

Health and Peace: The Future of International Emergency Health Responses during Violent Conflict

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Cover Photo: A helicopter from MONUSCO leaves Oica, North Kivu province, in the Democratic Republic of the Congo. January 15, 2019. World Bank/Vincent Tremeau.

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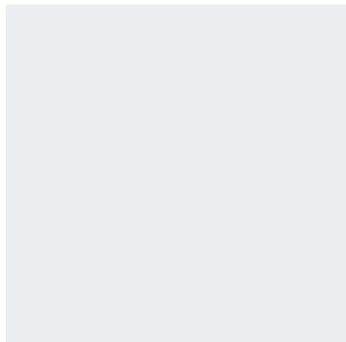
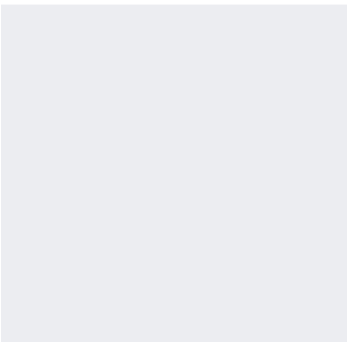
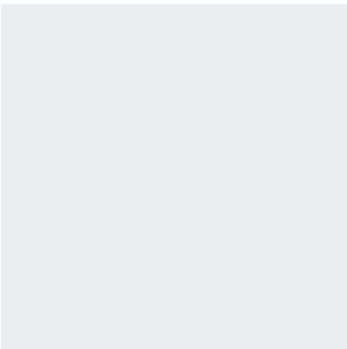
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ABBREVIATIONS

DRC	Democratic Republic of the Congo
DSRSG	deputy special representative of the secretary-general
GHPI	Global Health and Peace Initiative
HC	humanitarian coordinator
MSF	Médecins Sans Frontières
RC	resident coordinator
UN DPO	UN Department of Peace Operations
UN DPPA	UN Department of Political and Peacebuilding Affairs
UNDSS	UN Department of Safety and Security
UNMEER	UN Mission on Ebola Emergency Response
WHA	World Health Assembly
WHO	World Health Organization

Executive Summary

Recent health emergencies such as the 2018–2020 Ebola crisis in eastern Democratic Republic of the Congo (DRC), in conjunction with the early stages of the COVID-19 pandemic, demonstrate the importance of health responses that take the local context into account, especially in settings that are already affected by violent conflict. When humanitarian health responses fail to understand and adapt to their impact on conflict dynamics, they risk exacerbating those dynamics, impeding the health response, and placing health workers at risk. As healthcare becomes increasingly politicized, it is more crucial than ever to recognize the links between health and peace and promote a more deliberate approach to delivering emergency health responses in violent conflict environments.

The World Health Organization's (WHO) new Global Health and Peace Initiative (GHPI) emphasizes the need for emergency health responses that are both “conflict-sensitive” and “peace-responsive.” The process of developing the GHPI has reflected ongoing debates on the appropriate parameters for action at the intersection of health and peace. Under its first pillar—conflict sensitivity—the GHPI recommends strategies for adhering to the “do no harm” principle. Yet this principle can be in tension with the core principles of humanitarian health actors, including neutrality and impartiality. Under its second pillar—peace responsiveness—the GHPI applies the tools of conflict sensitivity to programming that seeks to proactively build peace through development and humanitarian activities. The GHPI recognizes that peace-responsive programming may not always be possible, and indeed, it is unclear under what conditions health actors should pursue such programming in conflict situations, if at all. The GHPI also grapples with challenges and risks related to ensuring national ownership over health and peace programming when the state is a party to the conflict, treating healthcare as a convener and common good in violent conflict environments, and coordinating between health actors and peace and

security actors engaged in health programming.

These dilemmas have operational implications that WHO and its partners will need to address when operationalizing the GHPI. Conflict-sensitive and peace-responsive health programming needs to manage the risks of politicization and securitization, such as the instrumentalization of activities by the government. Managing this risk requires strong political leadership, whether through the heads of WHO country offices or other senior officials. The following recommendations are aimed at helping WHO and its partners navigate these challenges when operationalizing the GHPI in violent conflict environments.

- WHO should develop the GHPI conceptual framework further, including by elaborating on when health actors should pursue peace-responsive programming and how they should coordinate with peace and security actors, as well as the relationship between the GHPI and political processes.
- WHO should design a strategy to operationalize the GHPI in violent conflict settings, including by developing tools, guidance, and training on conflict-sensitive analysis and programming; identifying the political skills required of those leading the implementation of such programming; and clarifying how to manage ethical dilemmas.
- The Executive Office of the Secretary-General should conduct a formal assessment of the Ebola emergency coordinator position during the 2018–2020 Ebola crisis.
- The UN Department for Safety and Security should review security risk assessment processes and safety and security measures and develop an inventory of safety and security measures that could be used in place of armed security.
- The UN Department of Peace Operations should review operational guidance for armed escorts and area security during site visits.

Introduction

In recent years, a number of serious health emergencies in territories experiencing armed conflict have drawn medical and public health services closer to politics underpinning those conflicts. In Syria, stakeholders in the conflict have instrumentalized medical assistance as a bargaining chip such that questions of humanitarian access are inexorably tied up in political negotiations. These challenges forced even the International Committee of the Red Cross (ICRC) to acknowledge that its assistance to those in need was skewed by the balance of power on the ground.¹ Since the military coup in Myanmar in February 2021, security forces have been accused of occupying dozens of health facilities and targeting health workers providing services to injured protesters and other civilians.² Also in 2021, both the Taliban and the Islamic State claimed responsibility for attacks on health services serving COVID-19 patients.³ This perceived increase in the politicization of healthcare has correlated with a significant increase in violent attacks against healthcare personnel, installations, and patients over the last decade.⁴ These trends prompted the Security Council to adopt Resolution 2286 (2016), which called for the protection of healthcare in conflict and reaffirmed the protected status of health workers under international law.⁵

In this context, international health actors are increasingly asking how they can better engage with conflict dynamics during emergency health responses. A better understanding of their positionality, they argue, will enable them to mitigate their potential negative impact on conflict

dynamics and reduce the risks of their becoming politicized—in other words, to become more “conflict-sensitive.” Some of these efforts, such as the World Health Organization’s (WHO) new Global Health and Peace Initiative (GHPI), go a step further, calling on health programs to include peacebuilding strategies that aim to deliver peace dividends through health interventions where feasible and appropriate. As political polarization around healthcare becomes a global phenomenon—the first six months of the COVID-19 pandemic saw a 50 percent increase in incidents of violence against healthcare workers as fear and misinformation about the pandemic spread—the links between health and peace seem only to be growing stronger.⁶ The GHPI and related efforts offer an important mechanism by which the international community can better grapple with this emerging trend and promote a more deliberate approach to delivering emergency health responses in violent conflict environments.

As political polarization around healthcare becomes a global phenomenon, the links between health and peace seem only to be growing stronger.

As these initiatives enter their operationalization phases, this policy paper asks what it means in operational terms for the international community to take a more conflict-sensitive approach to emergency health responses in violent conflict settings. These settings, of which there are currently seventeen, represent a small yet disproportionately risky subset of the “fragile, conflict-affected and vulnerable” situations in which the GHPI is intended to be primarily implemented.⁷ As international health and humanitarian actors build policy in this area, the paper examines the nascent assumptions about how health responses work—and are perceived to work—within modern conflict systems.

1 See: Dirk Druet, “United Nations Special Political Missions and Protection: A Principled Approach for Research and Policymaking,” International Peace Institute, July 2021.

2 UN Human Rights Council, *Situation of Human Rights in Myanmar: Report of the Special Rapporteur on the Situation of Human Rights in Myanmar*, Thomas H. Andrews, UN Doc. A/HRC/52/66, March 9, 2023; Damian Lilly, “The UN’s Response to the Human Rights Crisis after the Coup in Myanmar: Destined to Fail?” International Peace Institute, June 2021.

3 Safeguarding Health in Conflict, “Unrelenting Violence: Violence Against Health Care in 2021,” 2021.

4 See, for example: Els Debuf, “Evaluating Mechanisms for Investigating Attacks on Healthcare,” International Peace Institute, December 2017.

5 UN Security Council Resolution 2268 (May 3, 2016), UN Doc. S/RES/2268.

6 Brett C. A. van Stekelenburg et al., “Attacks on Health Care Workers in Historical Pandemics and COVID-19,” *Disaster Medicine and Public Health Preparedness* 17 (2023).

7 The World Bank Group Fragility, Conflict, and Violence (FCV) framework identifies seventeen conflict-affected countries, namely Afghanistan, Burkina Faso, Cameroon, Central African Republic, Democratic Republic of the Congo, Ethiopia, Iraq, Mali, Mozambique, Myanmar, Niger, Nigeria, Somalia, South Sudan, Syria, Ukraine, and Yemen. See: World Bank Group, “Classification of Fragile and Conflict-Affected Situations,” 2022, available at <https://www.worldbank.org/en/topic/fragilityconflictviolence/brief/harmonized-list-of-fragile-situations>.

The paper is aimed primarily at policymakers and practitioners involved in designing and implementing emergency health responses during situations of violent conflict, especially but not exclusively the GHPI. The paper draws on a series of interviews with UN, humanitarian, and health officials. It also builds on the findings of a previous study by the author on the international response to the 2018–2020 Ebola crisis and early stages of the COVID-19 pandemic in eastern Democratic Republic of the Congo (DRC), which focused on the operational implications of working at the intersection of health and peace. While this case was central to the origins of the GHPI, it is by no means the only case study or type of health emergency that should inform the health and peace agenda. The paper should thus be read alongside analyses of infectious disease responses in other settings, as well as responses to other types of health emergencies, such as trauma in besieged communities and the health consequences of natural disasters. Nevertheless, it is hoped that the paper's findings and recommendations will be helpful in supporting the operationalization of the GHPI and related activities at the intersection of health and peace in conflict settings.

The paper is structured in five parts. The first section discusses the global normative environment for emergency health responses in situations of violent conflict and proposals to strengthen the links between international health and peace activities, especially WHO's GHPI. The second section examines the concepts at the core of the GHPI initiative and considers their operationalization in violent conflict environments. The third section summarizes the emergency health response to the 2018–2020 Ebola epidemic in eastern DRC, how it interacted disastrously with conflict dynamics, and the lessons learned from the experience. On that basis, the fourth section highlights several risk areas that emergency health interventions working at the humanitarian-peace nexus in conflict will likely face and considers options for mitigating their impact. Finally, the paper concludes with recommendations aimed at supporting the further development of the conceptual framework for the health and peace agenda

and informing the operationalization of the GHPI and similar initiatives.

The Evolving Normative Environment

There have been several international efforts to strengthen the operational links between international health and peace. These include long-standing efforts to institutionalize the health-peace nexus in WHO, culminating most recently in the GHPI with its two pillars of “conflict-sensitive” and “peace-responsive” health programming.

The Multifaceted Roles of International Health Actors in Health Emergencies

Collectively, international health actors working in vulnerable settings fulfill a broad range of roles, ranging from high-level policy advice to individual clinical care. Each of these activities brings with it distinct (and sometimes conflicting) operational challenges, political considerations, and ethical questions. During health emergencies in situations of violent conflict, these roles converge under intense and challenging conditions. For the purposes of this policy paper, three operational categories of health response are particularly relevant. WHO's mandate covers all three of the areas, while other actors are only active in one or two of the categories.

- **Support to national health systems and services, including public health:** International health actors regularly work with national governments to strengthen ministries of health, develop national policies and standards for clinical care, and help governments plan responses to public health emergencies. This type of support to national governments is generally considered to fall within the scope of development work, and the principle of national ownership is central, in line with WHO's constitutional tenet that governments have the primary responsibility for the health of their population.⁸ However,

⁸ World Health Organization (WHO), “Constitution of the World Health Organization,” 2020, available at <https://www.who.int/about/governance/constitution>.

this work routinely occurs within countries experiencing violent conflict, including where the government is a party to that conflict.⁹ In 2023, for example, the WHO country office in Syria supported the ministry of health in redesigning its medical supply chain and establishing a national logistics system to deliver health supplies, including in areas in which the Syrian government is actively involved in military operations.¹⁰

- **Emergency humanitarian health response:** When crises and disasters, including violent conflict, result in large-scale suffering and loss of life, humanitarian health actors routinely undertake a range of emergency response activities, including disease-outbreak tracking, technical support and advice, provision of supplies, and the mobilization of health services.¹¹ WHO has an overarching coordination role as the leader of the Global Health Cluster, made up of dozens of international humanitarian health organizations, and as the coordinator of country-level health clusters. In this role, WHO coordinates the sharing and analysis of information, the identification of shared priorities for plans of action, and the responsibilities of different humanitarian health actors.¹² In addition to this coordinator role, WHO serves as a “provider of last resort,” implementing emergency health services directly to fill critical gaps in the humanitarian response. In all of this work, WHO and its humanitarian health partners are bound by the humanitarian principles of humanity, neutrality, impartiality, and independence.¹³ They are also bound by the principles of ethical

medical care, including that the primary task of healthcare personnel is to preserve physical and mental health and alleviate suffering and that the primary obligation of healthcare personnel is to their patients.¹⁴

- **Emergency public health response:** When an event in one state is determined to constitute a public health risk to other states and may require a coordinated international response to mitigate said risk, the WHO director-general may declare that the event constitutes “a public health emergency of international concern.” Under these circumstances, WHO may take on emergency response roles that transcend the national and international levels. Its functions include supporting the state in investigating and responding to the outbreak. Under certain limited circumstances, it is also empowered to gather and share information and advice on mitigation measures with other states without the consent of the host state. The guiding principles for this type of response include the protection of all people from the international spread of disease; the sovereignty of states; and the fundamental dignity, rights, and freedom of persons.¹⁵

The Institutionalization of the Health-Peace Nexus

The notion that healthcare and peace are closely intertwined has been broadly accepted since the formation of WHO. The organization’s constitution defines health as “a state of complete physical, mental and social well-being not merely the absence of disease or infirmity” and asserts that

9 WHO, “WHO Guidance on Preparing for National Response to Health Emergencies and Disasters,” December 20, 2021. While usually considered a development intervention, health actors’ support to ministries of health frequently serves disaster risk reduction and emergency preparedness objectives, which WHO considers one of the ways in which they engage with humanitarian emergencies. For example, WHO supports the development of national health emergency response operations plans, which lay out the structure, authorities, and responsibilities for a systematic, coordinated, and effective response during health emergencies. These plans are generally led by the government’s ministry of health but are expected to involve all national stakeholders involved in emergency and disaster management, such as the ministries of interior and defense. All WHO member states are required to produce national public health emergency response plans, including the creation of teams to “respond to events that may constitute a public health emergency of international concern,” by the International Health Regulations of 2005. See: WHO, “International Health Regulations (2005): Third Edition,” 2005, Annex 1, article 6.

10 WHO, “WHO and Ministry of Health Collaborate to Enhance Syria’s Medical Supply Chain,” press release, March 21, 2023.

11 WHO, “A Guidance Document for Medical Teams Responding to Health Emergencies in Armed Conflict and Other Insecure Environments,” June 18, 2021, p. 11.

12 WHO, *WHO’s Response, and Role as the Health Cluster Lead, in Meeting the Growing Demands of Health in Humanitarian Emergencies: Report by the Secretariat*, UN Doc. A65/25, March 16, 2012.

13 For an overview of the intersection of medical ethics and humanitarian principles, see: Grant Broussard et al., “Challenges to Ethical Obligations and Humanitarian Principles in Conflict Settings: A Systematic Review,” *Journal of International Humanitarian Action* 4, no. 19 (2019).

14 International Committee of the Red Cross (ICRC), “Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies,” 2015.

15 See: WHO, “International Health Regulations (2005): Third Edition,” articles 1, 3, 10, and 12.

“the health of all peoples is fundamental to the attainment of peace and security.”¹⁶ Its foundational documents laying out the relationship between WHO and other parts of the UN system establish the organization’s willingness to cooperate with the UN Security Council in “rendering such assistance for the maintenance or restoration of international peace and security as the Council may request.”¹⁷

More recently, there have been several attempts at operationalizing these principles as functions of the international health architecture. In 1981, the World Health Assembly (WHA) adopted a resolution highlighting the role of the health sector in promoting “peace as the most significant factor for the attainment of health for all.” In 1997, WHO established the Health as a Bridge for Peace program to link health interventions with peacebuilding in fragile and conflict-affected countries.¹⁸

It was not until recently, however, that this initiative began to gain traction alongside a sustained effort within the UN and humanitarian systems to bridge the previously siloed work of the UN’s humanitarian, development, and peace and security pillars. Citing the growing volume and duration of humanitarian appeals, the cyclical and protracted nature of many modern peace processes, and the fundamentally political nature of sustainable development, the 2016 World Humanitarian Summit adopted a “New Way of Working” focused on delivering longer-term resilience and stability in the course of providing more immediate assistance, as well as designing “collective outcomes” between the humanitarian and development pillars.¹⁹ This concept was later broadened to encompass the peace and security pillar and became known as the “humanitarian-development-peace nexus.” This

Precisely what constitutes appropriate programming at the intersection of humanitarian and peace activities has remained opaque in multiple sectors, including the health sector.

approach was seen as reinforced by the 2016 introduction of the concept of “sustaining peace,” which conceives of conflict prevention and peacebuilding as activities at all stages of conflict cycles and all stages of sustainable development.²⁰

Nevertheless, “peace” has never been fully integrated into the nexus as comfortably as the first two pillars. Some humanitarian actors fear that the design of collective outcomes with peace and security actors could undermine humanitarian principles, especially neutrality. Moreover, “peace” and “peacebuilding” are often highly sensitive terms for governments in fragile states, particularly when those countries are not on the Security Council’s agenda.

Consequently, precisely what constitutes appropriate programming at the intersection of humanitarian and peace activities has remained opaque in multiple sectors, including the health sector.

The Global Health and Peace Initiative

In this political and institutional context, WHO launched the Global Health and Peace Initiative (GHPI) in 2019 to “strengthen the links

between health and peace where possible without compromising health outcomes and without endangering health providers.”²¹ In a report to the 2022 WHA, the director-general justified the initiative as important to WHO’s work on five grounds. First, peace is a structural determinant to health, and when it is absent, health and health systems suffer. Second, the majority of WHO’s humanitarian health work, as well as most disease outbreaks, occur in fragile, conflict-affected, or vulnerable settings. Third, health has a “convening power,” as it is often seen as a common good by all sides in a conflict and is thus a useful starting point for rapprochement. Fourth, focusing on peace

16 WHO, “Constitution of the World Health Organization.”

17 WHO, “Agreement between the United Nations and the World Health Organization,” in *Basic Documents: Forty-ninth Edition*, 2020.

18 World Health Assembly (WHA), *Health for All in the Twenty-first Century*, UN Doc. A51/5, 1998.

19 UN General Assembly, *Outcome of the World Humanitarian Summit: Report of the Secretary-General*, UN Doc. A/71/353, August 23, 2016.

20 As described in the 2016 twin General Assembly and Security Council resolutions on sustaining peace. See: UN General Assembly Resolution 70/262 (May 12, 2016), UN Doc. A/RES/70/262; UN Security Council Resolution 2282 (April 27, 2016), UN Doc. S/RES/2282.

21 WHO, “Global Health and Peace Initiative (GHPI): Fifth Draft of the Roadmap,” May 25, 2023.

outcomes could strengthen the sustainability of WHO's work by improving the social and political environment in which this work takes place. Finally, a "conflict-sensitive" approach to the organization's work is necessary to "do no harm."

In practice, the GHPI advocates for the adoption of a "Health for Peace" approach to health programming. This approach consists of two components. First, it entails ensuring that health programs are "conflict-sensitive," meaning they are designed to proactively mitigate the risk of inadvertently exacerbating social tensions, contributing to conflict, or undermining social cohesion in a given society or community (also known as "do no harm"). Second, where the context, capacities, and risks allow, it entails designing and implementing health programs that are "peace-responsive," meaning they seek to improve the prospects for peace by, for example, strengthening social cohesion, equity, inclusivity, dialogue, or community resilience.

At present, the GHPI is an internal initiative of WHO, operating with a limited mandate and budget. Following the submission of the director-general's report to the seventy-fifth World Health Assembly in 2022, the WHA requested that WHO develop a road map on the way forward for the initiative, in consultation with member states. A draft road map underwent multiple internal (but public) revisions over the course of the year and was submitted to the seventy-sixth WHA in May 2023.²² While it was proposed that the WHA adopt the road map and instruct the director-general to begin reporting on its implementation, the assembly opted instead to "take note" of the road map and instructed that it be treated as a living document, subject to further review and consideration by the WHA.²³ This softening of language reflects the sensitivity of the issue and the level of ongoing debate among member states about the appropriate scope for the initiative.²⁴ Nevertheless, the resolu-

The political, operational, and logistical processes of delivering emergency health responses in insecure, highly polarized conflict environments risk drawing health actors directly into conflict dynamics.

tion arguably provides something of a mandate for WHO to further develop the initiative, including by promulgating guidelines and providing operational support for WHO country offices to implement health and peace programming.

The 2018–2020 DRC Ebola Crisis

While the priorities and limitations of programming at the intersection of health and peace are still being debated, it is important to consider the conceptual underpinnings and operational implications of the GHPI. It is also important to understand how the GHPI interacts with the principles, operational assumptions, and real-world experiences of humanitarian and peace and security actors. While the GHPI would apply to a much wider category of states, this paper concerns itself with the initiative's application in situations of violent conflict.

The international health and humanitarian response to the 2018–2020 Ebola crisis in eastern DRC provides an instructive case study of how

health actors can find themselves positioned within conflict systems. This crisis, which bled into the early stages of the COVID-19 pandemic, provides a salient illustration of how the political, operational, and logistical processes of delivering emergency health responses in insecure, highly polarized conflict environments risk drawing health actors directly into conflict dynamics.

Inserting an Emergency Health Response into Active Conflict Dynamics

In August 2018, the ministry of health of the DRC reported an outbreak of the Ebola virus in the eastern province of North Kivu. WHO subsequently designated the outbreak a public

²² Ibid.

²³ WHA, *Global Health for Peace Initiative: Draft Decision—Seventy-sixth World Health Assembly Provisional Agenda Item 15.3*, UN Doc. A76/7 Rev.1 Add.2, May 19, 2023; WHA, *Global Health and Peace Initiative—Seventy-sixth World Health Assembly Agenda Item 15.3*, UN Doc. WHA76(12), May 30, 2023.

²⁴ Interview with UN official, July 2023.

health emergency of international concern.²⁵ The epidemic was the first of its kind to occur within an ongoing violent conflict, which at the time featured multiple armed group insurgencies, a constitutional crisis, and ongoing security operations (and associated predation on local communities) by the national armed forces.²⁶ MONUSCO, the UN's peacekeeping mission in the DRC, was variously mandated to support these military operations, attempt to protect civilians from the rampant violence, and enable humanitarian actors to safely deliver assistance.

It was in this political and security context that the emergency health response to the Ebola epidemic was deployed. This response, which became known as the Riposte, was heavily influenced by the response to the 2014–2016 Ebola outbreak in West Africa, which was heavily criticized for WHO's lack of leadership and emergency response capacity, an operational approach that bypassed national systems, and disease control and treatment strategies that ignored local cultures, perceptions, and practices.²⁷ However, various international actors applied lessons from this experience to the DRC outbreak in different ways. Some in the international community cited the “perfect storm” of active conflict, rapid transmission, and community “resistance” to public health measures to justify a “policy of no regrets” that committed enormous resources and empowered WHO to decisively coordinate international action through its new Health Emergencies Programme.²⁸

At the same time, the Riposte heavily prioritized

national ownership and encouraged the DRC's ministry of health to play a central role in most aspects of the response.²⁹ WHO subsidized the deployment to the eastern provinces of a large number of ministry of health staff, many of them Lingala speakers from the center and west of the country.³⁰ In light of the ongoing fighting in the area, security considerations also dominated decision making. Emergency health actors began using national security services to provide escorts and area security. According to an investigative report by the Congo Research Group, some health actors also made payments to the DRC's notorious national intelligence agency (Agence nationale de renseignements) to support them in managing security risks throughout the affected area.³¹

Consequences for Security and Public Health

The large-scale, rapid, and heavily centralized insertion of the Riposte into the violent political economy of eastern DRC had profound effects on the effectiveness of the health response and the security of responders. The size of the response and its narrow focus on Ebola over other, more common causes of death (such as malaria and measles) led many local communities to question its motivations.³² Some, seeing the influx of new vehicles and medical personnel, concluded that Ebola had been manufactured by foreigners to generate income.³³ By surrounding itself with Congolese security forces and MONUSCO's armed peacekeepers, the Riposte directly associated itself

25 Aaron Aruna et al., “Ebola Virus Disease Outbreak — Democratic Republic of the Congo, August 2018–November 2019,” *Morbidity and Mortality Weekly Report* 68, no. 50 (December 2019).

26 For an overview of the conflict in the period leading up to the Ebola crisis, see: Judith Verweijen, “Stable Instability: Political Settlements and Armed Groups in the Congo,” Rift Valley Institute, 2016.

27 For a more detailed description of the international community's response to the 2014–2016 Ebola crisis in West Africa and its impact on the Riposte in the DRC, see: Dirk Druet, “Peace Operations at the Intersection of Health Emergencies and Violent Conflict: Lessons from the 2018–2020 DRC Ebola Crisis,” American Academy of Arts and Sciences, 2022.

28 “Ebola-Hit DRC Faces a ‘Perfect Storm’ as Uptick in Violence Halts WHO Operation,” *UN News*, September 25, 2018; WHA, *Reform of WHO's Work in Health Emergency Management: WHO Health Emergencies Programme—Report by the Director-General*, UN Doc. A69/30, May 5, 2016. When Ebola broke out in North Kivu, WHO quickly began deploying a workforce of epidemiologists, logisticians, field coordinators, and other specialists, reaching more than 1,500 staff who spent an average of 200 working days in the field. In total, over 3,580 health structures, including eleven Ebola treatment centers and twenty-five transit centers, were used as part of the response, and approximately 16,000 local frontline responders, including from the Congolese ministry of health, were deployed.

29 Even Médecins sans Frontières (MSF), well known for closely guarding its independence, initially agreed to participate in and coordinate its activities with the DRC government's coordination mechanism. MSF's then-president attributed this decision directly to the criticisms from the outbreak in West Africa. Interview with official in international organization, July 2021.

30 WHO, “Final Report of the Independent Commission on the Review of Sexual Abuse and Exploitation during the Response to the 10th Ebola Virus Disease Epidemic in DRC,” September 28, 2021.

31 Congo Research Group, “Rebels, Doctors and Merchants of Violence: How the Fight against Ebola Became Part of the Conflict in Eastern DRC,” August 2021.

32 Ibid.

33 Fondation Hirondelle, Demos, Harvard Humanitarian Initiative, and Icredes, “Influencers and Influencing for Better Accountability in the DRC,” July 2019, available at <https://www.hirondelle.org/pdfviewer/?lang=en&id=314>.

with unpopular actors in the conflict, which many in Beni accused of standing by as armed groups repeatedly massacred civilians.³⁴ Finally, the injection of hundreds of millions of poorly managed dollars into eastern DRC had perverse effects on the local political economy, producing what became known colloquially as “the Ebola business.” Among other issues, this created a permissive environment for sexual exploitation and abuse by national and international health workers.³⁵

These dynamics led to an unprecedented level of violence against emergency health responders. Between August 1, 2018, and February 27, 2020, WHO recorded more than 420 attacks on health facilities and workers.³⁶ This violence had immediate and serious effects on the Riposte’s ability to stem the spread of the virus. A study of contact tracing in eastern DRC between April 2018 and June 2019 found that incidents of violence against health workers correlated with a decrease in the speed at which patients were isolated after being identified, “with the average time between symptom onset and isolation rising from 8.1 days to 10.0 days after a disruptive event.”³⁷ At the conclusion of the epidemic in mid-2020, the mortality rate stood at approximately 65 percent, virtually unchanged from previous outbreaks despite improved treatments, the availability of a vaccine, and the enormous volume of resources invested.³⁸

The enduring mistrust was immediately felt in international efforts to slow the COVID-19 pandemic, which began during the same period. Rumors that a second trial of the Ebola vaccine was in fact a clandestine trial of a COVID-19 vaccine spread easily in eastern DRC. A study of the uptake of both Ebola and COVID-19 vaccines in the DRC

noted that “rumors circulated that COVID-19, like Ebola, was a business opportunity for pharmaceutical companies and their western backers... or that both COVID-19 and its vaccines were western schemes to exterminate the Congolese population.”³⁹

Contested Lessons for Health and Peace

From the 2018–2020 Ebola crisis, a consensus emerged within the international health community regarding the need to improve the capacity of health actors to understand and work within conflict dynamics. Within this broad consensus, however, contentious questions remain. How should the international health community engage with host governments when they are a party to the conflict and their approach threatens core operating principles and undermines outcomes? When an outbreak is perceived as a global security risk, how should the health community balance top-down imperatives with the rights and realities of vulnerable populations? Should the health community be accountable for its impact on conflict dynamics in politicized environments?

Although these questions have emerged in many national contexts during the international response to the COVID-19 pandemic, the urgency of that response has slowed their systematic consideration by policymakers. However, they are key to the success of current efforts to prepare future emergency health responses to operate more effectively in situations of violent conflict. It is thus important to critically analyze key concepts at the core of the health and peace agenda and consider the challenges, opportunities, and dilemmas related to its operationalization within conflict-affected settings.

34 Congo Research Group, “Rebels, Doctors and Merchants of Violence.”

35 Robert Flummerfelt and Nellie Peyton, “More than 50 Women Accuse Aid Workers of Sex Abuse in Congo Ebola Crisis,” *The New Humanitarian*, September 29, 2020; WHO, “Final Report of the Independent Commission on Allegations of Sexual Exploitation and Abuse.”

36 WHO, “Ending an Ebola Outbreak in a Conflict Zone,” November 29, 2020. The violence led to eighty-six injuries and eleven deaths.

37 Chad R. Wells et al., “The Exacerbation of Ebola Outbreaks by Conflict in the Democratic Republic of the Congo,” *Proceedings of the National Academy of Sciences of the United States of America* 116, no. 48 (October 2019).

38 Congo Research Group, “Rebels, Doctors and Merchants of Violence.”

39 Myfanwy Vaughan James and Shelley Susan Lees, “‘Are You Sure It’s Not the Corona Vaccine?’ An Ebola Vaccine Trial during COVID-19 in DRC,” *Medical Anthropology* 41, no. 5 (August 2022).

Operationalizing Health and Peace Concepts

The contested lessons from the DRC case are reflected in ongoing debates in the international community on the appropriate parameters for action at the intersection of health and peace. The uniquely transparent nature of the process for developing the GHPI, particularly WHO's practice of publishing progressive drafts of the GHPI road map online, permits a close analysis of how these debates contributed to the document's gradual refining and circumspection. For example, the document's description of the conditions under which "peace-responsive" programming should be pursued has gradually narrowed, and it has come to include more guidance for emergency health actors on navigating tensions among the principles and priorities for action. This section explores these debates from an operational perspective in an effort to contribute further nuance to the conversation.

Given emergency responders' failure to understand and mitigate their impact on the conflict environment in the DRC, the GHPI serves an important purpose in socializing the concept of conflict sensitivity more thoroughly within the health community.

Reconciling Conflict-Sensitive Health Interventions and the "Do No Harm" Principle

Conflict sensitivity, which is the core component of the GHPI and should apply to programming in all settings, is neither unique to the initiative nor controversial in the humanitarian health community. Indeed, conflict sensitivity is explained in the WHO "Red Book," which provides detailed technical guidance for medical teams preparing to deploy in situations of armed conflict or other insecure environments.⁴⁰ Nevertheless, given emergency responders' failure to understand and mitigate their impact on the conflict environment in the DRC, the GHPI serves an important purpose in socializing the concept of conflict sensitivity more thoroughly within the health community.

In practice, the GHPI recommends several standard conflict-analysis tools for analyzing the operational context of a potential health program and developing strategies to ensure the program is conflict-sensitive. These include conflict-sensitive strategies for targeting beneficiaries, sharing information, and engaging with communities, all of which are aligned with UN-wide guidance on the subject.⁴¹

In conflict environments, however, the "do no harm" principle can be in tension with the core principles of humanitarian health actors, including those of neutrality and impartiality, which oblige actors to provide assistance on the basis of need alone. For example, one humanitarian health actor noted that a conflict analysis for a prospective health intervention might identify the risk of intervention exacerbating conflict dynamics. For instance, negotiating with a non-state armed group leader for access to a population might strengthen that leader's negotiating position and prolong the conflict.

Nevertheless, impartiality may demand that humanitarian health actors deliver that intervention and engage with the armed group leader irrespective of the impact that might have on the conflict dynamics.⁴² The GHPI must therefore provide guidance on how these tradeoffs should be managed.

The Parameters and Risks of a Peace-Responsive Approach in Violent Conflict Settings

Peace responsiveness, the second component of the GHPI, applies the tools of conflict sensitivity to programming that seeks to proactively build peace through development and humanitarian activities. This concept, which Interpeace has expanded into a suite of operational tools, aligns with the objectives

40 WHO, "A Guidance Document for Medical Teams Responding to Health Emergencies in Armed Conflict and Other Insecure Environments," p. 25.

41 UN Sustainable Development Group, "Good Practice Note: Conflict Sensitivity, Peacebuilding and Sustaining Peace," May 2022.

42 Interview with officials in international organizations, March 2023.

of the humanitarian-development-peace nexus, including that non-peacebuilding actors should contribute to collective outcomes across these three pillars.⁴³

The GHPI road map states that the pursuit of peace outcomes “must be strictly tailored to the context and is not meant to be pursued on a systematic basis” and that peace-responsive programming should only be undertaken where the “context, capacities and risks” allow. It additionally clarifies that the initiative “seeks to contribute to ‘positive peace,’ which relates to the attitudes, institutions and structures that create and sustain peaceful societies... [and] does not intend to focus on political peace processes or negotiations.”⁴⁴

These circumspections require clarification of under what conditions health actors should pursue a peace-responsive approach in situations of violent conflict. The GHPI foresees a theory of change whereby peace-responsive health interventions could facilitate “rapprochement, building trust between parties to a conflict.”⁴⁵ Since WHO and its partners regularly implement emergency health responses amid ongoing armed violence, such opportunities could arise. However, using health interventions to promote peace in highly politicized, securitized environments presents obvious risks. These risks (discussed in more detail in the following section) include the potential politicization of health interventions, which could put both the success of the intervention and the safety of health workers at risk. While many of these risks are not unique to conflict settings, they are amplified by these settings’ polarized and securitized nature.

The GHPI road map is unequivocal in asserting that peace-responsive programming shall “always comply with medical ethics” and should only be

implemented “where possible without compromising health outcomes and without endangering health providers.” The above analysis suggests that, in violent conflict settings, this caveat would seem to limit the GHPI’s application to the mainstreaming of conflict sensitivity throughout WHO’s work, to the exclusion of peace-responsive approaches. This limitation by no means invalidates the GHPI in conflict situations; on the contrary, these environments’ high levels of risk make them, arguably, the highest priorities for conflict-sensitive analysis and programming and arguably the highest-priority countries for the designation of resources for this purpose.

Localization versus National Ownership when the State is a Party to the Conflict

Recent experiences have illustrated the importance of locally tailored health and communications strategies, the risk of undermining national institutional capacity during large-scale emergency responses, and the risk of empowering predatory national actors.

The GHPI asserts that health and peace programming “must be led at national level—from national authorities down to the community level—including setting priorities, addressing local conflicts, or linking communities with different levels of government.”⁴⁶ However, the principles of national and local

ownership do not always align in practice. Recent experiences of international health actors responding to public health emergencies, such as the COVID-19 pandemic, have illustrated the importance of locally tailored health and communications strategies, the risk of undermining national institutional capacity during large-scale emergency responses, and the risk of empowering predatory national actors in conflict settings if health interventions are not conflict-sensitive. Adhering to the principles of national ownership and localization is especially complicated in conflict settings when the state is a party to the conflict.

43 Anita Ernstorfer, Anne-Sofie Stockman, and Frauke de Weijer, “Peace Responsiveness: A Paradigm Shift to Deliver on Conflict Sensitivity and Sustaining Peace, Development in Practice,” forthcoming. See also: “Peace Responsiveness: Delivering on the Promise of Sustaining Peace and the Humanitarian-Development-Peace Nexus,” *Interpeace*, September 2021.

44 WHO, “Global Health and Peace Initiative (GHPI): Fifth Draft of the Roadmap.”

45 WHO, “Health and Peace Handbook,” forthcoming.

46 WHO, “Global Health and Peace Initiative (GHPI): Fifth Draft of the Roadmap.”

National ownership, while both an operating principle and, in many cases, a requirement for humanitarian health access, also comes with risks. It can exacerbate conflict dynamics and breed the predation on or marginalization of local communities. In the DRC, local communities often saw the Kinshasa-based health officials who arrived to lead the Riposte as predatory and not to be trusted. For some health actors, such as Médecins Sans Frontières (MSF), the answer may be to revert to the strictest possible level of independence, both from the host government and from other health actors working with the organization. This approach is not feasible for WHO, while other humanitarian actors fall somewhere on the spectrum between these two organizations. WHO must carefully consider how to maintain the maximum level of “effective” and “perceived” independence without eschewing the political imperative of national ownership. The GHPI road map acknowledges these challenges and foresees country-specific arrangements that reflect the nature of the relationship with the central government and the preferences of authorities at all levels.⁴⁷ Negotiating these arrangements is an innately political exercise requiring diplomatic expertise.

Similarly, when local communities mistrust central government institutions, the localization of health responses may be in tension with the principle of national ownership. Here again, health actors require a political strategy to preserve their independence and mitigate the risk of securitization at the local level (including reconsidering security arrangements), as well as find sources of information for local conflict analysis that are independent of and confidential from government partners. Such strategies must also include preparations to understand the information environments in which a health response is deploying and adopt measures to communicate effectively with populations.⁴⁸

Healthcare as a Convener and a Common Good

The GHPI cites healthcare as a platform for dialogue and cooperation between otherwise opposed parties in conflict. Even during active hostilities, it notes, parties have successfully negotiated temporary cease-fires to enable the provision of health services, often with the facilitation of humanitarian actors. The legitimacy enjoyed by WHO by virtue of its technical expertise and role as a norm-setting organization enables it to play this “health diplomacy” role and bring parties together to collaborate over the shared good of healthcare. WHO guidance on health and peace describes disease surveillance and response across conflict lines as presenting an opportunity for collaboration over a shared interest. Indeed, there are numerous positive examples of this concept in action in recent years, such as public dialogues in post-revolution Tunisia to design a more inclusive and responsive health system and technical cooperation between the Palestinian and Israeli public health systems around shared morbidity risks.⁴⁹ In the wake of the COVID-19 pandemic, greater attention is being given to the role healthcare plays in global cooperation and the diplomatic strategies of states and institutions.⁵⁰

In intrastate violent conflicts, particularly when the state is a party to the conflict, it is important to problematize and nuance the notion of healthcare as a public good, including when it is delivered by the international aid community. Local communities may not want the public health services being provided to them if they do not trust the service providers. As in the DRC case, individual and community health interests can conflict with national and international interests, exposing affected communities to overly coercive behaviors by national authorities. This conflict in interests can also lead to poorly contextualized responses

⁴⁷ Ibid.

⁴⁸ For an overview of past efforts, challenges, and emerging priorities for peace and security actors to communicate effectively in conflict settings, see: Jake Sherman and Albert Trithart, “Strategic Communications in UN Peace Operations: From an Afterthought to an Operational Necessity,” International Peace Institute, August 2021.

⁴⁹ WHO, “Health and Peace Initiative,” January 2020; Harvey Skinner et al., “Promoting Arab and Israeli Cooperation: Peacebuilding through Health Initiatives,” *The Lancet* 365, no. 9466 (April 2005).

⁵⁰ See, for example: Tanisha Fazal, “Health Diplomacy in Pandemic Times,” *International Organization* 74, supplement (December 2020).

that contribute to perceptions that the services provided do not respond to communities' most pressing needs.

As noted in the GHPI road map, conceptualizing health in these contexts requires us to differentiate between public health activities and individualized clinical care.⁵¹ As is clear from the Ebola case study and, more recently, the COVID-19 pandemic, public health emergencies of international concern touch upon multiple layers of public interest that inevitably reproduce patterns of global power and exclusion. In the DRC, local communities and political actors quickly and explicitly tied the Ebola response to Western agendas, a perception easily enabled by the Riposte's failure to address other, more localized health threats such as malaria. Making this distinction in environments where health and peace programming is being implemented will require careful positioning vis-à-vis national health actors, nuanced communication, and critical analysis of the assumptions underlying GHPI programming.

Healthcare as a Subset of International Peace and Security Strategies

Health programming is regularly a component of international peace and security activities. Examples include medical care provided to children newly separated from armed groups, medical and psychosocial support for survivors of conflict-related sexual violence, and the establishment of national health services in areas to which government authority has been restored following a political settlement or a security operation. In all of these cases, both development and humanitarian international health actors pursue collective outcomes that include sustaining peace.

While the GHPI road map acknowledges the importance of collaborating with UN and non-UN partners in delivering health and peace initiatives, it makes only passing reference to the potential for collaboration with UN missions and other peace and security actors. In practice, this collaboration

may be the least novel and least controversial of the concepts at the core of the health and peace agenda, offering an alternative approach to peace-responsive health programming in conflict settings. Under this approach, health actors are focused not on proactively generating peace dividends but rather on operating more effectively within national and international mechanisms for coordinating aid among peace, development, and humanitarian actors. These mechanisms include the cluster system; the humanitarian country team, especially in integrated mission settings with "triple-hatted" deputy special representatives of the secretary-general/resident coordinators/humanitarian coordinators (DSRSG/RC/HCs); and civil-military coordination fora. This coordination is not without risks and dilemmas for protecting humanitarian principles and medical ethics, but it may present a more viable approach to peace-responsive health interventions in armed conflict.⁵²

Mitigating the Risks of Health and Peace Programming in Violent Conflict Settings

As discussed above, implementing the health and peace agenda in violent conflict settings presents complex policy questions, operational dilemmas, and opportunities for strengthened collaboration. This section considers how some of these challenges could play out in operational terms, usually alongside international peace and security activities, and how WHO and its partners could address these challenges when operationalizing the GHPI.

Negotiating the Risk of Politicization

Situations of ongoing violent conflict create challenging political contexts for international health initiatives. In the DRC, the colonial legacy of public health as a mechanism of repression and

51 Humanitarian health actors, notably MSF, had been critical of previous iterations of the GHPI road map, which they argued failed to make the distinction between public health and individualized medical care, thereby collapsing two distinct bodies of medical ethics and policy considerations. See: MSF, "WHO Global Health and Peace Initiative: MSF Briefing Paper for the 152nd Session of the WHO Executive Board Agenda Item 12.3," February 6, 2023.

52 See, for example: Volker Franke, "The Peacebuilding Dilemma: Civil-Military Cooperation in Stability Operations," *International Journal of Peace Studies* 11, no. 2 (2006).

extraction, the relationship between the national health system and other parts of the state, and the proximity to the national and international security responses converged to create fatally low levels of trust in the health responses to Ebola and COVID-19. This low trust, exacerbated by the conflict-insensitive insertion of resources into the situation, enabled those who sought to politicize the response to advance their partisan interests, sustain rent-extracting arrangements, or simply access their perceived share of the influx of cash.

Even if these factors were less pronounced or better mitigated in future health responses, any peace-responsive health programming needs to manage the risk of politicization, such as the instrumentalization of activities by the government, as discussed in the preceding section. Managing these risks requires political and diplomatic sophistication among those designing and implementing peace-responsive health activities and those representing them. WHO personnel suggest that the responsibility for considering the potential peace dividends that could arise from a health program and negotiating these dividends with national political authorities and other stakeholders would fall to senior program staff rather than individual health workers, a strategy that insulates clinical staff from ethical hazards.⁵³

Ensuring Strong Political Leadership

Strong political acumen and leadership is necessary to implement peace and health programs in violent conflict settings. For health actors within the UN system, there appear to be three main approaches to securing in-country political leadership capacities. First, political leadership could be given greater priority as a function of the heads of WHO

country offices. These officials are responsible for negotiating the strategic and technical aspects of health programming and represent WHO within the UN country team, where the agency can influence conflict-sensitive and peace-responsive analysis and programming in the UN's standard strategic planning exercises. To be effective in this politically sensitive role and avoid being instrumentalized, heads of WHO country offices would need to possess political acumen and diplomatic skills and be supplied with adequate political and conflict analysis. As most current heads of office are drawn from the medical profession, they may not all possess the necessary training and experience.⁵⁴

In the DRC, the colonial legacy of public health as a mechanism of repression and extraction, the relationship between the national health system and other parts of the state, and the proximity to the national and international security responses converged to create fatally low levels of trust in the health responses to Ebola and COVID-19.

Second, health and peace initiatives in conflict environments could place greater responsibility for the political aspects of their work with senior UN political officials, notably "triple hatted" DSRSG/RC/HCs in integrated mission settings. This approach could be particularly useful where there are opportunities for healthcare

initiatives as broader international peace and security activities, such as support to political settlements or ceasefires. It could also help health actors and their partners across the humanitarian, development, and peace pillars better anticipate and meet these needs while reducing the risk of politicization.

The third approach would involve appointing new or different officials to provide dedicated political and strategic leadership during health emergencies. This model was adopted during the Ebola crisis in the DRC when, in May 2019, the secretary-general appointed then-MONUSCO DSRSG David Gressly as the UN's emergency Ebola response coordinator. This filled what former UN officials have described as a gap in political leadership during the health emergency.⁵⁵ The move came after senior officials from the World Bank, the European Commission,

⁵³ Interview with WHO personnel, March 2023.

⁵⁴ For a detailed examination of the challenges the UN human resources system faces in marrying nontraditional combinations of skill sets (in this case, political leadership and medical expertise) to meet the needs of complex, multidimensional roles in the field, see: Namie Di Razza, "People before Process: Humanizing the HR System for UN Peace Operations," International Peace Institute, October 2017.

⁵⁵ Interviews with former UN officials, October 2021 and April 2023.

Gavi, and the governments of the United States and United Kingdom issued a joint letter calling for the appointment of a senior official “who is fully and formally empowered to lead full time the relationship with the DRC Government on Ebola and is able to give direction to the UN family.”⁵⁶ WHO described Gressly’s role as “overseeing the coordination of international support for the Ebola response and working to ensure that an enabling environment—particularly security and political—is in place to allow the Ebola response to be even more effective.”⁵⁷

To date, there has not been a comprehensive assessment of the emergency Ebola coordinator position. However, a 2021 study by the Overseas Development Institute noted that creating distinct points of leadership—by vesting political leadership in the emergency coordinator while WHO continued to coordinate the health response—created confusion.⁵⁸ A more detailed analysis could assess the coordinator’s strategy for and impact on the political positioning and conflict sensitivity of the emergency health response, as well as how Gressly’s previous role as DSRSG of MONUSCO impacted these efforts. Such an assessment could shed light on priorities and dilemmas for political leadership during emergency health responses.

Mitigating the Risk of Securitization

Since conflict settings are among the most dangerous humanitarian operating environments, they are inevitably among those most at risk for the securitization of humanitarian assistance. The case of the DRC points to the benefits of maximizing the distinction between healthcare workers and security forces. Moreover, it highlights the devastating

effects that the securitization of healthcare can have on health and public health outcomes, conflict drivers, and the safety of healthcare workers.

At the same time, it is important to consider that in some settings, the national health system (and in the wake of Ebola and COVID-19, the international health system in some places) may be innately securitized because it is an endogenous, non-passive entity within a conflict system. Moreover, in situations where healthcare is politicized before a health emergency or a new health initiative, there may be limits to the ability of health actors to maintain their perceived neutrality and independence. This is particularly true for WHO and other UN actors, which will inevitably be perceived as aligned with the central government to some extent.

The case of the DRC points to the benefits of maximizing the distinction between healthcare workers and security forces.

Additionally, UN health actors seeking to implement conflict-sensitive and peace-responsive programming in highly insecure environments have limited agency to mitigate the risk of securitization, since the

UN’s security management system is, by design, largely unaccountable for substantive outcomes. It is, after all, the UN Department of Safety and Security (UNDSS), not UN health agencies, that sets the security precautions required for UN activities, including requirements for armed escorts, body armor, and multi-vehicle convoys. Still, there may be scope for UN health actors to advocate for UNDSS and UN peacekeeping operations to rethink their standard operating procedures for providing escorts and area security for politically sensitive operations. More conflict-sensitive analysis should help health actors determine when the risk of using international or national security services to deliver assistance outweighs the potential value.

56 Nicholas Crawford et al., “The Democratic Republic of Congo’s 10th Ebola Response: Lessons on International Leadership and Coordination,” Overseas Development Institute, March 2021.

57 WHO, “United Nations Strengthens Ebola Response in the Democratic Republic of the Congo,” press release, May 23, 2019.

58 Crawford et al., “The Democratic Republic of Congo’s 10th Ebola Response.” This finding was commensurate with the findings of a 2016 lessons-learned study conducted by the executive office of the secretary-general in collaboration with the International Peace Institute and the executive office of the UN Mission on Ebola Emergency Response (UNMEER), deployed to the Ebola crisis in West Africa in 2014–2016. The study found that the early siloing of UNMEER’s political and operational leadership coupled with WHO’s technical expertise and leadership would have promoted a more integrated and coherent international response. See: UN General Assembly, *Lessons Learned Exercise on the Coordination Activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General*, UN Doc. A/70/737, March 4, 2016; Adam Lupel and Michael Snyder, “The Mission to Stop Ebola: Lessons for UN Crisis Response,” International Peace Institute, February 2017.

Conclusion and Recommendations

The basic proposition of the GHPI and the broader health and peace agenda is that health interventions must be conflict-sensitive and preceded by a robust attempt to predict their secondary effects. This is critical to ensure that future health activities in conflict-affected, fragile, and vulnerable settings meet their objectives and “do no harm.” Amid the evolving international politics surrounding global health and the potential for more internationalized health emergencies in the future, situating local political economies and national political contexts at the center of WHO’s strategies for emergency health responses is fundamental to their success. From a global public health perspective, the international community has a strong interest in supporting these efforts and ensuring that costly and risky efforts to bring peace and alleviate suffering in violent conflicts are not undermined.

Violent conflict settings present risks for the delivery of peace-responsive health initiatives in line with the approach described in the GHPI road map. Undertaking peace-responsive health activities in a situation of ongoing conflict where a political settlement is not in place is fundamentally different from doing so in a pre- or post-conflict peacebuilding context. If WHO were to conclude that conditions in a given conflict context were appropriate for health and peace programming, the operationalization of the GHPI would benefit from further thinking. This includes considering questions around the role of peace and security actors in these situations, how health fits into political settlements and peacebuilding strategies, and how health and peace initiatives might best fulfill their objectives as well-coordinated components of these activities.

The following recommendations, addressed to WHO and other international humanitarian, health, and peace and security actors, are aimed at helping to operationalize the GHPI within violent conflict environments. They aim to assist in tailoring the operationalization of the GHPI to health programming in violent conflict settings and in identifying the capacities and resources necessary to achieve its core objective.

For WHO

WHO should further develop the GHPI conceptual framework before rolling it out to the field. In particular, it should:

- **Elaborate and ensure consistency in the GHPI’s guidance on the contextual conditions under which to pursue peace-responsive health programming.** Where relevant, the GHPI should describe how peace-responsive health programming will be implemented in alignment with humanitarian principles, such as in relation to government ownership. It should also provide guidance on how such decision-making processes can guarantee the delivery of impartial, needs-based health services, in compliance with humanitarian principles.
- **If it is intended to be applied in active conflict situations, ensure that the second pillar of the GHPI (peace responsiveness) addresses the delivery of health and peace activities in the context of international peace and security strategies and political settlements.** The GHPI should articulate priorities and strategies for increasing coordination and designing collective outcomes between the health cluster and peacebuilding actors such as the Departments of Peace Operations (DPO) and Political and Peacebuilding Affairs (DPPA), both at headquarters and in the field.
- **Clarify the conceptual relationship between the GHPI and political processes in conflict settings.** This includes identifying the role of health initiatives in opening space for intercommunity and national dialogue and negotiating access to armed groups.

WHO should design a tailored strategy to operationalize the GHPI in violent conflict settings. In particular, it should:

- **Prioritize the development and resourcing of tools, guidance, and training on conflict-sensitive analysis and programming that is tailored to situations of violent conflict.** These efforts should be undertaken in coordination with DPO and DPPA to ensure continuity and complementarity of efforts.
- **As part of guidance on conflict-sensitive**

analysis and programming, develop tools for understanding, planning for, and adapting to fraught information environments during international emergency health responses.

WHO should tailor strategic communication strategies and capacities for conflict settings with the assumption the healthcare may be politicized and that external health intervention may not be seen as a universal good.

- **Develop specific criteria for the political skill sets required for WHO country directors and related officials to lead conflict-sensitive programming and engage with international, national, and local stakeholders in violent conflict settings.** WHO should assess the profiles of current country directors against these needs and, if necessary, institute a recruitment and training strategy to ensure they meet these criteria.
- **Develop guidance for health and peace actors on how to manage ethical dilemmas that may arise in the delivery of their activities.** This should include guidance and training on how staff should navigate the inevitable dilemmas that will arise in complex conflict settings.

For the Executive Office of the Secretary-General

- **Conduct a formal assessment of the Ebola emergency coordinator position during the 2018–2020 Ebola crisis.** The Secretariat should generate recommendations for the secretary-


general on how to manage the challenges, opportunities, and risks facing political leadership during health crises in violent conflict settings and provide options for integrated political leadership in these situations.

For UNDSS

- **Conduct a review of security risk assessment processes and safety and security measures.** This could be done in consultation with humanitarian actors to account for the long-term consequences of short-term security measures.
- **Develop an inventory of safety and security measures that could be used in place of armed security for politically sensitive activities on an exceptional basis and with the approval of the designated official.** This should be done in coordination with the humanitarian community and other safety and security actors such as the International NGO Safety Organization.

For DPO

- **Review operational guidance for armed escorts and area security during site visits.** This should be done in consultation with humanitarian actors to explore alternatives to close-proximity protection.



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