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Book Section:

Rushton, S. (2026) Healthcare professionals, conflict prevention, and peacebuilding: towards peace through health? In: Birch, M. and Hagopian, A., (eds.) De Gruyter Handbook of Conflict and Health. De Gruyter Contemporary Social Sciences Handbooks, 12. De Gruyter, pp. 803-816. ISBN: 9783111250014.

<https://doi.org/10.1515/9783111250144-045>

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44 Healthcare professionals, conflict prevention, and peacebuilding: towards peace through health?

Simon Rushton

Abstract: Health workers are not only victims of armed conflict (although, all-too-often they are), but also have the potential to play important roles in preventing conflict, mitigating its effects, and building peace. Covering both theory and practice, the chapter examines the potential for health professionals to be agents for peace. Their ability to do so has been seen as deriving from a number of factors, including their ability to provide expert opinion on the damaging public health consequences of armed violence; the status of health as a ‘superordinate goal’ around which common ground can be found; and norms of medical neutrality which, in some circumstances at least, enable health professionals to play mediating roles.

The chapter begins by examining the development of thinking over recent decades about how to prevent conflict and restore peace where violence has broken out. It then goes on to examine the specific roles that have been identified for (and in some cases fulfilled by) healthcare professionals in this before looking ahead to consider the ways in which these ideas of ‘Peace through Health’ are challenged by social and political trends, in particular the undermining of medical neutrality and a more general rise in distrust of medical and other scientific professionals. The chapter concludes by pointing to some of the responses that have been suggested for these challenges, including making Peace through Health-relevant skills a core part of medical education, promoting best practice and successful initiatives, and working within professional associations to oppose war.

Keywords: peace, health, peace through health, conflict, war, professional, prevention, WHO

1. Introduction

The ways in which conflict harms health are well-known—and, unfortunately, have been repeatedly illustrated over countless wars throughout history. As the other chapters in this handbook show, the health effects of armed violence are many and various, from direct injuries and death, through the destruction of health facilities, and on to the longer-term

consequences of war which include displacement, poverty, disruption to education, and much more besides.

In the face of this, a tradition of thinking about the contribution of health professionals to preventing conflict, mitigating health harms, and restoring peace has emerged, and is the focus of this chapter. According to such thinking, health workers are not merely victims of armed conflict, but also have a degree of agency, with the potential to play a role in preventing conflict, mitigating its health effects, and building peace.

Covering both theory and practice, the chapter examines the potential for health professionals to be agents for peace which, it has often been argued, should be seen as a vital part of the promotion of public health. The chapter begins by examining the development of thinking over recent decades about how to prevent conflict and restore peace where violence has broken out. It then goes on to examine the specific roles that have been identified for (and in some cases fulfilled by) healthcare professionals in this. Finally, the chapter looks ahead to consider the ways in which these ideas of 'Peace through Health' are challenged by social and political trends that may undermine the ability of healthcare professionals to successfully pursue peace.

2. Preventing War; Building Peace

The end of the Cold War heralded hugely significant changes in the international political system, and also generated new thinking and perspectives on issues of armed conflict and peace. Attention in Western security policy communities quickly shifted away from the implications of superpower rivalry towards civil wars—at that time seen as the most common form of armed conflict, and the greatest threat to international security and stability. Discourses around the problems of state failure, ethnic cleansing, and secession came to the fore, as did debates around whether and in what circumstances international actors had a right—or even a duty—to intervene in wars happening elsewhere, often couched in the language of 'humanitarian intervention' (Wheeler, 2002) (even if there was frequently doubt about whether humanitarianism was the real, or at least only, motive for such interventions (Paris, 2014)).

This was accompanied by new thinking about the international community's approach to 'preventive diplomacy,' 'peace-keeping,' 'peace-making,' and 'peace-building.' In one of the most influential statements on these topics, UN Secretary-General Boutros

Boutros-Ghali's *Agenda for Peace* (Boutros-Ghali, 1992) set out a series of aims for the UN in the new post-Cold War context:

- To seek to identify at the earliest possible stage situations that could produce conflict, and to try through diplomacy to remove the sources of danger before violence results;
- Where conflict erupts, to engage in peace-making aimed at resolving the issues that have led to conflict;
- Through peace-keeping, to work to preserve peace, however fragile, where fighting has been halted and to assist in implementing agreements achieved by the peace-makers;
- To stand ready to assist in peace-building in its differing contexts: rebuilding the institutions and infrastructures of nations torn by civil war and strife; and building bonds of peaceful mutual benefit among nations formerly at war;
- And in the largest sense, to address the deepest causes of conflict: economic despair, social injustice, and political oppression. It is possible to discern an increasingly common moral perception that spans the world's nations and peoples, and which is finding expression in international laws, many owing their genesis to the work of this Organization. (Boutros-Ghali, 1992: 7–8)

The 'liberal peacebuilding' approach (Donais, 2012: 4–5; see also Paris, 2004) that *An Agenda for Peace* exemplified put a considerable emphasis on the UN itself as a mediator between conflicted parties, and rested upon a series of assumptions about the role of supposedly-shared international norms of 'good governance' (including democratic elections, human rights protections, the rule of law, and capitalist free markets) thought to be central to sustainable and lasting peace. Yet the approach quickly came to be criticized from both within and outside the UN system. Some saw it as a continuation of liberal models of Western intervention by other means (e.g., Chandler, 2006), and a brazen attempt to transplant (Western) ideas of democratic governance and free markets into parts of the world where other social, political, and economic traditions prevailed. Others pointed to a decidedly mixed record in practice, especially high-profile failures in the Balkans and Rwanda.

For their part, proponents of liberal peacebuilding bemoaned the fact that the UN was not being given the political support, nor the resources, that would be required to actually deliver on the aims set out in *An Agenda for Peace*. The so-called ‘Brahimi Report,’ published in 2000, identified a series of obstacles the organization faced, including unrealistic mandates, an inability to deploy properly-trained and well-equipped troops on peace-keeping missions, and a lack of planning capacity, as well as the continuing problem of a lack of agreement amongst member states about where and when the UN should become involved (Panel on United Nations Peace Operations, 2000).

The major alternative to the liberal approach was what Donais (2012: 5) called the ‘communitarian perspective,’ which emphasized ‘peacebuilding from below’ and was closely associated with the work of conflict resolution scholars and practitioners such as Johan Galtung and John Paul Lederach (Leonardsson & Rudd, 2015). These approaches brought a much greater emphasis on ‘the local’—both in terms of the cultures, traditions, and contexts that made each conflict unique, and also the ways in which actors at the grassroots level could be important agents in building peace. Individuals and communities, according to this perspective, had roles to play not just through participating in elections and capitalist markets as per the liberal approach, but through taking community-level action. This line of thinking opens up the conceptual space for a much wider range of actors to play roles in conflict prevention and peace-making, and also for those roles to take many different forms; not only high-level diplomatic efforts, but also more locally oriented actions to prevent violence and build trust and reconciliation, for example. It is here that it becomes possible to bring into focus the potential (and actual) parts played by health workers over many decades in advocating for peace.

3. Peace Through Health: Theory and Practice

The involvement of health professionals in attempts to promote peace long preceded this new wave of thinking about conflict prevention and peacebuilding. From the International Committee of the Red Cross (founded in 1863), to the *Association Médicale Internationale Contre la Guerre* (founded in 1905), to International Physicians for the Prevention of Nuclear War (founded in 1980) (Jenssen, 2002; Lewer, 1992; Maddocks, 1996), health professionals—driven by horror at the humanitarian consequences of armed conflict—have long been engaged with campaigns that have pursued various aims, from

attempting to place limits on acceptable conduct in war, to campaigning against particular types of destructive weaponry, to attempting to delegitimize the institution of war as a whole. In doing so, they have deliberately entered the political arena, whilst at the same time drawing legitimacy from their professional understanding that war has been (and continues to be) a major determinant of individual and population health.

We will return to the practice of ‘peace through health’ later in this section, but first it is important to examine the ways in which this has been theorized over recent decades. Undoubtedly, the most influential stream of this work has been that carried out by scholars at McMaster University in Canada, and their collaborators elsewhere, since the 1990s. Through engaging with work on peace studies (not least that of Galtung) as well as the concept of ‘multitrack diplomacy’ (Diamond & McDonald, 1993; MacQueen et al., 1997), these authors have mapped out the ways in which health professionals can contribute to the production of peace. Without wishing to over-simplify this large body of work, it is perhaps possible to identify four consistent themes that constitute the core of what has come to be known as ‘Peace through Health’ thinking—and that, as we shall see below, have been similarly central to the various efforts to put these ideas into practice.

First is the idea that war can be understood, or reframed, as a public health problem, and that theoretical/conceptual tools from public health can be useful ways of thinking about and acting on the problem of war. The immediate health consequences of armed conflict (both direct and indirect) provide an obvious starting point here. But Peace through Health work has gone beyond this, taking up Galtungian ideas (which had themselves been inspired by the medical sciences: Galtung, 1985) about the need for ‘positive peace’ (e.g., Arya, 2017); pursuing not just the ending of armed violence, but also tackling structural violence.

Second is the claim that health (sometimes specifically child health—e.g. Santa Barbara, 2005) represents a ‘superordinate goal’: a politically neutral value around which conflicted parties can find common ground (Arya, 2007: 374). This is crucial in providing those working within the health sector with an entry point, and legitimacy, to speak and act against violence and in defence of health without necessarily (at least in theory) being required to take a position in support of one side or another. This has been a fundamental part of the humanitarian ideals of neutrality and impartiality that have long been central to the work of bodies like the ICRC. But beyond providing a politically neutral entry-point,

proponents of Peace through Health argue that the status of health as a superordinate goal also opens up opportunities for engaging in peace-making activities, bringing conflicting parties together around the health sector, often on a local scale, in ways that can help to build trust and identify common interests.

Third, again importing ideas from the health sciences, is the claim that health professionals can engage in prevention efforts at various stages of the conflict cycle. These include 'primary prevention' (Levy & Sidel, 1997), engaging in advocacy and diplomacy to raise awareness of the health impacts of war, and in doing so to delegitimize armed conflict and/or the use of particular types of weaponry; 'secondary prevention,' which might involve direct involvement in mediation, whereby health workers could exploit the traditional neutrality of medical personnel in war "to help facilitate the removal of psychological barriers and so help bring belligerents together for meaningful talks" (Lewer, 1992: 96–7); and 'tertiary prevention,' "post 'hot' war peace-building" (Arya, 2004a: 246).

Fourth, Peace through Health scholars have made determined efforts to forward the idea that PtH needs to be recognized as a discipline (Buhmann, 2007: 61; MacQueen et al., 2001) and that these ideas should form part of medical education curricula (Hughes et al., 2001; Arya, 2004b; Arya et al., 2008). Amini and Arya (2019: 124-5), for example, argue that

with proper curriculum design and teaching strategies, peace through health education can be incorporated to enhance physician competencies, both in the Global North and South. The addition of explicit topics and—even more important—changes in orientation and approach to reflect peace studies and principles will mean more skilled physicians with the desired behaviours and attitudes, regardless of which discipline they might practice, and whether or not they work in zones of violent conflict.

The debate that has surrounded Peace through Health has generally been less about its normative appeal and more about the strength of the evidence that it works in practice (Vass, 2001; Rushton, 2008). Developing such evidence is a task to which the PtH community has turned in recent years, perhaps most notably through a 2019 Special Issue in *Peace Research* edited by Neil Arya (Arya, 2019); although even here questions arose about

the longevity or sustainability of, for example, temporary humanitarian ceasefires (Kelman, 2019).

Even if it is difficult to robustly demonstrate causality between health professionals' initiatives and achievement of stable and lasting peace (still less, 'positive peace'), there is a substantial track record of attempts to put the core ideas of Peace through Health into practice around the world, involving a variety of actors, from WHO down to small groups of health professionals, and in relation to all three categories of primary, secondary and tertiary prevention.

Arms control, as a form of primary prevention, is perhaps one of the areas in which there has been most demonstrable success. In the 1990s, for example, health professionals (working alongside a variety of other civil society groups) were heavily involved in the International Campaign to Ban Landmines. As Price (1998) notes, the signing of the Ottawa Treaty that outlawed anti-personnel landmines was the successful re-framing of the landmine issue as a humanitarian problem rather than as a question of military effectiveness (Price, 1998)—a classic example of deploying health as a 'superordinate goal.' Medical organizations continued to be prominent in attempts to get governments such as the US to sign up to the Ottawa Treaty (e.g., Physicians for Human Rights, 2010) (although, at the time of writing, the US, as well as other key powers such as China and Russia, is still not a signatory). More recently, medical professionals and organizations, including IPPNW, have played an important part in the International Campaign against Nuclear Weapons (ICAN), which was awarded the 2017 Nobel Peace Prize for its "work to draw attention to the catastrophic humanitarian consequences of any use of nuclear weapons," recognizing its role in producing the Treaty on the Prohibition of Nuclear Weapons which was opened for signature in 2017 and finally entered into force on January 22, 2021 (ICAN, n.d.). Although war very much continues to be a feature of contemporary life—and both anti-personnel landmines and nuclear weapons continue to be produced—these efforts do at least show the potential of health professionals, working in conjunction with other civil society actors, to play an important part in the development of international norms against particular forms of armed violence.

One of the earliest explicit 'secondary prevention'-type initiatives, often referred to in the PtH literature, was the Pan American Health Organization's 'Health as a Bridge for Peace' program in the 1980s, which included the negotiation of temporary ceasefires to

allow for polio vaccination of children in war-affected countries including El Salvador and Peru (de Quatros & Epstein, 2002). Later, WHO (in partnership with the UK's Department for International Development) sought to extend this strategy and to integrate conflict resolution across the range of its activities in Bosnia and Herzegovina (WHO Europe, 1998). Although these types of initiative seemed to fade from view after the 1990s (Rushton & McInnes, 2006), in recent years there has been something of a resurgence of interest, not least in the WHO under the Director-Generalship of Dr Tedros Ghebreyesus. The WHO's Global Health and Peace Initiative was launched in 2020 (Coninx et al., 2022). The fifth (and at the time of writing most recent) draft of the WHO's Global Health and Peace Initiative Roadmap describes its aims as being

to strengthen the role of WHO and the health sector as contributors to improving the prospects for peace—for example, by strengthening social cohesion, dialogue, or resilience to the impact of armed conflict or violence while empowering communities, in the framework of WHO's mandate and under national ownership. (WHO, 2023)

At the same time, however, some of the recent signs of health's status as a superordinate goal have been less than encouraging: a 2021 UN Security Council Resolution calling on warring parties to support a 'humanitarian pause' to allow for COVID-19 vaccination programs to be rolled-out was a resounding failure, having minimal impact.

Although it remains difficult to evidence the causal impact that individual health sector initiatives have on creating the conditions for a stable and lasting peace, evaluations of a number of programs have certainly found that they have had some effect. The WHO's programme in Bosnia-Herzegovina, for example, found it to have been effective in addressing a number of obstacles to a stable peace (WHO Europe, 1998: 33–39). Similarly, analysis of HEAL Africa's peacebuilding activities in the Democratic Republic of Congo found that its work (which included supporting victims of rape to pursue justice), identified sufficient evidence to show positive effects, whilst recognizing that "[m]easuring the success of peace-building activities is notoriously difficult to achieve, not least due to the unstable conditions in which research must be conducted and the inherently intangible nature of key measurement indicators" (D'Errico et al., 2010: 154).

4. Prospects and Challenges

As recent initiatives such as the WHO's Global Health and Peace Initiative demonstrate, there has been a resurgence in interest in exploring and maximizing the impact that health professionals can have on conflict prevention and transformation (Arya, 2019). Notwithstanding this, there are in the contemporary world a series of challenges that impede the ability of health professionals to be agents of peace—and that may, indeed, make such actions risky. In this section I focus on three such challenges: a trend towards the politicization of the roles of medics and other health professionals in conflict zones (a trend which, to some degree at least, has been precipitated by the actions of some health professionals themselves); an apparent decline in acceptance of the norms of medical neutrality, as protected under International Humanitarian Law; and finally, a wider distrust of expertise (not least medical expertise) which may impinge upon the ability of health professionals to utilize their social capital to advocate for peace.

The conduct of the wars of the early 2000s in Iraq and Afghanistan in particular raised new challenges around the roles and status of health professionals in conflict scenarios, and in some cases created new dangers. The US's use of healthcare service provision as a strategic tool to attempt to 'win hearts and minds' has been critiqued for raising ethical challenges (McInnes & Rushton, 2014) and potentially undermining the 'humanitarian space' (Audet, 2015) on which the activities of international medical aid workers rely. Perhaps even more egregious was the CIA's use of a fake vaccination campaign in an attempt to identify Osama Bin Laden (Shah, 2011)—a move which not only undermined norms of medical neutrality in war, but also raised significant dangers for actual vaccinators working in the region. These examples point to the obvious tensions that arise in relation to the political engagement of health professionals in conflict: tensions that humanitarian aid organizations have long been forced to navigate, doing so through reliance on the principles of neutrality and impartiality (Slim, 1997). Whilst this seems like a pragmatic and defensible approach, it is not one that should prevent health professionals from opposing war: it is possible to be impartial between the parties to a conflict, whilst being partial towards the aim of peace.

We have also seen an increasing apparent disregard for the long-established principles of International Humanitarian Law, under which health facilities and health

workers are protected from attack. A lack of consistent reporting, and changing patterns of conflict over time, make it difficult to determine whether attacks on health facilities have actually become more frequent—but at the very least, they have become more visible. Some have even feared that attacking healthcare facilities has become a ‘new normal’ (Blanchet et al., 2023). At the time of writing, the destruction of hospitals and other health facilities in Gaza dominates the news, with the Director General of the WHO asking

What type of world do we live in when health workers are at risk of being bombed as they carry out their life saving work [and] hospitals must close because there is no more power or medicines to help save patients? (UN, 2024)

In other recent and ongoing conflicts, including in Ukraine, Myanmar, Israel, Syria, and Sudan, deliberate attacks on healthcare have been widely documented, and certainly seem to have become ‘normal’ practice amongst combatants, in flagrant contravention of the Geneva Conventions (see Chapter 4). The consequences of this for Peace through Health initiatives are multiple, but clear. First, such attacks make the delivery of health and medical care during war much more dangerous, increasing the difficulties caregivers face in looking after their patients, whilst decreasing the resources (for example, facilities, equipment, and medicines) that they have at their disposal. In such circumstances, the scope for taking on additional roles (for example in relation to secondary prevention) is significantly circumscribed. Second, such attacks make it difficult for health professionals to remain physically present within conflict zones—again reducing their ability to engage in peace-making activities. Third, reduced respect for medical neutrality may make peace work more dangerous: even if impartiality between the parties can be maintained, such activities may be read by those parties as partial, increasing the risk. All of this, it might be argued, makes it even more important for those outside of conflict situations to engage in primary prevention.

Yet, finally, in many countries the political climate is not conducive to health professional activism. Alongside a rise in populism, distrust of medical and other scientific forms of expertise has been increasing (Lamas, 2024), perhaps seen most clearly in conspiracy theory-related vaccine hesitancy. This trend challenges the idea that healthcare is necessarily a superordinate goal (indeed, it can be divisive rather than uniting), and also

that healthcare professionals will necessarily be seen as legitimate and trusted voices on politicized topics.

How should the health sector respond to these challenges? Is the answer to retreat from political engagement? Or to engage more fully and more widely, seeking not only to prevent and resolve armed conflict, but also other forms of political and social division? Here it is argued that action is required from both within and outside the health professional community. From outside, it is essential that the norms of humanitarian international law are reiterated and strengthened. Work towards this goal may take various forms, but perhaps the two most important are increasing the provision of training for armed forces (including those from non-state armed groups) on International Humanitarian Law, and ensuring that there are consequences, for example through prosecution at the International Criminal Court, for those who act in violation of them. Within the health sector, as Peace through Health scholars have previously argued, there is much that can still be done. This might include making Peace through Health-relevant skills a core part of medical education curricula; promoting best practice and successful initiatives; and working within professional associations to oppose war. Promoting peace and justice is not easy work, and has never been. Yet there are opportunities for health professionals to continue, and expand, their roles as agents of peace—and for this to come to be seen as a core part of the professional commitment to health, at both the individual and population levels.

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