

## CHAPTER 5

### Armed Conflict and Health Policy

The discussion in this study has focused thus far on the indirect impact of war on population health, where health professionals, particularly in the humanitarian community, have played a key role in seeking more effective ways to reduce the wartime death toll from malnutrition and disease.

But, for some health professionals, the idea that the medical profession should focus primarily on reducing the human costs of wars has not been enough. Proponents of “Health as a Bridge for Peace” argue that health professionals also have a role to play in conflict prevention via education, in seeking to stop ongoing wars—“peacemaking” in UN-speak—and in postconflict peacebuilding, where the key security goal is to prevent wars that have stopped from starting again.<sup>1</sup>

The World Health Organization’s (WHO’s) “Health as a Bridge for Peace” program started in August 1997 and was accepted by the 51st World Health Assembly in May 1998. The various initiatives associated with the program are predicated on the assumption that health policy can help to create a more secure world in a number of different, but complementary, ways.

Three policy approaches that are associated with the concept of “Health as Bridge for Peace” are discussed here. Many of them are pursued by nongovernmental organizations (NGOs) rather than international agencies like the WHO and the United Nations Children’s Fund, and some predate the WHO’s “Bridge for Peace” program.

First, are the advocacy and education programs that seek to inform publics and governments about the true human costs of war. Enhancing public knowledge about warfare is seen here as contributing to conflict prevention.

Second, is the idea that trust generated by negotiating health interventions in conflict zones—typically to immunize children—can create enough confidence between enemies to jump-start negotiations that can eventually lead to peace settlements. From this perspective, interventions by health professionals can become stepping stones to peace.

Third, is the belief that, where official state policy improves the health outcomes of ordinary citizens in postconflict settings, this will enhance the legitimacy of the governments concerned and thus decrease the risks of wars restarting. Here, health policy is seen as contributing to postconflict peacebuilding—although this, as we will see, is a controversial issue.

#### Health Education and Conflict Prevention

Advocacy programs designed to educate publics about the true costs of war are based on the assumption that if publics, and indeed governments, understand that the true costs of conflict are far greater than commonly believed, the incentive for going to war will be reduced, while the incentives for conflict prevention, peacemaking and effective postconflict peacebuilding will be increased.

In the 1980s, physicians’ organizations, including the Nobel Prize-winning International Physicians to Prevent Nuclear War, waged a high profile public campaign to persuade publics and policy-makers that the true costs of nuclear war, which included the possibility of a consequent “nuclear winter,” were far more devastating than generally realized. Some analysts have argued that such campaigns helped create a “nuclear taboo” and that, as a consequence, nuclear war has become literally “unthinkable”—and thus less likely.<sup>2</sup>

The advocacy programs pursued by the International Rescue Committee in the Democratic Republic of the Congo (DRC), and those of literally hundreds of NGOs in other conflicts, are other cases in point. Advocacy is focused primarily on generating pressure to provide more resources to reduce the human costs of war via the provision of humanitarian assistance. But, few health professionals believe that humanitarian assistance is enough—many support the broader security goals of conflict prevention, peacemaking, and postconflict peacebuilding.

Focusing international attention on the human costs of war could, in principle, help further these latter goals. Indeed, there is little doubt that efforts by NGOs and international agencies to publicize the huge death tolls from war-exacerbated disease and malnutrition in the DRC, Darfur, and elsewhere, have made donors and attentive publics far more aware of the hidden costs of war. Nor is there any doubt that for more than a decade, donors and international organizations have been committing far more resources to humanitarian assistance, conflict prevention, peacemaking, and postconflict peacebuilding. Humanitarian advocacy campaigns have surely been one of the factors driving these changes.

### **Health Interventions and Peacemaking**

In a paper prepared for the 1995 World Summit for Social Development, the WHO argued:

Health is valued by everyone. It provides a basis for bringing people together to analyze, to discuss and to arrive at a consensus acceptable to all. The potential for using health as a mechanism for dialogue, and even peace, has been demonstrated in situations of conflict.<sup>3</sup>

“Bridge for Peace” advocates believe that because health, particularly children’s health, is valued by all parties, and because medical professionals who have a humanitarian mandate are traditionally seen as neutral, it may be possible for them to facilitate dialogue between the warring parties where other attempts have failed. The dialogue will initially be technical with a completely apolitical goal—to gain access to children in war zones in order to deliver very basic life-saving health interventions. But, health advocates believe that the degree of trust generated by negotiating humanitarian access can be built on and used to build a process of conflict mediation and, ultimately, resolution.

As Paula Gutlove puts it, health professionals, “can create a bridge of peace between conflicting communities, whereby delivery of health care can become a common objective and a binding commitment for continued cooperation.”<sup>4</sup>

Humanitarian ceasefires, often called, “Days of Tranquility,” have been implemented in many conflict zones and are held up as examples of the utility of the “Health as a Bridge for Peace” approach in practice. Here, a temporary truce is negotiated between government and rebels that permits health workers to enter conflict zones in order to immunize children against a variety of infectious diseases, or deliver food or other humanitarian assistance. Humanitarian ceasefires of this type have been implemented in many conflict situations in, for example, Afghanistan, Cambodia, El Salvador, Lebanon, the Philippines, Sudan, and Uganda.<sup>5</sup>

Sometimes the truce can be extended for considerable periods. In 1994, for example:

WHO-Afghanistan and the Afghan Ministry of Public Health brokered a cease-fire . . . during which children throughout the country could be immunized. The two weeks of tranquility became a two-month cease-fire during which an intensive “Mass Immunization Campaign” was carried out.<sup>6</sup>

These health interventions, which are most frequently referred to as “Bridge for Peace” initiatives in the literature, have undoubtedly saved lives, but there is little evidence that they have contributed in any major way to bringing wars to an end.

The claimed causal relationships between humanitarian health interventions and peace in the literature are problematic in a number of ways.<sup>7</sup> First, they are asserted, rather than demonstrated—and they invariably ignore the possibility that “Days of Tranquility” initiatives might be an *effect* of improved relations, rather than their cause.

Second, the “Bridge for Peace” literature is almost certainly subject to publication bias—that is, there is a higher probability that articles on successful, rather than unsuccessful, initiatives will get published in academic journals. The fact that many individuals writing in this field are advocates who may have little interest in publicizing unsuccessful cases does nothing to reduce the risk of bias.

Third, even where there is a clear *association* between “Bridge for Peace” initiatives and peace settlements, this does not necessarily indicate any causal relationship. Many of the conflicts that have witnessed “Days of Tranquility” have indeed ended, but it is far from clear that the health interventions played even a minor role in bringing them to an end.

Successes in what the UN calls “peacemaking” and “postconflict peacebuilding” have many causes. An editorial in the *British Medical Journal* may have been overstating things when it noted in 2001 that there were few examples of successful peace through health initiatives, adding that “it is ideology that is driving the movement at present.”<sup>8</sup> Yet, some eight years later, there has still been no systematic evaluation of the effectiveness of humanitarian interventions in driving subsequent peace negotiations.

Moreover, there is little recognition in the literature of the risks that “Bridge for Peace” initiatives may involve. The assumption that cooperation is *possible* because people on both sides of a conflict value good health does not mean that rebel groups will in fact choose to cooperate. Rebel leaders may perceive state-supported initiatives to deliver humanitarian assistance into war zones as tactics intended to generate support for the government, and reject them for precisely this reason.

Moreover, humanitarian assistance, as is now widely recognized, can have profoundly negative consequences in certain circumstances. As Mary Anderson demonstrated more than a decade ago, the food and medicine provided by international agencies and NGOs can have the perverse effect of fuelling the very wars whose human costs they seek to reduce.<sup>9</sup> Rebels often steal aid shipments, or impose a “tax” on their delivery and use the resources thus acquired to support their war effort. Rebel groups can also use “Days of Tranquility” to redeploy their forces to greater strategic advantage without fear of attack.

Humanitarian organizations today are well aware that aid can have perverse effects, however, and most now seek—though not always successfully—to ensure their operations “do no harm.”

Finally, while health professionals may aspire to leverage the trust generated in negotiating access to war zones to promote peace negotiations, few have the depth of knowledge of the political issues at stake, or the necessary experience mediating in such situations, to facilitate a negotiated settlement.

## Health Policy and Peacebuilding

In postconflict situations, governments that gain legitimacy in the eyes of their citizens are less likely to succumb to renewed rebel violence. As one review of the “Bridge for Peace” literature noted:

Through the provision of health and other public services to their populations, governments have the opportunity to (re)establish their legitimacy, reduce alienation

from society and, crucially, to visibly demonstrate that they are upholding their side of the social contract.<sup>10</sup>

An important source of what is sometimes called “performance legitimacy” is a government’s ability to provide goods and services that are desired by its citizens. And, the reliable provision of accessible health care is a critical determinant of performance legitimacy, even in poor countries where health services are often minimal. In 2007, for example, a survey of 18 African nations by Afrobarometer found that respondents’ satisfaction with their government was associated with their satisfaction with the delivery of social services such as health and education, as well as its political and economic performance.<sup>11</sup> Factors influencing satisfaction with health care were, in order of importance: perceived ease of access, the respondent’s level of poverty, perceived absence of corruption, and affordable fees for medical treatment.<sup>12</sup>

However if, as is often the case, it is NGOs, rather than the government, that are providing most of the health care in postconflict situations, the government is less likely to gain legitimacy than if its own health workers were providing the services.

As Margaret Kruk has noted, effective and equitable delivery of health care can influence citizens’ perceptions of the legitimacy of oppositions, as well as governments.<sup>13</sup> In southern Lebanon, where the national government has long underinvested in health care services, the militant Hezbollah organization has provided generous health insurance and efficient, accessible, and reliable health services to the local Shia population. In 2005, for example, some 50 hospitals in the country were being run by the organization, which also provides life and disability insurance, as well as other social services.<sup>14</sup> In the wake of the August 2006 war with Israel, Hezbollah’s rapid provision of health care and reconstruction aid appears to have only strengthened its legitimacy in the south.<sup>15</sup>

A major multi-country study by the RAND Corporation published in 2006 provided considerable support for the thesis that effective delivery of health services can enhance the legitimacy of governments in postconflict settings.<sup>16</sup> In evaluating the impact of the provision of health services in rebuilding Germany and Japan after World War II, and in Somalia, Haiti, Kosovo, Iraq, and Afghanistan, the authors concluded that “health can have an important independent impact on nation-building and . . . on security by helping to ‘win hearts and minds.’”<sup>17</sup>

## **Humanitarian Assistance and Counterinsurgency**

But, while the provision of health services in postconflict settings does not sound controversial, it can pose real risks for humanitarian health professionals in those situations where armed resistance remains. The “win hearts and minds” approach the RAND Corporation report refers to is, of course, a critically important element in contemporary counterinsurgency strategy. And, it is perceived as such by forces opposed to governments in Afghanistan and elsewhere. The Taliban attacks health facilities in the Afghan countryside because it has a direct interest in preventing the government in Kabul from “winning hearts and minds” and thus gaining legitimacy.

Some humanitarian organizations, notably the International Committee of the Red Cross (ICRC) and Médecins Sans Frontières (MSF), strongly repudiate any association between humanitarian actors and military campaigns in part for this reason. As the head of MSF’s Afghanistan mission noted in 2004:

The deliberate linking of humanitarian aid with military objectives destroys the meaning of humanitarianism. It will result, in the end, in the neediest Afghans not getting badly needed aid—and those providing aid being targeted.<sup>18</sup>

The ICRC and MSF have also refused to join the UN's integrated missions initiative, which is intended to improve the effectiveness of postconflict reconstruction efforts via a greater degree of coordination and integration between the organizations that undertake different mission responsibilities. Integrated missions are problematic for the ICRC and MSF because in postconflict situations where there is still considerable armed resistance directed against a government, humanitarian organizations that join an integrated mission cease to be neutral and impartial. They become, according to Jacques Forster, ICRC vice-president, part of "a political and military strategy to defeat the enemy. In other words, the subordination of humanitarian activities to political goals, using aid as a tool for local or foreign policy."<sup>19</sup>

Where humanitarian assistance is no longer perceived as being neutral, health workers and clinics may be targeted by rebel movements for precisely this reason. This, in turn, will have a negative impact on population health in the areas affected.

The risk is real. Attacks against aid workers worldwide in 2008 were the highest in 12 years and have increased appreciably since 2006. They have also become increasingly politically motivated, "reflecting a broad targeting of the aid enterprise as a whole."<sup>20</sup>

If threats to aid workers mean that service provision is reduced, then health outcomes will not improve, and any legitimacy gains that governments seek to achieve from enhancing health outcomes will not be realized.

However, while there is no doubt that the incidence of violent assaults against aid workers has increased worldwide, the violence has not been uniformly distributed. Indeed, some 60 percent of these violent assaults in 2008 took place in just three countries—Afghanistan, Sudan (Darfur), and Somalia.<sup>21</sup> All three countries were experiencing ongoing conflicts, and both Afghanistan and Somalia have Islamist movements strongly opposed to what they see as Western political agendas. The risks to aid workers are much lower in countries where there are major peacebuilding missions underway but no active rebel movements.

## Conclusion

The WHO's "Health as a Bridge for Peace" program is less actively promoted today than was the case even five years ago. The "Bridge for Peace" page is still active on the WHO website, but the links are now very dated. A recent UK review of the program suggests that the declining interest may be in part because the effectiveness of "Bridge for Peace" policies has been more asserted than demonstrated. The review, by Colin McInnes and colleagues, noted that:

Critically, the evidentiary base appears slim and overly reliant on anecdotal evidence rather than rigorous and systematic empirical work. Moreover, there has been little conceptual work done on key questions including: what works and why? What conditions are susceptible to such an approach? What level and form of health investment is required? When might it backfire and allow a conflict to continue? Can it be used to assist in ending conflicts, or just in post-conflict reconstruction? And can it be used to prevent conflict?<sup>22</sup>

None of this means that "Bridge for Peace" initiatives—like the "Days of Tranquility" immunization programs for children in conflict zones—are not worthwhile from a health perspective. Rather, it simply means their security benefits have yet to be compellingly demonstrated.

## ENDNOTES

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<sup>1</sup> This chapter draws on a background paper on “Health as a Bridge for Peace” prepared by Dr. Margaret Kruk for the Human Security Report Project (HSRP).

<sup>2</sup> See, for example, Nina Tannenwald, *The Nuclear Taboo: The United States and the Non-Use of Nuclear Weapons Since 1945* (Cambridge: Cambridge University Press, 2007), <http://www.cambridge.org/catalogue/catalogue.asp?ISBN=9780521524285> (accessed 5 November 2009).

<sup>3</sup> WHO Task Force on Health in Development, “Health in Social Development,” (WHO position paper prepared for the World Summit for Social Development, Copenhagen, Denmark, March 1995), 19. Cited in Paula Gutlove, “Health as a Bridge for Peace: Briefing Manual,” Institute for Resource and Security Studies, May 2000, <http://www.irss-usa.org/pages/documents/HBPbriefmanual.pdf> (accessed 5 November 2009).

<sup>4</sup> Gutlove, “Health as a Bridge for Peace,” 2, (accessed 5 November 2009).

<sup>5</sup> A major review of the literature in this field reported that the process of negotiating such ceasefires, “can have spill-over effects in terms of building trust among conflicting parties”; R. Rodriguez-Garcia, M. Schlessler, and R. Bernstein, “How Can Health Serve as a Bridge for Peace?” *CERTI Crisis and Transition Tool Kit Policy Brief*, May 2001, 9 <http://www.certi.org/publications/policy/gwc-12a-brief.PDF> (accessed 5 November 2009).

<sup>6</sup> Gutlove, “Health as a Bridge for Peace,” 3, (accessed 5 November 2009).

<sup>7</sup> A. Ciro, C. A. de Quadros, and Daniel Epstein, “Health as a Bridge for Peace: PAHO’s Experience,” *The Lancet* 360, Supplement (2002): 360; (Supplement 1): s25-s26.

<sup>8</sup> Alex Vass, “Peace Through Health,” *British Medical Journal* 323, no. 7320 (3 November 2001): 1020.

<sup>9</sup> See, for example, Anderson’s “Humanitarian NGOs in Conflict Intervention,” in *Managing Global Chaos*, eds. Chester Crocker, Fen Hampson, and Pamela Aall (Washington, DC: United States Institute of Peace Press, 1996), 343-354.

<sup>10</sup> Simon Rushton, “Health and Peacebuilding: Resuscitating the Failed State in Sierra Leone,” *International Relations* 19, no. 4 (December 2005): 442.

<sup>11</sup> Michael Bratton, “Are You Being Served? Popular Satisfaction with Health and Education Services in Africa,” (Afrobarometer Working Paper 65, Michigan State University, January 2007), <http://www.afrobarometer.org/papers/AfropaperNo65.pdf> (accessed 22 December 2009).

<sup>12</sup> *Ibid.*

<sup>13</sup> Taken from Kruk’s background paper on “Health as a Bridge for Peace” prepared for the HSRP.

<sup>14</sup> Matthew A. Levitt. “Hezbollah: Financing Terror Through Criminal Enterprise,” (testimony given to Committee on Homeland Security and Governmental Affairs, Washington, DC, 25 May 2005), <http://www.washingtoninstitute.org/html/pdf/hezbollah-testimony-05252005.pdf> (accessed 21 December 2009); Sabrina Tavernise, “Charity Wins Deep Loyalty for Hezbollah,” *New York Times*, 6 August 2006, <http://www.nytimes.com/2006/08/06/world/middleeast/06tyre.html> (Accessed 15 January 2010).

<sup>15</sup> Richard J. Brennan and Egbert Sondorp, “Humanitarian Aid: Some Political Realities,” *British Medical Journal* 333, no. 7573 (21 October 2006).

<sup>16</sup> Seth G. Jones et al., “Securing Health: Lessons from National Building Missions,” (Santa Monica, CA: RAND Center for Domestic and International Health Security, 2006), [http://www.rand.org/pubs/monographs/2006/RAND\\_MG321.pdf](http://www.rand.org/pubs/monographs/2006/RAND_MG321.pdf) (accessed 5 November 2009).

<sup>17</sup> *Ibid.*, 281.

<sup>18</sup> Kenny Gluk, “Coalition Forces Endanger Humanitarian Action in Afghanistan,” MSF, 6 May 2004, <http://www.msf.org/msfinternational/invoke.cfm?objectid=409F102D-A77A-4C94->

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<sup>19</sup> Jacques Forster, "An ICRC Perspective on Integrated Missions" (speech presented at an event hosted by the Norwegian Ministry of Foreign Affairs and the Norwegian Institute of International Affairs, Oslo, Norway, 31 May 2005), <http://www.icrc.org/Web/eng/siteeng0.nsf/html/6DCGRN> (accessed 5 November 2009).

<sup>20</sup> Abby Stoddard, Adele Harmer, and Victoria DiDomenico, "Providing Aid in Insecure Environments: 2009 Update," ODI HPG Policy Brief 34, London, UK, April 2009, 1, <http://www.cic.nyu.edu/internationalsecurity/docs/HPG%20Briefing%2034crc.pdf> (accessed 5 November 2009).

<sup>21</sup> Ibid.

<sup>22</sup> Colin J. McInnes, Kelley Lee, and Egbert Sundorp, "Health, security and foreign policy," *Review of International Studies* 32, no. 1 (January 2006): 18.