Talk to DIHAD 2024 session on "humanitarian diplomacy and global health challenges", 1600-1730 on 24 April

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As our panel is on humanitarian diplomacy and global health challenges, let me start by stating the obvious – peace is a pre-requisite for health. if we agree on that, the corollary question is: **Is health a weapon of war or a bridge to peace?**

We live in the deadliest of times since the Second World War. According to the Uppsala Conflict Data Program, there were 189 armed conflicts in the world in 2022 killing 311,000 people, sharply up from the 86 conflicts that killed 38,000 at the turn of the Millennium. The current Gaza war adds to the toll.

This does not convey the full horrors of contemporary wars. Presently, two billion – a quarter of global humanity – are directly and indirectly affected. Ten times more civilians than combatants are killed or injured. They are also displaced, impoverished, raped, tortured, and starved as today's conflicts are often a no-holds-barred affair as in Ethiopia's civil war in Tigray. They also last longer – an average of a decade or more. For example, in Syria or Yemen.

It is against that backdrop that the 75th World Health Assembly (WHA) in 2022 met under the theme of "health for peace, peace for health".

WHO defines health as complete physical, mental, and social well-being and not just the absence of disease or infirmity. It is also a fundamental right under the 1948 University Declaration of Human Rights. Self-evidently, wars are not good for health, and it is right that WHO should turn its mind to it.

However, there is a dilemma at the core of the health-conflict nexus. Healthier populations produce stronger warriors. Conversely, strategists know that attacking the enemy's civilian infrastructure such as food, water, electricity will sap an opponent's health and well-being, and so its war-making capacity.

Contagious diseases provide an example of health affecting the course of war. For example, the Crusades in the Middle East and the colonial conquest of the Americas. Deliberate disease spread was tried as a weapon as Napoleon attempted with malaria against the English, and the Nazis against the Allies. Nowadays, we call this bioterrorism, a growing risk at a time when deadly organisms such as Ebola and coronaviruses are emerging in the context of climate and environmental change. Additional are the lethal health risks from chemical or nuclear weapons.

Meanwhile, we know from numerous recent pandemics such as human and avian influenza, HIV and AIDS, SARS, and Ebola that diseases know no boundaries, and require international co-operation. But, as the earlier altercations over COVID-19 vaccines and shortages of essential drugs illustrated, access to medical technologies can become an existentialist

matter. This has securitised global health and politicised it as a critical agenda for G7, G20, and regional fora. That is also why at this year's WHA, a meaningful Pandemic Treaty is unlikely to be adopted. How quickly we forget the good intentions after Covid terrified the world.

With health becoming a security matter, its direct targetting gets justified. We see increasing attacks against hospitals, clinics, ambulances, medical supplies, and workers. WHO's surveillance system indicates that there were 1482 attacks last year, a four-fold increase since 2020. . The statistics under-estimate prevalence. Not all attacks are registered in the global recording system.

Ukraine and Gaza lead the pack of countries where healthcare is under assault, followed by Myanmar, Afghanistan, Central African Republic, and Syria. Yemen and several African nations such as Sudan, Nigeria, Democratic Republic of Congo, and Libya are also prominent.

This happens despite many norms and laws prohibiting attacks on healthcare and civilians including the Geneva Conventions, international human rights frameworks, and referrals to the International Criminal Court. These modern constructs build on values as old as humanity itself. In every corner of the world and across all cultures and religions, the sanctity of the healer and their business has always occupied a special place. It seems that our ancestors who fought many brutal wars had also figured out a package of moral and ethical rules to limit their damage.

But these taboos are no longer enough. How has our humanity got so degraded? Epidemiologists seek scientific – not moral – explanations. Some postulate that conflict spread is like a disease, akin to that caused by an infectious virus. Therefore, public health epidemic-reversal strategies should be tried. It means detecting and interrupting potentially violent situations, identifying, and changing the thinking and behaviour of those most likely to be violent, and changing group norms that perpetuate the use of violence. The "cure violence" theory has had some success with domestic and community violence in the West.

But local quarrels are far from macro-level wars. Nevertheless, comparable approaches are used by diplomats and development practitioners to address the grievances that underlie modern conflicts. Commonly, this is disgruntlement from contested governance and rights, and desperation of poor people denied their basic livelihoods. But peace dividends from diplomatic and poverty alleviation efforts are rare.

Could other health - inspired strategies foster peace? In Afghanistan, I saw the Taliban carrying flasks of polio vaccine during vaccination ceasefires. During Sri Lanka's bitter civil war, I listened to potential suicide bombers in trauma counselling centres undergoing change of heart and mind.

In the 1990s Bosnia war, I helped share medical resources to build co-operation across the Muslim-Serb divide, despite the parallel Srebrenica genocide. In Sudan, even as the Darfur genocide unfolded, I used my position as head of the United Nations at that time to push for a change in regulations to ease the access of raped women to reproductive and sexual healthcare.

In Sierra Leone, as a British government official, I went on Community Radio Kiss FM to negotiate with the rebels whose vicious conduct was legendary even as they demanded their favourite hard rock music to be aired in return for not chopping the limbs of their opponents. In Haiti, I heard how rumours of a cholera outbreak that threatened an explosion were defused by paramedics correcting misinformation.

There are countless examples of similar useful health interventions. But sadly, these countries where I worked are still troubled. Perhaps that is because while health-to-peace interventions are well-intentioned, they appear to work by reinforcing mutual self-interest arising from co-operating across warring divides. In short, they appeal to the selfish part of the human psyche and not the unconditionality that is at the heart of the healing task.

That is why major humanitarian bodies such as the International Red Cross Red Crescent and Medecins Sans Frontieres are loth to endorse the notion of health as a bridge for peace. Because, by doing so, it may politicise impartial humanitarian action, and reduce unfettered access to those who need help. But neither has this traditionalist caution stemmed assaults on the humanitarian medical mission.

The political economy of armed conflict suggests that while all wars eventually end, they do so only when one or other side wins or grinds each other to a halt. Then the balance shifts towards making peace. Therefore, the best we can claim for health interventions in conflict is that they may temporarily defuse violence. That is worth achieving, but could we do more?

Health professionals and the World Health Organization must go beyond counting destroyed hospitals and lamenting lost lives. They must help to figure out better strategies not just to pick up the broken pieces but to prevent and reduce the brutality of today's conflicts. Only by doing that can we keep alive the notion of a shared humanity. That is an essential pre-requisite for whenever warring peoples become ready to give peace a chance.

That must be fundamental challenge for today's humanitarian – or health – diplomacy.