Healing Under Fire

Medical Peace Work in the Field: Opportunities and Challenges

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Health and peace work has been documented in case studies by the Pan American Health Organization (PAHO), the World Health Organisation (WHO), Medical Peace Work (MPW) and others. Between 2012 and 2016 assessments on the potential of developing health and peace activities were carried out by the authors in four regions affected by armed conflict. This article presents the authors' initial observations, including examples of local initiatives for health and peace. It questions the assumption that health and peace work is feasible in all contexts and cultures, and points out the gaps in the understanding of this important concept.

Keywords: health, peace, conflict, violence, Syria, Thailand, Kurdistan, Myanmar

The Link Between Health and Peace

Much has been written about the theory and practice behind the concept of the health sector contributing to peace building. Those who advocate and promote a strong and natural link between health and peace include the World Health Organization (WHO), the United States Institute for Peace and such individuals as peace and conflict expert Johann Galtung.

Several terms have been used to represent the concept, amongst them: health as a bridge to peace (WHO)[1], peace through health (Arya and Santa Barbara 2008) and medical peace work (Medical Peace Work, Norway).[2]

[1] http://www.who.int/hac/techguidance/hbp/case_studies/en/

[2] http://www.medicalpeacework.org

The concept first emerged in the 1980s when introduced by the Pan American Health Organization (PAHO) as a multi-country, multi-agency programme supported by health ministers in the region, and was based on the principle that '*shared health concerns can transcend political, economic, social and ethnic divisions among people and between nations*' (de Quadros and Epstein 2002). At about the same time, a group of physicians from the United States and the Soviet Union started the International Physicians for the Prevention of Nuclear War, based on the belief that physicians' responsibilities included a commitment to the prevention of nuclear warfare.

Further endorsement of the concept came in 1981 when the World Health Assembly, the governing body of the WHO, confirmed in Resolution 34.38 that '*the role of physicians and other health workers in the preservation of peace is the most significant factor for the attainment of health for all*'.

Perhaps the most convincing argument for the health and peace concept is the threat of arms and war to public health. In 1996, the WHO and the World Bank predicted that wars would be the eighth-leading cause of mortality and disability by 2020 (Lopez and Murray 1996). Certainly, direct violence from guns and other tools of conflict contribute heavily to mortality and morbidity; but millions of people have lived and still live in precarious conditions due to the destruction that war inflicts and the displacement of populations that it causes. In such situations, access to essential services becomes limited, facilitating the transmission of preventable diseases. Modern warfare also has disabled millions mentally and psychologically, increasing substance abuse and delaying the return to productive livelihoods.

The proponents of the health and peace nexus make the point that working for peace is part and parcel of a sound public health approach. They emphasize the intrinsic

values of medicine – altruism and the reliance on scientific evidence to draw conclusions – which give physicians and other health professionals legitimacy across cultures and societies. It is assumed that the rigorous training, a problem solving approach and empathy inherent in the profession also bestow the qualities needed for peacemakers.

To further clarify the concept, 'peace' used by 4Change and Medical Peace Work is defined as '*a state of harmonious relationships, in which individuals and communities have unimpeded, secure and equitable access to the basic needs of life for their well-being*'. This definition derives from the concept of positive peace (Galtung 1969). Just as health does not mean the absence of disease, peace is not the mere absence of war or violence.

Using this interpretation, the application of health and peace becomes more diverse. It includes, for example, advocacy against deadly weapons, injustice, prejudice and human rights abuses; education in ethics, human rights and peace through health; the collection and dissemination of epidemiological and forensic data on the consequences of violent conflict; and ensuring equal access for all communities to development opportunities and humanitarian health assistance. Worldwide, hundreds of health workers are engaged in mitigating the effects of violent conflict and providing humanitarian health assistance, including mental health services, to ease the long-term psychological and social impact of violence, and to prevent cycles of violence. All of these actions can, within the definition here provided, contribute in one way or another to sustainable peace.

Many of these health and peace activities have not been fully studied documented, and the impact, in terms of peace dividend, not measured. This remains as

one of the main shortcomings of the approach. Further, questions remain in this field of work: is health and peace a universal concept? Is it applicable in all phases of conflicts? Should it be recognised as a discipline in health or in peace studies? Should it be mainstreamed? Most importantly, how do we best document the evidence?

The Origins of Healing Under Fire

In 2012, an initiative[3] for health and peace was taken by the authors along with former staff of the World Health Organisation, UNICEF and International Committee of the Red Cross. All of those involved in the initial stages had work experience in war zones, and most had worked directly in WHO's Health as a Bridge to Peace programme.

The goal of the initiative was the prevention and abatement of violence in conflicts through working directly with in-country national physicians. The initial thinking was based on two main assumptions: (1) that medical professionals in conflict affected countries would readily engage in violence prevention and health and peace activities; and (2) that they would be receptive to being trained in health and peace work. From the initial stages it was foreseen to test these assumptions in field activities, starting with a pilot project in Southern Thailand, and continuing on to other locations where opportunity presented and criteria allowed.

The first activities of the initiative focussed on defining a conceptual and operational framework for action; enlarging the network of international experts willing to engage in peace and health related actions and to support activities in terms of training, coaching, and mentoring; identifying a number of potential project locations;

[3] https://sites.google.com/site/rugiagli/

and developing a standard operating procedure. It was at the initial research and information gathering stages that MPW (Medical Peace Work) was contacted. MPW is a network of organisations and individuals who had developed an online training course to build the peace capacity of health professionals. Two of the founders of MPW contributed to training and coaching in the pilot project (Southern Thailand) using the material from the MPW online course. Collaboration with MPW was further intensified when the partners developed case studies of health and peace work, and audio-visual teaching materials beneficial for both online courses and face to face training in the field.

The long term experience in war torn countries of the group strongly pointed towards the adoption of a flexible approach based on sound pragmatism over a rigorous methodology. This facilitated response to unforeseen challenges that conflict contexts imposed.

Criteria adopted for selecting areas of potential intervention included: the phase of the conflict allows safe access; the existence of a relatively stable and functioning medical community; an enabling attitude of the government and in particular of the security forces regarding foreign presence and activity; the possibility of being transparent regarding objectives; the security risks appear manageable at the onset; and, knowledge within the group of the target area, or the presence in the field of a known local network that could serve as entry point facilitating the initial assessment.

Once a shortlist of locations for the project was selected, the operating procedure was established:

- Desk research to build up a thorough understanding of the conflict, the health system, the state of health services; the issues surrounding health care in the

conflict context, and initial search of appropriate local partners.

- Preparation for field assessment, including finding entry points, establishing contacts from all sectors of the society in order to build a deeper understanding of the conflict actors and dynamics.

- Field assessment to places in or near the conflict area for the purpose of conducting face to face interviews with a wide selection of contacts, triangulating information gathered, and consulting with potential partners. Specifically, the objectives of the field assessments are to gauge the attitude and interest of health professionals to engage in health and peace work; scout relevant activities already happening; and selecting the appropriate local partner.

- Designing a project with the local partner, which would include participatory tailor made learning sessions, documenting existing initiatives, and framing possible future initiatives to be implemented.

- Roundtable interaction with potential participants to understand more deeply attitudes, knowledge gaps, customs, and cultural sensitivities. This interaction is also meant to provide input into the design of capacity building activities.

- Planning, design and implementation of project activities, with the deliberate inclusion of creating space for mutual understanding, dialogue, collaboration and health and peace initiatives.

- Evaluation of all the phases of the project in the location selected.

Initially the main aim of the project was to work primarily with national physicians to support existing or potential health and peace/violence reduction initiatives. The

support proposed involved training, coaching, and mentoring. The crucial component was to allow health professionals from opposite sides of the conflict to participate in activities together, allowing them a safe space during activities to understand each other's challenges, and to build trust for future collaboration. To address gender and diversity gaps, the target group was subsequently enlarged to include all health professionals.

This article briefly presents the assessment missions and components of the overall project carried out by the authors over three years in four conflict affected geographic areas. Each of these areas presents a different phase and level of conflict, in starkly different contexts and cultures. The four areas were selected following the criteria outlined above with the exception of the mission carried out along the Syrian border. The authors engaged in an in depth discussion internally and with members of the wider network to weigh the risks of doing harm, versus the usefulness of introducing activities inspired by the health and peace concept. Two reasons compelled the authors to proceed with this assessment mission: the fact that health structures and personnel were directly targeted by war manoeuvres, and pre-existing relationships the authors had with key individuals and institutions in Turkey and Lebanon.

The authors' analyses and conclusions follow interactions (including interviews, roundtable discussions, workshops) in the field with health professionals, peacebuilding practitioners, journalists, artists, government officials, academics, NGOs, and international organisations. Much of what is described below is anecdotal, and not meant to be taken as case studies. The views expressed by the authors are strictly their own.

Lessons from Southern Thailand

The first activities in this project of health and peace work in the field were conducted in Southern Thailand. The conflict in the 'Deep South' (the southernmost provinces of Pattani, Yala, Narathiwat, and parts of Songkhla) of Thailand had been ongoing for decades. The escalation since 2004 of this conflict led to more than 6,000 deaths and the injury of nearly 11,000 people. A peace effort initiated by the Government in February 2013[4] generated hope that a settlement might be possible. With that policy in practice, civil society and community-based groups were encouraged to participate in activities in support of peace.

The health and peace activities initiated were the result of collaborative planning between Deep South Relief and Reconciliation (DSRR Foundation)[5] and 4Change[6]. DSRR Foundation is associated with the Prince of Songkla University Faculty of Medicine, and had built up good relations with the network of health professionals who graduated from the Faculty, and who were based in the South.

DSRR Foundation had been motivated to take on peace activities several years prior to the collaboration with 4Change, primarily as an approach to prevention. Epidemiological data on morbidity and mortality in the Deep South pointed to violence as one of the main public health concerns, along with the re-emergence of previously eradicated vaccine preventable diseases such as diphtheria, pertussis and measles. (Jeharsae, Chongsuvivatwong. 2015)

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[4] The peace talks were initiated by the Yingluck Shinawatra government in February 2013: http://peacebuilding.asia/understanding-the-southern-thai-peace-talks/

[5] An associate of the Prince of Songkla Faculty of Medicine, Department of Epidemiology.

[6] 4Change.eu an Italian non-profit organisation merged with tRI (the Rugiagli Initiative), and partner of Medical Peace Work.

Health workers from both sides of the conflict were invited by DSRR Foundation for a joint workshop on health and peace in December 2013 in proximity to the conflict area in Southern Thailand, bringing together for the first time both Buddhist and Muslim health workers to explore: (1) ways of working together to address public health concerns, and (2) their roles in promoting mutual understanding in the communities where they work. In the process, the participants were exposed to skills for handling the challenges faced in their work in conflict affected areas, and practical knowledge related to conflict management. Both Thai and international experts participated as resource persons for the workshop.

The joint workshop was designed to provide a safe space for health professionals from opposite sides of the conflict to find joint purpose, and new ways of engaging each other to solve problems larger than any personal preconceptions about the conflict. The relationships built were sustained by collaboration in initiatives that the participants themselves came up with. These initiatives became projects that started shortly after the joint workshop.

The initiatives involved negotiating sustained access to populations residing in 'red zones' which were off limits to health workers; mental health services targeting children who had witnessed violence with a view to preventing cycles of violence; active participation in the peace process representing civil society and community interests; and integration of health and peace subjects into the medical curriculum of the Prince of Songkla Medical Faculty. Almost one year following the joint workshop, implementation of the initiatives were still in place, and plans were made to conduct health and peace conferences to further disseminate the concept amongst health workers in the region. A book documenting the experience with contributions from all involved in the process was published in English, Thai, Yawi (a Malay local language) and

Arabic (Chongsuvivatwong, Chan-Boegli, and Hasuwannakit 2015).

Involving civil society in general, and health professionals in particular in peace work was a rather new concept in Southern Thailand. Even so, many were ready to participate in some way. Most physicians and nurses were more comfortable with working on cooperation to improve health services or access rather than for the purpose of peacebuilding or conflict transformation. On the personal side, the most pressing priority for participants was exploring new options to enhance coping mechanisms for staying safe and delivering the highest quality of health care in the conflict areas. For this reason, the majority of professionals found that building relationships and mutual understanding with counterparts from the 'opposing' side was the most acceptable practice amongst peacebuilding activities. Engaging directly in a peace process was seen initially as political and risky. Yet, as the collaborative initiative evolved, there were notable exceptions of health professionals who saw the potential of using their position and assets to contribute directly to the peace process.

Potential in Myanmar

An assessment of the potential for health and peace work in Myanmar was carried out in June 2014. The country had been in transition for three years, and was getting ready for historical elections in which for the first time, opposition parties such as the National League for Democracy (NLD) were allowed to participate.

At the time of the visit, despite the transition to democratic reforms and market economy, and the signing of ceasefire agreements between the Government and major

ethnic armed groups[7], immense challenges to peace and stability remained. Notable amongst these was the situation in Rakhine state, where communal violence was escalating between the Rohingya Muslim and the Rakhine Buddhist.

After years of conflict, health services throughout the country were underdeveloped and fragmented, with lack of resources and capacity. In Rakhine state, the health situation was even more precarious. Access to health services was being used as an extreme tool of polarisation. This imposed denial of access to health became the most prominent issue in the conflict. Medecin sans Frontieres (MSF) had been expelled from Rakhine State earlier in the year in February 2014, after decades of presence (Hodal 2014). The local State authorities, dominated by the ruling Rakhine Buddhists, claimed MSF took the side of the Rohingya Muslims. At the time of the visit, there were almost no Rohingya Muslim doctors left in the State, and none worked in the public hospitals and clinics. A few Rohingya midwives and health workers worked under the banner of international NGOs.

Rakhine Buddhist doctors and health professionals were present in larger numbers in the State, working almost exclusively in government hospitals in the Rakhine majority areas. However these Rakhine doctors were under severe pressure to work only for the Rakhine Buddhist communities. They and their families risked violent consequences if they provided services to, or collaborated with Rohingyas Muslims.

With this extreme polarisation, only medical doctors and health professionals from outside the Rakhine State were acceptable to both communities. However, even

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[7] The administration of the Government of President Thein Sein and 8 ethnic armed groups signed the National Ceasefire Agreements: http://www.eastasiaforum.org/2015/10/21/is-myanmars-nationwide-ceasefire-agreement-good-enough/

they received threats of violence when services were perceived as skewed towards one group or the other.

An attempt was made to see if there were examples of health professionals trying to ease the tension, and to mitigate the triggers of the conflict in the Rakhine State, even in this challenging context. We found two examples.

The first is the chief surgeon in the Free Muslim Hospital in Yangon, Dr Tin Myo Win. This hospital was established by a prominent Muslim family of physicians (Madha family) from Pakistan generations ago, and his descendants and family members have continued to provide health and medical services for all people, including the poor. Dr Tin Myo Win, a Buddhist, had been imprisoned by previous military governments for his role in the opposition party NLD. He was also the personal physician of the NLD leader Aung San Suu Kyi. Dr Tin Myo Win used his position in the hospital to spread the values of medical ethics and mutual understanding to his students of all religions, gender and ethnicities. Among his students were Rakhine Buddhists and Rohingya Muslims. This small act carried a great deal of significance in planting seeds of tolerance and striving for non violent solutions to conflicts. Dr Tin Myo Win was nominated as the chief peace negotiator in charge of the National Reconciliation and Peace Centre (NRPC) by Aung San Suu Kyi[8] when she became the Chief Counsellor (2016) in the NLD government.

Another example is Dr Tin Aye, the deputy head of the Myanmar Medical Association. Dr Tin Aye is one of the doctors who risked his own safety to work in the

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[8] Dr Tin Myo Win nominated as Chief Peace Envoy. http://www.rfa.org/english/news/myanmar/myanmar-armed-ethnic-groups-talk-peace-wtih-governments-new-mediator-05052016161519.html

Rakhine State. Even though he worked under the cover of international organisations, he used his position to access Rohingya communities to provide the necessary health services. In another context, he engaged his health counterparts in Kayin State, where one of the ethnic armed groups signed a ceasefire agreement with the Government, and attempted to see if there would be opportunities to work together to create a common health system after years of conflict and separation.

Health professionals the authors met during the visit showed a tremendous desire to learn and to be exposed to international standards and know-how. The country is still considered as one of the top conflicts going into 2017 (Guéhenno 2017), the potential for working with health groups in improving access to health, and ensuring inclusive health system and services, would contribute to the overall peacebuilding efforts.

Stalemate in Syria

The authors conducted a scouting mission along the Syrian border in Turkey and Lebanon in July 2015. At the time the war had already extracted a heavy toll on the health sector. Among the mission findings was the strong evidence suggesting that health facilities and personnel were primary targets of the war; evidence confirmed by a number of articles and reports that came out before and after the author's visit (Sibbald 2013, Amnesty International 2016, Physicians for Human Rights 2016). In response, health facilities were being moved or built underground, and bomb shelters had to be added to existing hospitals.

Damages to the health services were substantial in terms of physical destruction, casualties among health personnel and displacement of trained personnel. And communication between health personnel operating in areas controlled by different

actors was reported as practically nonexistent or limited to occasional personal contacts.

Overall, the picture that emerged was one of a dramatically fragmented health system, with health personnel working in dire conditions and exposed to acute levels of stress and trauma. As of July 2015, it was still possible to cross the border between Syria and Turkey, albeit with difficulties. A number of organisations based in Gaziantep, Turkey, some of which were operated by the Syrian Diaspora, provided technical training to Syrian health personnel working inside Syria, and tried to maintain supply lines to the health facilities there. Discussions were held with two notably active organisations, the Syrian American Medical Society (SAMS)[9] and the Union of Medical Care and Relief Organizations (UOSSM)[10] in Gaziantep.

The initial assessment immediately suggested that a direct dialogue building approach such as the one developed for Southern Thailand would not be appropriate in the prevailing Syrian context. The situation was extremely polarised not only politically but at the individual level as well. The weight of traumatic personal experiences emerged in several interviews to the point that the authors avoided using words such as 'dialogue' or 'peace' because they immediately raised tension and resistance and were perceived as politically charged. In addition, the workload and the working conditions of health professionals in opposition controlled areas, such as Aleppo, were such as to raise questions on the appropriateness and relevance of diverting precious human, financial and time resources from the urgency of caring for the sick and wounded.

There was little operational and psychological space to propose direct peace and health activities and most discussions with potential partners were diverted towards

[9] https://www.sams-usa.net/

[10] http://www.uossm.org/who_we_are

more pressing needs such as basic management training or medical supply for hospitals. Surprisingly, even in such scenario we encountered health professionals, particularly within UOSSM, who were eager to broaden the scope of their work to include elements that might lead to some forms of communication within the Syrian health sector that would reduce the violence. Others had tried approaching President Assad, who is himself a health professional.

UOSSM was the only health organisation among those contacted that showed understanding, commitment and will to engage in a programme that went beyond emergency relief activities. In coordination with them, the working hypothesis became the creation of separate but parallel paths of awareness capacity building, one for health workers engaged in opposition, and possibly Kurdish controlled areas, and another for health workers operating in Government controlled areas. Such paths were going to be designed also for confidence and trust building based on three elements: first, psychosocial support, aimed at increasing the resilience of health personnel and providing them with tools to recognize trauma in self and others. A second element was geared to the provision of relevant technical skills in public health to be defined together with potential participants. The third element focussed on personal growth and on increasing capacities to work in difficult circumstances such as mediation and negotiation, communication, leadership and networking.

These sets of activities were thought to respond to immediate needs of health professionals while preparing the ground and creating enough trust among the different groups to open the space, in a longer term perspective, to more direct dialogue building activities, such as joint workshops on selected health problems, and eventually, rebuilding the country's health sector.

UOSSM was providing training and humanitarian relief mostly in the opposition held areas. To be effective and impartial, health personnel working in government held areas must also be contacted and engaged. This was possible due to a contact made through the Medical Peace Work network. This contact was a woman physician from Damascus a leader of the Syrian Women's Forum for Peace[11] and Jozour, an NGO focussed on building civil society with outreach mainly in Government held areas. After several direct consultations, the response was positive. In spite of attempts, a scouting mission to Damascus with Jozour proved impossile. However, a survey of attitudes amongst health personnel working in government held areas could be conducted via the Jozour network. Results were inconclusive mainly due to translation issues, but a network of health professionals covering the whole Syria would now be possible. On the positive side, the leaders of UOSSM and Jozour took their own initiative to contact each other to discuss the potential of working together. Through them, attitudes, capacity needs, and inputs to the design of potential activities from both opposition and Government held areas could be compiled.

Critical assumptions for the implementation of a programme such as the one described with some hope of success were that the latest attempt to find a path for the cessation of hostilities in Syria[12] could gain momentum and open some political and operational space, secondly that the fragile possibility of bringing health personnel from inside Syria to Turkey would hold.

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[11] http://syrianwomenforumforpeace.com/en/

[12] In July 2015, Staffan de Mistura, the UN Special Representative, tried to revive a political peace process for Syria prompting the four committee initiative. The initiative envisaged the creation of four thematic discussion workshops aimed at preparing ground for a ceasefire and a fully fledged peace process. The four themes proposed were: Safety and Protection for All; Political and Constitutional Issues; Military and Security Issues; Public Institutions, Reconstruction and Development. http://un-report.blogspot.it/2015/07/de-misturas-proposal-for-syria-syrian.html

The months that followed the initial assessment shattered any hope that the health and peace programme for Syria maintained any viability, obliging the authors and partners to put the project on hold. Specific funds were mobilised by the authors to respond to the most urgent needs of populations in the besieged areas in Syria.

Integration in Northern Iraq

Iraqi Kurdistan was considered as a potential location for health and peace activities for its relative stability that allowed unimpeded access, acceptable security conditions, and the presence of a well-established health community with a functioning health system. In addition, there were factors which pointed to the important contribution peace and health related actions could potentially make. Iraqi Kurdistan is surrounded by conflict areas. Its relative stability has made it a preferred destination for refugees from Syria and of internally displaced people (IDP) from other regions of Iraq such as Anbar, Ninewa and Sinjar area.[13] At the time when the scouting mission took place (July 2016), a military offensive to retake Mosul from Daesh[14] was pending and the international community was anticipating a massive humanitarian crisis as a consequence.[15]

The planning process for the mission was accelerated by an invitation from the Free Yezidi Foundation to observe a Psychological First Aid Training session in a

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[13] In 2016 approx numbers of refugees and internally displaced population (IDPs) in Kurdistan were: 250.000 refugees from Syria and 1.200.000 IDPs. KRG and UN data

[14] Reports of impending operation came from news, humanitarian and other agencies: http://blog.forecastinternational.com/wordpress/mosul-offensive-a-test-for-iraqi-forces/

[15] At the time of the assessment mission UNHCR predicted 600.000 displaced following the military offensive. As of January 2017, 160.848 people were displaced from Mosul and surrounding areas since the military offensive began on 17 October 2016. UNHCR Flash Update http://reliefweb.int/sites/reliefweb.int/files/resources/Iraq%20Flash%20Update%20-%2015JAN17.pdf

Yezidi IDP camp in Khanke. The mission itinerary included Erbil, the capital town of the Kurdistan Regional Government (KRG), Duhok and Khanke. Interviewees included NGOs, UN organisations, Directorates of Health, Government humanitarian response units, Government Foreign Relations office, the Hawler Medical Universities, professors, instructors, academics, refugees and IDPs.

The waves of population displacements had substantial impact on Iraqi Kurdistan. Whilst the majority of the displaced population were hosted in private settings spread among resident communities, public services for basic needs were overstretched. The influx of IDPs in the region caused a population increase of 28% (World Bank 2015) in a period when Iraqi Kurdistan was undergoing an acute financial crisis that forced the KRG to reduce public servants' salaries by 70%, a decision which impacted the capacity of the entire system to respond to the needs of displaced and resident population alike. Further, the strained, if not adversarial relations between the KRG and the Baghdad central Government, between the two major political parties in Iraqi Kurdistan (Kurdish Democratic Party and Patriotic Union of Kurdistan) which were once in a 'civil war', and the tensions between Kurdish residents and the Sunni Arabs displaced from other parts of Iraq, added fuel to an overall fragile political and economic context.

The health services in Iraqi Kurdistan were bearing the weight of the burden of patient influx and Kurdistan health professionals were often in the front lines of emergency response. Health academic institutions and the Directorates of Health had been doing their best to augment human resources to cover the immediate and anticipated needs. However, in interviews with recent medical faculty graduates, it emerged that the existing education and training were ill adapted to enable doctors and nurses to effectively respond to changing demands and the prevailing context.

Examples cited also pointed to non-health skills which would have been useful, especially negotiating with military personnel to allow access for ambulances and patients, or to allow IDPs into public services.

These findings were confirmed by the leadership of Hawler Medical University (HMU)[16] in Erbil who explained that specific training targeting the capacity of their students to deal with the transforming reality in Kurdistan was much needed. In discussion with the leadership of HMU, it became evident for both parties that a partnership for capacity building in peace and health topics would be beneficial. HMU was interested in developing curricula which covered topics not traditionally included in medical faculties in Iraq in order to adapt to the context. HMU formed a working group of professors and instructors to work on the design of pilot workshops with 4Change/MPW, then testing them prior to integration into the medical curricula. Subjects mutually agreed upon emerged as focus of a pilot programme: tackling public health consequences of massive population movement, the management of health consequence of violence with a special emphasis given to gender based violence and a wide range of 'soft skills' to enable health workers to engage with more ethical awareness and competence to the difficult circumstances they might face, psychological trauma healing and stress management, medical ethics, conflict and stakeholders analysis, advocacy for health, and negotiation and mediations skills.

The commitment of HMU toward an approach to health based on ethical values, dialogue building and violence reduction was confirmed during the planning phase. First, HMU agreed to a set of standards based on ethnic, gender, and religious diversity

[16] HMU is a public university based in Erbil. It is one of the few functioning universities and the only solely Medical University in Iraq.

in the selection of participants. Built into the pilot project would be the inclusion of health workers who were based in, or would be sent to contested areas with displaced populations or marginalised groups. In addition, the workshops would be expanded to cover all areas of the KRG territory, no matter which political party was in control.

In the course of interviews and discussions, it became clear that there was a certain degree of awareness of the role health professionals could and should play in fostering understanding between communities polarised by tensions, and for this, ethical behaviour in this profession was crucial. It was particularly significant that these points were made by the de facto minister of foreign relations of the KRG, further putting weight on the importance of education and training for health professionals enabling them to be role models for good relations in divided communities.

Based on the discussions and the information collected during the assessment mission a concept note outlining the main features of a potential project to be implemented in Kurdistan was developed in partnership with HMU and at the time of writing is under evaluation for financial support from private foundations.

Conclusion

In all the four areas briefly discussed in this article, the word ‘peace’ was most often taken by people encountered to mean a political process. It carried a highly charged connotation, and whether or not to engage in peace work depended on the context. In Thailand and Myanmar, where official peace processes were in place, health professionals were willing to consider, and in some cases even enthusiastic to engage in health and peace work. In the Kurdish areas of Iraq, where polarisation, political divisions and inequality were on the rise, the concept of health and peace had to be approached from the angle of adding value to medical and health studies, in order to

contribute to a more advanced and modern development of the region. In Syria, where official peace processes had repeatedly collapsed, the word ‘peace’ had dangerous implications, and was viewed with scepticism.

Taking all the limits of the work presented in this article into account, there are a few lessons that can be drawn and that might help guide future work in this area.

It is essential to understand how the terminology inherent to peace and health is perceived and to what extent it is accepted in any given context. Words such as ‘peace’ ‘conflict resolution’, and ‘reconciliation’ can be perceived as political, and as such, create suspicions and obstacles. On the other hand, wordings such as ‘violence prevention’, ‘mutual understanding’, or ‘medical ethics’ were found to be less controversial. There are already examples where a semantic shift has facilitated the implementation of health and peace activities with some degree of success (Arcadu 2003). As far as health and peace field action is concerned, ‘semantic sensitivity’ should be an integral part of the conflict or cultural sensitivity toolbox. For the more extended application, the terminology for ‘peace’ related to health and peace work must find a common definition amongst practitioners before being disseminated and advocated.

Regarding the initial assumptions that medical professionals would be willing to engage in health and peace actions and to receive training for this, the observations made by the authors are summarised below.

Health professionals were willing to engage in some form of peace and health activity and to receive training for it provided that their immediate concerns and learning needs were addressed first and foremost. The majority of those interviewed were most concerned about security for their families and their patients. Of equal concern was coping with the impact of military operations on health services. National

health workers working in conflict areas frequently faced dilemmas such as how to stay impartial, and how far to engage with the authorities and the military, such as in cases of negotiation for access to besieged communities.

The majority of those we interviewed were interested in receiving training particularly if it responded to practical problem solving in their context. In no case was training refused outright.

Among those who expressed interest in health and peace work, most expressed interest in similar topics for capacity building. These included: mental health and psychological trauma healing, management of violent behaviour, conflict analysis, 'do no harm', staying impartial in polarised contexts, negotiation skills, practical and contextual applications of international law, techniques for handling suspicions and security, refugee health, and the international humanitarian system. Areas of particular interest were: coping with the dilemmas of working in conflict areas, and ethical responses to witnessing abuses.

We observed that each context requires a fresh and tailor made approach. Partnerships with local institutions, and consultations with the participants for the design of capacity building activities are crucial to relevance and sustainability.

Regarding partnership with national entities, the authors believe they bring local networks, knowledge, and cultural sensitivity to planned activities. Among the most important factors for success and sustainability of capacity building activities is the active presence of a local champion or champions for health and peace work. We have learned that with their commitment and passion, they tend to drive the learning and practice and provide the necessary leadership for follow up.

Although donor countries provide ample resources for the training of international medical staff to work in conflict areas abroad as expatriates, national health personnel are often neglected as a precious resource – not only as connectors for expatriate staff but also as connectors in communities polarised by conflicts. The field work discussed above shows the value of national and international collaboration and how the focus on building the capacity of national health professionals can add a precious resource in times of conflicts. Examples of indigenous efforts in health and peace work exist, and must be supported and documented for future applications and learning.

This article attempts to address a few questions regarding health and peace work. Can the concept be applied universally across all cultures and in all conflicts? Is it feasible for national health professionals, who are more prone to be caught in a conflict? Is it feasible to systematically introduce peace-building knowledge and skills to health professionals in the midst of conflict? During which phase of a conflict would this best be applied? Which topics would be universally essential, and should tailor-made courses be designed?

The authors believe that the project has only partially answered these questions, albeit in an anecdotal way. There is a need for a concerted effort to document existing activities of national health professionals in their efforts during all phases of the conflict to prevent and mitigate the impact of violent conflicts. It is equally important to find ways to support these efforts, and to enlarge the network of practitioners in this field.

References

Amnesty International. 2016. "Syrian and Russian forces targeting hospitals as a strategy of war." https://www.amnesty.org/en/latest/news/2016/03/syrian-and-russian-forces-targeting-hospitals-as-a-strategy-of-war/.

Arcadu, Gabriella. 2003. Health as a Bridge for Peace in Indonesia 2000-2003. Evaluation Report. Unpublished: https://www.dropbox.com/s/vzjx5ihj7aqhokw/EVALUATION%20REPORT.pdf?dl=0.

Arya, Neil, and Joanna Santa Barbara, eds. 2008. *Peace through health: how health professionals can work for a less violent world*: Kumarian Press.

Chongsuvivatwong, Virasakdi, Louisa Chan-Boegli, and Supat Hasuwannakit, eds. 2015. *Healing under fire: The case of southern Thailand*.

de Quadros, A Ciro , and Daniel Epstein. 2002. "Health as a bridge for peace: PAHO's experience." *The Lancet* 360:s25-s26.

Galtung, Johan. 1969. "Violence, peace, and peace research." *Journal of peace research* 6 (3):167-191.

Guéhenno, Jean-Marie. 2017. "10 Conflicts to Watch in 2017." *International Crisis Group*.

Hodal, Kate. 2014. "Burma tells Medécins Sans Frontières to leave state hit by sectarian violence." *The Guardian*. https://www.theguardian.com/world/2014/feb/28/burma-medecins-sans-frontieres-rakhine-state.

Lopez, Alan D, and Christopher CJL Murray, eds. 1996. *The global burden of disease, 1990–2020. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*: World Health Organisation and the World Bank.

Physicians for Human Rights. 2016. "Anatomy of a Crisis: A Map of Attacks on Health Care in Syria." https://s3.amazonaws.com/PHR_syria_map/web/index.html.

Sibbald, Barbara. 2013. Physicians, health facilities targeted in war-torn Syria. Can Med Assoc.

World Bank. 2015. The Kurdistan Region of Iraq: Assessing the Economic and Social Impact of the Syrian Confl ict and ISIS. Washington, DC.