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MEDICAL INITIATIVES IN CONFLICT AND PEACEBUILDING

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Introduction

Medical diplomacy must be made a significantly larger part of our foreign and defense policy, as we clean up from costly and deadly wars in Afghanistan and Iraq. America has the best chance to win the war on terror and defeat the terrorists by enhancing our medical and humanitarian assistance to vulnerable countries. By delivering hope we will deliver freedom.¹

That health interventions offer a potential contribution to security has begun to attract interest from both the security and the health communities. According to such a view well-planned and targeted interventions can not only improve health outcomes but can also contribute to achieving wider political goals. In other words, health interventions need no longer be solely 'for health's sake', but may *at the same time* serve a useful political purpose. The attraction of this idea has grown over recent years. Increasingly the West in general, and the US in particular, is facing complex emergencies where military intervention is not aimed solely at affecting political elites (whether that be bolstering or removing them)², but is also intended to achieve community-level objectives. These have included efforts to improve relationships between local communities and occupying forces (particularly important in an age of 'asymmetric warfare'); attempts to increase people's perception of the legitimacy of their government; and actions designed to promote peace and reconciliation between antagonistic communities within a state. US military dominance means that the really difficult battles are no longer traditional military ones. Far more challenging is the task of winning the hearts and minds of a people. Health interventions have increasingly been seen as having a part to play in delivering on these explicitly political objectives.

But this basic logic can be operationalized in very different ways, and in pursuit of very different political ends. Former Director General of the WHO, Gro Harlem Brundtland talked of health being "a bridge to peace", while former US Secretary of Health Tommy Thompson focuses in the above quote on "winning hearts and minds", "Defeat[ing] the terrorists" and, he argues later in the article, "win[ning] the war on terror – at a relatively low cost". Simply put, for Thompson health initiatives can help win the war, while for Brundtland they can help build the peace. Yet both rest upon the same logic: that health interventions can change people's attitudes, and thus have desirable political effects.

All of the types of health intervention which we discuss in this paper fall under the broad concept of 'health diplomacy'. As Feldbaum and Michaud argue 'health diplomacy' should not be conceived of solely in the narrow sense of "diplomatic negotiations for global health", but should also incorporate the use of health programs to achieve what they term "ulterior foreign policy goals".³ In other words health diplomacy is a two-way street: it involves both the use of foreign policy tools to support global health goals, and the use of health initiatives to support foreign policy goals.

It is the latter which is of primary interest here. We address both interventions designed to 'win the war' and those intended to 'build the peace'. We begin by examining the manner in which medical aid has been used by the United States in Iraq and Afghanistan to highlight the distinction between two types of intervention – 'tailgate medicine' and 'medical diplomacy'. The second part of the paper examines the manner in which health initiatives have been incorporated into peace processes and peace building. The paper concludes by highlighting a range of problems and dilemmas common to both 'war-winning' and 'peace-building' interventions. We argue that all health interventions are inherently political. What is different about the present situation is that this political element has been made more explicit and become a much clearer part of the rationale for how and why interventions are made. This new policy context poses challenges for all of the actors involved. The humanitarian aid community has legitimate concerns over the dangers of sacrificing its traditional reputation for neutrality and impartiality, but must nevertheless find a way to work effectively in the new landscape of health diplomacy. For the foreign and security policy communities the challenge is one of improving the extent to which it delivers on health: unless it does so the hoped-for political and military gains are unlikely to be achieved.

Military forces have a long history of providing medical aid to civilians, both in conflict and in other emergencies. Not least under the Geneva Conventions they have requirements to respect the sick and wounded, whilst occupying powers (such as the US initially in Iraq) have obligations to ensure adequate health care for the civilian population.⁴ In both Iraq and Afghanistan however US health assistance, and in particular military medicine, was used not only to improve health but as part of a wider political and military strategy. Of course there was nothing new in using health aid as part of a military campaign. In Vietnam for example MEDCAPS (variously Medical and Civic Action Projects or Medical Civil Assistance Programs) had been used as part of US counter-insurgency strategy.⁵ But two developments provided a new intellectual context for such operations in Iraq and Afghanistan.

The first was the idea of 'soft power' - that states can achieve their political objectives not only by coercion and inducement but by attraction through ideas, values, cultural goods and institutions. That health could be a tool of soft power was explored in the early years of this decade by academics such as by Ilona Kickbusch,⁶ but the theory had already been put into practice by the US military prior to Iraq and Afghanistan.⁷ Health as soft power has become a highly controversial area however. The International Committee of the Red Cross' Code of Conduct, for example, explicitly states that 'We shall endeavour not to act as instruments of government foreign policy'.⁸ This reflects a long standing and influential perspective on medical ethics where the provision of health care should be based on need rather than affiliation to a particular political or ethnic grouping. However, as we discuss later in this paper, the debate is a complex one characterized by a good deal of conceptual confusion and few easy answers.

The second development was the movement away from a narrow perspective of operations in Iraq and Afghanistan to 'full spectrum operations'. Medical aid could play a role in such operations. It is clear that the Department of Defense is investing significant amounts of time and money into providing development assistance (indeed the Pentagon now accounts for 20% of US ODA),⁹ and health interventions are a significant part of this strategy,¹⁰ while the use of military medics in full spectrum operations is now part of US military doctrine.

Tailgate Medicine

Historically, MEDCAPs have usually taken the form of tailgate medicine, and have indeed sometimes been synonymous with this. 'Tailgate medicine' is so called because it can literally be delivered from the back of a truck. Even when it is based in more formal surroundings such as local schools or small clinics, military medics often arrive in trucks and depart the same way rather than being based

within the local community. It is characterised by ad hoc initiatives, sometimes informal but sometimes authorised by local commanders, using spare medical capacity. Its focus is on primary care and acute medical conditions and is invariably short term in nature.

Notwithstanding the medical benefits, the primary purpose of tailgate medicine is usually political and military.¹¹ The key operational objective is to build popular support both for US forces and for the local government. Its target is public opinion and the means of influencing it is through demonstrably addressing a basic human need.¹² This is not to say that humanitarian impulses are wholly absent, or that some individual ad hoc actions may not be wholly motivated by pressing humanitarian need; but as a policy, tailgate medicine is geared towards influencing hearts and minds rather than improving the health of the civilian population.¹³

The problem with tailgate medicine however is that its medical deficiencies risk the very gains in public opinion which it is designed to produce. These deficiencies include a short term focus on acute conditions and primary care, and the lack of follow-up. If secondary or tertiary care is needed, then there is no guarantee that referral systems will work or that local capacity exists for this. Diagnosis may be compromised by poor understanding of local customs, lack of knowledge of endemic conditions, possible difficulties in translation and a lack of testing equipment and facilities. Treatment may also be compromised by poor understanding of customs and practices – reports are common of drugs being misused in such circumstances. Perhaps even more problematic in the long-term is that tailgate medicine risks undermining confidence in local government agencies by replacing them or demonstrating their inadequacies, while treating one community may lead to resentment from a nearby rival community. The ad hoc nature of such operations also means that long term infrastructure projects involving inter-agency co-operation may not receive the attention they need, yet these are often the projects which are crucial for stabilising a region in the medium to long term. Moreover the primacy of the military mission may mean that resources are suddenly taken away leading to further resentment amongst the local population whose expectations had been raised. Finally, tailgate medicine may actually in some circumstances heighten insecurity by drawing large crowds – not always of those needing medical attention – which offer attractive targets to terrorists including suicide bombers, especially if such operations are advertised in advance.¹⁴

Military medics face more difficulties. Their primary responsibility lies in supporting the medical needs of the military of which they are part, and if surplus capacity is available, then this might be used to promote the health of local civilians. But what happens if the conflict escalates and this spare capacity disappears to deal with military casualties? Expectations raised by the presence of military medics may be crushed, while those civilian patients requiring ongoing care and attention may find that this is no longer available. Moreover, despite the aspiration of an 'exit strategy', the end point for most military operations fluctuates. This means that the time military medics spend with local communities is uncertain, risking long term care and perhaps leading to an emphasis on short term treatment rather than capacity building. Moreover a conflict can be fluid with the result that forces move around. If an area is secured and forces move on, what residual health care remains? If an area is abandoned to the enemy, might those treated by US forces be seen as collaborators rather than innocents who happened to be in need of medical care? And might enemy forces also provide medical care, perhaps better attuned to local needs because of language or cultural factors, turning healthcare into an area of competition where the US, despite its scientific prowess, is at a disadvantage simply because it might not understand the local population? Finally, the nature of the military mission may change altering both medical capacity and relations with local communities. In Iraq, the US moved from the status of an occupying power to support for the new government, while in Somalia a mission to assist the delivery of

humanitarian aid quickly escalated into something much more dangerous. These changes affect relations with local communities and the ability to deliver ad hoc medical care.

Overall therefore, tailgate medicine appears to present as many risks – on both strategic and humanitarian grounds – as it does advantages. Amongst its advantages are some short term medical benefit, especially for acute conditions, and from this an improvement in public opinion at the local level. This may have tactical benefits and in some instances strategic effect. One example of the latter might be when tailgate medicine addresses an issue which receives considerable media attention. (The corollary of this is that the failure to use spare medical capacity may attract high profile media criticism undermining the public relations effort.) However the ad hoc nature of such operations means that they are vulnerable to rapid changes. Indeed the potential for such operations to backfire and create resentment is clear. More importantly, if the political and military aim is national stability, then tailgate medicine appears to be a poor means of achieving this. Its focus is too local and short term and it is unable to address the infrastructure and training needs necessary to build a viable national health system.

Medical Diplomacy

In contrast to tailgate medicine's ad hoc nature and focus on short term primary care, medical diplomacy can be more long term and focussed as much on infrastructure requirements, including training of medical personnel, as on immediate treatment needs.¹⁵ It is therefore much more broadly conceived than tailgate medicine, exploiting a key US soft power advantage. Nor is it solely limited to conflict situations. A number of commentators have identified the use of 'health diplomacy' by other states (especially Cuba and China) to develop goodwill, which has in turn encouraged the US to engage in similar acts.¹⁶ Indeed former Assistant Secretary of Defense Cascells has admitted as much, drawing particular attention to the success of China in "winning hearts and minds by providing healthcare, roads and education" through its aid activities and suggesting that the US needs to compete in this area.¹⁷

Precisely how medical diplomacy differs from development assistance in the health sector (which may similarly increase goodwill) is unclear. The difference might be simply an institutional one – is the DoD/MoD or USAID/DfID leading the way? Alternatively it might be tentatively suggested that the key difference is in whether the political aims or the health outcomes are prioritised. However, this may oversimplify an often complex mix of motives and assumes that motives are shared across a government.¹⁸ What medical diplomacy does tap into however is a strong sense that this is a comparative advantage which could be used to influence target populations and build goodwill. The foreign and security policy community in the US in particular clearly believes that hearts and minds can be won through health investments. Indeed a case can be made that health investments are not simply an attempt by the US to exploit an area of comparative advantage for political purposes, but are an area of competition within a conflict.¹⁹

Of course reconstruction and development is a difficult task, and even well-managed and targeted reconstruction efforts would deliver limited political benefits in the short term. Thus tailgate medicine still holds some attraction, not least for its immediacy and its short term tangible benefits. This can be crucial in a media intrusive environment where failure to treat may be a PR disaster, but may also appeal to the 'can-do' action-oriented attitudes of the military. Nevertheless as one US military officer recently commented:

I used to believe in MEDCAPs, but I saw that we achieved greater, more long-lasting, enduring effects when we focused on improving their medical system.²⁰

Bringing communities together: Health as a Bridge for Peace

In addition to medical diplomacy and tailgate medicine, a further type of intervention falling under the broad definition of health diplomacy are attempts to leverage the health sector as a tool of peacemaking and peacebuilding. In contrast to medical diplomacy and 'tailgate medicine', the origins of HBP are to be found chiefly in the health and development fields. Again, it is important to recognise the broader intellectual context within which HBP developed. Although, its origins can be traced back to the 1980s, HBP has been to a great extent a post-Cold War phenomenon, with the aftermath of the Balkan conflicts of the 1990s being a key testing ground. As such, HBP has developed alongside a general increase in attention on the role of the international community in post-conflict peacebuilding. Following Boutros-Ghali's seminal 1992 statement *An Agenda for Peace* the challenge was laid down for all parts of the UN System to examine what contribution they could make to creating the conditions for peace and stability in conflict and post-conflict settings. The WHO was not exempt from this and began seriously considering the ways in which its work could play a part. In doing so WHO looked to the past for inspiration, in particular PAHO's activities in Central America in the mid-1980s. It was from here that the 'Health as a Bridge for Peace' terminology was drawn, and from here that some of the lessons which informed the later, somewhat broader, attempts to leverage the health sector for peacebuilding were learned.

The concept of Health as a Bridge for Peace has often been expressed at the idea that health can be a 'superordinate goal'²¹, a relatively non-contentious issue which can transcend division between communities and promote dialogue and cooperation. AS WHO puts it, "Health can be a neutral meeting point to bring conflicting parties together to discuss mutually beneficial interventions."²² Here we reject the idea that such interventions are apolitical. Indeed they are inherently political: their entire purpose is to leverage health interventions in order to achieve a political effect (in this case to promote peace). Proponents of HBP seek to address this potential tension firstly through the argument that peace is a prerequisite to health (and therefore that peace is the business of all health-sector actors), and secondly through the claim is that it is possible to achieve both health and peace outcomes without sacrificing one for the other. It is because HBP operations represent a coming-together of health interventions and political goals that they should be seen as a part of health diplomacy, and it is also for this reason that they have attracted concerns over their potential for taking WHO beyond its technical mandate and politicizing its role.²³

During the 1980s PAHO pioneered the negotiation of temporary humanitarian ceasefires to allow vaccination programmes. The conflicts in El Salvador and Peru in particular were widely identified as major obstacles to the successful eradication of polio, and PAHO and its collaborating organizations set about a process of convincing those governments and their opposition guerrilla insurgencies of the need to agree temporary ceasefires to allow the vaccination programme to be fully implemented on a nationwide basis. These initiatives ran parallel to the regional peace process (the Contadora initiative). In terms of health effects, this proved extremely effective. But the bigger claim is that they made a contribution to peacemaking by establishing constructive dialogue. Most obviously, both sides *were* persuaded to temporarily lay down their arms in order for the vaccination process to be carried out. The significance of this should not be underestimated: it was a real achievement by health advocates working in the context of a lengthy and frequently brutal civil war, and it stands in stark contrast to more recent cases elsewhere in which polio eradication efforts have been hampered by the deliberate targeting of vaccinators by militant groups.²⁴ Yet these days of tranquillity were by their very nature temporary. Once they were over the fighting resumed. Actually

demonstrating a causal link between these initiatives and the comprehensive peace process which culminated in the signing of the Chapultepec Accords in February 1992 is exceedingly difficult. Despite this, there is a widespread and oft-repeated perception that the days of tranquillity *did* make a meaningful contribution to peace.²⁵ However, the 'causes of peace' in El Salvador were many and varied and the PAHO immunization programme does not appear in the literature on the Salvadoran peace process at all. Neither is it clear that the temporary ceasefires significantly raised the level of trust between the FMLN and the government. We cannot entirely exclude the possibility that the immunization campaign had some political effects in helping to bring the parties together, but the evidence suggests that its significance was limited. Furthermore, there is an alternative interpretation of the immunization campaigns which presents them not some much as a 'bridge to peace' but rather as a part of a wartime PR campaign intended to garner goodwill for the government.

Despite the difficulties associated with evidencing the effectiveness of the days of tranquillity the core ideas did not die. Similar initiatives were implemented in numerous subsequent cases including Afghanistan, Angola, Bosnia, Chechnya/Russia, Democratic Republic of the Congo, Guinea-Bissau, Indonesia, Iraq, Lebanon, Mozambique, Philippines, Dominican Republic, Sierra Leone, Somalia, Sri Lanka, Tajikistan, and Uganda.²⁶ In particular the 1990s saw attempts by WHO and its partners to apply the basic logic underlying the 'days of tranquillity' far more widely. In so doing the 'Health as a Bridge for Peace' label was stretched to apply to a number of different engagements in conflict and post-conflict situations. In the mid-1990s HBP began to emerge within the WHO as an explicit part of its approach to the provision of health assistance in complex humanitarian emergencies. The WHO's expanded definition of the concept described it as

a multidimensional policy and planning framework which supports health workers in delivering health programmes in conflict and post-conflict situations and at the same time contributes to peace-building. It is defined as the integration of peace-building concerns, concepts, principles, strategies and practices into health relief and health sector development.

The Health as a Bridge for Peace concept is rooted in values derived from human rights and humanitarian principles as well as medical ethics. It is supported by the conviction that it is imperative to adopt peace-building strategies to ensure lasting health gains in the context of social instability and complex emergencies.

In achieving the primary goal of health for societies prone to and affected by war, we as health professionals recognize responsibilities to create opportunities for peace.²⁷

The idea of integration is key: that peace-building aims can be built into humanitarian assistance and development activities without undermining their effectiveness as health measures. It was noted above that both medical diplomacy and tailgate medicine can end up prioritising the political aims over health outcomes (although, of course, they seek to make a contribution to both). Humanitarian ceasefires, perhaps, fall more on the opposite weighting of these two priorities, the delivery of medical services being the essential task whilst political effects are hoped for but rarely demonstrable in practice. The WHO definition of HBP, however, effectively rejects this dichotomy, by arguing that peace is a prerequisite for achieving lasting health gains. The two are, therefore, indivisible. According to the WHO definition health professionals not only have the opportunity to make a contribution to peacebuilding, but "responsibilities to create opportunities for peace." This is, of course, a difficult thing to achieve in practice, and one which lies beyond the traditional skill-set of most health professionals.²⁸

One of the clearest examples of such a programme, and the one we focus on here, was the 'Peace through Health' programme implemented by WHO and the UK's Department for International Development in Bosnia and Herzegovina (BiH) in 1997-8. The Dayton Peace Agreement presented particular challenges to organizations like the WHO charged with the reconstruction of the country. The problems was not simply a damaged health infrastructure, but a health system ethnically divided as a result of the Dayton agreement into two. In fact, given the divisions between Bosniaks and Bosnian Croats within the Federation of Bosnia and Herzegovina, there were effectively three systems.²⁹ The key elements of the HBP programme were therefore focussed upon reducing discrimination, polarization, centralization of power and violence. The attempt to use the health sector to promote reconciliation was the focus of many of the activities carried out under the programme.³⁰

Once again, the question of effectiveness as a peacebuilding measure raises its head. And once again this is a difficult question to answer. Nevertheless, it was argued that WHO's efforts had indeed contributed to reducing polarization in the health sector; establishing a legal framework to combat discrimination; promoting dialogue and confidence building; and fostering cross-community activities amongst other things.³¹ Whilst these remain difficult to measure, the carrying out of a critical and reflective evaluation of the project lends more credibility to the claim that a contribution to peace was achieved.

Dangers and Dilemmas

Although they are in some ways quite different enterprises with markedly different institutional origins, there are a number of fundamental similarities between HBP-type engagements and health interventions in conflicts. Both are essentially seeking to leverage health for political ends. Both rest upon an assumption that the provision of public goods such as health and medical services can change attitudes in desirable ways. The modalities are somewhat different, as are the ways in which the balance between health goals and political goals is struck. Each, however, is an example of the new health diplomacy.

However, there are a number of common dangers and dilemmas which confront all of these attempts to leverage health for political ends in different ways and to different extents. Here we discuss five which arise out of the preceding discussion.

1. Timeframe

The timeframe in which health and political ends are meant to be achieved leads to very different ideas about what should be done and how. It is extremely difficult to secure gains across all timeframes simultaneously, and doing so requires more than one type of approach. Furthermore, as we have shown here, there can be tensions between them. The ultra-short term nature of 'days of tranquillity' could in some cases prolong conflict rather than bring peace. Tailgate medicine brings the danger of usurping the local health infrastructure and undermining the long-term credibility of the host state. Longer-term HBP and medical diplomacy efforts may do little to reduce tensions in the short term, and could even increase them if there is a perception of political bias.

2. Demonstrating effectiveness

All of these activities are intended to produce outcomes which are inherently difficult to measure. Questions such as whether hearts and minds have been won, of whether peace has been secured, and whether reputations have been improved do not lend themselves to easy answers. Proponents of all of the activities which we have discussed here routinely point to anecdotal evidence of their successes. Detailed evaluations are the exception rather than the rule.

Causal mechanisms are rarely explained and intervening variables rarely identified. Rather, there is a tendency to assume linkages between certain activities and certain outcomes. Bringing people together, for example, is often presented as leading inexorably to greater understanding between communities. This is one possible outcome, but it is not the only one.

3. What to do about the host state?

Despite the rhetoric about the importance of strengthening national governments, the primarily externally-led interventions considered here bring a danger of actually undermining the government. The temptation in post-conflict situations is for a greater degree of international intervention in domestic health policy making.³² But such an approach neither builds local capacity nor does it increase the population's confidence in their own government. Indeed it may serve to foster long-term dependency and undermine the state's credibility. Such problems are even more real, of course, when the political aim is not to build confidence in the host government at all, but rather to improve attitudes towards an intervening force.

4. Self-defeating actions elsewhere

Both medical diplomacy and HBP operations tend to be comparatively minor moves in much bigger political games. Clear examples of this can be seen in all of the activities which we have examined here. Tailgate medicine has been used in Iraq and Afghanistan in an attempt to win over the local populations at the same time as other actions (the mistaken aerial bombardment of a wedding celebration in Afghanistan, the abuses of prisoners at Abu Ghraib) undermine that very same message. The HBP initiative in BiH was carried out in the context of the Dayton Accords which set the agenda for the health system (not the other way around). Thus the attempts to bring communities together and promote reconciliation through the health sector was taking place after the administrative apparatus of health has been formally separated along ethnic grounds.

5. Which takes priority – political aims or health outcomes?

There are inherent tensions between health objectives and political aims. The boundary between 'pure' humanitarianism and aid for a political objective is a fuzzy and uncertain one, and the approaches we have examined here have all attempted to strike this balance in different ways. Privileging one or the other can lead to failures of different sorts, and attempting to achieve both can lead to achieving neither.

Politicization , impartiality and neutrality

Finally, probably the most common criticism of all of these types of activities is the danger of politicizing those health professionals (both local and international) who are responsible for delivering health services.

Although the aims of the different types of intervention we have discussed here are markedly different, both are seeking to leverage health for political ends. In doing so they challenge the traditional idea that health interventions can (or should) be separated from politics. This idea has historically been seen as fundamental to the operation of humanitarian and health agencies working in conflict situations. The ICRC, for example, sees its status as an “impartial, neutral and independent organization” which has an “exclusively humanitarian mission” as fundamental to its ability to deliver humanitarian assistance.³³ WHO has also traded on its status as a politically-neutral health – focussed actor in order to gain access for aid delivery in conflict situations. The idea of involvement in the delivery of foreign and security policy objectives is a direct challenge to such a view and has frequently been strongly resisted by some international NGOs and others.³⁴

In the HBP case the ‘politically-driven’ nature of the operations is not always made explicit. Indeed there is a tension at the very heart of the concept: on the one hand the claim is being made that health is a politically-neutral arena in which trust can be built; on the other it is being claimed that there can be political outcomes (the promotion of peace and reconciliation) from certain types of interventions. But as noted above, it is not inevitable that health will turn out to be universally seen as a common good around which trust can be built. In fact the opposite is possible – health (and in particular access to health services) can become a bone of contention around which further distrust, discrimination and injustice can coalesce. There were concerns raised during the WHO’s consultation that HBP could lead to a politicization of its role, hindering its ability to work effectively in conflict settings. Whilst military medics delivering tailgate medicine are generally less vulnerable to having their ability to deliver services threatened by perceived politicization – after all, by virtue of the uniform they wear they are much more obviously associated with one side in a conflict – there have been concerns raised that their activities can negatively impact upon other agencies by encouraging the idea that health assistance is politically-driven.

Describing the problem as one of the entry of politics into humanitarian assistance may, however, be the wrong line of attack. All health interventions are inherently political because they always involve choices about where, how and when to intervene and for whom. Paul O’Brien, advocacy coordinator for CARE in Afghanistan, argued that

(1) Humanitarianism is and should be political, (2) humanitarians can and should speak out about the justice and injustice of war, and (3) accepting funding from belligerents in war can make both principled and pragmatic good sense.³⁵

It is certainly the case that there are extremely serious issues at stake in this debate. In a number of recent conflicts charitable medical organisations have been targeted by belligerents. Even the ICRC – “the most apolitical of humanitarian agencies”³⁶ – found itself targeted by suicide bombers who drove an ambulance packed with explosives into its Baghdad headquarters in 2003, killing 12 people.³⁷ Despite their proclaimed neutrality, because their humanitarian actions benefit one side to the cost of the other, charitable organisations may be seen by some as part of the struggle.

Part of the problem in this ongoing debate has been one of terminology. Terms such as ‘apolitical’, ‘neutral’ and ‘impartial’ have often been used interchangeably or in inconsistent ways. Even if we accept that health interventions can never be entirely apolitical, the distinctions between neutrality and impartiality still causes problems. Dominick Donald distinguishes between impartiality and neutrality thus:

An impartial entity is active, its actions independent of the parties to a conflict, based on a judgement of the situation; it is fair and just in its treatment of the parties while not taking

sides. A neutral is much more passive; its limited actions are within restrictions imposed by the belligerents, whilst its abstention from the conflict is based on an 'absence of decided views'.³⁸

According to these definitions impartiality may well be desirable for those working in conflict situations, but neutrality - often interpreted as a passive stance precluding the passing of judgements on the behaviour of the parties to a conflict - may not.³⁹ Kenneth Anderson has criticised the 'moral poverty of neutrality' arguing that "It is not possible for *everyone* to stand aside as neutrals, even for the worthy purpose of treating evil's victims humanely, lest evil be allowed to triumph."⁴⁰ It is not desirable to have limits on humanitarian aid imposed by the warring parties, nor for agencies working on the ground to be prohibited from criticising the actions of one side or the other (for example, in relation to human rights abuses). It is for this reason that many humanitarian agencies have in recent years moved away from neutrality as the underpinning principle of their humanitarian character. But arguably this stance has now come under attack as humanitarian aid agencies find themselves becoming targets.

Too often, we argue, there is a failure to distinguish between being non-political (which we argue is never possible in the case of health interventions), being neutral (which brings the problems associated with passivity), and being impartial. It is the latter, that health sector actors must strive to achieve in conflict and post-conflict situations. They should avoid favouring one side or the other as far as possible, but remain politically/morally driven. HBP actors should remain impartial between the parties, but partial to the goal of building peace. In reality, of course, even humanitarian agencies who attempt to remain scrupulously impartial are regularly subject to accusations of favouring one side or another in a conflict situation. This is perhaps inevitable, and one of the difficulties inherent in providing health assistance in conflict situations.

¹ Tommy G. Thompson, 'The Cure for Tyranny', *The Boston Globe*, 24 October 2005. Available at http://www.boston.com/news/globe/editorial_opinion/oped/articles/2005/10/24/the_cure_for_tyranny/

² This approach was not limited to the Cold War, but was seen in post-Cold War crises such as Somalia and Iraq where the problem was seen as the leadership of a state, not its people. Removal of leaders such as Milosevic, Aideed and Saddam Hussein would allow the development of democracy and peaceful relations. Unfortunately, as events in Somalia and then Iraq and Afghanistan have demonstrated, this does not always follow.

³ Harley Feldbaum & Joshua Miachaud, 'Health Diplomacy: Navigating Between Global Health and Foreign Policy'.

⁴ See for example Elspeth Cameron Ritchie and Robert L. Mott, 'Military humanitarian assistance: the pitfalls and promise of good intentions', in *Military Medical Ethics* vol.2, p.824.

⁵ Baker, p.68. See also Robert J. Wilensky, *Military Medicine to Win Hearts and Minds* (Lubbock: Texas Tech University Press, 2004).

⁶ Ilona Kickbusch, 'Influence And Opportunity: Reflections On The U.S. Role In Global Public Health', *Health Affairs* vol. 21, number 6 (2002), available at <http://content.healthaffairs.org/cgi/reprint/21/6/131>.

⁷ MS Baker and P Ryals, 'The Medical Department in military operations other than war. Part II: Medical civic assistance program in Southeast Asia', *Military Medicine* 164/9 (1999), pp.619-25.

⁸ See Ritchie and Mott, pp.819-20.

⁹ Stewart Patrick & Kaysie Brown, 'The Pentagon and Global Development: Making Sense of the DoD's Expanding Role', Center for Global Development Working Paper No. 131, November 2007.

¹⁰ S. Ward Casscells, 'DoD's increasing role in global public health', CSIS, January 7 2009. Powerpoint slides available at: http://www.csis.org/media/csis/events/090107_casscells.pdf. Audio available at http://media.csis.org/globalhealth/090107_globalhealth.mp3

¹¹ Ibid.

¹² See also Ritchie and Mott p.810; and 'Voices from the front'.

- ¹³ Tailgate medicine is also used in peacetime operations where the purpose may be training. See Ritchie and Mott p.810.
- ¹⁴ Malish, Scott and Rasheed, pp137-9; Baker op. cit.; Ritchie and Mott op.cit., p.813;
- ¹⁵ Tommy G. Thompson, p.1
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