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Approaching Peace Through Health with a Critical Eye

Neil Arya

It has been a privilege to be asked to edit this edition of *Peace Review* and to see such interests in the connections between peace and health. Peace through Health (PtH) was developed at McMaster University in Canada in the 1990s as a theoretical concept with practical applications such as field projects. Building on the Health as a Bridge to Peace (HBP) policy and planning framework of the Pan American Health Organization (PAHO) and the World Health Organization (WHO) in the 1980s, the framework encouraged collaboration, policy development, training, and service delivery across borders and lines in conflict, integrating peacebuilding "concerns, concepts, principles, strategies, and practices into health relief and health sector development."

PtH was formally recognized by the 1998 World Health Assembly as part of its "Health for all in 21st Century." At McMaster University, Yusuf, MacQueen, Santa Barbara, and others developed a taxonomy of mechanisms, capacities, and stages of conflicts where peace promotion, prevention, peacemaking, and peacebuilding might occur. The formation of the Red Cross, International Physicians for the Prevention of Nuclear War (IPPNW), humanitarian ceasefires, and collaborative health work across borders in Central America were each examined as Peace through Health ventures. At the turn of the century, the WHO convened meetings and the Lancet McMaster Peace through Health Challenge conferences developed a community of practice that offered alternative approaches to war in Afghanistan and Iraq. Soon after, courses, a book, and an endowed Chair on Peace through Health were developed; however, momentum then stalled and dissipated.

After a hiatus of a decade there has been resurgent interest in the Peace through Health mode over the last couple of years. This renewed interest is perhaps fueled by a climate of fear with issues and challenges related to migration, refugees, terrorism, racism, religious intolerance, threats of war, and failures of limitless War on Terror by various U.S.

administrations, leading to a search for alternative approaches. With IPPNW playing a lead role in development of the 2017 Nobel Peace Prize recipient, International Campaign against Nuclear Weapons (ICAN), the revival of interest in WHO Eastern Mediterranean Region (EMRO) to develop work on health as a Bridge to Peace, and a newly launched Lancet SIGHT Commission just launched on Peace, Gender, and Health as interrelated to sustainable development goals (SDGs), and development of a new organization of health workers and academics in war zones, the field in burgeoning.

Academically, a few conferences have developed during this time such as: in Britain—Medact Health through Peace conferences, in Shiraz, Iran—the International Conference on Health for Peace, and in Canada—the PEGASUS Conference on Peace Global Health and Sustainability. A series of online teaching modules were also developed with the support of Erasmus from the European commission. Work with the American Public Health Association (APHA) with an extended article in the *American Journal of Public Health* (AJPH) as well as publications such as *Medicine, Conflict and Survival* and *Conflict and Health* have occurred more recently, all of which support revived interest in the field.

But have we really moved beyond the challenge placed by Alex Voss in the *British Medical Journal* and developed more evidence beyond ideology, to offer more analysis than opinion? We cited top down, macro-level, humanitarian ceasefires as arguably both a health and peace success in El Salvador in the late 1980s, getting people together to discover their superordinate goals and building an environment of trust. Galli noted that in Sudan in the mid-1990s, however, such ceasefires may not have been a "bridge to peace," but rather, allowed for the re-arming, and repositioning of forces as well as the smuggling of weapons. Hendrickson and Macrae found that NGOs delivering aid were forced to sign agreements with the government or rebels, which severely limited their independence, so much so that the ICRC refused to participate. Jabbour expressed concerns that getting people to work together on health projects, failing to consider historical context or current issues of inequity and justice, might merely paper over differences, rather than being real peacebuilding. This work begs the question—how do we evaluate whether humanitarian ceasefires can lead to sustained peacebuilding or whether collaborative health work will lead to peace?

This issue of *Peace Review* is meant to advance the field, turning a critical eye to evidence for Peace through Health. Included here are conceptual pieces that address macro-level health diplomacy; using global health, health care, disease, and vaccine campaigns that address the

question, what is level of evidence required to show that health can be an instrument to promote peace? We then have pieces on humanitarian assistance, cholera, and peacekeeping in Haiti, and the role that disease, the health sector, and situations of conflict play in terms of their interactions and impact on peace and health during the Ebola crisis' in West Africa and Congo over the last decade. Finally, we end with a piece on micro-level use of peace training in a social medicine course held in Uganda and the US. The following situates the various essays that comprise this issue on Health and Peace:

Séan Brennan's "Biopolitical Peacebuilding—Peace through Health," reflects on the history of the development of Conflict Resolution and Peace Studies in response to the Cold War nuclear buildup. This work explores the parallels in development of Peace through Health in the context of what might be seen as failure of post conquest peacebuilding in many parts of Africa and the Middle East, even with the barely hidden neocolonial goal of resources resource exploitation. "Biopolitical Peacebuilding" is defined as building peace through societal health objectives work and data on health of a population, along with peacebuilding concepts, principles, strategies, and practices to direct health care and social services to the most in need. As a form of soft power it aspires to move beyond negative peace, tackling direct and structural violence to create a positive peace in order to transform local power relations and resource provision. Vijay Kumar Chattu and Andy W. Knight's "Global Health Diplomacy as a Tool of Peace" describes various examples of how Global Health, vaccine, disease, and medical diplomacies, each bring together a wide range of actors to promote health and prevent disease through collaboration but also to promote peace.

Arguing the opposite is Ilan Kelman in his essay, "Does Disaster Diplomacy Succeed for Health?" Scrutinizing disease, vaccine and disaster diplomacy, Kelman finds poor evidence for the effectiveness of either to promote peace. While conceding that there may be short term catalysis, Kelman asserts that no case studies have shown that lasting peacebuilding (influence on conflict, violent and non violent or cooperation, inter-state, intra-state, and non-state) that was initiated or fully supported by humanitarian ventures. Acknowledging the examples of Banda Aceh, where post 2004 tsunami disaster diplomacy may have supported but not initiated peacebuilding providing political space, he contrasts this with Sri Lanka, where it may have been an excuse to continue violence. Kelman uses the rejection of the U.S. offers of aid following the Hurricane Katrina from countries such as China, Cuba and Russia, seen as politically hostile, as representing failure of disaster diplomacy. With

regard to vaccines and disease eradication he recognizes that conflict and health systems breakdown affects the ability to eradicate disease, but feels that humanitarian ceasefires generally failed, only temporarily stopping fighting, with warring parties ignoring the opportunity to build trust. In fact, Kelman indicates that ceasefires may have offered false hope to populations. A poorly done trial with the antibiotic Trovan to deal with meningitis in Nigeria, and use of a hepatitis B campaign to get DNA to positively identify Bin Laden set back trust in the health system and efforts to eradicate polio in situations of conflict. Kelman asks if actively linking eradication programs and conflict resolution has helped or hindered health goals.

So is health diplomacy useless and should health and health work design be independent of understanding conflict? Part of the answer relies on the metrics of evaluation. With the presence of confounders and multifactorial reasons for violent conflict to end or to be perpetuated deep analytical tools are required. What is the threshold to define success? Are subtle effects or mitigation of damage sufficient to be defined as successful? Is macro-level political peace the only worthwhile objective? How do we attribute causation if effects are years down the line?

Building an environment of trust, establishing communication channels, and finding common goals may not see results for many years and the more distal this is the more difficult is it to relate to the health venture. Some have pointed to a rapprochement between Greece and Turkey after a series of earthquakes and to a lesser degree, reduction in tensions in India/Pakistan after the earthquake in Kashmir as evidence of such of disaster diplomacy. But are these enough to consider disaster an opportunity? Those supporting efficacy of peace through health most often see it as only one component of multitrack peacemaking or peacebuilding, not as a sole initiator or perpetuator of peacebuilding. Though it may be difficult to prove or disprove that the health action may or may not have mitigated damage, it is even more difficult to prove that health diplomacy is counterproductive or diverts resources or attention in some situations. Absence of evidence as Donald Rumsfeld famously said is not evidence of absence.

Social scientist Lynne Woehrle, teaching and research peacebuilding within a college of nursing in "Connecting Health and Peacebuilding in Theory and Practice," reflects on a review of the literature, together with exploratory dialog with peace studies and health sciences faculty identifying commonalities, divergences, and interconnections in approaches. She sees a shared interest in both direct and structural violence problems; similar theoretical insights; and agreement on the importance of applied interventions and community engagement. Woehrle feels that health and

peace come together as both utilize: a socio-ecological worldview; complexity thinking/problem mapping; the continuum of resilience and trauma focusing on assets rather than deficits; as well as seeing the community as a place of practice. She believes that "Bridging disciplines through concepts such as social justice, forms of violence, engaged practice, and systems theory opens new opportunities for collaboration and team science." and that together health and peacebuilding may challenge power hierarchies.

A Complex Humanitarian Emergency (CHE), described by Barry Pakes in *Encyclopedia Britannica*, is a type of disaster caused by and results in a complicated set of social, medical, and often political circumstances, usually leading to great human suffering and death and requiring external assistance and aid. CHEs are associated with a variety of factors, including war, poverty, overpopulation, human-caused environmental destruction and change, and natural disasters. The next three essays relate to humanitarian situations, beginning with mine: "Making Health Work for Peace in Humanitarian Situations," which focuses on dilemmas faced by humanitarian health workers. It points out major challenges, but also how the study of peace principles and concepts (along with human rights, ethics, development, participatory approaches, cultural sensitivity, etc.) can assist humanitarian health workers. My piece includes a bit on history of peace through health projects at McMaster.

Komlan Agbedahin's "Haiti beyond Complex Humanitarian Emergencies" begins with discussion of the politics of humanitarianism. Agbedahin examines challenges related to UN peacekeepers (MINUSTAH) in Haiti post the 2010 earthquake. Agbedahin believes that beyond the mandate to assume security duties and disarming gangs, there was a mandate to ensure social justice and issues such as sexual abuse and exploitation by peacekeepers. In addition, the cholera outbreak was found subsequently to be related to Nepali peacekeepers who affected this mission. Rather than health and humanitarianism being a connector, it actually led to a breakdown of trust. MINUSTAH's loss of credibility affected its ability to be effective. The lack of accountability, the assumption of diplomatic immunity, grudgingly accepting only limited "moral responsibility" rather than much financial (dependent on voluntary contributions from donors) further exacerbated this.

Peter Mameli in "Collaborative Public Health Management of Ebola in Africa," contrasts Ebola responses in West Africa and the DRC over the last few years. It seems obvious that conditions of peace with a better functioning health care system, supported internally and externally should lead to better health outcomes. As Mameli states Nigeria was fortunate

that its Ebola outbreak in 2014 was in the Lagos area at a time when no Boko Haram incidents occurred in that region. This year, attacks on health workers and medical facilities in northeast DRC hinder efforts at disease containment, raising the possibility of spread to neighboring countries. The potential of the Ebola crisis management to reduce violence to create positive peace—which for Mameli includes" bonds of support emerging from crisis settings that expand politically, socially and economically beyond disease," is underutilized. He explores Global public health partnerships and the roles of Leadership, Local engagement, INGOs, and Public Health experts.

Mameli only touches on the effects of structural violence on disease containment. What happens to vulnerable individuals, families, and communities affected by Ebola who are in precarious settings? What are the benefits and harms of reporting in terms of ostracization, quarantine affecting the ability to cultivate fields or do other work? What happens to farmers when to prevent zoonoses, for example, pandemic flu in which global fears cause wholescale destruction of livestock? Would these affect individual's willingness to report and communities to follow up on recommendations?

Teaching social and structural determinants of health, including sexual orientation, gender norms, reproductive health, the role of medicine and health professionals in society, to trainees of diverse religious, ethnic, socioeconomic, and racial backgrounds is challenging. Amy Finnegan, with U.S. and Ugandan colleagues, discusses the value of peace education, in particular teaching environments. She creates a constructive dialog with medical students to help them prepare for future careers in "Teaching Constructive Dialogue as a Social Medicine Tool for Peace." The impetus for this was the opportunity to teach a mixed group of medical students from the U.S., Netherlands, and Uganda during a one month course on social medicine in Gulu, Uganda at a time of legal issues and security challenges for LGBTQ2+ individuals in Uganda. Divergent perspectives were also found in U.S. inner city contexts experiencing structural inequality and historical disadvantage.

Constructive dialog involved listening, understanding positions, and examination of values and beliefs within a safe space where rapport could be built. Students could develop communication skills for having difficult conversations through a lens of curiosity. Teaching "the importance of paying attention to emotions, and acknowledge that facts rarely change minds but relationships can," seeking "to infuse an approach grounded in humility," "feeling discomfort is ok, but that feeling unsafe is not."

The willingness to change one's mind is important and may provide a lesson in the U.S. today with polarized debates on migration, ethnic and religious tensions, abortion, capital punishment, guns with Left and Right, Red and Blue States, Urban and Rural. We hope you enjoy this issue and use this as a time to reflect on your own values and ways of peace practice and to recognize the potential to help in teaching, research, and practice.

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Neil Arya is a family physician in Kitchener Ontario. He is the president of the Canadian Physicians for Research and Education in Peace, and Chair of the PEGASUS Global Health Conference. He is a past Vice-President of International Physicians for the Prevention of Nuclear War (IPPNW), which won the 1985 Nobel Peace Prize and of President of Physicians for Global Survival (PGS) and has written and lectured around the world about Peace through Health. E-mail: narya@uwaterloo.ca