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COMMENTARY

# Healing under fire – medical peace work in the field

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## Introduction

In 2012, an initiative to revive the health and peace concept was taken by the authors along with other committed individuals.[1] Those involved in the initial stages had significant work experience in war zones, and many had been instrumental in the definition and launching of the World Health Organisation's Health as a Bridge to Peace programme. The initiative was later regrouped under 4Change, an Italian-based non-profit association.[2] In 2015, 4Change joined the European network Medical Peace Work (MPW) whose focus is the education of health professionals in violence reduction and peacebuilding actions.[3]

The initiative is rooted in the long experience of health and peace practice developed by the WHO, academics and practitioners (Arya and Barbara 2008; Quadros and Epstein 2003; Gutlove and Thompson 2006). Its goal is the prevention and abatement of violence in conflicts by leveraging the influence, trust and relationships of in-country national health professionals. 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.

In addition, a set of questions required exploration: is health and peace a universal concept? Is it applicable in all phases of conflicts? Should it be mainstreamed as a discipline in health or in peace studies? Most importantly, how do we best document the evidence?

The first test to this approach was a project developed in Southern Thailand, followed by three other assessments carried out in Myanmar, along the Syrian borders and in Iraqi Kurdistan. These represent four starkly different scenarios;

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this commentary is an account of what the authors have encountered during these missions, the constraints, the outcomes, and some lessons, what were the outcomes and some lessons that are currently guiding the authors' work.

All field activities have been carried out following a step by step approach. First, was desk-based research aimed at conflict and stakeholders analysis and on identifying potential contacts. Second, a field assessment was organized to interview a wide range of informants, to assess the feasibility of a health and peace project, identify viable partners and scout other relevant activities already underway. When opportunities were present in terms of local commitment and funding, the field assessment was followed by a roundtable with key stakeholders to assess attitudes and needs and to plan for ad hoc capacity building actions. Lastly, was the planning, design and implementation of specific project activities and subsequent evaluation process.

For the scope of the activities here described, 'peace' 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'.[4]

## Lessons from Southern Thailand

Southern Thailand was selected as pilot project to test the assumptions for its accessibility, not least in terms of an entry point in the form of a request for collaboration in health and peace work from a credible local partner.

At the time of the assessment (July 2013), the conflict in the southernmost provinces of Thailand of Pattani, Yala, Narathiwat and parts of Songkhla had been ongoing for decades. The escalation since 2004 of this conflict led to more than 6000 deaths and the injury of nearly 11,000 people. A peace effort initiated by the government in February 2013 generated hope that a settlement might be possible.[5]

Even though the health and peace pilot project was an initiative of the authors, it was very much the result of collaborative planning between the local partner, Deep South Relief and Reconciliation (DSRR Foundation), and 4Change. DSRR is associated with the Prince of Songkla University Faculty of Medicine, and had established good relations with a large network of health professionals based in the 'Deep South'. Moreover, DSRR was already active in peace activities primarily as an approach to preventing deadly diseases and violence (Jeharsae and Chongsuvivatwong 2015).

Funding for implementation was secured during the assessment mission and this allowed for a fast unfolding of implementation steps. Health workers from both sides of the conflict were invited by DSRR for a roundtable discussion on health and peace in July 2013. This 'icebreaking' event was able to generate a shared goal and the framework for a future joint workshop. The word 'peace' was considered too controversial to include in the title of the workshop, therefore it

was agreed to call the initiative 'Supporting Mutual Understanding and Violence Reduction'.

In December 2013, for the first time, Buddhist and Muslim health workers were brought together in a five-day workshop 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 topics – which emerged during the Roundtable – such as conflict analysis, human rights and humanitarian law pertaining to health in times of conflict, negotiations and mediation, managing suspicions, and medical ethics in times of conflict. The format was interactive, using case studies brought by participants and international resource people.

Crucially, the workshop was designed to provide a safe space for health professionals from opposite sides to find 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 during the workshop. 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 governmental 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 topics 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. For the majority of participants, the priority 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 most acceptable practice amongst peacebuilding activities was building relationships and mutual understanding with counterparts from the 'opposing' side. A small minority saw their own potential in engaging directly in a peace process.

Three years on, even with the official peace process stalled, participants in the original workshop are continuing some kind of activity related to their peacebuilding skills. Most notable is the effort, now almost completed, by the Prince of Songkla Medical Faculty, to mainstream health and peace studies by offering the Thai version of the entire Medical Peace Work course online.[6]

## Entrenched positions in Myanmar

At the time of the field activities in June 2014, immense challenges to peace and stability remained despite the transition to democratic reforms and market economy and the signing of ceasefire agreements between the government and major ethnic armed groups.[7] These challenges were also seen by the authors as an opportunity; the country was opening up and geographical and political access was increasing.

After years of conflict, health services throughout the country were underdeveloped and fragmented, with lack of resources and capacity. Of particular concern was the situation in Rakhine state, where communal violence was escalating between the Rohingya Muslims and the Rakhine Buddhists and where access to health services was being used as an extreme tool of polarization. This imposed denial of access to health became the most prominent issue in the conflict. With this extreme polarization, only medical doctors and health professionals from outside the Rakhine State were acceptable to both communities. However, even they received threats of violence when services were perceived as skewed towards one group or the other.

During the assessment mission, we conducted two roundtable discussions in Yangon to assess the potentials for dialogue building within the health sector. The first one was with medical interns at the Free Muslim Hospital in Yangon, facilitated by Dr Tin Myo Win, the Chief Surgeon who is one of the few Buddhist physicians practising and teaching there.[8] The interns were from all ethnic and religious groups in the country, including Rakhine Buddhists and Rohingya Muslims. Findings were instructive: the health and peace concept was well received and it was considered to have potential to improve health in the Rakhine State. However, concerns for the safety of health workers overshadowed any potential benefits. The Muslim–Buddhist polarization was at such a level in Rakhine as to put at risk any health worker engaging in a dialogue building action with representatives of the opposing faction.

The second Roundtable discussion was held with a group of Rohingya Muslim health professionals in Yangon, facilitated by a Rohingya Member of Parliament. The professionals were concerned for their families and friends who were still inside Rakhine State, and for their own future in the country. It was clear that fear reigned and rapprochement of any kind with the Rakhine Buddhist health professionals would not be feasible.

Despite the downward spiral in Rakhine State, it was noteworthy that health and peace activities were familiar or acceptable to most health professionals we contacted. There was recognition that they could play a role in the nationwide peace process launched by the government. Potential was there, but the Muslim–Buddhist dynamic was so entrenched that little operational space was left for health and peace actions. We decided not to push forward for the implementation of health and peace activities in Myanmar: our assessment was that

the situation was not conducive to meaningful action. However, we have maintained open channels of communication should national counterparts come forward with specific needs in this area.

## Stalemate in Syria

Syria was not an ideal scenario to conduct a field assessment. The authors engaged in an in-depth discussion to weigh risks and opportunities of approaching a situation with high level of violence and on the risks of doing harm. Ultimately, the authors were compelled to proceed, moved by the recurring news of health facilities and personnel directly targeted by government military strategies as confirmed by a number of reports that came out before and after the author's visit (Sibbald 2013; Amnesty International 2016; Physicians for Human Rights 2016). A second factor was the pre-existing relationships the authors had with key individuals and institutions in Turkey and Lebanon.

The scouting mission took place along the Syrian border in Turkey and Lebanon in July 2015. At the time, damages to the health services were already substantial in terms of physical destruction, casualties amongst health personnel and displacement of trained professionals. Communication between health personnel operating in areas controlled by different actors was reported as practically nonexistent or limited to occasional personal contacts. Lastly, informants interviewed confirmed the direct attacks to health facilities and personnel.

Overall, the picture that emerged was one of a dramatically fragmented health system, with health personnel 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 organizations based in Gaziantep, Turkey, provided technical training to Syrian health personnel working inside Syria, and tried to maintain supply lines to the health facilities there.

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 polarized: 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 were perceived as politically charged and immediately raised tension and resistance. In addition, working conditions of health professionals in opposition-controlled areas were such as to raise questions on the appropriateness and relevance of diverting precious resources from emergency care.

Surprisingly, even in such a scenario we encountered health professionals, particularly within the Union of Medical Care and Relief Organisations (UOSSM),[9] who were eager to broaden the scope of their work to include elements that might lead to some form of dialogue within the Syrian health sector.

In coordination with UOSSM, the working hypothesis became the creation of separate but parallel trust building paths, one for health workers engaged in

opposition, and possibly Kurdish controlled areas, and another for health workers operating in government-controlled areas. These paths included activities such as psychosocial support, aimed at increasing the resilience of health personnel; the provision of relevant technical skills in public health; and increasing skills to work in difficult circumstances such as mediation and negotiation. These activities were thought of as a first level of engagement of health professionals aiming, in a longer term perspective, at a more direct dialogue building actions.

The initiative needed also to build a network with health personnel working in government held areas. Thanks to the Medical Peace Work network, the authors contacted a prominent woman physician from Damascus, leader of the Syrian Women's Forum for Peace[10] and Jozour, an NGO focussed on building civil society. In spite of attempts, a scouting mission to Damascus proved unfeasible but, through Jozour, it was possible to start engaging health professionals in government-controlled areas. Through UOSSM and Jouzur, attitudes, capacity needs and inputs to design potential activities from both opposition and government held areas could be compiled.

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 mobilized by the authors to respond to the most urgent needs of populations in the besieged areas in Syria.

## Integration in Northern Iraq

The scouting mission in Iraqi Kurdistan was conducted in July 2016. This region 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 health community and a functioning health system. In addition, Iraqi Kurdistan's 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.[11] At the time of the scouting mission, a military offensive to retake Mosul from Daesh was pending and the international community was anticipating a humanitarian crisis, with UNHCR estimating up to 600,000 new displaced people.

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 Yezidi IDP camp in Khanke. The mission itinerary included Erbil, the capital town of the Kurdistan Regional Government (KRG), Duhok and Khanke.

The waves of population displacements, that caused a population increase of 28% (World Bank 2015), had a substantial impact in the region and public services, especially health, were overstretched in a period when Iraqi Kurdistan was undergoing an acute financial crisis that forced the KRG to reduce public servants' salaries by 70%.

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), 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.

Health academic institutions and the Directorates of Health were struggling 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.

These findings were confirmed by the leadership of Hawler Medical University (HMU)[12] in Erbil who explained that specific training targeting the capacity of their students to deal with the transforming reality in Kurdistan was much needed. HMU was keen to develop and test new curricula, not traditionally included in medical faculties, to allow for integration into the standard course of study.

Tentative subjects for a pilot programme were mutually agreed and included: tackling public health consequences of massive population movement, the management of health consequences of gender-based violence, and a wide range of 'soft skills' to enable health workers to engage with more ethical awareness and competence in the difficult circumstances they might face, such as psychological trauma healing and stress management, medical ethics and negotiation and mediations.

HMU agreed to a set of standards based on ethnic, gender and religious diversity in the selection of participants and to include in the project health workers who were based in, or would be sent to, contested areas with displaced populations or marginalized groups.

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 polarized communities, 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, putting further weight on the importance of education and training for health professionals enabling them to be role models for good relations in divided communities.

At the time of writing, a joint HMU/4Change/MPW project is under evaluation for financial support from private foundations.

## Conclusion

In all four areas, the word 'peace' possessed a highly charged political connotation. Whether or not to engage in peace work very much depended on the context. In Thailand, with an official peace process in place and low intensity

level of violence, health professionals were willing to consider, and in some cases even enthusiastic to engage in, health and peace work. In Myanmar, despite an ongoing official peace process, the violent Buddhist–Muslim public discourse and the tensions in Rakhine state made the issue 'too hot to handle' by health professionals. In Iraqi Kurdistan, where polarization, political divisions and inequality were on the rise, the concept of health and peace was seen as having the potential to contribute to a more tolerant society and to the 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 commentary into account, there are a few lessons that can 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 sensitivity toolbox.

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 summarized below.

In all four scenarios there were, amongst health professionals, a number willing to engage in health and peace work. The form this engagement took was very much dependent on the phase of the conflict and the level of violence. In all contexts, the primary concern was security for families and patients. Of equal concern was coping with the impact of military operations on health services.

In no case was training refused outright. Amongst topics of interest, a convergence was noted. Almost all expressed the need for capacity building in mental health and psychological trauma healing, coping with the dilemmas of working in conflict areas, management of violent behaviour, conflict analysis, 'do no harm', staying impartial in polarized contexts, negotiation skills, contextual applications of international law, techniques for handling suspicions and security, refugee health, and the international humanitarian system.

Regarding the questions posed in the opening of this commentary – is health and peace a universal concept? Is it applicable in all phases of conflicts? Should it be mainstreamed as a discipline in health or in peace studies? Most importantly, how do we best document the evidence? – we offer the following reflections from our field work:

Health and peace might be universal concepts but their application in the field is not. Each context requires specific analysis and an approach tailored to respond to local needs and dynamics. Crucial for meaningful action are a strong

partnership with local institutions, and consultations with potential participants to ensure relevance to capacity building activities.

There were indications from our fieldwork that the topics suggested for capacity building workshops were universally helpful to health professionals working in conflict areas. Health and peace studies as a discipline was desirable and feasible in two of the four cases (Prince of Songkla University, Thailand; Hawler Medical University, Iraq). We conclude that mainstreaming these studies should be seriously explored and evidence of benefits against risks analyzed.

Finally, there is a need for a concerted effort to document existing activities of national health professionals in their efforts to prevent and mitigate the impact of violent conflicts. These bring important evidence to the discipline and case studies for teaching. It is equally important to find ways to support these efforts, and to link the networks of practitioners in this field.

## Notes

1. The Rugiagli Initiative: https://sites.google.com/site/rugiagli/.
2. www.4change.eu.
3. www.medicalpeacework.org/.
4. This definition derives from the concept of positive peace as described by Galtung (1969). Just as health does not mean the absence of disease, peace is not the mere absence of war or violence.
5. The peace talks were initiated by the Yingluck Shinawatra government in February 2013: https://peacebuilding.asia/understanding-the-southern-thai-peace-talks/.
6. https://www.medicalpeacework.org/mpw-courses.html.
7. The administration of the Government of President Thein Sein and 8 ethnic armed groups signed the National Ceasefire Agreements: https://www.eastasiaforum.org/2015/10/21/is-myanmars-nationwide-ceasefire-agreement-good-enough/.
8. Dr Tin Myo Win is considered a role model of tolerance and co-existence and he was nominated as the chief peace negotiator in charge of the National Reconciliation and Peace Centre (NRPC) by Aung San Suu Kyi when she became Chief Counsellor in 2016.
9. https://www.uossm.org/who_we_are.
10. https://syrianwomenforumforpeace.com/en/.
11. 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.
12. HMU is a public university based in Erbil. It is one of the few functioning universities and the only solely Medical University in Iraq.

## Disclosure statement

No potential conflict of interest was reported by the authors.

## Notes on contributors

*Louisa Chan Boegli* is a native of Hong Kong, and a UK and US trained medical doctor who has over 25 years experience in international humanitarian and development work

covering Africa, Southeast Asia, Afghanistan, the Balkans and Sri Lanka. She was responsible for the development of Health as a Bridge to Peace programme at WHO headquarters (WHO, Geneva), and later became a founding member of Humanitarian Dialogue (HD, Geneva). In this capacity, she led the effort to broker the initial Cessation of Hostilities agreement between the Republic of Indonesia and the Free Aceh Movement. She is the co-founder of the Rugiagli Initiative (tRI, Rugiagli) that developed the health and peace project described in this article. tRI subsequently merged with 4Change, a partner of Medical Peace Work. Dr Chan Boegli is on the governing board of the PeaceNexus Foundation, and the Nonviolent Peaceforce.

***Maria Gabriella Arcadu*** is a political scientist with 20-year experience in conflict-affected and fragile countries. Since the late 1990s she has been involved in research and programmes exploring the peace-health and security nexus and she has been involved in the Health as a Bridge for Peace programme of WHO, implementing actions in Egypt, Indonesia and Sri Lanka. She has worked in various capacities for United Nations agencies, nongovernmental organisations and universities developing capacity building programmes. She has worked in South East and Central Asia, Africa, Middle East and the Balkans. Since 2009 she is Director of 4change, a non-profit association she co-founded that provides training and research activities in conflict-prone areas.

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