficient level of practical training given to medical and other personnel involved with detainees and asylum-seekers on the provisions of the Conventions..."<sup>20</sup>

Funding remains a challenge for health professionals who work in the South.

## **Recommendations**

To improve local people's right to justice and to protect the work of all people involved in that protection, recommendations have been made from various corners that should be heeded:

- There are calls for the amendment of the security laws, particularly by civil society. The amendments should integrate human rights approaches and due process.
- There is the issue concerning access to fundamental legal safeguards for detainees. There should be more effective measures to ensure, in law and practice, that all detainees are afforded all fundamental legal safeguards, including the right to access promptly independent medical assistance.
- There should be attempts at fostering deeper understanding and good relationships among the authorities, civilians and health professionals, which would help reduce some of the limitations. This would particularly benefit the work of health professionals.

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<sup>20</sup> Supra note 17, para 26.

- The forensic science requirements should be strengthened by expanding the number of forensic doctors in the southern provinces.
- There should be more mandatory and specific training programmes provided for medical and other personnel involved with detainees, and the human rights approach should be integrated in training.
- Communities should be encouraged to help create a sustainable funding base.
- Civil society should have a more active role and more participation in the reconciliation or peace process.
- All sides must abide by human rights and the rule of law, particularly to respect the neutrality of civilians and medical professionals and the need to protect them.

## Conclusion

In sum, the human rights violations – from both the implementation of security laws and the insurgency – affect everybody in the area, including the medical professionals. A process of reconciliation may be possible if the human rights violations are seriously tackled. The issues concerning the justice system include human rights violations during arrest, the investigation process, access to the court and a fair trial. These issues are the priorities to tackle. Respect for human rights and the rule of law from both sides of the conflict would also strengthen the reconciliation and peace in the southern provinces. The medical professionals could help reduce human rights violations by impartially and actively being committed to their work – the medical professionals whose work relates to the justice process have to be impartial witnesses to detect and address human rights violations. Medical professionals should also provide medical assistance and health care services without discrimination. However, the independence of the profession and safe working conditions are key for medical professionals in the southern provinces.

Lastly, a peaceful society is synonymous with a healthy environment, while a healthy environment comes from a healthy population. For the situation in the southern provinces, where violent incidents still arise, the number of deaths and casualties are continuing to mount, and human rights are still violated by the conflict. The work of medical professionals is very important and necessary to people who live in the southern provinces. No matter how desperate the situation might be, medical professionals are one of the last hopes for the victims and their relatives, helping to heal families and reunite society.



## Chapter 12

# When Medicine Is Not Enough: Negotiation Fundamentals for Physicians

*Kimberlyn Leary*

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When physicians work in armed-conflict zones, warring adversaries may see them as partisans rather than as neutral. Doctors may be viewed with suspicion if they have recently been in 'enemy territory'. Health care workers may be pressured to share information about civilians that could be used to endanger them. It takes more than medicine to cope with such challenges. Physicians can benefit from knowing the fundamentals of negotiation and mediation and can use those skills judiciously as another instrument for healing.

Traditionally in many cultures, negotiation has been assumed to be a zero-sum game. Either the winner takes all or disputants agree to split the difference, even if such a compromise is suboptimal for all. Until recently, most models of negotiation were based on theories of economic rationality, which assumed that people always act logically and in their own best interests. Now many mediators and negotiators take a different view. They see conflict as a process in which the people in a dispute shape the nature of the problem by how they talk about it as well as by how they relate to one another. Successful negotiations require joint interchange so that the interests of all parties may be represented creatively. Responsible outcomes exist in the context of effective relationships. Thus, the goal of transforming conflict often transforms the individuals involved in it.

The Program on Negotiation, based at Harvard's Law School, has pioneered an approach to negotiation that emphasizes collaboration and interactive problem solving. Founded by Roger Fisher (co-author of *Getting to Yes*, the most widely cited negotiation text of all time) and a group of colleagues, the Program on Negotiation is an inter-university collaboration, drawing from the faculties of Harvard, MIT, Tufts and the Simmons Graduate School of Management. The Program on Negotiation has led the field of conflict transformation by teaching many generations of practitioners the skills of problem-solving negotiation and interest-based bargaining.

Why do people negotiate at all? Negotiation presupposes a conflict between parties in which what party A wants is not necessarily what party B seeks. In certain instances, party A might be the more powerful party and wants to force party B to concede. Such victories can be costly. Party B could always retaliate, leading to an endless cycle of repeating violence. Negotiation represents an alternative. People negotiate their differences when they believe they will be better off by trying to persuade and influence one another than if the status quo were to persist.

In a positional negotiation, two or more parties have different positions or stances on what constitutes a successful outcome. Each party tries to pressure or persuade the other side to abandon their respective position. Positional negotiations usually result in zero-sum outcomes, where there is only one winner.

Interest-based bargaining focuses on the interests or the underlying reasons that cause people to take one position or another. Interests frequently can be met by a variety of positions, creating opportunities for mutual gain.

The distinction between positions and interests is often taught through a negotiation simulation exercise called Kaylee Nut. Participants take the role of a researcher who wants to cure cancer or the role of a researcher who aims to cure AIDS. Both have discovered that the Kaylee nut has medicinal properties that prompt them to believe it will lead to new medicines to rid the world of these scourges. The problem is that there is a limited supply of Kaylee nuts available. Each researcher needs the exact same number of nuts to develop a cure, but there are not enough to share across their labs.

When this exercise is given to physicians, lawyers, undergraduate students and others attending workshops at the Program on Negotiation, invariably the first round of negotiations are positional. The researcher who wants the nuts to cure cancer will try to persuade the other researcher of the merits of his/her claim to the nut and vice versa. With some coaching on how to identify interests (chiefly to ask lots of 'why' questions), some negotiating pairs discover the 'trick' in the case – that the researcher who wants to cure AIDS only needs the shell of the Kaylee nut for the medicine while the researcher who wants to treat cancer needs the meat of the nut for her preparation. By focusing on interests, they can now easily reach an agreement about how best to harvest the nuts.

Interest-based negotiations are possible in many scenarios. Workshop participants may work their way through a set of progressively more complex negotiation simulations to build their expertise. Whether the simulation is to negotiate a salary, reparations from a chemical spill or a treaty to stem climate change, the basic principles remain the same: focus on interests over positions, brainstorm on opportunities for mutual gain and develop options for solving the problem.

Of course, problem-solving negotiations like these are relatively easy to describe but much harder to do.

People often fail to negotiate (well) when they rush to judgement rather than continue to ask questions or when they search for a single right answer rather than seeking to identify a range of options. At other times, people fail to negotiate at all because they do not realize they can – in other words, they do not recognize that they are in a position to bargain or influence. Indeed, in many cultures, negotiation is synonymous with compromise and weakness.

Other cultures may treat negotiation as a reward rather than as a method of solving problems. Some governments may insist they will not negotiate, for example, with terrorists. Honoured at the Program on Negotiation's Great Negotiator of the Year in 2002, United Nations Special Envoy Lakhdar Brahimi asserted the importance of "accompanying people in conflict". He noted that in the conflicts in which he has worked (in Lebanon, Iraq and now Syria), he went to speak with the "thugs" and not the "nice people". "To stop the fighting," he said, "means talking with the people who are actually doing the fighting."

In addition to interests and options, the building blocks of collaborative negotiations include alternatives, attention to standards and agreements. Negotiators must first determine their own interests (what they really care about) just as they must school themselves in the interests of the other side (what do they really care about). Alternatives come into play next, especially BATNAs. The acronym stands for the Best Alternative to a Negotiated Agreement. This is your plan B or what you will do if the negotiation does not produce an outcome you are willing to accept. For instance, 'If I can't get access to the Kaylee nut, is there some other substance that I might use instead for the medication I am developing?' The single most effective way to improve your negotiating power is to improve your BATNA. If your plan B is a good one, you can enter the negotiation with more confidence.

In addition to determining their BATNA, negotiators must remember that the other party has a BATNA too! Taking the time to reason out what their BATNA might be may help you decide if the other negotiator's confidence is genuine or misplaced.

Once negotiating partners have identified interests and done their homework on alternatives, they are ready to devise a process to generate options. This is best facilitated through brainstorming in which two parties agree to generate ‘what if’ answers and/or possibilities that might allow as many of the interests on both sides to be met in a solution. Brainstorming requires an open mind and the ability to explore without committing to the feasibility of any particular option (or your willingness to accept it, even if it is feasible) until the brainstorming phase concludes.

Once the parties settle on a pool of possible options, they still have to decide which ones are the best ones to implement. External standards and validated criteria can be used to help the parties reach agreement on what is fair and reasonable. If, for example, harvesting the Kaylee nut is more labour intensive, perhaps it is fair for the researcher who needs it to contribute a larger share of the production costs.

It is important to remember that negotiators usually have constituencies back home to whom they must answer and who become important when the negotiation has concluded and it is time to implement the deal.

Interest-based bargaining requires the negotiator to oscillate between being a participant and an observer. Roger Fisher and his colleagues refer to this as the difference between being on the balcony and being on the dance floor. Both are important in the course of a negotiation. When you are on the balcony, you have a terrific perspective on the negotiation. But to actually make a move, you have to be on the dance floor. Good negotiators move back and forth between the balcony and the dance floor – between taking action and observing. They are also alert to partisan perceptions or the mistake of failing to take into consideration perspectives other than their own.

Partisan perceptions can be illustrated quite easily. For example, a widely accessible image on the internet shows a picture of a duck. Or is it a rabbit? The image has been constructed in such a way that some viewers immediately identify the long flat shapes to the side of the head as a beak indicating a duck. Others may see the same flat shapes as the long ears of a rabbit. Which is right? Both are correct. But imagine the difficulty you will have in talking with someone who sees a rabbit when the only thing before you is clearly a duck.

In the face of partisan perceptions, how is it possible to get people to listen to one another? First, it is important to listen to what the other side says if you wish to be relevant to them. Second, it is critical to develop the capacity to represent the interests that are sacred to the other side – not just those that are revered by your side. Third, it is helpful to be oriented towards goals informed by interests. Finally, it is even possible to develop a point-of-view about conflict as an expression of neutrality.

Louisa Chan Boegli, who is core executive and founder of the Rugiagli Initiative, has suggested that although mediators want to see themselves as without having any viewpoint, they in fact stand for a dialogue process. In situations of violent conflict, mediators typically arrive hoping to stop the violence. The mediator's neutrality does not mean he or she has no stake in the proceedings; rather, it refers to the mediator's effort not to pass judgement on either side. Chan Boegli suggests this is the true meaning of being neutral and impartial.

In the ordinary course of events, people typically respond to conflict in predictable ways. When groups feel threatened, they close ranks and turn away from outsiders. Or a group might respond to conflict by striking back. Escalations, of course, can increase tensions. Groups in conflict might submit to their adversary if the cost of conflict is perceived to be too high but nurture a grievance that festers over time. 'Chosen trauma' is the name psychologist Vamik Volkan has given to the sense of the injustice perpetrated on the group's ancestors at the hands of an enemy group. The story of that injury can live on across many generations. Finally, groups in conflict can defer, agree to disagree and resume their conflict at another time.

Social scientists Roy and Judy Eidelson have identified core beliefs that influence conflict and are associated with its escalation. These include: a belief that one's group is superior, that the group has a legitimate grievance or that the group is at a disadvantage. Uncertainty and distrust also can cause conflict to escalate.

Some social scientists typically believe that humanity is innately aggressive. Others, like William Ury, another co-author of *Getting to Yes*, have been persuaded to a different view. In his book titled *The Third Side: Why We Fight and How We Can Stop*, Ury suggests that co-existence rather than organized violence better describes the first 99 per cent of human history. He argues that organized violence to deal with differences only emerged as human communities shifted from being hunter-gathers to agrarian farmers. With this change came tensions over fixed resources. These tensions were the breeding ground for systematic forms of violence.

Ury suggests that a long view of history actually reveals that human beings are predisposed towards cooperation and negotiation. Natural third parties (friends, co-workers, civic organizations and physicians) act as what Ury calls a "social immune system to prevent the further spread of violence". This is the 'Third Side'. Negotiation, for Ury, is not work to be delegated to specialists but rather a matter of everyday community life. Ury's Third Side concept is directed at helping stakeholders become empowered to appreciate that they have a say in the violence within their borders and a voice to combat it.

Being able to say no is important to this process. In his most recent book, *The Power of the Positive No*, Ury writes: "Saying no to any one thing or person is simply another way of saying yes to something or someone else." Ury helps his readers to appreciate that a map of 'nos' is a blueprint to true interests. His model is simple and elegant – and surprisingly effective at helping people to discern what is most important to them.

Physicians and health workers are natural members of the Third Side. At the same time, physicians may also see themselves as a breed apart by virtue of their specialized training. Doctors also may be biased to autonomy and may need to self-consciously attend to thinking about cooperative engagement. Medicine is quite hierarchal; roles and expectations about how those above and below them should be treated may impede the ability of physicians to remember that solutions can come from all stakeholders.

Sara Cobb, at George Mason University's School for International Conflict and Resolution, suggests that when people are in the role of a mediator, it is useful that they favour versions of reality that establish what each party has suffered. Additionally, mediators may be most effective when their comments include positive connotations of each party and endorse variations and texture in the intentions of others.

Mediation in this context can be thought of as a 'sacred practice'. It is profoundly enriching to steward people through change. To be effective in the long run, physician negotiators, mediators and purveyors of the Third Side must learn how to immerse themselves in distress without being numb themselves. To be effective, healers must make sure to preserve their own capacities, including by creating or accessing a sense of 'sanctuary'. Developing such a practice enables mediators to feel anchored in their own values while bringing out the stories that conflicting sides need to share about their lives in order for change to be possible.

# Chapter 13

## Managing Suspicions and Building Trust

*Urs Boegli*

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Fieldwork in a region heavily punctured with armed conflict is dangerous for any professional. Many types of fieldworkers have options regarding whether they stay and continue their operations or work only in the lulls. Medical fieldworkers, however, have few options. The fourth Geneva Convention of 1949 provides protection to all civilians during times of armed conflict; and there are international humanitarian rules to ensure that medical aid and health care facilities continue to operate during armed conflict. These rules, however, also remind that individuals working for humanitarian organizations or medical facilities are civilians who warrant protection.

Intentional attacks against medical personnel and medical facilities that display the distinctive emblems of the Geneva Conventions (the red cross in particular) are prohibited and constitute war crimes under the Rome Statute of the International Criminal Court. Although the various legal protections for health care and humanitarian workers in armed conflicts exist and are imperative, they can do nothing to actually protect fieldworkers if those rules are not respected. Increasingly in armed conflict situations, the rules, if they are even known by insurgent groups, are not respected. Medical fieldworkers need to be vigilant and as self-aware as possible.

There are three steps that medical fieldworkers can follow to better protect themselves and the work they do as they remain dedicated to their duties:

1. Understand and apply the concept of 'do no harm'.
2. Analyse and understand the conflict and its issues.
3. Engage with all protagonists of the conflict.

#### **Do no harm**

The principle of 'do no harm', the time-honoured message associated with the Hippocratic Oath and the basic principle governing Western medicine, is familiar to doctors and nurses around the world. It is a small but nevertheless crucial step to apply this principle not only to the practice of medicine but to fieldwork. Yet, medical aid workers can sometimes cause harm, albeit unintentionally.

The 'do no harm' principle implies first and foremost the notion that in a situation of armed conflict, the presence of aid workers and the humanitarian assistance they provide can help improve the situation. But in a conflict, aid is often not neutral. Even well-conceived and intended aid can make a situation worse – through unintended consequences.

For instance, a humanitarian ceasefire, which is the popular and often-sought outcome of a negotiation aimed at improving the situation of conflict victims in the field, can lead to more harm. Of course, medical and other aid alleviates suffering once it is possible for relief workers to reach and supply civilians in distress and maybe to evacuate and treat the wounded and sick. But while aid workers go about their business during a pause of hostilities, combatants regularly rearm and regroup and prepare for the next deadly round of hostilities. This is the unintended consequence. And the combatants often do so in a way they could not have had it not been for that temporary interruption of hostilities so precious to the protagonists of the humanitarian intervention.

Furthermore, aid represents influence and wealth to those who control and/or receive it. This, too, has the potential to influence the conflict. Often, there are people who use aid resources to either benefit their side of the conflict or to weaken the other party. In such a situation, aid can cause harm. For example, a military commander who authorizes medical visits to some villages but blocks access to others is probably doing this to advance his own position and to reinforce his strategy. By doing so, he uses a humanitarian operation to his own ends and forces an operation intended to help an entire area leave a portion without much needed help – a harmful outcome that denies some villages medical assistance and damages the reputation of the team, even if that team intended to help everyone.



### Connectors and dividers

The concept of 'do no harm' for aid organizations working in conflict zones was developed by Mary Anderson, an American scientist associated with Harvard University. She had noticed situations in which the aid provided by aid organizations in conflicts or situations of violence did not reduce violence but instead helped escalate it. One of her fundamental findings was that in each conflict situation there seemed to be some individuals who inherently polarize and drive apart communities. She called them the 'dividers'. And there are others who strive to maintain and improve links by focusing on common elements that keep communities together. She called them the 'connectors'. Her approach, recommended here, focuses on aid workers recognizing and strengthening the connectors while watching out for the dividers and constantly being mindful not to play into the dividers' hands.

Since 1996, Mary Anderson has published several books and reports developing the principle of 'do no harm'. Two of her key resources are recommended reading:

[www.cdacollaborative.org/media/52500/Do-No-Harm-Handbook.pdf](http://www.cdacollaborative.org/media/52500/Do-No-Harm-Handbook.pdf)  
[www.berghof-handbook.net/documents/publications/anderson\\_handbook.pdf](http://www.berghof-handbook.net/documents/publications/anderson_handbook.pdf)

Certainly a well-thought out and implemented aid programme will be beneficial, but attention must be paid to its design in a way that leads to the reduction of tension and towards the abatement of violence. This is the essence of the do-no-harm approach.

A well-considered, designed and managed aid programme can strengthen local capacities, including the capacities for abating violence and building peace. Aid can strengthen the connectors – those individuals who bring communities together by decreasing tensions and divisions between them instead of increasing them or letting them grow unchallenged until they lead to destructive conflict.

During their work in the field and while observing what is going on around them, aid workers, such as medical staff on a field mission, will easily notice that there are people who antagonize and polarize (the dividers) and people who seem to unify the communities in which they live and work (the connectors). Both are found in nearly every conflict situation.

By being attentive to this notion and by observing the protagonists of the conflict who aid workers are obliged to deal with, it becomes possible to stay clear of the polarizers and dividers and to support and strengthen the connectors – or maybe even become one of them.

#### **Understand the conflict**

A do-no-harm approach is based on an understanding of the conflict and its main issues. For the aid worker who is likely to be met with suspicion and whose intention is questioned when working in the field, it helps to think through a few basic questions before going into communities:

- What might drive any suspicion of a neutral medical team that only wants to look after the sick and wounded?
- What is positively appreciated about that medical team?
- What is merely tolerated?

A do-no-harm approach for fieldwork should be based on a sound analysis of what drives the persons who ‘matter,’ those who can help or hinder medical field work – the stakeholders. What is their background, what are their policies and even their politics? As part of an approach to better understand the conflict and its issues, it is crucial to begin by identifying the key stakeholders:

- Who are the people who matter and why could they be suspicious?
- What are the relevant cultural aspects?
- What motivates your interlocutors? What are their true interests, what really matters to them?

This analysis helps to understand whether the stakeholders will be forthcoming or problematic. It should give aid workers a sense of the influence that various stakeholders can have on the aid work and on those who can help or hinder that work.

Ultimately, such analysis should indicate if there is room for a win-win situation.

The next challenge becomes how to create such a win-win situation.

At this stage, those who try to understand the individuals they have to interact with in their work in the field should create a ‘stakeholder map’. Such a map can involve the use of a clever and interactive computer program, often used by corporate social

responsibility departments of large corporations. In the case of a medical team tasked with obtaining the permission and guarantee of all parties to travel to a community in need of care, a much simpler approach will suffice: Divide a sheet of paper into four quadrants. In the top two squares, write the names of people with influence. In the lower two squares, write the names of those who matter less. Separate them by placing those who appear unhelpful in the left side and those who seem helpful in the right side.

As the following simple stakeholder map illustrates, the result should be four groups of individuals whom aid workers must deal with, each requiring a specific course of action:

- upper left square – those who are unhelpful but important
- upper right square – those who are well disposed and powerful
- lower left square – those who are unhelpful but unimportant
- lower right square – those who are helpful but unimportant.



*Note:* There are many examples of stakeholder maps available on the internet; search for 'stakeholder mapping template' for examples and further methodological help.

In the illustration, it is easy to see who is both influential and helpful – those in the upper right (green) square – who thus require maximum attention. Similar attention must be paid to people who are powerful but unhelpful – those in the red square. They represent strong nuisance value. Even though they will never be partners (unlike the key players), they must be managed with care because they could be disruptive. Those in the two lower boxes should not be ignored either; but the effort to interact with them is less crucial and should not distract from dealing with the important ones.

By understanding this paradigm, it is easier to plan what actions to take to reduce suspicions. Mapping and understanding stakeholders will not only help reduce suspicion, it will also help in devising a strategy to engage.

## Engage with all protagonists of the conflict

In a do-no-harm approach to fieldwork, engagement is indeed crucial. Engagement should focus both on all the people who are suspicious of neutral fieldworkers and individuals who understand them and are even ready to actively support them.

The analysis for mapping the helpful stakeholders forms the basis of a successful engagement strategy. The analysis will reveal that different stakeholders have different needs and concerns. For an engagement strategy with sometimes difficult stakeholders, such as local authorities or even members of the opposition, it is important to develop key messages.

In the case of a medical team working in a conflict environment, any key message must focus on the desirability of such work for all parties. Engagement must bring all protagonists to the understanding that the medical work must be encouraged, facilitated and supported and that it must never be jeopardized or halted.

To describe such work in an understandable way and to assure that even aspects that seem entirely obvious are properly communicated, the guiding questions that journalists rely upon when writing a news story must be applied: Who? What? Where? When? Why? And how? This simple approach appropriately applies to medical fieldwork: who is doing what for whom, when, where and how. Followed by why it is necessary and why it is performed. The answers to each question form the key messages.

Even if such a description often seems to state the obvious for those doing the fieldwork every day, it can be surprising to discover how much of it is not publicly understood and therefore how a few such words of explanation greatly illuminate and benefit a situation.

In formulating those key messages and in gauging what exactly is important to communicate, fieldworkers will profit from a reflection of their own situation. A simple tool for this purpose also derives from the business community: the SWOT analysis, which is a listing of an organization's or a team's **s**trengths, **w**eaknesses, **o**pportunities and **t**hreats. Such analysis produces a clear picture of who will have consequences for the priorities when it comes to effective communication and engagement. A short analysis, best done as a team, will help a group of medics to define their assets, such as all the outcomes that make people feel positive about a visiting medical team. Conversely, a brainstorming can reveal what aspects might

trouble those whom the team encounters in the course of their work. Some thinking on where the main dangers loom but also a listing of all the opportunities a field visit brings to patients *and* the community will further help.

Ideal engagement consists of forging numerous long-term relationships. Creating links that finally add up to a network of personal relations is probably the most crucial step towards improving the long-term safety and security of any fieldwork in a dangerous conflict situation. Simply knowing all the players and being known to them, talking to them regularly – not only when something is needed from them – are key elements of an engagement strategy.

***Important caveat:*** The benefits of a relationship-based approach are massive, but there are limits to it as well. One in particular is that familiarity can create contempt.

Fieldworkers need to be careful with their personal attitude at all times. When engagement is confused with flattery, an engagement strategy can backfire, and the attempt to communicate openly can be perceived as opportunistic. Fieldworkers can find themselves in this situation when it comes to dealing with those who actually permit the work: They can show too much respect, pronounce bottomless admiration or express exaggerated solidarity with an authority. In other words, they flatter.

People in power often develop a keen sense of reality. They know well that they are not liked and possibly even detested but that their consent is needed. Although flattery might work occasionally, a better strategy is to approach such people as fellow professionals and to refrain from overbearing expressions of sympathy, empathy or praise. Keep in mind that the sweeter and the more kowtowing a medical aid worker is in a meeting with an authority, the nicer and the more kowtowing that person of authority will assume the worker will be when meeting the other side. The behaviour may be interpreted as insincere or manipulative. Thus, suspicion will brew and ultimately even contempt.

Therefore, on a personal level, sobriety, objectivity and a matter-of-fact style can only advantageously complement the necessary impartiality and neutrality of a fieldworker in a conflict zone.

A well-reflected engagement and communication strategy is not rocket science and does not require specialists' input. Luckily, many ingredients of a successful engagement strategy are simply dictated by common sense: be transparent, consistent and always careful in what is said. The little mental test – Could I say this to the other side also? – can help to avoid the emotional or hyperbolic statements.

#### **Favour interactivity: Inform, consult and involve**

When concluding that more communication is needed, fieldworkers are often inclined to only inform: to talk ('communicate'), to produce and provide more information material, etc. But improved communication is actually a strategy built on three actions: inform, consult and involve.

'Informing' is straightforward: you talk, they listen, period. 'Consulting' requires a bit of thought. But declaring how things should be through an announcement is rarely the best strategy. Why not try interactivity? For example, sound out or ask a stakeholder what he/she thinks about, say, the plan of a relief team in the field. With the chance to comment and express an opinion, that stakeholder will more likely be willing to engage. The difference between a declaration and a consultation is enormous. Through interactivity, the stakeholder who initially is meant to be informed of an action becomes truly what the term suggests: someone who is part of an issue, who has a stake in its outcome.

A well-thought-through communication strategy goes further than just talking to stakeholders or interacting with them. The ultimate goal is to transform stakeholders into supporters. Interactivity that asks stakeholders to give their opinion and to participate can often create supporters. And supporters are what a medical team in a conflict context needs in good supply.

Transforming stakeholders into supporters should be a goal. But finding and adding supporters in a medical fieldwork must be part of a comprehensive strategy. Supporters can come from all corners. They can be eminent personalities, such as older individuals who have acquired clout and respect. Other supporters can be celebrities, even media stars. Of course, medical work is not for amateurs; but imagine a well-known personality shown providing comfort to patients, maybe not in the field but in a hospital. If a well-known personality can somehow be associated with medical fieldwork, the advantage can be massive. UNICEF and other UN organizations, for example, use goodwill ambassadors – often movie stars – to raise awareness of difficult issues. Many times, such celebrities venture into the field to make a point more poignant.

Then there is the media. The media is a powerful tool that must be used with caution. Their messages travel wide and far and fast. Although that is good for an aid organization's key messages, it also unfortunately applies to mistakes. The media can be just as willing to broadcast your misstep as your good work. Therefore, an unguided remark, the one you regret seconds after you made it, will make it into the broadcast or into tomorrow's paper.

In a situation of tension or conflict, the mass media of choice is often radio. Even in less developed areas, such as rural communities, the radio is listened to and local stations are often the ones with the most faithful audience. A sound communication strategy might consist of identifying and engaging a local – non-partisan! – radio station willing to broadcast an aid organization's message.

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**Virasakdi Chongsuvivatwong**  
**Louisa Chan Boegli**  
**Supat Hasuwannakit**  
**Editors**

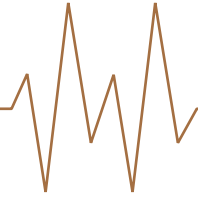
# ABOUT THE CONTRIBUTORS

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**Gabriella Arcadu, PhD** is a political scientist with expertise in conflict-affected, transitional and fragile States. She is the founder and director of 4change (since 2009), a non-profit association that conducts training and research activities in conflict-prone and fragile countries. Since the late 1990s, Dr Arcadu has been involved in the Health as a Bridge to Peace (HBP) programme of the World Health Organization, implementing actions in Egypt, Indonesia and Sri Lanka and assisting in the development of an HBP training package. In 2005 she assisted in the drafting of the Health and DDR section of the Integrated Disarmament Demobilization and Reintegration Standards, later adopted by the United Nations. In 2010 she drafted for the World Health Organization a global policy for civil–military coordination in the health sector on carrying out field research in Afghanistan. She has worked in different capacities for UN agencies, universities and NGOs, developing projects for various donors. Dr Arcadu has 20 years of experience in institutional strengthening and capacity building and governance programmes. She has worked in South-East and Central Asia, Africa, the Middle East and the Balkans.

**Urs Boegli, MBA** is a member of the advisory team of the Evian Group at IMD (Lausanne, Switzerland), a think tank that unites global corporate, government and opinion leaders, focusing on globalization, trade, poverty alleviation and inequality. Previously, he held senior positions with the International Committee of the Red Cross (ICRC) in Angola, Thailand, Cambodia, Lebanon, Sudan and Former Yugoslavia and at headquarters in Geneva. His career with ICRC spanned 20 years and his last posting was Head of the Washington, DC office where he initiated the organization's Guantanamo prison visit programme

Mr Boegli now focuses on helping companies to analyse and address socio-economic issues, identify and interact with stakeholders, create appropriate management systems and help develop, implement and monitor programmes for communities. His work includes exploring how society impacts business and how corporations can have a constructive role in regions where they operate while enhancing business focus, acceptance and reputation.



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**Louisa Chan Boegli, MD, MPH** is the founder and a core executive member of the Rugiagli Initiative, which she founded in 2012 with three other health and international affairs experts. The initiative focuses on building the capacity of national doctors working in conflict areas and on promoting international collaboration in health as a bridge to peace.

As a doctor, she worked in conflict areas for the International Committee of the Red Cross and the World Health Organization (WHO). For four years, she was the focal point for Health as a Bridge to Peace programme at WHO Headquarters, where strategy, policy and projects were formulated and implemented. In 1998, she became one of the four founding members of the Centre for Humanitarian Dialogue in Geneva, where she initiated a series of dialogue between the Republic of Indonesia and the Free Aceh Movement, which led subsequently to the successful suspension of the armed conflict. She was also instrumental in starting up the Centre's activities in Myanmar. Dr Chan is a member of the Non Official Group of Friends of Sri Lanka, which for three years actively engaged the Sri Lankan government and Tamil leadership in post-war political solutions to the conflict.

Dr Chan holds a medical degree from the University of California, Los Angeles and a Master of Public Health degree from the London School of Hygiene and Tropical Medicine.

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**Pantip Chayakul, MD** is Associate Professor of Internal Medicine and Infectious Disease in the Department of Medicine, Prince of Songkla University. She also works in the Medical Education Unit PSU. Dr Pantip is the current Associate President of the Deep South Relief and Reconciliation Foundation.

Dr Pantip holds a Doctorate in Medicine and a Diploma of Tropical Medicine from Mahidol University, Thailand

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**Virasakdi Chongsuvivatwong, MD, PhD** is Professor of Community Medicine. He founded the Epidemiology Unit of Prince of Songkla University in 1986, its International Graduate Programme in 1992, the Institute for Research and Development for Southern Health in 2004 and co-founded the Deep South Relief and Reconciliation Foundation in 2010, of which he is the current President.

His research work early in his academic career started with the health problems of southern Thailand, especially in the Deep South, and later expanded to international and global health. He was a member of the World Health Organization taskforce on reproductive epidemiological research from 1988 to 1994. He has provided more than 40 consultative visits to several health research institutes in East, South-East and South Asia. Over the past three decades, Dr Virasakdi has received international and Thai research grants and has published more than 200 research articles indexed in PubMed, with more than 1,700 citations in Scopus Database. In 2009, he received the National Outstanding Research Award from the National Research Council. He also received the 2012 National Outstanding Teacher Award from the Council of University Faculty Senate of Thailand.

Dr Virasakdi holds a medical degree and Diploma of Tropical Medicine from Mahidol University, a Bachelor of Arts in Economics from Sukothaithammathirat Open University, Master and PhD of Epidemiology degrees from the University of Newcastle, Australia and an Honorary PhD in Culture Study from Walailuk University.

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**Mayuening Eso, MSc** is a consultant with the Deep South Coordination Center and manages the database of victims affected by the unrest situation in Pattani province. She also assists the government in collecting data on victims of the violent conflict.

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**Supat Hasuwannakit, MD, MPH** is the Director of Chana District Hospital in Songkhla province (since 1999). He is interested in the social aspects of health and is a core member of the Rural Doctors Association of Thailand. He is currently Secretary of the Deep South Relief and Reconciliation Foundation.

Dr Supat holds a medical degree from Chulalongkorn University and a Master in Public Health degree from the Institute of Tropical Medicine, Antwerp.

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**Rohani Jeharsae, RN, PhD** is currently the Associate Dean of Faculty of Nursing, Prince of Songkla University, Pattani Province. Previously, she was a research supervisor at the Centre of Research and International Relation, Nepal Institution of Health Science (2011–2012), under the support of Fredkorpset Norway. Her research work since 2005 has focused on the consequences of armed violence on health in the Deep South of Thailand, especially in fragile groups, such as children, widows and people with disabilities. From 2009 to 2011 she managed a project for improving the quality of life of victims due to the violent conflict in Narathiwat province with funding from the European Union.

Dr Rohani holds a Bachelor of Nursing degree and a Doctor of Philosophy in Epidemiology from Prince of Songkla University.

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**Metta Kuning, PhD** is the Director of the Deep South Coordination Center (DSCC) and former head of the Department of Mathematics and Statistics, Prince of Songkla University, Pattani campus. She founded the DSCC in 2009 and created the database of violence-related victims. She also manages various projects assisting the families of the victims to recover from the disaster and find empowerment to provide for their family through self-help groups. She also organized a revolving fund for people who are poor in Pattani province, funded by international agencies and domestic donors.

Dr Metta holds a Bachelor of Mathematics degree and a Doctor of Philosophy in Epidemiology from Prince of Songkla University.

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**Kimberlyn Leary, PhD, MPA** is the Chief Psychologist at the Cambridge Health Alliance and an Associate Professor at Harvard Medical School. She is also a Faculty Affiliate at the Program on Negotiation at Harvard Law School, where she previously was a Visiting Scholar working on relational processes in negotiation and in clinical practice. In 2009, she received an MPA from the Harvard Kennedy School and was awarded a Public Services Fellowship. She is currently on detail to the White House Office of National Drug Control Policy.

Dr Leary's research interests include the role of first impression in shaping initial dialogues and work on emotion and negotiation. Her published work also addresses racial and cultural issues in health care settings. Dr Leary teaches courses on leadership to undergraduates at Harvard College, on advanced negotiation and mediation to senior executives at Harvard Law School and on physician–community engagement at Harvard Medical School. She was previously on the faculty of the University of Michigan, Ann Arbor.

Dr Leary has won numerous awards for her scholarship and teaching. She chairs the Scientific Program Committee at the American Psychoanalytic Association. She sits on seven editorial boards, including the Harvard Mental Health Letter and the Harvard Negotiation Journal. Leary is also a trustee on the Board of Directors at Austen Riggs, a private psychiatric hospital. At the Cambridge Health Alliance, she directs educational programming on primary-care behavioural health integration, the effective coordination of Accountable Care and team effectiveness in Medical Homes.

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**Klaus Melf, MD** is working within health administration at the Department of Community Medicine of Bergen Municipality in Norway and is currently finalizing a medical specialization in community medicine and public health. He holds a part-time position at Uni Research Health, affiliated with the University of Bergen, where he is developing an online course for general practitioners on the issue of intimate partner violence and female genital mutilation. He is serving a new term at the Board of the Norwegian affiliate of the International Physicians for the Prevention of Nuclear War. In 2005, he initiated the European Medical Peace Work network and is scientific coordinator for the seven online courses and teaching material at [www.medicalpeacework.org](http://www.medicalpeacework.org).

Dr Melf holds a Doctorate in Medicine in Occupational Medicine from Germany and a Master in Peace and Conflict Transformation degree from Norway.

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**Withoo Phruksanan, MD, LLB** is an instructor with the Forensic Medicine and Toxicology Unit at the Department of Pathology, Faculty of Medicine, Prince of Songkla University, Hat Yai Campus (since 2007). He is also Assistant Dean for Student Development of the Faculty of Medicine, Prince of Songkla University (since 2008). His interests are forensic medicine, law and human rights, especially the human rights abuse in the Deep South of Thailand.

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**Paisit Pusittrakul, LLB** is a researcher in human rights and international law. He was a research assistant to Prof. Viti Muntarbhorn at the Chulalongkorn Law Faculty, where he contributed in 2011 to *The Study on the Prohibition of Incitement to National, Racial or Religious Hatred: Lessons from the Asia Pacific Region* for the Office of High Commissioners for Human Rights and a book on ASEAN human rights mechanisms, *Unity in Connectivity? Evolving Human Rights Mechanisms in the ASEAN Region* by Prof. Muntarbhorn. In 2013 he conducted research for the United Nations Development Programme, producing the report *Legal Scan on Protection of the Rights of Women Living with HIV in Healthcare Settings: Study in Thailand*.

Mr Paisit graduated from the Faculty of Law, Chulalongkorn University, Bangkok. He is now engaged in a Master in Laws (International Law) programme at the Faculty of Law, Chulalongkorn University.

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**Norbert Ropers, PhD** is Senior Research Fellow at the Center for Conflict Studies and Cultural Diversity as well as the Institute of Peace Studies of the Prince of Songkla University in Pattani province (since 2012). He also serves as Programme Director for Southeast Asia for the Berghof Foundation (since 2010). Dr Ropers has been connected with the Berghof Foundation for more than 20 years. He was a founding shareholder and director of Berghof Peace Support and initiated the Berghof Research Centre for Conflict Research in Berlin, of which he was Director from 1993 to 2004. From 2001 to 2008, Dr Ropers headed the Resource Network for Conflict Studies and Transformation in Sri Lanka. Previously, he worked for the Institute for Development and Peace (University of Duisburg), the Royal Institute of International Affairs (Chatham House, London) and the Peace Research Institute Frankfurt. He was also the director of the academy of the Gustav Stresemann Institute in Bonn.

His practical and academic work is now focused on peace processes, conflict analysis and transformation, mediation and dialogue facilitation. During his career, he has focused on international relations, global trends research, transnationalism and intercultural communication.

Dr Ropers graduated in Sociology and holds a Doctor of Philosophy in Sociology from the Johann Wolfgang von Goethe University in Frankfurt/Main, Germany.

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**Vorasith Sornsrivichai, MD, PhD** is currently the Secretary-General of the Southern Health Foundation ([www.SHFthailand.org](http://www.SHFthailand.org)) and a technical expert with the National Institute for Emergency Medicine. He was the Deputy Director of the Institute for Research and Development for Southern Health and a member of the Faculty of Epidemiology Unit of Prince of Songkla University. His work in the Deep South began in 2004 with a multisector strategic working group in health development in the domain of security and safety, emergency and referral system, violence-related injury surveillance and relief. He is the founder of Violence-related Injury Surveillance ([www.DeepSouthVIS.org](http://www.DeepSouthVIS.org)), Online Security and Safety Resource and the Knowledge for Deep South ([www.K4DS.org](http://www.K4DS.org)). He is a founding member of Deep South Watch and the Center for the Study of Conflict and Cultural Diversity in southern Thailand, Prince of Songkla University and also a founding member and treasurer of the Deep South Relief and Reconciliation Foundation.

Dr Vorasith holds a medical degree from Mahidol University, a certificate in Field Epidemiology from the International Field Epidemiology Training Program, Ministry of Public Health, Thailand and Doctor of Philosophy in Epidemiology from Prince of Songkla University.

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**Ananchai Thaipratan, MD** is a senior physician in the Department of Surgery, Yala Regional Hospital. He is also Chairman of Emergency Medicine and Traumatology for Yala Medical Education Centre. He is a consultant for the Thai Islamic Medical Association and the Young Muslim Association of Thailand and is on the subcommittee for drafting the manual of operation for performing autopsies in Muslim cases. He is a member of the Committee on Human Rights and is the Chairman of the Foundation of Medicine and Public Charity. He is also on the Committee of Yala Primary Education Service Area and a committee member of the Higher Education Commission, Islamic University in Yala province. He has been awarded the Excellent Government Officer Award twice.

Dr Ananchai holds a Doctorate in Medicine from Chiang Mai University and a Diploma of Surgical Urology from Mahidol University, Bangkok.



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**Wallapa Thakan, RN** is the Programme Manager of the Institute of Research and Development for Health of Southern Thailand (since 2004) and conducts the Graduate Volunteer and Youth Volunteer projects. From 1980 to 2004, she was a nurse practitioner at Songklanakarind Hospital.

Ms Wallapa holds a Bachelor of Nursing from Prince of Songkla University and Master in Adult Nursing degree from Mahidol University and a Bachelor of Arts in Law degree from Sukhothaithammathirat Open University.

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**Pechdau Tohmeena, MD** is the Director of the Regional Mental Health Center in the Southern Provinces Branch of Thailand. She has been an advisor and guest lecturer at the medical faculty at Princess Narathiwat Rachanakarin University, Narathiwat province and an advisor to the Civil Society Council of Southernmost Thailand. She previously served on the Committee of the National Reconciliation Council.

Dr Pechdau received her medical degree from Universiti Kebangsaan Malaysia and a Master in Political Science degree from Thammasart University, Bangkok as well as an Advance Certificate in Promotion of Peaceful Society from King Prajadhipok's Institute and the Peace Mediation Course from Swisspeace in Bern, Switzerland.







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