BMJ Global Health

Power dynamics and health initiative design as determinants of peacebuilding: a case study of the Syrian conflict

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ABSTRACT

Peace-through-health has emerged as a promising concept but with variable evidence of success. Cooptation of health initiatives in conflict is believed to be a major challenge undermining peacebuilding potential. We examine the role that existing power structures and health initiative characteristics play at various levels of a conflict in peacebuilding outcomes. Using the Syrian conflict as a case study, we assess healthcare initiatives' characteristics and their peacebuilding tendencies accounting for power dynamics at the (1) state citizen, (2) interbelligerents and (3) intercommunity conflict levels, drawing on the WHO's framework for health and peace initiatives. Healthcare interventions at state citizen and interbelligerent levels generally addressed combat-related and material-dependent health needs, relied on large-scale international funding and centralised governance structures, and bestowed credit to specific agencies with political implications. These characteristics made such initiatives prone to cooptation in conflict with limited peacebuilding capacity. Healthcare initiatives at the community level addressed more basic, service-dependent needs, had smaller budgets, relied on local organisations and distributed credit across stakeholders, making them less amenable to cooptation in the conflict with more propeace potential. A pilot peacebuilding health initiative designed to leverage these propeace attributes navigated the political environment, minimised cooptation and fostered community collaboration, resulting in peacebuilding potential. In summary, peacebuilding health initiatives are more likely to materialise at the community as compared with higher political levels. Further studies, accounting for conflict power structures, are needed to examine the effectiveness of such initiatives and identify methods that maximise their peacebuilding outcomes.

Summary box

⇒ Peacebuilding potential of health initiatives is a function of the conflict level targeted and initiative design including health needs addressed, governance model, funding source and amount, and allocation of social attributions.

⇒ In the Syrian case, limited peacbuilding outcomes are observed in health intervnetions at higher conflict levels; these interevnetions generally address combat-related and material-dependent health needs, rely on large-scale international funding, have centralized governance structures, and bestow credit to specific agencies with political implications.

⇒ Community level initiatives demonstrate greater peacebuilding potential as they address more basic, service-dependent needs, have smaller budgets, rely on local organizsations, and distribute credit across stakeholders. These factors make them less amenable to cooptation in the conflict with more pro-peace potential.

INTRODUCTION

The health-through-peace framework was developed in the early 1990s as a new academic discipline studying the role of health interventions in peacebuilding.[1] Adopted modus operandi by leading international agencies such as the WHO with its Health and Peace Initiative,[2] the framework has been advanced in countries such as Ukraine, Somalia, Sri Lanka, Sudan and Tunisia.[3] Despite this, the concept continues to face scepticism due to limited data on its effectiveness.[4–6] Scepticism is frequently directed at the anecdotal evidence supporting the peacebuilding benefits of health interventions and the omission of examples in which health interventions are co-opted by the conflict.[4 7] One potential explanation for the concept's variable success is that there is insufficient attention given to the role that health initiative design and existing power structures play in determining an initiative's peacebuilding potential.[8]

The Syrian conflict offers an illustrative example of where health initiatives have been undertaken with variable success in peacebuilding. Gaining the unfortunate legacy of the 'worst man-made disaster since World War II',[9] the Syrian conflict has resulted in 590 000 dead, 5.5 million refugees, 6.6 million internally displaced persons and 13 million locals impacted by the socioeconomic collapse

and poor services including healthcare.[10–13] Using the Syrian conflict as a case study, this analysis examines how health initiative characteristics and power dynamics at several conflict levels shape an initiative's peacebuilding outcomes. This analysis examines the determinants of peacebuilding outcomes of health initiatives in Syria; a historical account of the conflict is out of the scope of this paper and is provided elsewhere.[11 14]

A literature review of published reports and peer-reviewed literature was conducted. We also drew on our collective field experience observing and implementing health initiatives in Syria; specifically working with international agencies and with/in local non-governmental organisations (NGO) on healthcare provision, community health campaigns, and humanitarian support mechanisms for refugees, internally displaced individuals and citizens of northern and southern Syria. We recognise that our positionality, including our nationality (Syrian, Syrian American or Arab American), language (all fluent in Arabic), our personal life-history (ie, ranging from only visiting to growing up in Syria), and professional experiences (ie, ranging from having done no prior research or practice to extensive academic and community work over 20 years in Syria) influence the design, conduct and interpretation of our analysis. Our mix of 'insider and outsider' positionalities relative to the Syrian conflict benefit our analysis. As insiders, we benefit from being able to ask meaningful questions given a priori knowledge in terms of culture and political context, enabling us to produce more 'thick description'. As outsiders, we benefit from being able to sufficiently detach ourselves from the culture and conflict to be able to study without bias.

We conducted the analysis at three levels of the power structure using a categorisation introduced by WHO's thematic paper on Health and Peace.[3] State citizen level refers to disruption of vertical relations between the state and its citizens due to state-associated violence, territorial withdrawal, neglect and poor services. The interbelligerent level concerns the conflicts between armed parties or mid-level authorities, often driven by competition over political dominance, resources or differences in ideology, religion or ethnicity. Intercommunity level refers to the disruption in the horizontal relations between individuals and communities along primordial conflicts, which is aggravated by collective trauma due to atrocities and marginalisation.[3]

General approaches of health initiatives at each level were assessed based on public reports, peer-reviewed scholarship, and field experience; aspects evaluated included the nature of healthcare provided (e.g., material vs service-dependent), geographical scope (e.g., national, regional or local), funding amount and sources, logistics (e.g., central vs local), implementers (e.g., authority linked vs community members) and credit attributions (e.g., authorities, agencies or community).

Peacebuilding outcomes are defined according to the global theory of change introduced by the WHO

thematic paper[3] at each level. These are respectively: (1) improving citizen-state cohesion and health equity through dialogue between state institutions, healthcare provides and humanitarian organisations; (2) promoting crossline cooperation in health governance to address mutual health concerns and (3) promoting health by healing of social divisions and addressing physical and mental scars of war. Based on their contributions to peacebuilding, healthcare attributes were categorised as conflict-prone or propeace.

We present, at each level, the power dynamics of the conflict as it concerns health provision, a characterisation of existing health initiatives, and the propeace and conflict-prone attributes of these health initiatives. Thereafter, we conclude by discussing a pilot project translating potential peacebuilding approaches identified in this analysis.

STATE CITIZEN LEVEL
Conflict and health
The conflict has resulted in profound disruption in the relationship between citizens and state institutions. State institutions have withdrawn from and/or have been completely delegitimised in some territories, and there is a lack of confidence in their ability to govern in others.[15] This has resulted in a vacuum that was filled with de facto powers in various parts of Syria, all pursuing legitimacy and autonomy, leading to de facto partitioning. Currently, about 13 million Syrians reside in 60% of Syrian territory governed by the Government of Syria (GoS); 2.6 million Syrians reside in northeastern Syria (approx. 30% of Syria) governed by the Autonomous Administration of North and East Syria (AANES); and 4 million Syrians reside in northwestern Syria (approximately 10% of Syria) under the control of various de facto powers.[13]

During the conflict, the health system was subject to destruction of infrastructure, attacks on and exodus of health workers, several outbreaks of communicable diseases, and a weaponisation of healthcare services mostly attributed to the GoS.[16–18] In GoS areas, a shrinkage in the public health system occurred, with severe reductions in health services.[19] In the Northwest, state institutions were replaced by humanitarian organisations.[20] In the Northeast, the more ambiguous political status produced weak and redundant health systems.[21] The politically driven curtail on humanitarian crossings to this region limited humanitarian access outside of the GoS mechanism. With minimal presence of GoS in the Northeast, health services were further reduced.[21]

Characterisation of health initiatives
A comprehensive account of all health initiatives over the past decade is beyond the scope of this paper. Nonetheless, general characterisations of these initiatives can be made. The majority of healthcare initiatives at this level addressed combat-related health needs, and sustained public health service given the collapse of

the public health system.[13] The restrictions of international humanitarian agency access to armed conflict areas, mostly imposed by GoS,[22] resulted in a segmented regional scope of health initiatives. The extensive needs were material-intensive and infrastructure-intensive, requiring large amounts of funding from international agencies[17] and engagement of various actors, often politically involved in the conflict.[23] Implementing agencies were the Ministry of Health in GoS areas, a number of humanitarian, mostly diaspora-lead organisations in non-GoS areas, and self-proclaimed health authorities such as Idlib health directorate in the Northwest and AANES in the Northeast.[20 24]

Peacebuilding attributes of health initiatives

There is little evidence that these initiatives helped build dialogue and meaningful collaborations between states authorities and medical communities, health equity and citizen-state trust—the peacebuilding goals stipulated by WHO for health initiatives at this level. Rather, health initiatives at this level exhibited many conflict-prone components that are likely to have limited their peacebuilding capacity. Since most initiatives were in the context of active military combat, they were often subject to politicisation[25] and weaponisation.[18] Their large funding budgets and need for centralised logistics made them attractive for cooptation through taxation and diversion of aid funds, which were often funnelled in corruption channels or armament.[12 26 27]

Given that these initiatives were the main venue for healthcare provision, they were prone to competition for credit to establish and maintain legitimacy and loyalty among citizens. This led to concerns about inequal distribution to harness loyalty, which further deepened citizen-state mistrust.[28] This was clear in dealing with COVID-19; while the GoS was in charge of the vaccination and testing for the Syrian Arab Republic, it had limited operational capacity in the Northeast and none in the Northwest. This shortcoming—due to lack of capacity or intent—led to the GoS's failure in capitalising on an opportunity to rebuild citizen-state trust.[29]

INTERBELLIGERENT LEVEL
Conflict and health

Intraterritorial conflicts between various state and non-state armed factions have been a key characteristic of the conflict. While more consolidation took place in GoS territories, during the war various interterritorial division existed with besieged areas such as Eastern Ghouta had major health crises.[30] Residues of the armed conflict in Dara'a, Southern Syria resulted in renewed conflict between various armed factions[31] and also with neighbouring armed factions in Swaida.[32] These dynamics were magnified in the more anarchic Northwest where there is no central authority. Various armed groups competed over legitimacy and governing powers.[20] Less profound conflict exists in the Northeast, where Kurdish-lead

AANES exerts authority over a large part of the Northeast.

The power struggle at this level has manifested in deeper healthcare sector fragmentation with armed de facto powers each creating their own health 'system', competing over funding, and fighting to gain legitimacy. This has yielded uncoordinated healthcare structures that are redundant, underfunded, underequipped and undergoverned.[20]

Characterisation of health initiatives

Health initiatives at this level share many attributes with those at the citizen-state level. This is especially evident in the Northwest, where many competing armed groups exist and belligerents see health as a weapon of war.[20] Health facilities were often the first to be targeted in order to demoralise fighters and communities. The recent dwindling armed conflict allowed for more non-combat health services, especially in the context of the COVID-19 pandemic. There was also still heavy emphasis on material intensive care such as building intensive care units, providing ventilators and specialised care.[33] The geographical scope of these initiatives remained very territorial, following de facto powers domains and donors mandates.[20] Internationally funded diaspora organisations with perceived political stigma were the main implementers. Across the different factions, healthcare is perceived to be a venue for establishing and sustaining legitimacy and relevance.

Peacebuilding attributes of health initiatives

Health initiatives at this level also fell short of achieving meaningful crossline collaborations to address shared health concerns,[3] demonstrating a high-burden of conflict-prone characteristics. During the peak of the armed conflict, crossline transport and exchange deals (coauthor ZA was actively involved in those) achieved minimal peacebuilding outcomes, given that they were occasional, largely transactional and based on narrow interest calculations with no intention to build trust. Also, such deals often required financial incentives to belligerent parties, becoming a venue for taxation and diversion of aid funds into the armed conflict as a USAID probe investigation revealed.[12 26 27] Such outcomes are similar to those observed in other humanitarian initiatives between armed factions.[4]

Serious attempts were made by political actors, such as the Syrian Opposition Coalition with the support of international donors, to integrate the various components of health systems in the Northwest,[20] and now between the Northwest and Northeast,[34] without success. Healthcare was viewed as a tool to gain legitimacy among group subordinates, delegitimise rivals, and to pressure opponents. Hence, there was no incentive for de facto powers to engage in cross-authority work. This is evidenced with health interventions related to the COVID-19 response also failing to induce meaningful collaborations at this level.[20]

INTRACOMMUNITY AND INTERCOMMUNITY LEVEL
Conflict and health
The political struggle in Syria contributed to the disintegration of Syrian society along a myriad of schisms.[11 15] Unlike the combat-based interbelligerent conflict between armed factions, the intercommunity conflict represents widespread disruptions of relations between communities at large, risking long-term social institutionalisation of the conflict.

Notwithstanding relatively limited research at this level and acknowledging the local heterogeneity of conflict experiences of individuals and communities across Syria, there is substantive documentation of the overall patterns of social degradation in the country.[15] While occurring in the context of the main political conflict, intercommunity conflicts reflect different motives. The immense conflict-related psychosocial trauma, the dire needs and the limited resources experienced by most Syrians, increased intercommunity and intracommunity security competitions along various socioeconomic schisms.

One example of a tangent, but profound intercommunity and intracommunity schism is that between ISIS-connected tribes/families and neighbouring communities of ISIS victims,[35 36] which occurred mostly along prior intertribal or agrarian-pastoral conflicts.[37] Many other conflicts were aggravated along sectarian,[38] ethnic[39] and tribal schisms[40] with increasing insecurities bringing about ever-narrowing definitions and narratives of 'us vs them'.[41] For example, the intercommunity conflict in Southern Syria between Swaida and Dara'a residents with tit-for-tat kidnapping and severing of traditional socioeconomic relations between neighbouring towns, despite a limited and remote history of direct conflict.[42]

The impact of socioeconomic collapse on public health services is just as destructive as the armed conflict itself.[43] Health services are now even more clustered in urban centres with further privatisation of profitable health sectors, accentuating health inequalities that predate the war.[44 45] Social disintegration disrupted traditional community patterns of day-to-day healthcare. Many rural and tribal communities' lost connections with their traditional healthcare provider, now across-the-line. The shortage of community healthcare workers due to attacks on healthcare workers[46] is further exacerbated by the exodus of physicians following the recent economic collapse.

Characterisation of health initiatives
Given their scale, and the lack of a comprehensive scholarly work, knowledge of community-based health initiatives is limited to those linked with research projects, mostly addressing Syrian refugees,[47–50] in addition to fieldwork experience. These health initiatives vary from fundraisers seeking to address health needs among the needy, to community-based healthcare programmes[48 49 51] and community volunteer campaigns facing health crisis such as COVID-19.[50 52]

These initiatives mainly address basic health needs for individuals in need or for communities facing shared threats such as COVID-19. The geographical scope is mostly restricted to local communities. They rely heavily on local and diaspora charitable donations and fundraisers. They are often implemented by local civic society organisation and volunteer medical community members, with credit often attributed to community members.

For example, COVID-19 elicited a collaborative community response in the Northwest where prior political attempts had failed: a number of technical health entities used limited resources, open-source services and volunteer campaigns that included locals and diaspora members to combat COVID-19.[50] A very similar community response was observed in Swaida in Southern Syria with a community campaign 'lets pass together' spontaneously mobilising volunteer health professionals to perform home visits and donations to combat COVID-19.[52] One of the authors (MA) was involved in iniatives in Swaida, while another (ZA) was involved in initiatives in the Northwest and GoS areas, where physicians involved in crossline educational sessions included fellow physicians and community leaders.

Peacebuilding attributes of health initiatives
Unlike upstream levels, community health initiatives demonstrate trends to advance towards peacebuilding by engaging community members in collaborative efforts to overcome the physical and mental health scars of war and address shared threats.[3] Despite COVID-19 increasing health insecurity and inequalities as well as sharpening intercommunity and intracommunity competition over oxygen supplies and hospital beds,[53] it also induced a collaborative response via community initiatives to face the pandemic.[50 52] The favourable peacebuilding outcomes at this level are in line with the findings of one of the most prominent peace and health initiatives with horizontal interventions targeting community conflict in Bosnia and Herzegovina.[54]

The COVID-19 response across the three levels of power structure provides a good opportunity to contrast elements of health initiatives at these levels and identity their conflict-prone and propeace attributes. At state citizen level, the COVID-19 response focused on securing capital-intensive, material-dependent health needs such as PCR testing, vaccination, isolation units and intensive care units.[29] These operations were implemented by state institutions and de facto authorities with inefficient execution and ongoing concerns of corruption and diversion of funds. At the community level, in contrast, there have been organic pro-peace trends which have been driven by scarcity and a common threat. Initiatives largely relied on volunteers and were more labour-intensive, unleashing potent psychosocial healthcare forces of empathy, solidarity and trust. Credit was shared among various stakeholders, including local and national authorities.[52] These attributes made such initiatives propeace and minimised their predisposition to cooptation.

A PILOT PROJECT IN SYRIA

Designing effective peacebuilding health initiatives with minimal conflict-prone, and maximal pro-peace potential requires a meticulous examination of the power structures at the various levels of the conflict (eg, accounting for the incentives and motivations of involved stakeholders, including funding sources and implementers) and the design of health initiatives (eg, what health needs are addressed, how the project is governed, and how attribution is distributed).

Conflict levels and areas of intervention

Based on this analysis, the intracommunity and intercommunity levels of the conflict are likely the most amenable to peacebuilding initiatives. Areas with low conflict legacy, low political tension and spontaneous collaborative tendencies serve as optimal starting points. Accordingly, the Governate of Swaida in Southern Syria was identified as an appropriate candidate to implement a peace-through-health initiative.[42] In 2020, COVID-19 health insecurities escalated existing intracommunity conflicts in Swaida with competition over oxygen supplies and hospital beds.

Health needs targeted

The labor-dependent component of a spontaneous community campaign, 'Let's Pass Together'[52] (ie, home nursing visits) was the main health service provided in this pilot. To avoid entangling with existing community competition over oxygen supplies, the programme limited its role to providing communication infrastructure to rotate existing oxygen tanks and securing competitive pricing for oxygen refilling for programme participants.

Organisational model, funding, geographical scope and implementers

A diaspora-based, grassroots NGO working on humanitarian-development-peace nexus projects in Syria provided organisational and operational support, medical mentoring and grassroots funding. Given its distance from local struggles and its ability to secure funding, the diaspora NGO was able to subtly navigate local politics and help design the local organisational structure. Logistics were coordinated by a technical team from different local organisations. Operations covered most of Swaida with a 'franchise-like' model of centralised procedures and decentralised implementation. Healthcare workers signed up in the volunteer campaigns, and were compensated for home visits. Volunteer Syrian American physicians provided teleconsultation for local staff.

Navigating conflicts: power mapping, stakeholder and incentive structure analysis

Swaida Health Directorate (SHD), the Syrian Arab Red Crescent (SARC), prominent figures of the local medical community, medical staff, humanitarian NGOs and local leadership in control of oxygen supplies and vendors were all engaged. Based on some statements of local medical community at the beginning of the campaign, initially, the effort was perceived to undermine the authority of the SHD, which was struggling against a raging pandemic with limited resources. This led to them raising regulatory limitations of the campaign and its staff. There was also competition between prominent community medical figures and NGO over claiming credit for the campaign.

To overcome these power dynamics, the programme assigned organisational leadership to technical leaders from different organisations rather than prominent community figures. This minimised competition over credit. Clan leaders with oxygen supplies were incentivised to share their data by securing competitive oxygen refill pricing for participants, and providing free nursing services for their members. The programme identified incentives to promote collaboration with SHD and SARC, which included acknowledging SHD's efforts in combating COVID-19 and improving the morale of their struggling health workers. As such, the campaign was framed as a collaboration between the community and the SDH to offload the burden placed on local hospitals to home services. In addition, financial gifts were provided directly to SDH staff and SDH was publicly credited for securing these bonuses. While no financial incentive was provided to any official, the arrangement proved successful in securing a constructive collaboration through the campaign.

Pilot project peacebuilding outcomes

The intracommunity peacebuilding outcomes for the pilot project are in line with the WHO goals for Health and Peace.[3] Diaspora and local technocrats worked together. More than 90 nursing teams of nurses were recruited, trained and deployed across the governorate with a focus on underserved areas using SDH medical points. Coordination with the SARC was secured to use their hot line and dispatch service, which was imperative and useful. Volunteer nurses were equipped with medical supplies, personal protection equipment and were compensated for their home visits from diaspora and local donations. The local team was able to tally oxygen tanks in the community across the governorate—information that was previously not shared due to competition. Per programme reports, more than 2000 patient homes visits were delivered, hospital admissions were reduced, and 110 nurses were employed over a period of 6 months.

Using the infrastructure that this COVID-19 campaign created, the programme is currently being expanded towards intracommunity peacebuilding, targeting other acute medical conditions with a focus on intercommunity interfaces in rural areas at the frontiers of conflict lines in Southern Syria with Dara'a to the West and Bedouian communities to the East. Similar programmes are being planned in areas with similar conflict legacies and power structures such as East Homs and AlHasaka in northeastern Syria. Such projects can be adapted as a part of a multipronged programme actualising the

humanitarian-development-peace nexus to promote progressive collaboration at the intercommunity level and beyond across Syria.

CONCLUSION

Analysis of the Syrian case suggests that while health initiatives at higher levels of the conflict are essential to securing direct conflict humanitarian needs, they are more amenable to cooptation in the conflict and are more likely to result in questionable peacebuilding outcomes. Despite the limited evidence, community-based health initiatives appear to be more likely to avoid power cooptation and garner peace-building outcomes. Community health initiatives can be a promising venue for peacebuilding in complex conflicts.

Nonetheless, there are several challenges in implementing such projects. The horizontal structure and reliance on organic and indigenous elements require great efforts of capacity-building at the technical and organisational levels. The interactions with various diaspora and local conflict structures is a challenge[47] and requires intense capacity-building and social engineering. Similarly, interactions with higher political structures will test the limits for such interventions, as they transition from the intracommunity to the intercommunity, and national levels. In addition, these programmes must also navigate non-conflict related, sociocultural barriers, which limit individual participation and access to healthcare. Further studies are needed to examine the effectiveness of various modalities of peacebuilding health initiatives across different power structures. Such information will be essential to advance the peace-through-health doctrine.

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