

Doctors and Peace: An Introduction to Peace through Health

Tromsø Presentation
Feb. 24, 2004

PEACE THROUGH HEALTH *WHAT IS IT?*

*“emerging academic discipline
to study how health
interventions in actual and
potential war zones may
contribute to peace.”*

*Exploring synergies: How can
work for health contribute to
peace or how do we
simultaneously address health
deficits and peace deficits*

WHAT IS HEALTH?

World Health Organization Definition (1947)

“Health is the state of complete physical, mental and social well-being not merely the absence of disease and infirmity.”

ALMA ATA (1978)

- **health, which is a state of complete physical, mental and social wellbeing**, and not merely the absence of disease or infirmity, is a **fundamental human right** and that the **attainment of the highest possible level of health is a most important world-wide social goal** whose realization requires the action of many other social and economic sectors in addition to the health sector.
- **II**
The existing **gross inequality in the health status** of the people particularly between developed and developing countries as well as within countries is **politically, socially and economically unacceptable** and is, therefore, of common concern to all countries.

* International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

OTTAWA CHARTER for Health Promotion (1986)

• **Prerequisites for Health**

- The fundamental conditions and resources for health are:
 - a peace,
 - b shelter,
 - c education,
 - d food,
 - e income,
 - f a stable eco-system,
 - g sustainable resources,
 - h social justice, and equity.

* CHARTER ADOPTED AT AN INTERNATIONAL CONFERENCE ON HEALTH PROMOTION*
• The move towards a new public health, November 17-21, 1986 Ottawa, Ontario, Canada
• * Co-sponsored by the Canadian Public Health Association, Health and Welfare
• Canada, and the World Health Organization

WHAT IS PEACE?

VIOLENCE Galtung.

- means to solve conflicts, when the parties are incapable or unwilling to find more constructive ways.
- avoidable insults to basic human needs including Survival needs, Well-being needs, Identity needs, and Freedom needs.
- Insults include death, misery, repression and alienation)
- Typology of violence might include direct, structural and cultural (religion, ideology, language, art, science). Threats of violence are also violence. War is an extreme form of collective violence.

PEACE

- a state of integrated, respectful, just, cooperative, nurturing, positive relationships and may include spiritual, psychological and emotional elements
- not merely the absence of direct, cultural, and structural violence (negative peace), but a state of complete loving, harmonious acts to elicit the good in each other (direct peace), of complete equitable, horizontal relations (structural peace) and of complete positive culture, which promotes peace and non-violence (cultural peace).

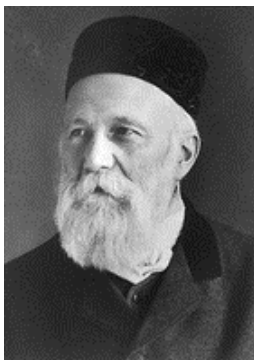
Galtung, J. (1996). Peace by peaceful means: peace and conflict, development and civilization. London, Prio /Sage)

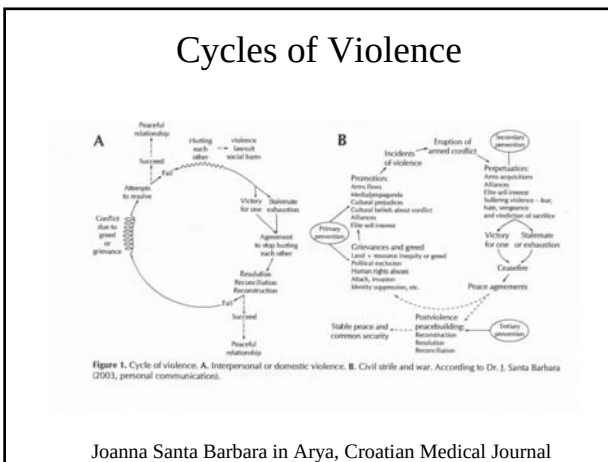
The Health Peace Connection

	Health	Peace
Definition	physical, mental and social well-being	Integrated, respectful, cooperative, positive relationships, may include spiritual, psychological and emotional elements
<i>Not simply</i>	absence of disease and infirmity	absence of war or violence
<i>Further</i>	fundamental right or resource	? a right for children
Determinants/ Fundamental Conditions/Basis for a Secure Foundation	peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice, equity	biological, social, cultural, environmental, behavioural, economic, political factors
Conflict Transformation/ Promotion of Health	process of enabling people to increase control over, and to improve their health through advocacy	involves systemic change, catalysing changes at deepest level of beliefs, assumptions and values as well as behaviour and structures

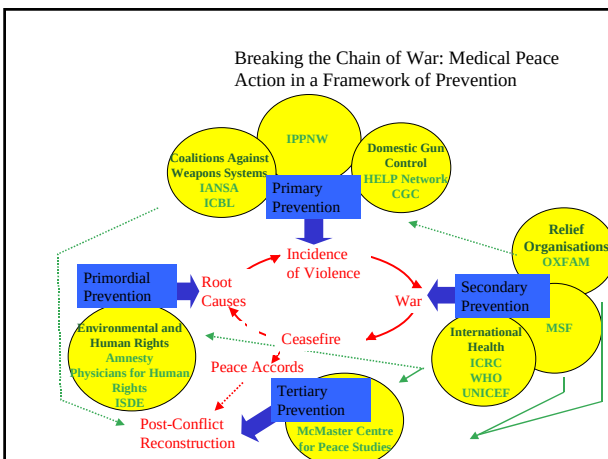
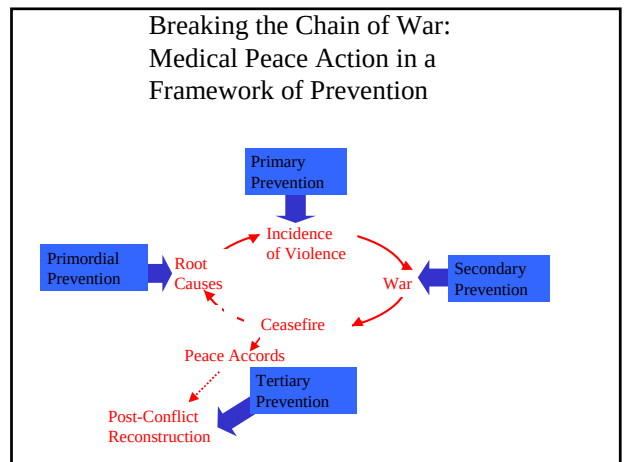
Think also of human rights, human security etc.

Henri Dunant





Joanna Santa Barbara in Arya, Croatian Medical Journal



Peace through Health Working Model

	Primordial Pre-conflict	Primary Conflict	Secondary Post-conflict	Tertiary
Character	Altruism - Evocation and Broadening	Personification of "Enemy"	Solidarity - Extension of	Disent and Non-cooperation
Who we are, What we represent: e.g. Altruistic intelligent	Diplomacy			
Knowledge	Public Health - Epidemiology, Prevention	Psychological - analysis of conflict, cycles of violence, post traumatic stress, concepts eg. psychic numbing, conflict mediation/transformation	Principles and Practice: lessons from General Systems	Medical Ethics
What we know, What our training is	Teaching: Communication of knowledge	Sensitizing: Putting a human face on suffering	Maintaining structural integrity for society	Healing of communities: Physical, Psychological, Social, Spiritual
Activity	Supraordinate Goals - Construction of	Redefinition of the Situation		
Each of the above				

Peace through Health Mechanisms

USING INFLUENCE

A black and white photograph showing four men in suits. In the foreground, two men are shaking hands; the man on the left is seen from the side, while the man on the right is facing him. Behind them, two other men are standing and smiling. The setting appears to be an indoor office or meeting space with large windows in the background.[illegible]

KNOWLEDGE

What we know

What we know

HOW CAN DOCTORS CONTRIBUTE?

- DIAGNOSIS AND TREATMENT
 - PUBLIC HEALTH MODEL
 - PRIMARY SECONDARY TERTIARY PREVENTION
 - HARM REDUCTION STRATEGIES
 - EPIDEMIOLOGICAL METHODS
 - STATISTICAL SIGNIFICANCE VS CLINICAL SIGNIFICANCE

- **DIAGNOSIS AND TREATMENT**
 - **PUBLIC HEALTH MODEL**
 - PRIMARY SECONDARY TERTIARY PREVENTION
 - HARM REDUCTION STRATEGIES
 - EPIDEMIOLOGICAL METHODS
 - STATISTICAL SIGNIFICANCE VS CLINICAL SIGNIFICANCE

Confronting the small arms pandemic

Unrestricted access should be viewed as a public health disaster

Pandemics throughout the world have witness to the terrible consequences of small arms. But do we truly understand the impact and the epidemiology of the small arms pandemic, and can we devise effective strategies for prevention as we have for other major public health threats? The capacity for reducing constraints, reliable, and relevant data is limited by various cultural, economic, infrastructural, and logistic factors even in developed countries on the one hand. Nevertheless, we have some solid data on the state of the problem and indicators suggestive of possible solutions.

The United States, for instance, has over 200,000 deaths a year from small arms—wounded, soldiers, and innocent—the highest rate in the developed world. In that country firearms are the leading cause of death, among 15-year-olds to 35s, slightly ahead of vehicle crashes, and the third leading cause of deaths in those aged under 35.¹ While the US rate of firearm deaths is roughly equivalent to that of Canada (1.3 per 100,000), its number rate with handguns is 15 times the Canadian rate.² Countries with similar culture, economy, and ethnic unity but with different gun possession rates also have widely different firearm death rates, strongly correlating with the percentage of households with guns. For example, Britain's firearm death rate is about 0.5 in 100,000 while the US rate is 10.5.³ Households with firearms are three times more likely to have murders and five times more likely to have suicides than all countries that similar households without firearms.⁴ These data suggest that firearm deaths may be prevented by controlling the supply and possession of guns.

Data from the developing world are less clear, especially in conflict situations. In most post-conflict regions in Central America and Africa, a very small percentage of guns are registered, estimates of the total in circulation vary widely, and reporting of casualties may be affected by fear of the authorities. Nevertheless, small arms were ubiquitously the primary cause of death in the 1990s, accounting for 15% of all deaths, and 300,000 deaths a year.⁵ Together with the estimated 200,000 people who die each year from firearms in non-conflict situations, these deaths account for a quarter of the 1.8-2.5 million deaths due to violence in a typical year in the 1990s.⁶ The numbers are rising, as the present and hidden numbers of soldiers, Mafic combatants, and the major perpetrators and direct victims of small arms violence, but in some countries—non-conflict—disproportionately women and children—wounded by a large percentage of all deaths, and may also affect the psychological and social health of the population.

Issues have also been elevated in economic terms. Small arms purchases account for perhaps US\$10 billion annually, but in some countries the proportion of the roughly \$600bn spent on military hardware annually worldwide.⁷ In the economic circumstances that can be far greater in Colombia violence primarily related to small arms has been calculated as costing up to 25% of the country's gross domestic product (GDP). Violence on International Small Arms Control: Injury Surveillance and Research, (Emmons, 1998).

While weapons are viewed with hostility and, casualties may not be substantially reduced. In the

1998

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02 APRIL 1998

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HOW CAN DOCTORS CONTRIBUTE?

• DIAGNOSIS AND TREATMENT – PSYCHOLOGICAL MODELS

- CONCEPTS OF SECURITY
- CYCLES OF VIOLENCE
- TRAUMA HEALING, PTSD
- HARM REDUCTION STRATEGIES

SECURITY

- 1. protection from physical harm,
- 2. access to resources to meet basic needs
- 3. an illusory psychological dimension

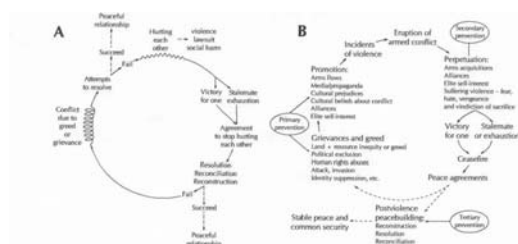


Figure 1. Cycle of violence. A. Interpersonal or domestic violence. B. Civil strife and war. According to Dr. J. Santa-Barbara (2003), personal communication.

WHAT IS ADDICTION?

- a primary, chronic (relapsing) neurobiologic disease,
- with genetic, psychosocial, and environmental factors influencing its development and manifestations.
- characterized by behaviours that include one or more of the following:
 - impaired control over drug use,
 - compulsive use,
 - continued use despite harm (physical, psychological, social, legal, interpersonal),
 - and craving.
- may include the phenomena of tolerance, withdrawal, loss of control over use of drug
- Large amount of time spent acquiring or recovering from the effects

SUBSTANCE DEPENDENCE-DSM IV

- Maladaptive Pattern of Use Leading to:
 - ❑ Persistent desire OR unsuccessful attempts to Cut down or control use
 - ❑ Drug taken in larger Amounts OR Longer period than intended
 - ❑ Tolerance
 - ❑ Withdrawal
 - ❑ Time spent in Activities in acquiring, using or recovering from the effects of the drug.
 - ❑ Drug use is Salient. (decrease/cessation of other activities)
 - ❑ Compulsive use despite Harm
- 3/7 criteria necessary in the same 12 month period

PURPORTED REASONS FOR NUCLEAR WEAPONS?

- 1. SECURITY
- a)vs. PAKISTAN
- b)vs. CHINA
- 2. DETERRENCE
- 3. WE CAN KEEP THEM SAFELY
- 4. NPT DISCRIMINATORY
- 5. MOTIVATION FOR OTHERS TO DISARM
- 6. PLAYER ON INTERNATIONAL STAGE

GENERAL SYSTEMS THEORY

Bertalanffy

- **Weltanschauung (worldview).** "We are seeking another basic outlook: the world as organization. This [outlook] would profoundly change the categories of our thinking and influence our practical attitudes. We must envision the biosphere as a whole ... with mutually reinforcing or mutually destructive interdependencies. [We need] a global system of mutually symbiotic societies, mapping new conditions into a flexible institutional structure and dealing with change through constructive reorganization."
- **Ubiquity and unification principle**
- **Complementarity Law**
- **System Holism Principle**

Table of Faulty Premises of Biomilitary Thinking

- **Technological fixes**
- The Magic bullet Surgical Strike
- Get to make last move
- The Perfect Shield
- No side effects
- **Incomplete Analysis**
- Causation Association
- Wrong End Point
- Wider application of drugs
- Trade-offs Externalization of Costs Weighing Costs Benefits
- **Prevention Preemption**
- Every good disease must be in want of a Cure
- Unilateralism

HOW CAN DOCTORS CONTRIBUTE?

- **DIAGNOSIS AND TREATMENT**
 - MEDICAL MODEL (GENERAL SYSTEMS THEORY)
 - IMMUNIZATION
 - ANTIBIOTIC, PROBIOTIC, TREATMENT RESISTANCE
 - BALANCE OF FLORA
 - CAUSATION VS. ASSOCIATION
 - MULTIFACTORIAL ETIOLOGY
 - END POINTS, UNFORESEEN CONSEQUENCES
 - DIFFERENTIAL DIAGNOSES, LIKELIHOOD, TRIAGE
 - HOLISTIC HEALING, ROOT CAUSES





PEACEFUL CHILDREARING

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Physicians for Global Survival (Canada)

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Physicians for Global Survival (Canada)

PEACE means...

- ...Mutually helpful relationships among people.
- ...Resolving conflicts through peaceful means.

The best place to begin to foster PEACE is in our homes.

Peaceful childrearing is based on three RELIEFS:

- Every child is special, precious and has inner goodness.
- Every person deserves to be treated with respect - children and parents.
- Everyone in a family, brought to school, needs to cooperate to help each other.

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PROBLEMS WITH HITTING CHILDREN
(if hitting them in other ways)

Research shows that physical punishment may have the following long-term effects on children:

- Lower sense of self-worth
- More anxiety
- More aggression and risk of suicide
- More drug abuse
- Lower IQ in girls
- More violence to teachers and sisters
- More violence outside the family
- More teenage antisocial behaviour
- More violence to spouses
- Less chance of a good salary

As well, parents who use physical punishment are more likely to slide into serious child abuse. This doesn't mean that one slap will damage your child's development, or that everyone who was hit as a child becomes a troubled adult. These outcomes are averages for hundreds of people. On average, the harder the physical punishment, the worse the outcome.

Physical punishment may bring behaviour under your control. But the child is likely to try to "get away with" undesired behaviour when no one is watching. What we really want is to raise children with strong moral values about good behaviour and firm self-control.

IF IT'S HARMFUL, TO HIT, HOW SHOULD I DISCIPLINE MY CHILD?

Children learn good behaviour in a number of ways. Even difficult and impulsive children will respond better to some of the following:

LAYING GOOD FOUNDATIONS

- Foster a secure attachment. Spend a lot of time with young children—feeding, being available, and trying to understand how the child feels.
- Develop a cooperative relationship with the child. Say "yes" whenever it's reasonable. Play, have fun, and laugh together.
- Set an example of kind, respectful, and cooperative behaviour by everyone in the family. Try not to model behaviour such as yelling or judging others.

ENCOURAGING DESIRABLE BEHAVIOUR

- Set high, but realistic, good behaviour goals.
- Catch your child behaving well, even if it's just playing quietly and on the behaviour and its setting the table once again.
- Talk and listen. Engage behaviour and why it's wanted. Listen and respond to what the child is saying. But do not argue. Arguing over an already well-settled disagreement.
- Watch and guide. If guidance is needed, guide children as they go. Gradually as they get more responsible.
- Create opportunities and help with it.
- Teach children to be by listening to each other. Encourage them to act on the best of both.
- Show stories (show children of people in cooperative, kind, and good qualities. Use "heroes" in TV, video, etc.).
- Set up a "Family Co" everyone in discuss consequences and have great ideas for a new great idea for making and writing.



Iraq Sanctions and War- Medical Action								
Time Frame								
← Gulf War I—Post-War Rebuilding			Sanctions			Gulf War II 2003→		
Prevention Stage								
	Primary	Secondary	Tertiary	Primary	Secondary	Primary	Secondary	Tertiary
Characteristic								
Character	Activism eg. Dr. Y H-V	Dr. Y, H-V Dissent		Various including IPPNW		IPPNW Coalition Against War		
Knowledge		Dr. Y, H-V Medical ethics	Harvard	Harvard	ICRC, UNICEF WHO	Medact Report		
Activity			MSF Relief Organisations		ICRC, UNICEF WHO		MSF ICRC WHO UNICEF OXFAM	

Criticisms of Model

- Outer peace not inner peace
- Biomedical, Western version of Peace
- No respect for alternative practitioners
- Focus on Doctors vs other Health Professionals

A HISTORY OF PEACE THROUGH HEALTH AT MCMASTER: CASE STUDIES

Harvard International Study Team Iraq, 1991

International Study Team 1991

- Child Mortality and Nutrition Survey
- Health Facilities Survey
- Income and Economic Survey
- Child Psychology Survey- Magne Raundalen, Atle Dyregrov
- Water and Wastewater Survey
- Electrical Facilities Survey
- Environment and Agricultural Survey
- Women's Survey
 - 43 International delegates;
 - 29 Public Health Surveyors
 - 9 interpreters

\$100,000 US plus in-kind contributions (RJA, Jordanian students,

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Vol. 327 No. 18 THE GULF WAR AND PEDIATRIC MORTALITY IN IRAQ — ASCHERRO ET AL. 931
THE NEW ENGLAND JOURNAL OF MEDICINE
Sept. 24, 1992
SPECIAL ARTICLE

EFFECT OF THE GULF WAR ON INFANT AND CHILD MORTALITY IN IRAQ

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GODFREY DEHAES, M.D., ERIC HOSKINS, M.D., JIRALLA LAOONG, M.D.,
MEDAN PARSEY, M.B., B.S., M.P.H., SALEH QADERI, M.B., B.S.,
SAHER SHUQADEF, M.B., B.S., DR. P.H., MARY C. SMITH, M.Sc., AND SARAH ZAIDI, M.Sc.

Abstract Background. Increased malnutrition and morbidity among Iraqi children after the onset of the Persian Gulf war have been reported by several fact-finding missions. The magnitude of the effect of the war and the economic embargo on child mortality remains uncertain, however.

Methods. We conducted a survey of 271 clusters of 25 to 30 households each, chosen as a representative sample of the Iraqi population. The households were selected and the interviews conducted by an international team of public health professionals independent of Iraqi authorities. In each household all women 15 to 49 years of age were interviewed, and the dates of birth and death of all children born on or after January 1, 1985, were recorded.

Results. The study population included 16,076 children, 768 of whom died during the period surveyed (January 1, 1985, to August 31, 1991). The age-adjusted relative mortality for the period after the war began, as compared with the period before the war, was 3.2 (95

percent confidence interval, 2.8 to 3.7). No material change in the relative risk was observed after adjustment for region of residence, maternal education, and maternal age. The increase in mortality after the onset of the war was higher among children 1 to less than 12 months old (relative risk, 4.1; 95 percent confidence interval, 3.3 to 5.2) and among those 12 to less than 60 months old (relative risk, 3.8; 95 percent confidence interval, 2.6 to 5.4) than among those less than 1 month old (relative risk, 1.8; 95 percent confidence interval, 1.4 to 2.4). The association between the war and mortality was stronger in northern Iraq (relative risk, 5.3) and southern Iraq (relative risk, 3.4) than in the central areas (relative risk, 1.9) or in Baghdad (relative risk, 1.7).

Conclusions. These results provide strong evidence that the Gulf war and trade sanctions caused a threefold increase in mortality among Iraqi children under five years of age. We estimate that an excess of more than 46,900 children died between January and August 1991. (N Engl J Med 1992;327:931-6.)

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Health of Children in War Zones Project

Can. Gov't committed \$20 million to support CRC (1992)

1994-1996 \$1.5 million, 3 years

3 Health Reach field work projects

- Former Yugoslavia \$600K
- Sri Lanka \$200K
- OPT Gaza \$200K

4 Study Groups

- measurement tools applied to population health in war zones
- Developing the theory of health initiatives promoting peace processes
- Youth group to promote awareness of issues
- Explorations of Afghanistan project s, landmines

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Health of Children in War Zones: Gaza Child Health Survey



Thomas Miller, MD assisted by Mustafa El-Masri, MD and Samir Qouta

In Cooperation with the Canadian Centre for Studies of Children at Risk and the Centre for Peace Studies (McMaster University)

MILLER

Emotional and Behavioural Disorders (CD, ADHD, & ED) by Parent

Number of Disorders	6-11 Years Old (N=458)	12 and Up (N=211)
One or more disorders	158 (34.5%)	34 (16.1%)
One disorder	126 (27.5%)	25 (11.8%)
Two disorders	21 (4.6%)	7 (3.3%)
All three disorders	11 (2.4%)	2 (0.9%)

MILLER

Table 5: Comparison of Prevalence Rates of GCHS and OCHS for children ages 6 to 11(Parent and Teacher)

Disorder	Gaza Child Health Survey (N=458)		Ontario Child Health Study (N=2006)	
	Boys %	Girls %	Boys %	Girls %
CD	22.9***	7.3***	6.2***	2.1***
ADHD	11.9	8.5**	9.7	3.3**
ED	49.0***	44.8***	11.1***	11.7***
One or More Disorder	55.7***	46.8***	19.6***	14.6***

MILLER

Case Study #2: Health Reach Sri Lanka

1991: International Study Team Iraq

1992: Centre for Peace Studies, Centre for International Health at McMaster co-found Health Reach (War and Health Program)

"To investigate and promote, within the framework of international covenants, the health and well-being of civilian populations and children, in zones of armed conflict"

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Health of Children in War Zones McMaster University (1993-1996) 'Health Reach: Sri Lanka Survey Project'



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- 1990 Muslims forcibly displaced from Jaffna;
- Massacres in Batticaloa
- SLA; Counter-reprisals; Displacement; LTTE interior; Home guards;



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Study Rationale:

1. recent generation of children in Sri Lanka exposed to unprecedented social and military violence
2. Physical health needs receive programming and attention; in contrast little formal attention to psychosocial / psychological needs
3. Existing counseling services need program development for therapeutic work with children
4. Delivery of health and educational services gives little attention to psychological status of children, e.g. war effects

Study: Document the relationship between the occurrence of psychological disorders and the exposures of conflict-related violence in Year 6 school children from all ethnic groups in Batticaloa, Kurunegara and Polonnaruwa districts.

Emphasized:

- Local training;
- Strengthening existing resources;
- National consultation and dissemination to "promote discussion of psychosocial care for children affected by civil conflict in the Sri Lankan context"

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Psychological effects of armed conflict on Sri Lanka children

- 6 war affected communities (3 ethnic groups: 2 Sinhalese, 4 Tamil (2 Muslim, 2 ethnic Tamil) local school Year 5 classroom
- 60 trainees Sinhalese/Tamil (interviewing skills, child trauma psychology, use of study questionnaires)
- 4 day 1-1 process: conflict related exposures; self-identified most traumatic event; symptoms-behaviours re. PTSD; Depression; Grief; follow up home visits
- 308 schoolchildren total



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- Psychological effects of armed conflict on Sri Lanka children: 308 schoolchildren in six war affected communities (3 ethnic groups)
- Sinhalese, Tamil regions (Muslim, non-Muslim)
- 4 day process: PTSD; art; Depression; Grief; war exposures; home visits



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Health Reach Sri Lanka Study
 Psychological Distress in Sri Lankan Schoolchildren
 Exposed to Armed Conflict
 (n=325, 8 affected communities (4 Sinhalese, 4 Tamil)).

In Batticaloa (eastern Sri Lanka) 2 ethnic Muslim and 2 non-Muslim communities were studied, reflecting the divisions in the local conflict.

Findings in Batticaloa (170 schoolchildren, age 9-11)

- 41% victims of conflict related violence (homes attacked, being shot at, beaten, or arrested)
- >90% disrupted schooling, displacement of home, multiple occasions
- 15% forced separation from parents (longer than one month)
- 89% direct exposure to shelling, shooting and/or bombing
- 80% extreme poverty and deprivation due to the war e.g. going without a home, food or shelter
- 53% seeing dead bodies
- 15% direct family member killed by war fighting
- 15% 'disappearance' of family member (following abduction or detention, presumed dead)
- 95% personally experienced event of threatened death, serious injury) at risk of post-traumatic stress disorder (PTSD)
- 20% score 'severe/very severe' for PTSD, depression, and unresolved grief reactions

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Spiral Garden & Cosmic Bird Feeder
 At the Bloorview MacMillan Children's Center

About the Gardens | Programs | Schedule | Publications | Workshops

Spiral Garden and Cosmic Bird Feeder are integrated, outdoor art, garden, play programs at Bloorview MacMillan Children's Center in Toronto, Canada. These programs bring children (with and without special needs) from the community together with the children at the rehabilitation centre to have a shared creative experience in a natural context, the garden. Through the metaphor of the garden, we celebrate our interdependence with the natural world as the context for healing our children, ourselves, and the Earth. Through gardening, the arts, and play we collectively explore and express ways to nurture all our relations. All aspects of the person - physical, emotional, spiritual, rational, and intuitive - are integrated in the process. At the heart of the process, at the centre of

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The grounds and activities are accessible to children with differing needs. By focusing on abilities we see an entry point into the activity for each person, we are able to work, play, and grow together.

The model we employ is articulated as a constellation of art, garden, and play. The garden grounds us in the natural world, which is a continual source of inspiration. The arts are the vehicle to give form to our expressions. Play is the pervasive spirit of openness and intuition. Story is used to weave the images, artifacts, and characters that emerge into a narrative. And ceremony is used to honour all the elements together in communal events.

The site is organized in a way such that the children move freely between activity areas. The activities are offered in different areas of the garden, within earshot of each other, but far enough one can focus on what is at hand. The children are free to choose what they want to do. Thus said, the staff are present to engage and inspire the children (as they often inspire us). The time to move about, explore and play is punctuated with group time, where we come together for music circle, sing, and share stories. Connections are drawn this way between activities, the story, the garden, and different areas on site.

Activities include: gardening, clay, weaving, sand painting, bread baking, woodworking, painting, puppet making, music, percussion, dance, performance, costumes, story telling, and more.



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