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Human rights, transitional justice, public health and social reconstruction☆

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ABSTRACT

Mass violence, armed conflict, genocide, and complex humanitarian emergencies continue to create major social and public health disasters at the dawn of the 21st Century. Transitional justice, a set of policies designed to address the effects of war on traumatized communities and bring justice, lies at the nexus of public health, conflict, and social reconstruction. Despite the paucity of empirical evidence, advocates of transitional justice have claimed that it can alleviate the effects of trauma, deter future violence, and bring about social reconstruction in war-affected communities. Empirical evidence – including new data and analyses presented in this article – suggests a link between trauma, mental health and attitudes towards and responses to transitional justice programs, but there has been little theoretical discussion about the intersection between public health and transitional justice, and even less empirical research to generate discussion between these two fields. Yet, public health professionals have an important role to play in assessing the impact of transitional justice on communities affected by mass violence. In this paper, we offer a conceptual model for future research that seeks to examine the relationship between transitional justice programs and their potential value to the fields of medicine and public health and discuss the methodological issues and challenges to a comprehensive evaluation of this relationship. To illustrate the discussion, we examine new data and analyses from two cases of contemporary conflicts, eastern Democratic Republic of Congo (DRC) and northern Uganda.

Introduction

As we approach the end of the first decade of the 21st century, mass violence, intrastate wars, genocide, and subsequent complex emergencies continue to produce major social and public health disasters. In 2008, there were 345 ongoing conflicts worldwide, of which 134 (39%) involved massive or sporadic violence that resulted in millions of deaths (Pfetsch, 2008). In addition to casualties, wars and violence destroy infrastructure and the institutions that sustain a society, such as rule of law, health care and the educational system. Violence also leads to long term physical, social and psychological effects among survivors who may have lost family members, those who no longer have the means to sustain their livelihoods, or who have experienced amputation, disfigurement, displacement, torture, abduction, sexual violence, malnutrition and disease.

While attention to the mental health needs of survivor populations has become an integral part of the public health response to man-made disasters, clinical and psychosocial programs have not been comprehensively evaluated nor are they particularly well-funded due to fundamental conceptual disagreements such as the utility of such concepts as post-traumatic stress disorder (Ghobarah, Huth, & Russett, 2004; de Jong, 2002; McNally, 2003; Pedersen, 2002; Salama, Spiegel, Talley, & Waldman, 2004). At the same time, there has been increasing discussion about the role and importance of psychosocial wellbeing for the processes required to rebuild societies and promote development (Fletcher & Weinstein, 2002; Miller, Omidian, Rasmussen, Yaqubi, & Daudzai, 2008; Pham, Weinstein, & Longman, 2004; Snyder & Vinjamuri, 2004; Staub & Pearlman, 2001; Sullivan & Tifft, 2001; Vinck, Pham, Stover, & Weinstein, 2007). Fletcher and Weinstein (2002) proposed using the term "social reconstruction" as a comprehensive concept that captures the reversion of social breakdown as a result of war and mass violence. We use "social reconstruction" in this paper to reflect the synthesis required to rebuild a state after mass violence.

Transitional justice, a term first coined in the mid 1990s, lies at the nexus of public health, conflict and social reconstruction. The concept refers to the range of approaches that societies moving

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from repressive rule or armed conflict use to reckon with legacies of widespread or systematic human rights abuse as they progress towards peace, democracy, the rule of law, and respect for individual and collective rights so as to prevent future human rights abuses (ICTJ, 2009; Kritz, 1995). Diplomats, human rights and victims' organizations have advanced such mechanisms as criminal prosecutions, truth commissions, lustration or vetting programs, reparations programs, gender justice, security system reform, and memorialization efforts to hold perpetrators accountable and to acknowledge the impact of war, repression and human rights abuses on individuals and communities (Kritz, 2002; Roht-Arriaza & Mariezcurrena, 2006; Teitel, 2003). These mechanisms have been implemented in more than 90 countries including South Africa, the states of the former Yugoslavia, East Timor, Iraq, Cambodia and Rwanda among others (Hayner, 1994, 2002; Sikkink & Walling, 2007). Most transitional justice mechanisms address the gravest human rights abuses: crimes against humanity, war crimes, and genocide.

While most health practitioners recognize the physical and psychological consequences of mass violence, the contribution of transitional justice programs to social and individual repair is less clear. In this paper, we examine why medical and public health practitioners should be aware of the impact of transitional justice programs (both direct and untoward) and factor these effects into programs of clinical treatment and community health planning.

Despite the paucity of empirical evidence, transitional justice has been touted to deter future abuses of human rights, combat impunity, lead to forgiveness and reconciliation, promote social reconstruction, and alleviate the effects of trauma (Akhavan, 1998; Bassiouni, 1996; Fletcher, Weinstein, & Rowen, 2009; Herman, 1997; Kritz, 2002; Stover & Weinstein, 2004). Thus, it is thought to have both societal and individual effects by contributing to the conditions that allow for peaceful, democratic and stable countries and atoning for the wrong done to victims. However, critics have argued that pursuing justice in the midst of an ongoing conflict has a ripple effect and may hinder delivery of humanitarian aid, ongoing peace negotiations and agreements, particularly where powerful actors capable of blocking such agreement fear punishment for past actions. Darfur, Sudan is a recent case in point. Because of these wide-ranging goals and intense debate, transitional justice and its relationship to trauma has emerged as an important determinant of social reconstruction in the medical and public health literature (Basoglu et al, 2005; Bayer, Klasen, & Adam, 2007; Pham et al., 2004; Vinck et al., 2007).

Similarly, transitional justice has been argued to have salutary direct and/or indirect health benefits (i.e., physical, mental and social well-being) on individual victims and traumatized communities. The proposition echoes the idea that health inequalities may be rooted in social injustices (Hofrichter, 2003) and that if war has health consequences, then peace, stability and justice should alleviate those consequences.

These assumptions, and the implementation of transitional justice mechanisms have generated a lively debate among mental health practitioners, legal professionals, anthropologists and international and local non-governmental organizations on how traumatic experience shapes the ability of individuals and groups to respond to transitional justice initiatives (Pham et al., 2004; Vinck et al., 2007) and in return, how the initiatives affect individual and community health (Boettke & Subrick, 2003), societal healing (Gibson, 2004), and deterrence of violence (Stromseth, 2003). As of this time, however, there has been little theoretical discussion about the intersection between transitional justice and public health, and even less empirical work to support these discussions (Basoglu et al, 2005; Mendeloff, 2009; Snyder & Vinjamuri, 2004; Thoms, Ron, & Paris, 2008).

Several studies have examined various dimensions of the relationship between transitional justice initiatives, exposure to trauma and responses to trauma such as PTSD (Bayer et al., 2007; Field & Chhim, 2008). These studies have been cross-sectional in nature and, as of yet, do not permit definitive identification of a causal relationship. There has been a lack of standardization of how the various independent and outcome factors are defined, measured and analyzed (i.e., exposure to the trauma events, assessment of symptoms for PTSD, depression, disability, reconciliation, desire for revenge, and forgiveness). In this paper, we offer a conceptual model for future research that seeks to examine the relationship between transitional justice programs and their potential value to the fields of medicine and public health and discuss the methodological issues and challenges to a comprehensive evaluation of this relationship. In the first section, we provide a brief overview of transitional justice mechanisms, their processes, and assumptions. In the second section, we review the impact of violence on health. Finally, we look at the proposed model and examine some of the methodological issues and challenges to a comprehensive evaluation of the relationship between health and transitional justice.

The evolution of transitional justice and its assumptions

With strong financial and political support from the international and donor community, transitional justice is a relatively new and rapidly evolving field (Bell, 2009). Whether seen as an extension of human rights theory and practice, international humanitarian law, international criminal justice or democracy building, it is apparent that these multilevel interventions in response to repression or conflict represent a concerted effort by the world community to develop a consistent and pragmatic response to states where these violations have occurred. The history of transitional justice began with the desire to deliver justice, combat impunity and perhaps, to mitigate the effects of trauma and prevent future violence. Teitel (2003) divides the evolution of transitional justice into three phases. The first phase began in 1945 in the aftermath of World War II when there were widespread calls for justice on behalf of the victims who suffered the horrors perpetrated by the Nazi regime and resulted in the first multilateral effort to recognize the global impact of certain crimes, the Nuremburg Trials. These trials emphasized that individuals must be held accountable for their acts and thus contributed to the evolution of international criminal justice.

A second phase began in the post-cold war world, with the collapse of the Soviet empire in Eastern Europe, the military juntas in South America, and the apartheid regime in South Africa. A challenge for the newly-democratic countries was how to respond to the human rights violations of the previous regime and new questions were confronted (Roht-Arriaza & Mariezcurrena, 2006; Rotberg & Thompson, 2000). First in many of these countries, prior dictators and the military still enjoyed some civilian support and indeed, they were involved in negotiating the end of the regime and granting themselves amnesties. If their interests were ignored, there was a potential risk of reigniting the violence. Second, several diplomats and human rights activists feared that the newly installed governments might be too fragile to create a competent judicial process to try alleged perpetrators. Such criminal trials would demand significant financial, political, and human resources. These dilemmas ultimately led to alternative transitional justice processes such as truth commissions and other complementary approaches such as amnesty and reparation programs.

Truth commissions, unlike trials, are "less confrontational" to the prior regime (Roht-Arriaza & Mariezcurrena, 2006). Trials only address the needs of victims as a secondary goal, based on the assumptions that a trial record of truth and retributive punishment

will honor their suffering and deliver justice, with the primary objective being the state's obligation to uphold rule of law and prosecute those who violate international human rights and international humanitarian law. One premise of truth commissions is that when survivors tell their story and learn more of what happened, they achieve "closure" and therefore leave the trauma behind, thus promoting forgiveness. By having perpetrators confess and atone, an environment is created that allows former enemies to live together again (Hayner, 2002). By establishing a historical record of human rights abuses and acknowledging victim experience, society is thought to move closer to reconciliation. While these are worthwhile goals, there is no hard evidence that truth commissions achieve these objectives (Dwyer, 2003; Mendeloff, 2004; Snyder & Vinjamuri, 2004).

Reparations programs have also been developed in conjunction with or as alternatives to truth commissions in several countries (Rubio-Marin & de Greiff, 2007). The purpose of reparations, which may be material or symbolic, is to contribute towards the repair of the damage suffered by victims who have suffered physical violations, property destruction or job loss. Reparations can take the form of monetary payments and non-monetary benefits such as health and education.

After a change of a regime or government, some countries have instituted lustration (for those affiliated with groups that committed human rights abuses) and vetting of individual wrong-doers whereby they purge and prevent individuals who were abusive, corrupt, or incompetent from holding elected office and other public sector positions. On the other hand, non-punitive measures such as amnesty have also been implemented.

The third and current phase of transitional justice emerged in the early 1990s in response to the ethnic cleansing in the countries of the former Yugoslavia and Rwanda. In 1993, the United Nations Security Council created an ad hoc International Criminal Tribunal for the former Yugoslavia (ICTY) followed in November 1994, by the International Criminal Tribunal for Rwanda (ICTR). The experience with the ICTY and ICTR led to the creation of the International Criminal Court (ICC) in 2002. Meanwhile, national and/or hybrid tribunals have been established in Indonesia, Iraq, Sierra Leone, Kosovo, Bosnia and Herzegovina, Timor Leste, and Cambodia. This further development in international criminal justice attempts to incorporate the local judiciary in the process of criminal trials and to make the trials more relevant to local interests – a concern that arose from the experience of the ICTY and ICTR.

A systematic review of empirical research on transitional justice found that most studies conducted thus far suggest that transitional justice mechanisms have had no or only moderately positive effects to stated goals such as promoting reconciliation and the rule of law, deterring violence, and providing healing for the victims. A few studies found negative effects (e.g., reigniting violence and retraumatizing victims) (Thoms et al., 2008). However, all of these studies have been observational and hence lack the ability to make causal inferences. Monitoring and evaluation of TJ programs has proven difficult because the explicit and implicit goals (outcomes) of transitional justice are ambiguous and broadly based social and political goals, conceptually linked to democratization, power sharing, reconciliation, peace, disarmament, demobilization and reintegration and health (Thoms et al., 2008). Better conceptualization and theory is needed to evaluate the impact of transitional justice. While it is reasonable to assume that war causes health effects, can we make the assumption that TJ mechanisms will reverse the incidence and prevalence of these effects? Given the lack of empirical evidence of any health effects, should health professionals devote more resources and more actively engage in this dialogue to assess the effects of transitional justice programs on health?

Mass violence, human rights, transitional justice, and public health

The principal goals of public health and medicine are to treat, mitigate, and prevent disease, mental illness, disability, and premature death and to promote physical, mental and social well-being. Health is influenced by ecological and environmental changes, individual socio-demographics and behavior, technology and industry, microbial adaptation, and public health measures (Taylor, Latham, & Woolhouse, 2001). "Whatever structural, social, and cultural factors lie upstream in the sequence of causes and health determinates, at some point – downstream – there are psychological and biological processes at work, linking the paths between the macro-contextual determinants (the political economy) with the micro-worlds of individual experience" (Pedersen, 2002).

Health outcomes offer a good measure of social and political processes and the programs designed to respond to mass conflict. Direct outcomes include death, physical and mental injury to both combatants and civilians, displacement of civilians and health staff, and destruction of health infrastructure during the crisis. There are also long term effects on the health of the population (Ghobarah et al., 2004; Iqbal, 2006; Levy & Sidel, 2008). At the community level, mass conflict disrupts health delivery and disease control programs, destroys infrastructure rendering inadequate surveillance and response systems, and leads to a collapsed health system. This may create conditions conducive to infectious and chronic diseases (Gayer, Legros, Formenty, & Connolly, 2007; Ghobarah et al., 2004). Reverse effects can also be observed (e.g., a positive impact such as returns of a displaced population to its original home community as a result of transitional justice and other political processes). Other indirect health outcomes of mass violence include diversion of resources away from health programs, increase in domestic violence, and damages to the environment (Levy & Sidel, 2008).

Public health and transitional justice approaches are linked by a shared common goal to promote and protect individual and societal physical, mental, and social well-being. Modern public health, as a field of study, recognizes that there is societal dimension and context to individual and population well-being (Mann, Gruskin, Grodin, & Annas, 1999). This recognition is reflected in the World Health Organization's expanded definition of health, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Transitional justice evolved to respond to the systematic and widespread abuses of human rights worldwide. Transitional justice recognizes that human rights abuses too can be mitigated and prevented by adherence to international law. These legal regimes (international humanitarian law, international human rights law, international criminal law) protect the well-being of individuals and society.

Many possible research questions link health, conflicts, and transitional justice: What are the various health responses to trauma exposure (e.g., PTSD, depression, chronic illness as a result of stress, suicide, risky health behaviors such as alcohol, smoking, other drug abuse, and unprotected sex with multiple partners)? Does transitional justice contribute to healing among victims, or on the contrary to retraumatization? Does "healing" translate into better health outcomes at the individual and societal level?

Research skills and tools used in medicine and public health such as epidemiology and biostatistics may be able to further advance inquiry into the expected outcomes of transitional justice so as to promote individual and societal healing (Thoms & Ron, 2007). The challenges lie in the conceptualization and operational mode of measurements and sharing of research findings across disciplines. This can be overcome through more coherent and

coordinated efforts that explicitly link existing assessment and active surveillance of conflict-related morbidity and mortality to transitional justice-related political programs (Fottrell & Byass, 2009).

A conceptual framework for exploring the relationships between health and transitional justice

Here we introduce a conceptual framework for integrating the transitional justice framework and health outcomes and we suggest a new area of research and theoretical conceptualization. Specifically, the framework explores three direct and indirect relationships illustrated by Fig. 1: 1) the effects of human rights abuses and violations of international humanitarian law on health, 2) the relationship between health outcomes resulting from exposure to human right abuses and the desire for, attitudes towards, and level of participation in transitional justice-related activities, and 3) the effect of transitional justice processes on health.

The first dimension of this framework explores the effects of violations of human rights and international humanitarian law on health. There are at least three practical objectives for health practitioners: first, this assessment provides data to develop interventions and humanitarian assistance programs; second, it alerts policymakers to the consequences of violence; and third, it provides evidence to support policy making in institutional reform and sustainable human development. By explicitly linking health assessments to transitional justice objectives, the data may have additional value such as: 1) providing decision makers with empirical information on population needs and priorities to establish transitional justice; 2) provide evidence for transitional justice proceedings; and 3) establish baseline data for evaluating transitional justice processes.

Data on the impact of human rights abuses and mass violence on health can be collected by retrospective cross-sectional surveys, and information surveillance systems. Health outcome measures include mortality, injuries due to violence, disability, morbidity, and mental health outcomes. Monitoring of crude mortality rate is one of the most commonly used health consequence indicators. These rates can be captured through a retrospective mortality survey such as those implemented in the Democratic Republic of Congo (Coghlan et al., 2006), Iraq (Roberts, Lafta, Garfield, Khudhairi, & Burnham, 2004), and Sudan (Depoortere et al., 2004). Although surveillance systems have been found to underestimate mortality rates by ten-fold (Guha-Sapir, 2004), data generated from these systems can be used to track mortality and morbidity patterns over time. This permits detection of patterns and may expose the systematic nature of the violence.

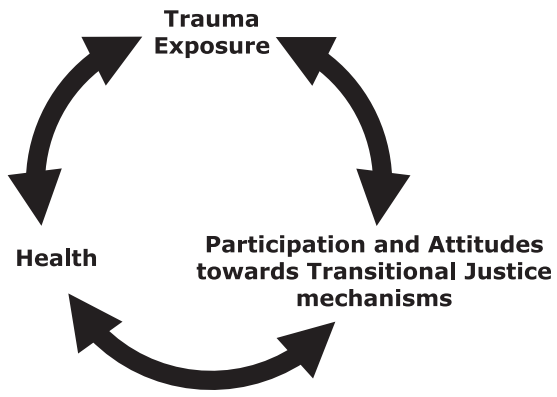

Fig. 1. Linking trauma, health, and transitional justice.

Psychiatric epidemiology has measured the clinical effects of exposure to violence and human rights abuses. For examples, Lopes Cardozo, Vergara, Agani, and Gotway (2000) used a cross-sectional cluster sample survey to examine the mental health consequences of the war in Kosovo; Mollica et al. (1999) studied the relationship between disability and psychiatric symptoms after ethnic cleansing among Bosnian refugees in a cross-sectional survey design; and de jong et al. (2001) utilized survey techniques to study prevalence rates for PTSD in post-conflict countries.

Other tools such as the Dirty War Index (DWI) have been introduced to link exposure to trauma and other "undesirable or prohibited" war related health outcomes with international humanitarian law. (Hicks & Spagat, 2008). The DWI illustrates how public health practitioners can monitor the impact of political processes and contribute to conflict early warning. Such tools also can provide empirical evidence for trials or truth commissions.

The second dimension of the proposed framework explores the relationship between violence exposure and TJ initiatives. In seeking to rebuild societies, it is important to understand how traumatic experience shapes the ability of individuals and groups to respond to transitional justice and in turn, how these initiatives affect individual and community health. Cross-sectional surveys can be designed to assess attitudes towards transitional justice mechanisms such as trials, truth commissions or amnesty provisions, For example, in 2002, the authors analyzed data from a multi-staged stratified cluster random survey of 2074 respondents in Rwanda to examine these inter-relationships. We found preliminary evidence of an association between exposure to multiple trauma events as measured by the total number of exposures, symptoms of PTSD, attitudes towards judicial responses, and openness to reconciliation. Increased exposure to traumatic events was associated with lower odds that survivors of the 1994 Rwandan genocide would support gacaca, a government-organized and modified grassroots court system to trial perpetrators, or a desire to reconcile as evidenced by decreased support for the interdependence of Hutu and Tutsi. After controlling for the effects of other significant variables, we found that those with PTSD symptoms as measured by the PTSD Checklist-Civilian Version were less likely to support the Rwandan trials and two critical components of reconciliation – community and interdependence (Pham et al., 2004).

In 2005, we conducted a multi-stage stratified cluster random survey of 2585 adults residing in four districts of northern Uganda. We found respondents reporting symptoms of PTSD and depression were more likely to favor violent over nonviolent means to end the conflict [respectively, (OR, 1.31; 95% CI, 1.05–1.65); (OR, 0.77; 95% CI, 0.65–0.93)] (Vinck et al., 2007). In this population, psychological symptoms associated with the trauma may be associated with a desire for retribution rather than restorative ways to deal with the past. Mechanisms identified to achieve peace were also associated with socio-cultural and demographic factors. These findings may have implications for policymakers when introducing policies aimed at building a lasting peace. For example, when amnesties are granted to those responsible for war crimes, many affected individuals may feel that the authorities have not responded to their needs. The same concerns may arise in response to other accountability mechanisms such as truth commissions.

A cross-sectional survey of 1358 war survivors conducted in the former Yugoslavia found that neither a desire for revenge nor a desire for redress were associated with symptoms of PTSD and depression (Basoglu et al., 2005). However, threat to safety and loss of control over life were strongly associated with PTSD and depression [respectively, (OR, 2.91; 95% CI, 2.27–3.74); (OR, 2.30; 95% CI, 1.75–3.03)]. Studies such as these suggest that there may be a relationship between exposure to traumatic events, health

outcomes, and attitudes towards transitional justice. The subsequent question then is to examine how transitional justice programs impact health outcomes, the third dimension of our framework.

Transitional justice mechanisms potentially can mediate individual and community health by directly alleviating the exposure to trauma, assisting with ongoing efforts to promote coexistence among former enemies, reducing the effects of trauma such as PTSD, anxiety, or depression, preventing the morbidity and mortality related to further mass violence through improvement in rule of law, reduction of impunity, and increasing quality of life. Our research in Rwanda suggested that the relationship of trials to reconciliation cannot be assumed, nor can we assume that justice is defined solely by legal processes. Furthermore, the data from Rwanda indicate that there may be stages to reconciliation (Pham et al., 2004). Perhaps people establish trust by establishing social ties from which a shared vision and collective future can emerge; only then might they accept and promote social justice. Once this foundation has been established, people might be less willing to use violence that would lead to destabilization. At that point, they would have more to lose and might be less willing to risk a return to violence.

Political economists, Boettke and Substrick (2003), analyzed the World Bank Indicators to examine the relationship between rule of law, development, and health indicators. Rule of law was a measure of "the extent to which agents have confidence in and abide by the rules of society, in particular the quality of contract enforcement, the police, and the courts, as well as the likelihood of crime and violence (Kaufmann, Kraay, & Zoido, 1999)." Improvement in the rule of law indicator was found to correlate positively with several health indicators: 1) increase in life expectancy at birth, 2) decreased infant mortality, 3) increased sum of public and private health expenditures as a ratio to total population, 4) increase in the number of hospital beds per 1000 people, 5) increased childhood immunization rates for diphtheria, pertussis, and tetanus, 6) increased childhood immunization rates for measles, and 7) increased numbers of physicians and safe births. They concluded that improvement in rule of law led to improvements in health outcomes either directly or indirectly through improvements in the level of development.

We still know little about the processes of social reconstruction, such as reconciliation, about which debates on definition persist. By simultaneously examining transitional justice and trauma and its effects, we may advance our understanding of trauma recovery and its relationship to peace building. Studies such as these can suggest policy strategies that maximize the possibility of individuals and communities rebuilding their lives. What follows is an analysis exploring those questions in two case countries using data collected by the authors.

The interrelationship of health and transitional justice: two case studies

To illustrate the discussion, we examine new data and analyses from two cases of contemporary conflicts, eastern Democratic Republic of Congo (DRC) and northern Uganda. The data consist of two multi-stage random cluster surveys of 2620 adult residents in eastern DRC (North Kivu, South Kivu, and Ituri Districts) and 1404 adult residents of northern Uganda's Acholi Districts (Amuru, Gulu, Kitgum, and Pader). The surveys took place from March to June 2007 in northern Uganda and September to December 2007 in eastern DRC. Details of methods, including multi-stage random sampling, instrument development and translation, and training have been described elsewhere (Pham, Vinck, & Stover, 2009; Vinck & Pham, 2008). Ethical approval was received from the Human Subject Committees of the University of California, Berkeley, Tulane University, and the School of Public Health, University of Kinshasa, DRC.

Virtually everyone living in the Acholi Districts of northern Uganda and eastern DRC has been affected personally and directly by the ongoing conflicts (see Table 1). When asked "who are the victims of the conflict," virtually all (98%) stated that they were the victims. In eastern DRC, only 2% (51 respondents) reported that they had not experienced any of 8 listed trauma events. All but one respondent in northern Uganda reported having experienced at least one of the listed trauma events. In eastern DRC, 45% of the males reported symptoms of PTSD as measured by the PTSD checklist-civilian version, while only 38% of the females reported symptoms of PTSD. The finding is not consistent with the current literature (Breslau, 2001; Kessler, Sonnega, Bromet, & Nelson, 1988; Pham et al., 2004; Vinck et al., 2007) nor with the northern Uganda data where females were more likely to report symptoms of PTSD than males (unadjusted OR, 5.77; 95% CI, 4.55, 7.31).

We examined the relationship between exposure to violence, symptoms of PTSD, and attitudes towards justice (See Table 2). One measure of this was whether or not the respondent would accept amnesty for those who committed war crimes if it were the only way to peace. There were two consistent findings between eastern DRC and northern Uganda: Those who reported symptoms of PTSD were less likely to accept amnesty for those who committed the violence in eastern DRC (OR, 0.77; 95% CI, 0.64, 0.97) and northern Uganda (OR, 0.42; 95% CI, 0.31, 0.57). However, those who had at least one family member killed or who were displaced from their homes were more likely to accept amnesty than those who did not. This is consistent with findings from other studies (Bayer et al., 2007; Field & Chhim, 2008; Orth, Montada, & Maercker, 2006). In eastern DRC, those who witnessed violence, had been abducted, and/or were forced to commit violence were less likely to accept amnesty. In northern Uganda, those who witnessed violence were more likely to accept amnesty than those who did not. This difference may be explained by the fact that there were active peace negotiations in northern Uganda at the time of the survey and a campaign among religious and traditional leaders that promoted peace and forgiveness. These two cases highlight the complex relationship between violence, health, and transitional justice initiatives.

Challenges to measurement of transitional justice and health

Beyond the conceptualization of a health and transitional justice model, several challenges to systematic collection and examination of empirical data must be recognized. What follows is a list of issues and recommendations for future discussion and study that may contribute to the health and transitional justice research agenda proposed in this article. It is not meant to be exhaustive, but rather illustrative of the challenges that lie ahead.

Table 1
Exposure to trauma and symptoms of PTSD.

	Eastern Democratic Republic of Congo n (%)	Northern Uganda n (%)
Property destroyed	2390 (95.3)	1305 (96.5)
Displaced from home	2139 (85.5)	1268 (93.7)
Witnessed violent episodes	2131 (84.0)	1242 (91.8)
Family member killed	1606 (64.2)	1151 (85.1)
Abducted	913 (36.5)	374 (27.6)
Physically injured/disabled	865 (34.5)	65 (4.8)
Forced to commit violence	412 (16.5)	284 (21.0)
Sexually violated	396 (15.8)	55 (4.1)
Symptoms of PTSD		
Women	473 (37.9)	486 (75.6)
Men	570 (45.2)	248 (34.8)
Total	1043 (41.6)	734 (54.1)

Table 2
Variables associated with positive attitude towards amnesty.

	Eastern Democratic Republic of Congo		Northern Uganda	
	Adjusted odds ratio (95% CI)	*p*-Value	Adjusted odds ratio (95% CI)	*p*-value
Gender (Female)	NS	NS	1.67 (1.23, 2.2.4)	0.001
Symptoms of PTSD	0.77 (0.64, 0.97)	0.006	0.42 (0.31, 0.57)	0.002
Witnessed violence	0.65 (0.48, 0.88)	0.006	1.62 (1.14, 2.29)	<0.001
Abducted	0.70 (0.57, 0.86)	0.001	NS	NS
Family member killed	1.26 (1.02, 1.57)	0.029	1.67 (1.21, 2.30)	0.002
Forced to commit violence	0.71 (0.67, 0.89)	0.003	NS	NS
Displaced from home	1.68 (1.30, 2.16)	<0.001	3.42 (2.47, 4.78)	<0.001

Issues of measurement

Defining constructs or measures that reflect concepts under study is an important part of a conceptual design, and one that rarely leads to common agreement and establishment of standards. The health-transitional justice research agenda is not exempt from that challenge, and, arguably, because it is a multidisciplinary endeavor, the definition of a shared language is even more important. For example, defining the type and nature of mass violence can be challenging. Several models have been described to systematically assess individual victimization, using physiological (e.g., injuries) and sociological (e.g., level of disruption) factors, economic factors (e.g., property loss), programmatic approaches (e.g., based on needs), or measures of psychological impact of exposure to violence, such as PTSD. One recent example is WHO's proposal to classify violence based on two axes: 1) the nature of violence (physical, sexual, psychological, or deprivation); 2) type of violence (self-inflicted, interpersonal, and collective) (Krug, Mercy, Dahlberg, & Zwi, 2002). Similarly, the literature offers a range of "health outcomes" that can be measured and used as the unit of analysis in evaluating the impact of transitional justice on health, such as changes in the level of exposure to trauma and reduction of mortality and morbidity, or changes in symptoms associated with response to trauma, such as PTSD, depression, and reduction in disability adjusted life years. Such health outcomes may be considered appropriate measures of long term goals of transitional justice to deter crime and "heal" victims. These goals can take years to be detected and measured. To identify such health indicators, the first step is to formalize a logical framework that identifies short and long term health-related goals of transitional justice as well as measurable indicators for these goals. Such a framework is proposed in Fig. 2.

Issues in study design

In social programs such as trials and truth commissions, the intervention is complex and its effects are difficult to define and measure. For example, what is the intervention? Is it contact with the transitional justice mechanism, participation in those mechanisms? Who are the 'beneficiaries' of the program on whom impact should be measured? Who will determine which intervention is most appropriate and who administers it? One possible indicator is to examine how individuals or communities come into contact with a trial or commission. Looking at Fig. 2, there are several ways in which an individual can be exposed to transitional justice (or 'receive the intervention'): for example, they can receive "knowledge" of trial proceedings by reading newspapers, or listening to radio programs. Individuals can also directly participate in the proceedings as witnesses, victim participants and staff members of the trials. Finally, even with no knowledge or direct participation, individuals can be indirectly affected by direct outcomes of transitional justice programs, for example, living in a community where transitional justice has made an impact on rule of law.

The issue of defining the intervention has implications for the overall study design. Randomized controlled trials are often used for impact evaluations and causal studies. However, they rarely are applicable in the context of transitional justice due to the difficulty of assigning interventions randomly, ethical considerations and because of the level of resources required. One further constraint is the difficulty in isolating the effects of transitional justice from that of other interventions. Possible confounding factors include 1) other ongoing humanitarian, development, and political activities, 2) individual and community socio-demographic characteristics, 3) individual and community self-efficacy and resiliency; 4) ethnicity or class, 5) cultural/local factors, 6) racism and extreme nationalism, and 7) pre-conflict conditions and environments. Therefore, assessing, monitoring and evaluating complex interventions such as transitional justice mechanisms requires multi-phased mixed method approaches and/or other quasi-experimental study designs (Campbell et al., 2000; Smyth & Schorr, 2009. The underlying problem with non-randomized studies is the confounding factors. One way to overcome this is to triangulate the results from multiple approaches and apply Bradford-Hill's guidelines (Bradford-Hill, 2005) for making causal inferences with non-randomized experimental designs (i.e., strength of association, consistency, specificity, temporal sequence, plausibility, coherence with biological background and previous knowledge, and analogy). Another possible design involves the comparison of the results of the intervention outside the control of the investigator when the intervention has

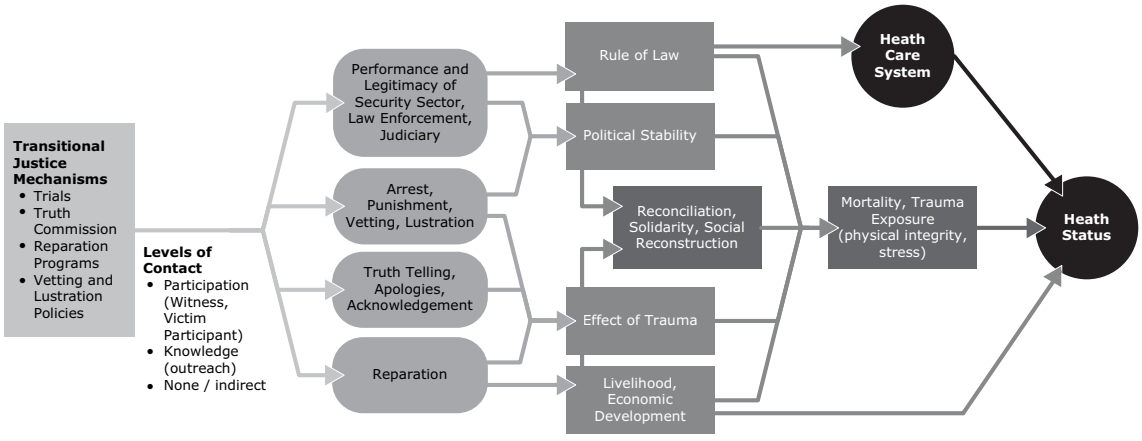

Fig. 2. Conceptual framework for health-transitional justice impact evaluation.

occurred for reasons other than scientific and investigation. For example, if a court or truth commission has randomly selected eligible victims to participate in the court or commission proceeding. Such studies are often referred to as 'natural' experiments.

Issues of coordination and "merging of the field"

Finally, the implementation of a health and transitional justice research agenda resides in the multidisciplinary approach needed to tackle such studies and the need for collaboration among the multiple stakeholders. Such collaboration requires guidelines and explicit protocols on how data are collected, shared and used. Importantly, each discipline needs to understand the vocabulary and objectives of other disciplines. Health researchers must have some knowledge of humanitarian law principles and laws and transitional justice responses and diplomats, lawyers and political scientists must be knowledgeable of the methods used to derive these health measures. One example is the Standardized Monitoring and Assessment of Relief and Transition (SMART). As part of this initiative, the Center for Research on the Epidemiology of Disasters together with the Harvard Humanitarian Initiative convened a symposium to "open" this type of dialogue and coordination between disciplines (Ratnayake, Degomme, & Guha-Sapir, 2009).

Conclusion

Transitional justice models have emerged as a direct response to the real and complex challenges of attaining effective and sustainable peace in post-conflict countries and even amidst endemic and escalating violent situations such as in Uganda and Sudan. These experiments in international justice have been subject to great debate (e.g., what are the goals of transitional justice programs, whether justice programs promote or hinder peace, and whether transitional justice is a legitimate field or a cloak to cover the lack of will of the international community to intervene in situations of mass violence) and the controversies are likely to continue. Debates and controversy aside, the mere fact that billions of dollars are invested in these transitional justice programs (e.g., over 2.4 billion U.S. dollars have been spent on the ICTY and ICTR) warrants comprehensive evaluation of these mechanisms. We suggest that health professionals have a role in assessing the health effects of such mechanisms and in developing new programs that may address the gaps that currently exist in the rebuilding of societies after war and atrocity.

What then does public health bring to the table? In the ongoing evolution of transitional justice, we suggest that health professionals can contribute to the critical set of interventions after human rights violations and mass violence by assessing the relationships between transitional justice and individual, community, and societal health. Traditional health interventions (e.g., vaccination campaigns, clinical treatment, and water and sanitation) alone only have limited impact on health and cannot minimize the effects that war inflicts on society. We suggest that health practitioners need to be involved at the political and policy level with diplomats, government officials, and human rights advocates. Historically, public health has had a strong experience in prevention, using an evidence-based approach, and coordinating across disciplines and sectors (Salama et al., 2004). By using its basic science of epidemiology, public health can examine how a population at large is affected by both violence and the attempts to rebuild societal infrastructure. With its emphasis on physical and mental health promotion, public health can work within the TJ framework to maximize the wellbeing of affected populations and contribute to institutional reform and social reconstruction. Assuring the delivery and access of medical and social services to victims can make an important contribution to transitional justice mechanisms by acknowledging the needs of survivors. The growth of interest in the interrelationship of health and human rights offers a model for how public health as a discipline may support TJ efforts (Braverman & Gruskin, 2003; Farmer, 2005). Finally, public health has a wealth of experience in monitoring and evaluating programs and might then contribute to an understanding of the impact of TJ in a particular context and culture (Krug et al., 2002; Pham & Vinck, 2007; Thoms & Ron, 2007). In combination with health-related research from other disciplines (e.g., anthropology and political science), a health perspective may contribute importantly to the design and effectiveness of TJ programs and to the social reconstruction of countries after mass violence.

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