BMJ Global Health

Health is a bridge for peace: let us make use of it

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To cite: Al Mandhari A, Ghaffar A, Etienne CF. Health is a bridge for peace: let us make use of it. *BMJ Global Health* 2022;**7**:e010577. doi:10.1136/bmjgh-2022-010577

Received 30 August 2022
Accepted 31 August 2022

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In June 2021, we, the leadership of WHO Eastern Mediterranean Regional Office (EMRO), Pan American Health Organization (PAHO) and the Alliance for Health Policy and Systems Research, issued a call for papers on peace for health.[1] Since that time, a little more than a year ago, peace in the world has declined. This has devastating implications for health. For example, 75% of health facilities in Ethiopia's Tigray region have been destroyed or damaged in recent conflict.[2] In Northwest Syria, more than 70 health facilities have ceased functioning since 2019 because of conflict.[3] In Myanmar, the public health system has nearly collapsed since the coup in February 2021. Since February 2022, there have been more than 200 attacks on hospitals, ambulances and health workers in Ukraine. In fact, health is under attack. A recent report found that there were 1335 incidents affecting healthcare facilities reported across 49 countries and territories in 2021; these conflicts not only constrained access to care, but directly affected nearly 1500 health workers, with at least 94 assaulted, 161 killed, 170 kidnapped, 320 injured and 713 arrested.[4 5]

These attacks on health and healthcare workers are obviously unacceptable. Yet creating peace alone is not enough. Similar to the spirit of WHO Constitution which states that 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,[6] peace is not just the absence of conflict. Violence, political instability and fragility as well as unrest all affect the physical and mental health of people and health workers—thus damaging health systems and shaping larger determinants of health. Peace is a necessary and critical determinant of health and well-being; focusing on safeguarding health can also help end conflict and relieve tensions. Accordingly, WHO led by its director general, Dr Tedros, continues to call for using health as a bridge for peace.

Building on the work of PAHO, WHO formally launched its Health as a Bridge for Peace framework in 1997. In 2019, EMRO together with the Government of Oman launched a Health for Peace (HoPE) initiative.[7] This effort aims to create greater awareness and promote peace through diplomacy, programming efforts and building capacity. More broadly, WHO's current programme of work commits the organisation to 'identify, harmonise and systematise its contributions to sustaining peace in fragile-affected, conflict-affected and violence-affected settings'.

When we issued this call for papers, we called for submissions to focus on questions, like how can health, directly and indirectly, promote peace as well as mitigate and prevent conflict? Are there specific past instances or historical examples where or when this has occurred? Have they been codified? What insights do they offer? What are the components of 'HoPE', and how should it be conceptualised? The submissions and papers published as part of this supplement, representing diverse WHO regions, begin to address these questions and contribute to developing and advancing a future policy and research agenda.

Khan *et al*[8] identify three avenues, that is, fostering trust, facilitating health cooperation and enhancing social cohesion, as the foundation of the Eastern Mediterranean Region's Health for Peace Initiative. They argue that health policy-makers can do more to operationalise health as bridge to peace through a combination of conflict analysis, advocacy and improved capacity building of health workforce for peace skills and partnerships.

Meagher *et al*[9] find that having diverse gender leadership in health systems during conflicts offers greater prospects for sustainable peace and more equitable social economic recovery in the postconflict period. They argue that focusing on gender diversity of leadership and governance in health systems strengthening offers an improved way

to link peace and health, particularly in active conflict settings.

Coninx *et al*[10] share insights into how health can help create peace in Africa through conflict sensitive planning and programming in WHO's Global Health for Peace Initiative. They report on this initiative's efforts in Burkina Faso, Cameroon and Somalia. Among other things, they highlight the need for generating additional evidence as well as engaging member states in high-level advocacy for these efforts.

Allen *et al*[11] share insights from Libya, where chronic disease care is acutely vulnerable to the conflict situation there. They note how conflict exacerbates an escalating burden of non-communicable diseases, stoking civic unrest and creating further violence and political instability. Conversely, they share how health systems improvements serve populations across Libya without distinction, creating a collective civic identity and contributing to reconciliation, small but important bridges towards peace.

Al Ghatrif *et al*[12] examine the experience of peacebuilding in Syria through health with a particular emphasis on the power of actors. They conclude that accounting for power structures is necessary to understand the nexus between peace and health; they also find that peacebuilding initiatives are more likely to materialise and be sustainable if driven at the community level.

Décobert *et al*[13] analyse peacebuilding efforts through health service provision in contested territories in southeast Myanmar. To build trust, a Swiss-funded effort provided equal funds to both 'sides' in a decades-long conflict. The authors argue that health can provide a bridge towards peace formation, if relationships are developed in a politically sensitive way during strategic moments of opportunity.

Hyder *et al*[14] note that 'the relationship between peace and health (remains) complex, multifactorial and fraught with challenges of definitions, measurements and outcomes.' In their article exploring peace and health in the Americas, they call for further strengthening the scholarship and empirical work on this issue from an interdisciplinary perspective.

We recognise that many public health professionals, policy-makers and researchers still do not fully recognise or appreciate the linkages between health and peace. Evidence to support, implement and evaluate 'HoPE' programmes remains limited and requires much greater political attention and commitment. We hope this special issue will serve as a foundation for catalysing more research and policy action recognising and realising the importance of the connection between peace and health.

Contributors All authors have contributed equally.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; internally peer reviewed.

Data availability statement There are no data in this work.

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