The engagement of health professionals with war has a long history. We can assume, that throughout the 10,000-year history of human warfare (Fry 2006, 134–41), there have been healers trying to mend the injuries inflicted by those who did battle. But intertwined as these functions were, they came from two different systems in human society—warriors and healers—and from different castes, different social groups, and different spheres of decision making. There were those (whether warrior kings or civilian diplomats) who decided between war and peace, and there were those who knew how to heal. In this book, however, we propose that healers have a role in the prevention and mitigation of war and other violence. On what is such a proposition founded?

The answer lies partly in the success of the public health or community health model as a powerful factor in improving human health over the last several centuries. This model demands that even while the practitioner is healing injuries and illness, there must always be a drive to identify and act on prior causes, often seen as a chain or web of causes. Not only cure, but also prevention, becomes the imperative. As we will demonstrate, war is an important determinant of death, of injury, and of illness both physical and mental. How can the health professional act preventively on war and other violence?

This may seem a daunting prospect until the reader realizes that the path has already been lightly trodden. There is a short, innovative, and exciting history of defining war as a public health problem and attempting to act on it in various ways from the health perspective. This book will introduce you to these efforts and, we hope, encourage you to join them.

IMPACT OF WAR ON HEALTH

War and other violence have devastating effects on human health. There were well over 100 million deaths from war in the last century (Project
Ploughshares 1996; Elliot 1972). Each year over 1.6 million people worldwide lose their lives directly to violence, accounting for 14 percent of deaths among males and 7 percent of deaths among females aged 15–44 years worldwide—those in the prime of life (Krug et al. 2002). The World Health Organization and the World Bank predict that war will be the eighth leading cause of disability and death by 2020 (Murray and Lopez 1996). For every person who dies as a result of such violence, many more are injured and suffer from a range of physical and mental health problems.

Malnutrition and undernutrition occur with increased frequency during and after wars. Disruption of infrastructure allows the spread of waterborne cholera, dysentery, and typhus. HIV/AIDS may be spread as soldiers engage in unsafe sexual practices with multiple partners. New diseases such as Ebola “emerge” with greater frequency, and diseases such as measles, malaria, and tuberculosis are; difficult to reduce; as a direct result of war (Connolly and Heymann 2002, Diamond 1997, Holdstock 2002).

Women may suffer from sexual and physical abuse and may be at increased risk of sexually transmitted diseases including HIV/AIDS, increased reproductive complications, and mental health problems (Shanks and Schull 2000). Refugees and internally displaced persons (IDPs) suffer from increased mortality, disability, and psychological distress (Santa Barbara 1997).

Violence costs countries billions of US dollars each year in health care, law enforcement, and lost productivity. The Inter-American Development Bank in Latin America has estimated the direct and indirect cost of (direct) violence for Latin America at US$140–170 billion per year, up to 15 percent of GDP (GIIS 2001); some claim figures up to 25 percent of GDP in Colombia (Vieira 1998). These figures may be somewhat lower now.

In 1986 public health specialists and health promoters determined, and stated in what became known as the Ottawa Charter (WHO 1986), that the fundamental conditions and resources for health are (in this order) peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. Not only is peace the first prerequisite for a “secure foundation” for health, but war also undermines each of the other conditions fundamental to health. We believe then, that to improve the health of populations, it is our responsibility to reduce violence and promote peace, especially in settings of impending, actual, or recent violent conflict.
WHAT IS PEACE THROUGH HEALTH?

Throughout the world, clusters of people working in the health sector (physicians, nurses, psychologists, sociologists, anthropologists) are attempting to address, in their own ways, issues related to the impact of violence on human health, and, in particular, violence at its largest scale—war. In doing so, they have found that there are ways in which health workers can actually contribute to peace. These new approaches go by several names, including Peace through Health, Health as a Bridge to Peace, and Medical Peace Work. We use the first of these names in this text. Peace through Health, then, refers to those ways that peace is advanced through work from the health sector.

In a search for solutions, health professionals have found themselves in dialogue with peace scholars and arriving at new approaches together. This text attempts to synthesize over fifteen years of applied work and thought in this area and to provide a roadmap of how to do Peace through Health work.

FOR WHOM ARE WE WRITING THIS VOLUME?

We are writing this book for all health practitioners (and students of health practice) who adopt a public health approach to the impact of war and other violence on health. This includes those in regions not at war who are concerned with the potential for massive violence by the use of weapons of mass destruction, those who are working in war and postwar zones, those who are dealing with violence at a scale where it falls under the heading of human rights abuse, those who are providing humanitarian assistance in conflict situations, and those who are dealing with the health effects of oppression and exploitation. Three possible scenarios follow.

Health professionals in zones of violence

You work in the emergency department in a Central American city hospital. You are astonished by the number of gun injuries you see, many of them fatal. Some quick research reveals that gun injury mortality in your country is far higher than in neighboring countries and forty times higher than in the least violent countries in the world. Your country is only six years from the end of a vicious war that left huge quantities of firearms distributed throughout the population. As your research deepens, you find other factors that may contribute to the high rate of gun violence. These include a “macho” culture assigning positive value to male violence, high rates of poverty and inequality,
unemployment, gang formation around the drug trade, and a sense of lack of political participation. Political polarization and concerns about a resumption of political violence also exist. You decide that you can no longer continue just to bandage victims, but want to look at how to prevent such violence.

Those providing humanitarian assistance

You are a health worker or humanitarian aid worker in a country that has just had an earthquake. This disaster has occurred during a civil war between the government and ethnic factions in the province. Ongoing differences in religion, social class, economics, and urbanization were fueling the violent conflict. You feel that you are too busy dealing with acute problems to think about abstract concepts such as peace.

Yet the issues intrude in your work anyway. Will you remain neutral? Will you cooperate with the government? Will you demonstrate solidarity with the population? Will you use armed guards to secure your aid so it can be delivered? Does the natural disaster offer any opportunities to deal with the violent conflict?

Those involved in rebuilding after violent conflict

Let us move a few years later. The civil war has abated, and direct violence has been reduced. You are looking for ways to support those who want to knit the social fabric together again and diminish the likelihood of recurrent eruption of violence. The health system needs to be rebuilt, and there is international aid to accomplish this—but, as usual, little for peacework. Nationalist factions are discussing the creation of parallel ethnically segregated health systems. You see a potential role for yourself here in strengthening the social fabric, and you must make your case to the international funding agency What do you have to offer?

Peace Studies Students and Peace Workers

Those who have specialized in the dynamics of violence, nonviolence, conflict, conflict transformation, and reconciliation may find themselves working in alliance with various sectors of society, such as the media, representatives of religious institutions, and (in the case of the work highlighted here) the health sector. (This topic is explored further in Part III of this book.) An example:

You are a student of peace studies working for the summer as part of a government-funded rural health team. In this area, 95 percent of inhabitants are indigenous people. They are a minority in most of the country and have been so since the arrival of Europeans in the seventeenth century. For the next three centuries, the indigenous people suffered violence, expropriation of their land,
and attempted extinction of their culture through a residential school system in which punishment discouraged use of the indigenous language and practice of its customs.

Measured by all indicators, the health of this population is much worse than that of the majority population. The indigenous people’s housing, water system, sanitation, and school infrastructure are all substandard compared to the rest of the population. Unemployment is high. A nearby mining development employs very few of these people, although the land was expropriated from them with an agreement to offer employment opportunities.

Recently, an aboriginal group occupied a piece of land on which a business entrepreneur was building a new suburb. The protestors’ ongoing land claims demonstration was conducted nonviolently, but it elicited a massive police response in which two indigenous people were shot dead.

Your health team genuinely wants to help these young people. You are aware, from the youth who come to the clinic, that there is hopelessness and despair among them—and an attraction to guns and violence. Accident, homicide, and suicide rates are very high among youth. What are your skills and limitations in helping to address the situation?

The aim of this volume is to help promote the improvement of health and the restoration of peace in large-, medium-, and small-scale conflict situations. We hope that it leads to further training of future health professionals in peace and conflict transformation principles. We hope that it helps those working internationally and domestically to clarify their own goals and values; to recognize their knowledge, skills, assets, and deficits; and to apply the principles of Peace through Health to their work and even to other aspects of their lives. We have tried to provide you with the tools to enlist your own unique knowledge, skills, and values in the quest for peace.

Before we proceed, however, we should make sure that we have a common understanding of several terms.

**WHAT IS PEACE?**

We define it thus: Peace is an attribute of a relationship between two or more entities in which, at least, no harm is being done to any party, and conflicts are resolved nonviolently; at most, it is a harmonious relationship of mutual benefit and cooperation. The “entities” in the relationship can be aspects of yourself, two or more people, or two or more groups, nations, states, or regions. We sometimes extend this idea to consider peace between humans and Nature and peace between the present generations of humans living on Earth and those who will live here in the future.
The opposite of peace is not conflict, which can be constructive and creative as well as violent and destructive.\(^1\) Rather, the opposite of peace is violence, which we now must consider.

**WHAT IS VIOLENCE?**

Here we call upon the thinking of peace researcher Johan Galtung.\(^2\) He defined violence as *avoidable insults to basic needs* (1996, 1997), *diminishing life potential*. Continuing with Galtung, we think of basic needs as fourfold: *security, well-being, identity, and freedom*. It is easy to see that killing or injuring someone will insult their need for security and obliterate or diminish their potential for a happy life. What about someone who is persistently undermined and denigrated by others? He or she is also losing potential for a happy life—words can do violence too. What about a situation in which the way a society is structured means that whole groups of people have lower potential for a happy life, perhaps because they are too poor to fulfill their well-being needs or because they adhere to a particular religion or belong to an ethnic group that is excluded from certain opportunities? Is this violence too? Galtung included such factors in his definition. He spoke about *direct violence*, wherein there is a conscious action directed by one entity against another, with intent to harm—hitting someone, dropping a bomb on a village. Then he described *structural violence*, in which the structures of society prevent certain people from fulfilling their potential for a happy life. This could occur in a family in which girls and women are oppressed, or it could refer to economic globalization, which causes some to grow ever richer while others are hungry. Structural violence can quite often be measured in life expectancy differences. Galtung added a third category, *cultural violence*, by which he meant those attitudes, values, and beliefs that justify direct and structural violence. Perhaps the most prevalent form of cultural violence is the belief that the lives of one’s own group (religion, ethnicity, nation) are more worthy and valuable than the lives of others.

Those who work in the framework of Peace through Health may focus on any or all of these types of violence, especially the large-scale, direct violence of war.

**WHAT IS WAR?**

We use a definition derived from one of the founding thinkers in Peace through Health, Graeme MacQueen. *War is mutual, mass, persistent, lethal*
direct violence engaged in by two or more groups. It can be useful to think of war not as a sporadic event, but as a phase of a war system, in which the politics, economies, and cultures of countries are engaged in ongoing preparation for war, which periodically erupts in spasms of killing. We can also envisage a peace system, in which the politics, economies, and cultures of countries are engaged in the maintenance of harmonious, cooperative relationships by means of conflict transformation systems, minimal or absent threat levels, respect for law, and multiple relationships of mutual benefit.

Because violence, and especially war, often ensue from conflict, we must return to consider this complex idea.

WHAT IS CONFLICT?

Conflict occurs when two or more entities pursue apparently incompatible goals. Here again, these entities may be aspects of oneself, small groups, or regions of the world with populations of billions of people. Goals may be pursued with such intensity that people are willing to inflict violence on others to try to get what they want. A great deal of knowledge has accumulated about how to deal with conflict constructively and non-violently. Much of it resides in each culture; some of it is consciously taught as conflict resolution or conflict transformation—for example, in peer mediation in some schools or in courses at the college level.

Those who work in the challenging environments of war zones need, at the very least, to understand the dynamics of the situations in which they work. Sometimes their demonstrable knowledge of peace processes is put to use, as when one of the McMaster University team members working in Afghanistan was appointed to that country’s Independent National Commission on Strengthening Peace and worked to bring excluded parties into the peace process in Afghanistan.

WHAT IS HEALTH?

The Constitution of the World Health Organization (WHO 1992) defines health as “not merely the absence of disease or infirmity” but, more holistically, as a “state of complete physical, mental and social well-being” (WHO 1946).

What determines health, in an individual or a population? Good genes, good nurturance, and good lifestyle provide a foundation. We can then consider exposures to aspects of the human environment that may adversely affect health: insufficient housing and clothing, injuries, toxins,
microorganisms, and experiences that cause mental stress. It is clear that different populations, and different portions of the same population, incur different degrees of exposure to these factors that diminish health. Some people’s lives are more protected than others’.

What influences these different degrees of exposure? We think about the following six phenomena as especially important and as interwoven in complex ways: poverty, war and other violence, environmental degradation, disintegration of community, poor governance, and poor human rights observance. All of these factors are known to be correlated with lower levels of population health. In this book, we focus on war, but war, most unhappily, brings the other five lethal factors in its wake. Protective influences in the environment include the availability of education and health care.

PEACE AND HEALTH

Peace and health are both widely agreed-upon human goods; both are often proposed as human rights. Both are supported by disciplines founded on value structures (unlike “hard sciences” such as physics). The structure of health science thinking in terms of the sequence diagnosis, prognosis, therapy is also very useful in application to war, violence, and other conflict. In transposing this structure, the health worker’s emphasis on therapy—the imperative to search for solutions to the problem—may be helpful in encouraging political analysts to think creatively beyond diagnosis, or beyond a single (military) solution for every problem.

Another conceptual transposition from health studies to peace studies is elaboration of the idea of prevention. In the health arena, primary prevention applies to action on the chain of causes preceding the onset of illness or injury. In the peace arena, it means acting on the multiple causal factors leading to the eruption of violence. Secondary prevention in health involves actions to shorten the course of illness or to lessen its ill effects on the body. In peace processes, it means to shorten the course of a war or to mitigate its effects on populations. Tertiary prevention applies to actions to rehabilitate the person after illness or injury, or the population and the society after the damage of war. In each case—that is, in the primary, secondary, and tertiary prevention of war and other violence—there are roles appropriate to health professionals, as we shall show.

In each of the scenarios described above, you could choose to treat only the problem under your nose—gun injuries, humanitarian needs, health system reconstruction, or hopeless, angry, indigenous youth. Or you could turn your gaze “upstream” to the sources of the health deficits
in the hope of acting preventively. What part has violence, in any of its forms, played in the problems before you? As soon as you expand your vision in this way, you are likely to discover gaps in your knowledge. You will want to be able to analyze what you are seeing and to devise constructive ways of lessening the suffering incurred. This book aims to fill those gaps. But first, we must identify them.

Where you begin will depend on whether you are approaching the problem as a health worker or a peace worker, so you may choose your point of entry accordingly. You will want to analyze the health deficits in this situation, actual or potential. It will be helpful to do a violence analysis, taking into account direct, structural, and cultural violence, as defined above. This analysis will be informed by knowledge of the impact of violence on health.

You may wonder, at this point, about the role of the health worker in addressing peace. The concept of multisector peacework may help you see how it fits with the responsibility of all sectors of society to work toward peace.

Each of our scenarios illustrates a different kind of conflict underlying the violence. You will understand your context for action better if you do a conflict analysis, including identifying the stage of conflict. In complex, large-scale violence, this analysis will frequently benefit from the training of peace specialists or political scientists and from learning from more than one expert. Part of this analysis will be understanding important elements of the history and culture of the arena where you are working. An ideal team for generating the understanding of context would include health workers, peace experts, political scientists, anthropologists, and human rights advocates, with as many as possible of these from the local population (quite possibly not with formal training).

At this point, you are ready to consider whether, as a health worker, you may be able to work “upstream” to improve some of the peace deficits causing ill health; or whether, as a peace worker, you can work with a health team in a useful way. You will need, from at least this point, to work closely in a team with people from the area of focus and to know something about forming good partnerships and good teams. You will benefit from hard-won knowledge gained in this area and summarized in several analytic tools to apply when approaching a problem.

Now comes the most creative part of peace-health work: considering what processes might be helpful in expanding both health and peace. It will help to have some knowledge of previous Peace through Health work and the mechanisms by which it operates. Strategies applied in other situations may or may not be relevant to yours. For example, the “Ceasefires
for Immunization” strategy described in “Humanitarian Ceasefires” in Chapter 17 has been used in El Salvador, the Philippines, Afghanistan, and many other places, but it probably is not relevant to any of our scenarios. We need to make explicit the values that underlie our work and to remind ourselves of ethical principles. Respect for universal human rights will be part of our value set. Among declarations of human rights, and in particular among those intended to apply in war, we may find principles that act as valuable levers to move governments to take actions that we believe will promote peace and health.

We hope that when you finish this book, you will have the knowledge, inspiring examples, and evaluative tools to design and implement these ideas for your own peace and health projects. Part I continues with a chapter on the history of Peace through Health and introduces basic concepts in the area. Part II looks at the impacts of war and the weapons of war now and in the future. Part III examines principles and values in Peace through Health. In Part IV we describe ways of approaching problems. Part V presents case studies at each level—primary, secondary, and tertiary prevention. These are examples from which you might learn how to design your own interventions before, during, and after the violent phases of conflict. Part VI deals with evaluation of the peace component of Peace through Health work. Part VII shows how we expand the scope of what is commonly considered violence prevention and health work. Finally, in Part VIII, we conclude with a few other special topics. We hope that the methods and examples provided are both inspiring and practical, demonstrating how you might work whether you are a student, a health professional, or a peace practitioner.

REFERENCES


NOTES

1. An example of a creative conflict outcome is the resolution of a border conflict between Peru and Ecuador. These two countries went to war over their border in the Condor mountains in 1941, 1981, and 1995. Shortly after the last war, peace researcher Johan Galtung remarked to a diplomat of one of the countries that their conflict could be transformed by establishing a binational park in the area. This has been done, greatly to the benefit of the Amazonian indigenous people in the mountains, whose families were previously divided by the violent conflict (Galtung et al. 2002).

2. Johan Galtung was born in Oslo in 1930. He is widely regarded as a founding father of peace research. He generated the Transcend method of conflict transformation and has applied it in 45 major conflicts. His concept of “structural violence” has been fruitfully applied by many thinkers. He has held professorships in numerous universities, has 12 honorary degrees, and has published over 1000 articles and 100 books on peace-related topics.

3. Peer mediation is a system of conflict resolution in an organization where some members are trained as mediators. They perform that function, sometimes working in small teams, when conflicts arise among members of the organization. This approach to conflict is often found in schools.

4. This list is a little different from the factors prominent in the current studies of the World Health Organization’s Commission on the Social Determinants of Health. Most of the factors in these studies would be subcategories of our typology. For example, poor housing, urban slum-dwelling, and unemployment would fall under our broad category of poverty. On the other hand, the Commission on the Social Determinants of Health does not include war, poor governance, or environmental degradation in its arena of study.