Can Medicine Contribute to Preventing War?

Six years ago, an editorial in the British Medical Journal raised the question, “Can medicine prevent war?” (1). The question was intended to be provocative, of course, and the following essay is a response.

The Nature of Wars

To consider primary prevention, we must analyze causal factors.

It may be useful to note the research definition of “war” as organized violence between two factions, one of which is, or aspires to be, a state, and in the current episode of which there have been at least 1,000 deaths. A physicians’ definition of war might be more like “A deliberate use of maiming, killing and disease for political purposes by two or more factions…”

Current and recent wars can be classified in two large categories:

1) wars initiated by the US to secure resources and regional power, or in revenge for injury; and
2) intranational wars, usually with a mixture of territory, resource, and identity issues, some with secession in the agenda.

We might consider the core issues causing war as a combination of grievance and greed, or, put another way, of legitimate and illegitimate issues. However, many instances of both grievance and greed do not erupt in war. We must consider what predisposing factors offer an “opportunity” for leaders to use large-scale political violence to achieve their ends.

| War I: | Recent examples are the wars in Afghanistan and Iraq, and there is currently a risk of war against Iran and North Korea. |

The core issues are control of commodities, expansion of influence, elimination of competitors and vengeance. The opportunity is provided by extreme military power, including nuclear weapons, economic leverage, alliances, and a culture legitimating dominance, military solutions to violence, and arrogance towards other cultures and skin colors.

| War II: | Of the latter, there are currently about three dozen, with a particular concentration in Africa. This number has been decreasing since 1990, although no one knows why. A recent World Bank policy research report provides the following data on the impact and correlates of a civil war (2). |

Intranational wars are far more likely to occur in low-income countries, and have the effect of reversing development. Immediate deaths, injuries, and illness affect far more civilians than combatants. Most wars cause people to flee areas of combat and result in large numbers of displaced people within their own country, or refugees, mainly in neighboring countries. Infant mortality levels immediately rise and remain elevated over pre-war levels for five years, on average. Infectious disease rates, especially of malaria, increase, and contribute to diminished life expectancy of the population. Human Immunodeficiency Virus (HIV) rates increase proportional to the level of militarization of a country. Sexual violence is very high during war, further spreading HIV. Demobilization of military after wars increases HIV in the region. Psychological illness rates are high, especially of anxiety, depression and post-traumatic stress disorder. All of these effects continue to be felt for years after a cease-fire is reached.

During and after such wars, military spending increases and spending on human needs decreases. Corruption in government and other institutions increases. There is a capital drain as those with assets to invest take them out of the country. Measures of democratization show that it usually deteriorates after a war.

Some of these ill-effects will be played out in the neighboring countries, especially if there has been a heavy influx of refugees. Global costs of intranational wars include affected countries being host to hard drug production and to terrorist training.

Correlates of Intranational Wars

Major correlates are a combination of low income, declining income, low economic growth, and arguably inequality. Some research-based models find that inequality does not correlate with a risk of war, others place it as the prime factor (3). Essential elements of opportunity seem to be “lootable goods” such as oil, diamonds, gold, hardwood timber, rare elements, drugs or the possibility of factionalization, usually ethnicization, of the conflict. The exportable commodities provide both a greed incentive for violent conflict and the means to maintain an army.

Other factors increasing the “opportunity” for a violent political conflict are (4):

- small arms proliferation;
• low levels of education and employment;
• “youth bulge” - high proportion of young people in the population, who are easily recruited into armed factions. (But this factor operated only until the end of the Cold War, not now, and no one knows why.);
• inadequate political institutions for conflict resolution and security;
• culture legitimizing violent conflict resolution;
• money flows for arms purchase from neighboring states hostile to the state in conflict or from wealthy diasporas;
• shaky early democratization, especially with poor minority rights;
• elite self-interest in violent conflict;
• media fomentation.

Having just emerged from a civil war causes a country to have a 44% risk of another outbreak of violence in the next 5 years. This is probably because many of the above factors continue to operate.

Possibilities for Prevention, Working from the Health Sector

We can think of prevention as acting on the core conflict issues before there is resort to violence, and acting on the correlated factors that predispose to violence.

Major players in prevention of violent conflict are the UN and its agencies, regional organizations, nation states and international financial institutions. Health professionals and other civil society players may take up roles in dealing with both predisposing factors and core conflict issues. Physicians may be eloquent in commenting on core conflict issues, an example being Eyad El Sarraj, prominent Palestinian psychiatrist who issued much warning and advice to leaders of both sides of the Israel-Palestine conflict, before it reached “war” levels of political violence (5). Physicians’ organizations were very active in attempts to prevent their countries joining the US-led coalition against Iraq in 2003 – successful in Canada, unsuccessful in Britain and Australia.

Health sector organizations, especially affiliates of International Physicians for the Prevention of Nuclear War, have worked for over two decades against the militarization of societies and economies, pointing out the losses to expenditure on health and the determinants of health through high military expenditures. They have paid special attention to weapons that threaten catastrophic human destruction – nuclear weapons, chemical and biological weapons, to landmines, and more recently, to small arms.

At the level of global governance, health sector organizations have lobbied for measures to create a safer global political environment. The predominant role of such organizations in the creation of the International Criminal Court is a good example of action at this level.

Direct health sector engagement in high-risk countries is another arena of action. Regarding the very high risk in immediately post-conflict countries, the World Bank Report makes some interesting comments. Policies signaling the government’s intention for social inclusion and care, specifically health and education, promote economic development in a much shorter time span than could be accounted for by actual improvements in health and education. The interpretation of this phenomenon is that such policies mean that the government is honoring the spirit of the accord, and that people will therefore take the risk of investing in infrastructure. The capital flight that usually continues in the post-violence setting slows. Conversely, a government that continues high military spending in this phase thereby increases the risk of further breakdown into violence. Civil society organizations, both indigenous and from outside, could attempt to influence the policy in this direction and to partner such efforts.

As a further contribution to this area, Anthony Zwi and his associates have written extensively on reconstruction of health systems in post-violent conflict environments to increase social equality and inclusion (6). The WHO network Health as a Bridge to Peace has also worked extensively in this mode (7) as well as the Institute of Resource and Security Studies (IRSS). Paula Gutlove of IRSS says, “Health care that features cooperation between professionals from different sides of a conflict can be a model for collaborative action, and can help to create the community infrastructure that is essential for an enduring peace” (8).

Health sector organizations have also tried to influence cultural constructs relevant to war and peace. In the case of high-risk post-violent conflict countries, interesting work has been done from the health sector, combining interventions to improve mental health with input on social healing, or peace education. The McMaster series of projects on the health of children in war zones is an example of such work (9,10).

While we know that immediately post-war countries are at high risk of future war, we are also moving towards a capacity to predict other future wars. Clusters of scholars throughout the world have developed tools for risk assessment and early warning (11). It is attractive to consider the possibility of indigenous health professionals working with international health professionals on ways to lower risks in these at-risk countries.

Work on maternal and child mortality, for example, could potentially be framed as peace work in reducing the risk factor of the “youth bulge.”

Collier et al (2), writing in the World Bank Report, see progress in prevention of violent conflict as distinctly feasible. Others point out that a good deal of prevention work is already happening (12). Perhaps this is why the number of wars is decreasing. Collier et al (2) suggest adding to the Millennium Development Goals (13) the goal of halving the incidence of intranational war by 2015. Whether formally adopted or not, the health sector has a role to play in this goal.
References