CPER#1667567, VOL 0, ISS 0

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Peace Review: A Journal of Social Justice, 0:1–12, 2019

ISSN: 1040-2659 print / 1469-9982 online
DOI: 10.1080/10402659.2019.1667567

Making Health Work for Peace in Humanitarian Situations

Neil Arya

From the time of Florence Nightingale, humanitarian health and aid workers have dedicated themselves to the welfare of patients outside of their own communities, nobly sacrificing their own safety, economic well being, mental health, and sometimes even life. They witness and deal with the human consequences of violent conflict and care for those that are directly affected by it. Dedicated humanitarian professionals such as Albert Schweitzer, Henri Dunant, founder of the Red Cross, and James Orbinski, representing Médecins sans Frontières (MSF), all accepted Nobel Peace Prizes for such work.

The primary mission during natural and "human-made" disasters may be to assist persons in need, to shine a ray of hope, and to create humanitarian space, but health professionals in particular, are also potentially in influential positions to promote peace. With their direct involvement in healing they have a certain credibility with the global community, which can contribute to their influence as advocates for peace, whether through raising awareness of relevant issues with the general public or specific interest groups, or by influencing decision makers directly.

Humanitarian aid itself, however, is neither neutral, nor intrinsically good for peace, even with the best of intentions. Without careful design, programs and interventions of state and non-state actors, including the UN and INGOs, can exacerbate direct and structural violence-supporting factors that lay at the root of the conflict such as stereotyping, polarization, and discrimination. Depending on how they plan their work, communicate with those around them, and respond to the complexities of specific contexts from day to day, those who work in situations of armed conflict can make a difference, positive or negative.

This essay is intended to show how understanding the possible pitfalls for, and deficits of, humanitarian health workers, in terms of orientation and training, may help health professionals to be better prepared as they go in the field. It suggests ways humanitarian health

workers may decide on the right place and time to work, what is not enough or too much involvement, when to transition from service to advocacy, to Do No Harm, as Mary Anderson said, alluding to the Hippocratic Oath.

What happens when benevolent people enter a zone of need, in order to help? Significant language and cultural competence training may be impractical for humanitarian workers on short-term placement. Even without logistical barriers, some large humanitarian NGOs are also concerned that with too much integration or identification, people on the ground may "go native" and be less objective or impartial in providing aid. Thus, when busy dealing with acute illness and focused on saving lives, alleviating suffering and giving dignity to the most vulnerable, marginalized and forgotten parts of the population, development perspectives and peace principles such as sustainability, participation, and good governance may be allowed to fall by the wayside. Some believe that putting energy into ensuring such efforts would actually drain resources or impede others with expertise from acting properly in their roles. It seems, however, at least an acknowledgement and effort to consider these principles, particularly when humanitarian assistance morphs into development, may make such humanitarian efforts ultimately more fruitful.

Some say that aid itself prevents local solutions, development of structures by authorities to deal with the needs of their own populations, and that assistance, if delivered, should never last more than a few weeks or months. Introducing external resources into a conflict-prone, resource-scarce environment can distort local economic activities or free up internal resources that can be used to pursue war. Seemingly positive activities such as creating jobs and paying living wages, may increase competition and suspicion among those who are proportionately disadvantaged.

In Afghanistan and Haiti, post-disaster (natural and human-made) aid apparently widened income gaps. Supporting governmental efforts may lead to centralization of power and authority and the disempowerment of local people. Getting people to congregate to receive assistance may increase the chance of protection but clustering may also make them more vulnerable to attack. Humanitarian workers sometimes exert even more direct damage on local culture and people. As noted by the *Lancet*, at an extreme, aid workers and military peacekeepers in West Africa were discovered to have sexually exploited refugee girls and women. This was not just devastating for the lives of many, but earned the resentment of the local population.

At a geopolitical level Amelia Branczik believed that aid has allowed the outside world a humanitarian alibi to do nothing about the political context, creating some sense of normalcy and contributing to the

fragmentation and pacification of the Palestinian people. Shahin & Azar stated that "For twenty years now the international donor community has financially supported Palestinian institution-building, infrastructure development, the economy, public employees' salaries, health and education, social welfare, the police, electricity production, …" And this aid comes with golden handcuffs that influence political and social decisions of the Palestinian people, since donors can turn off the tap at any time, as they did with the 2006 Hamas elections.

Aid can also be an opiate, diminishing internal motivation towards political change. Post Oslo, aid to support the process eventually meant that 30% of the Palestinian GDP came from donors. Some complain that 'NGOization' of the Palestinian economy distorts labor markets, allowing workshops to replace community work. A self-sustaining industry, may have been created with mental health providers from various ministries, NGOs, para-governmental organizations, and UN bodies each competing for "humanitarian market share." Within the health sector, NGOs have chosen to neglect local capacities and non-health care entities and approaches in favor of a top down system approach to health. And beyond that were neocolonialist, culturally insensitive assumptions. Giacaman et al. decried the presumption that "Western mental health technologies had universal validity, and were relevant to or wanted by the largely non-Western populations affected."

Aid workers in situations of violent conflict often face difficult choices for which they may not be trained. In the aftermath of the 10-week 1994 Rwandan genocide, which saw the slaughter of over 800,000 Tutsi and Hutu moderates, NGOs in eastern Zaire found themselves inadvertently becoming participants in the conflict. The camps, supported and supplied by the international humanitarian community, were being used as safe havens allowing perpetrators to escape from justice, regroup, and restart war. Forty thousand defeated FAR (Forces Armées Rwandaise) together with tens of thousands of militia, including the Interahamwe (those who attack together), many génocidaires managed food distribution and may have used their bases in the camps to launch raids back into Rwanda. More shocking, it seemed that within the camp some local Hutu staff contributed to the abuse, and possible death of many Tutsis.

Will a humanitarian mission cooperate with governments and/or rebel authorities? How should it work with militias and militaries? By working through existing power structures in order to gain access to people in need, international assistance agencies can prolong oppression by authoritarian regimes. Militaries and armed groups out to win the hearts and minds of the people sometimes engage in humanitarian and development activities, blurring the distinction between military and civilian.

Collaboration risks loss of trust and the neutral status label in the eyes of some, which may compromise access, and perhaps even render them targets. Even attending government functions with military presence in situations of conflict without such issues may compromise the perception of evenhandedness.

But how else can such workers secure their aid so it can be delivered? Will they carry weapons themselves? Will they hire armed guards to protect their delivery of goods? Will they bribe? Each of these "solutions" may "buy into" the terms of existing conflicts. But failing to do so may endanger health workers' lives, health, or security, and those of other people (for example, patients, colleagues), or their program or initiatives in general. Sometimes organizations realize that a line has been crossed, and it is best to withdraw.

Cross-border intervention by the Great Powers is often perceived cynically, even by citizens of those countries pursuing it, not as a means to restoring justice, but as a way to gain control over resources. But war, by and large, is no longer cross-border, nor governed by the international codes of war. Humanitarian aid sometimes becomes a party or stakeholder in the conflict. Principled approaches face challenges as humanitarians have recently been subject to deliberate attack with "on the ground" operations, in for example, South Sudan, Congo, and Liberia.

An example of the extreme difficulty in negotiating "humanitarian space" was described by James Orbinski in *An Imperfect Offering*. Arriving in Baidoa, Somalia in September of 1992 for an MSF project, he found 350 dying daily from the war-induced famine, increasing to 1,700 per week (50 times the normal death rate). MSF, the Red Cross and other aid agencies were paying armed guards to protect aid workers and food supplies. Ultimately violence turned against the U.S. military and other foreigners. The failure of the U.S. led response in Somalia directly affected the lack of response to the genocide in Rwanda.

How can organizations deal with complicity and hypocrisy of their own governments, especially if they are funded by them? When do they compromise their neutrality? Is it better merely to work on each side to ensure safe delivery of aid? What happens to individuals in front of them? Negotiation is a natural part of any human interaction and understanding context assists us in choosing particular courses of action or inaction. To engage in conflict resolution and negotiation, and mediation skills can be beneficial.

As Head of Mission of MSF, James Orbinski faced such a dilemma in Rwanda during the 1994 genocide. In the end he relied on his own gut instincts, basic humanity and the humanitarian impulse, deftly negotiated

between militias and used collaboration with Romeo Dallaire's UN troops to safeguard many, mitigating the effects of genocide. Ultimately, Orbinski, was unable to influence macro-level events within Rwanda and the international community and paid a high personal price physically, psychologically, emotionally and spiritually.

When the time came, however, for him to accept the Nobel Peace Prize on behalf of MSF in 1999, though aware that ICRC workers had been killed in Chechnya by rebels just a few days before, he did not shy away from addressing a major humanitarian issue of the day, denouncing the Russian bombing of Grozny: "I appeal here today to his Excellency the Ambassador of Russia and through him, to President Yeltsin, to stop the bombing of defenseless civilians in Chechnya. If conflicts and wars are an affair of the state, violations of humanitarian law, war crimes and crimes against humanity apply to all of us."

Advocacy entails pleading to support, or speaking in favor of someone, a cause, or a policy. The International Committee of the Red Cross mission statement describes it as an "impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of war and internal violence and to provide them with assistance." Many humanitarian workers shy away from advocacy for human rights, for what they see as political activism, concerns with fundamentally different objectives, which should be realized by other individuals, organizations or institutions. The ICRC sees public silence as essential; not humiliating or embarrassing power structures is "realistic idealism," allowing it to be more effective. MSF, developed out of concern that such silence in Biafra, Nigeria, made things worse, endeavors instead, to shine a light on damaging practices hoping this may reduce them. It considers *témoignage* or witnessing as a central tactic.

When should we engage and when do we boycott? At a macro level, Margaret Thatcher and Ronald Reagan supported "constructive engagement" with apartheid South Africa though sanctions when applied with the clear internal support of the disadvantaged majority led to delegitimization both internally and externally and eventually to the fall of the regime. Though they realized continuing sanctions would cause pain for themselves, in Haiti, in the late 1980s, Paul Farmer noted that activists opposing the Duvalier dictatorship distributed a flyer asking the international community not to "punish us with your aid." As Israelis are unwilling to distinguish between their citizens and activities in the Occupied Territories where their Occupation is a clear violation of international law, some say that the best option is supporting BDS (Boycott, Divest and Sanctions). But rather than highlighting the unacceptability of

action, does this risk cause a circling of wagons, increasing a sense of victimhood, alienating those whom we need to convince?

When humanitarian agencies circulate pictures or stories of war-based atrocities as a means of enlisting support for their work, they may fuel a cycle of accusation and counter-accusation, and sometimes perpetuate conflicts among groups. How can they avoid being manipulated into selectively or distortedly communicating, particularly in unfamiliar contexts with a limited spectrum of friends? What if this gets them kicked out of the country?

Tactically, when trying to respond to crises, what should we do about human rights issues that are not central to our mandate such as access to essential medicines, issues related to sexual orientation, gender, or female genital mutilation (in itself, a charged term). Is it better to constructively engage or publicly denounce? Even if we know what is right and attempt to act in solidarity, publicizing human rights abuses can increase outrage, dehumanizing one side and provoking a hardened defensive response in the perpetrators. We can condemn child labor but without establishing alternative structures this can cause additional suffering, as often its elimination can affect the livelihoods of individuals and families.

The challenge for humanitarian organizations is often to weigh the consequences for those who will no longer receive their services against the possible benefits of speaking out. The choice organizations such as MSF generally make is to witness if access to people in need and delivery of care is compromised by a situation, to leave other human rights issues to human rights organizations.

Roberto Belloni criticized humanitarianism for sustaining a "worldview in which individuals are either victims or perpetrators rather than human beings in [a] complex set of relationships." Mark du Bois reflecting on MSF at age 40 noted that, "It is now, in middle age, that we acquire the maturity to accept what has always been true: it is ridiculous to expect governments, rebel groups, insurgents, criminal syndicates or national armies to adopt the benevolent positioning of a charitable organization, and that the abuse of humanitarian aid is an enduring and inevitable component of the landscape in which we operate." Du Bois saw a transition in MSF from a grassroots, idealistic volunteer movement to a more mature organization dedicated to fundraising and safety of its staff with a "bulge around our collective middle."

Hugo Slim noted that, "The notion that 'being humanitarian' and 'doing good' are somehow inevitably the same is a hard one to shake off." Ethical dilemmas (ones where each course of action would violate some principle) abound in humanitarian practice. Slim believed that an

ethical analysis was an essential part of humanitarian practice to differentiate between tough choices masquerading as moral dilemmas, choosing the lesser of two wrongs or evils. In fact, the humanitarian health ethics group at McMaster has developed one such humanitarian health ethical analysis tool, (HHEAT: https://humanitarianhealthethics.net/home/hheat/hheat/) that has been demonstrated to guide people in the field.

Those from the Global North often fail to realize that they bring their own cultural biases to an aid situation. Equally important, however, for those offering assistance in the form of relief activity is acknowledging where they come from in terms of motivational bias. Donini classified these actors and perspectives into the following categories: first, principled—for example, the Dunantist tradition followed by the ICRC with a narrower definition of humanitarianism limited to life-saving assistance and protection of civilians, based on core principles of neutrality, impartiality, and independence, wary of accepting funds contributed by governments, overt advocacy for human rights, and reconstruction activities. Second, pragmatic—recognizing the importance of principles but placing a premium on action—for example, "Wilsonian" US agencies, collaborating with the foreign policy interests of their national governments who fund them. Third, solidarity—including addressing the political and economic root causes of conflict to the point of working and advocating for social transformation mixing elements from humanitarian, human rights, and developmental perspectives. And Fourth, dogmatic—faith-based, whether explicit or not, operating though compassion and charitable service using any of the above three strategies.

These categories may, of course, overlap. Each approach comes with its own ethical imperative and perspective as to what is to be done, and operates in an ethical or moral, contractual, legal and institutional context. And each may be perceived differently by locals rather than what is intended by the humanitarian actor. Acknowledging the value and limitations of one's own approach, can make us more effective, or at least understand when things go wrong.

From Peace Studies skills training workshops on "conflict-sensitivity" and communication, can be useful for health workers to act constructively in war zones. These could include understanding, nonviolence, violence and conflict analyses, negotiation and mediation, reconciliation and conflict resolution/transformation. Conflict analysis for example would help with understanding background, history, types of violence, who is involved in a conflict, what it is about, why it manifests itself in this way, how it is being conducted, etc. Other bodies of knowledge include intercultural communication, peace processes, international human

rights norms, humanitarian law, human security and codes of conduct, which can be derived from such disciplines as psychology, social work, sociology, political science and law. Sometimes it is from our failures and mistakes that we learn best.

While such training can help deliver humanitarian assistance in such situations to avoid aggravating conflict, peace activities or projects can also be considered, as I will illustrate from experiences of our McMaster Peace through Health group. Sometimes this can be integrated into other work, and sometimes specific peacebuilding interventions may be undertaken. Our team developed after the failure of young physician graduates who formed the Gulf War Peace Team to stop the 1991 war in Iraq, and subsequent sanctions.

Public health researchers, Eric Hoskins and Rob Chase, were part of the humanitarian shield efforts to mass at the Saudi-Iraqi border to prevent the Coalition attack. Hoskins worked together with connections at Harvard, to form the Harvard/International Study Team that undertook several studies of the essential health infrastructure (hospital facilities, water, and sanitation) and a nation-wide child mortality study in Iraq 3 months after the cessation of the First Gulf War in 1991. As described by Chase below:

> The study organizers gained official permission for unrestricted access to health facilities and communities across the country for the 60+ member international team with 20+ Jordanian translators. To achieve this, the earlier, non-aligned efforts of the "Gulf Peace Team" as a failed peace protest that re-geared to support delivery of humanitarian relief during the hostilities were key.

Logistical support for the survey field teams included vehicles and drivers from the Iraqi government in most areas and from UNHCR in the Kurdish "liberated" areas in the North. Despite official permission from both sides and other precautions, local Kurdish translators and citizenry were at times suspicious of the intentions of the field teams. Chase's team encountered Kurdish distrust of the Baghdad-based support personnel, as well as interference by Baathist agents in Mosul when they were conducting household surveys out of UNHCR vehicles. Such activities would scarcely be contemplated in the hyper-violent context of Iraq since 2003.

The study findings, principally directed at a US and international audience, were instrumental in exposing the extent of civilian casualties (a quadrupling of infant child mortality) and deliberate destruction of health infrastructure.

While not ending sanctions (which were in fact tightened), in follow-up to the study, Hoskins successfully campaigned in Canada for the

conversion of frozen Iraqi assets into humanitarian medical relief for Iraq. He later co-founded War Child Canada, which has supported a hospital rehabilitation project in Karbala, Iraq based on his strong relationships with local medical professionals.

As with the Iraq study, the research they try to do in, or about, conflict situations, what information health professionals record during conflict, and how they record it, could all have an impact on the conflict itself. Based on the project experience of such McMaster University colleagues, funding was secured to initiate further research on the health of children in war zones including Chase's study in Sri Lanka discussed below.

We need to recognize that most people do not require outside health sector interventions to positively cope with adversity and traumatic stressors, and that relying on the resilience and internal capacities of individuals and populations may assist in avoiding such harmful impacts. Nurses and other allied health professionals seem better equipped to approach problems more holistically than physicians, but we must move beyond the health disciplines to intersectoral partnerships in order to design interventions that can address various forms of violence, including exploitative and repressive social structures, as well as domestic violence, child abuse, youth violence, and suicide. The development of the Butterfly Garden in Sri Lanka is one such example of moving beyond a plan, in this case research, listening, and learning from communities and collaborating with those generally not considered health professionals, as described by Rob Chase, the physician who had studied the population and later helped make connections for healing.

The Tamil-speaking, ethnically mixed, eastern Batticaloa district of Sri Lanka (two-thirds ethnic Tamil and one-third Muslim) studied by the 1995 McMaster study team became the setting of massacres, disappearances, and displacement beginning in 1989. Of the 170 children interviewed in 4 Batticaloa community sites, 41% had been direct victims of conflict related violence, 95% reported personally experiencing events of threatened death, serious injury to be at risk of post-traumatic stress disorder. Ninety-two percent of such events were conflict related. One fifth of the children scored in the severe/very severe range for PTSD. The initiative endeavored to shift from researching the mental health of children to a second (unfunded) intervention phase to respond to the problems uncovered at different levels—child psychological needs, local capacity development and community reconciliation.

It seemed apparent that a mental health sector intervention could be affordable, practical and successful. A creative expressive arts model was

felt to be most appropriate, and the talents of Canadian artist Paul Hogan were engaged to explore prospects in Sri Lanka to work together with Jesuit Fr. Paul Satkunanayagam, a qualified counselor and educator, who had founded a local counseling center for ex-detainees and torture survivors. A multi-ethnic committee of local representatives, in partnership with school, religious, and community leaders was established to seek funding and refine plans for a small NGO to be called the Butterfly Peace Garden. Training local artists possessing a "contemplative, respectful spirit" to act as animators, they accompanied children through personal engagement and using imaginative play involving earthwork, artwork and heartwork, to ultimately help heal the trauma of war and promote resilience. The Garden became a sanctuary, a space to honor children. Together, they planted herbs, cared for abandoned animals on site, designed costumes, developed stories, played music, worked with clay and paint. The Butterfly Garden in Sri Lanka shows how other professionals' expertise may be incorporated, and how resilience may be fostered rather than solely treating trauma in a biomedical way.

Learning from other disciplines may help health professionals design conflict sensitive, and culturally appropriate, interventions to prevent violence and to foster individual and societal empowerment, and resilience (the capacity to do well in difficult circumstances). From anthropological or social science case studies we learn that key informants, participant observation, and focus group interviews may help to understand the nature of conflict and its resolution, and the design of culturally appropriate and conflict sensitive interventions. Knowledge of culture can often assist in understanding the resistance of populations to interventions and facilitate more successful outcomes and true partnerships.

Participation of locals at each stage of a health project-assessment, design, implementation, monitoring and evaluation is important. This is especially important in longer-term complex emergencies where distinctions between relief and development become less clear and damage from such neglect become more apparent. The utilization of local knowledge and key community people in the program development and training of local primary health care workers may involve mutual learning and support and develop cultural competence on each side, thereby promoting sustainability. Sometimes locals can enhance initial ideas helping to reorient projects to their needs.

Afghan Canadian physician Seddiq Weera found this when returning to his native Afghanistan to lead a series of workshops with McMaster University colleagues, in partnership with the Afghan University in February 2001, in Peshawar, Pakistan, where much of the Afghan refugee

community took shelter. What began as a way of engaging media and working on reducing prejudice among children transformed into something much larger as the community wanted more peace training. Intellectuals, opinion leaders, political leaders, journalists, writers, educators and NGOs across the political spectrum, all participated, with a special effort to promote the participation of women. After the Taliban fell, given Weera's access to the new Afghan leadership, Western governments and international agencies, McMaster colleagues assisted in development of a psychosocial model of conflict transformation and a peace education curriculum for Afghan school children ages 10–15. Major transferable outputs included a training manual and a storybook addressing mental health issues in families and demonstrating peaceful principles. For the less literate, the stories have been animated by hand puppets.

The humanitarian health sector has powerful capacities for peacebuilding. In order to be effective, and to avoid harm, even from a service point of view, the humanitarian health sector must also recognize its limitations. Knowledge deficits of health care training applicable to situations of humanitarian assistance include domains of peace studies such as conflict analysis, conflict transformation and reconciliation along with international human rights norms, and humanitarian law. Skills deficits include the ability to monitor events and effect continuous political analysis, to use nonviolent communication and to act in a culturally sensitive manner. This essay attempted to highlight a few issues and to demonstrate how peace skills together with ethical analysis, human rights, cultural sensitivity, developmental perspectives, participatory approaches, can identify ways to address some of the gaps, also utilizing some of the experiences of our McMaster Peace through Health group.

Thanks to Marion Birch, Joanna Santa Barbara, Melissa Whaling, Rob Chase (author of a couple of examples), Maria Kett, Jodi Pipes, Ann Duggan and Anke Raber for discussion and editing of this piece at various stages.

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