

# Peace Through a Healing Transformation of Human Dignity

## Possibilities and Dilemmas in Global Health and Peace

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Collective violence leads to grievous harm for affected populations, impacting both combatants and noncombatants. In recent years there has been an increased focus on the relationship between peace and health, with the World Health Organization calling for health professionals to engage in efforts to promote peace. While the notion of “health as a bridge for peace” is promising, there are many ambiguities in this emerging field, creating moral and practical dilemmas. In this manuscript I will discuss some of the challenges within the paradigm of health and peace using an exemplar of my research within the Israeli-Palestinian conflict. **Key words:** *genuine encounter, healing, human dignity, human rights, Israeli-Palestinian conflict, Lonergan, peace, transcendent pluralism*

**V**IOLENT CONFLICT has a grave impact on human health and well-being. Collective violence affects not only combatants, but with increasing frequency, the civilian population as well. Waldman<sup>1</sup> points out that in recent violent conflicts across the globe, the principal victims have been civilians. Civilian morbidity and mortality are often due to the indirect consequences of conflict related to

displacement from homes and barriers in access to food, shelter, clean water, sanitation facilities, and professional health care. Refugees and internally displaced persons often suffer from high mortality rates.<sup>2</sup>

Nursing practice and knowledge development have been profoundly influenced by nursing leaders who provided care to the people wounded during war. For example, Clara Barton’s legacy of caring includes not only victims of the American Civil War but also the Spanish-American War in Cuba.<sup>3</sup> Meleis points out that nursing interventions during war were an important stage in helping nursing define its mission and domain of knowledge that influenced the discipline’s theoretical base. Indeed, both the Western tradition under Florence Nightingale and the Eastern tradition under Rufaida Bent Saad al-Aslamiya were shaped by such experiences. Nightingale and her nursing staff provided care to soldiers during the Crimean war while al-Aslamiya cared for the wounded during wars in the time of the prophet Mohammed. Both these women viewed the domains of nursing knowledge as encompassing the patient as well as the environment of care.<sup>4</sup>

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In recent years, health care has been championed as a “bridge for peace”<sup>5</sup> with the potential to reduce conflict through a variety of interventions. However, health care providers working in situations of violent conflict practice under a range of domains including humanitarian relief, human rights promotion, and health sector development. These areas emerge from paradigms with very different principles and assumptions. If we are to realize the potential of health as a bridge for peace (HBP) and avoid harmful unintended consequences, it is important to critically analyze the conditions under which this might best be achieved.

The following article explores some of the varying domains of global health practice that relate to violent conflict and discusses dilemmas within these efforts. An exemplar is provided of my own research and practice within the context of the Israeli-Palestinian conflict to illustrate some of the challenges in peace-health initiatives.

## HEALTH AND PEACE

The World Health Organization (WHO) argues that prevention of violent conflict is an important component of public health. “Good public health practice requires identifying risk factors and determinants of collective violence, and developing approaches to resolve conflicts without resorting to violence.”<sup>2(p220)</sup> Indeed, the Ottawa Charter for Health Promotion,<sup>6</sup> of which the WHO was a cosponsor, listed “peace” first among the conditions necessary for health. As noted by Waldman, “war and public health are fundamentally incompatible pursuits.”<sup>1(p63)</sup>

In a position statement, The International Council of Nurses (ICN) has declared its strong opposition to armed conflict citing a particular concern with “the direct and indirect impact on health and development and violation of basic human rights.”<sup>7</sup> In a further position statement related to eliminating weapons of war and conflict, the ICN calls on national nurses associations to work to

eliminate particularly destructive armament such as nuclear and biological weapons, warning that their use may result in catastrophic consequences for global public health. “The death, injury and devastation resulting from use of these weapons exceed the response capacity of the health care systems or civil defence [sic] plans....” The ICN calls upon nurses to lobby governments to abide by international agreements and to solve conflicts nonviolently. Furthermore, this position statement declares that nursing’s respect for human life and dignity, as espoused in the ICN Code of Ethics for Nurses, places a responsibility on nurses to work for the elimination of the precipitating factors of violent conflict that pose a threat to human life and health.<sup>8</sup>

McGuire & Boyle<sup>9</sup> point out the ways in which militarized language permeates our culture and public discourse, creating an environment that is unsafe and unhealthy. They call for nurses to work on a collective and organized level to help transform society toward a more nonviolent culture. This includes educating ourselves and others about the effects of war and weaponry, political advocacy, critiquing the justification for war, and conducting research into the suffering associated with war.

A framework called HBP was formally adopted by the WHO in 1998 to support health care workers in conflict and post-conflict regions in running health programs that contribute to peace building. HBP is defined as “the integration of peace building concerns, concepts, principles, strategies and practices into health relief and health sector development.”<sup>5</sup> The WHO describes HBP as being rooted in medical ethics as well as human rights and humanitarian principles. The essence of this model is a “technical space” in which health care personnel from conflicting sides work jointly in service, training, and policy initiatives.<sup>5</sup>

MacQueen and Santa-Barbara use the term “health-peace initiative” to describe any activity that has the goal of both advancing a population’s health and improving their level of peace and security. For example, in El

Salvador, organizations successfully negotiated “days of tranquility,” with fighting suspended for 3 days every year to immunize children.<sup>10</sup> Drawing on the success of such initiatives, MacQueen et al<sup>11</sup> call for a new discipline focused on peace through health.

The related term “global health diplomacy” has been described by Kickbusch et al<sup>12</sup> from the lens of negotiation related to multiactor compromises and agreements in the area of global health policy. The authors note corresponding movements of diplomats becoming more involved in global health issues and public health experts becoming involved in diplomacy. These movements have created a need for joint policy development as well as professional training to build capacity. Recent developments in Switzerland and Brazil are cited as examples.

Ten strategies have been identified through which health care professionals can promote peace. These include (1) redefinition of the conflict as a threat to public health, (2) the creation of super-ordinate goals that transcend the conflict, (3) mediation towards cooperation and conflict transformation, (4) dissent and noncooperation with unjust practices, (5) advancing knowledge related to the impact of the situation on health, (6) strengthening connections in the social fabric, (7) solidarity such as human rights advocacy, (8) promoting social healing and reconciliation, (9) extending altruism to help parties overcome demonization, and (10) restricting the destructiveness of war such as through weapons bans.<sup>13</sup>

Research in the area of health and peace is in early stages but suggests the need for rigorous attention to strategies and evaluation. A case study analysis comparing HBP interventions by the WHO in Angola, Bosnia and Herzegovina, Eastern Slavonia (Croatia), and Haiti concluded that the most comprehensive and effective program was in Bosnia and Herzegovina. Effectiveness was related to having clear organizational principles, country-wide coverage, comprehensive technical programs, strong leadership in the field, multidisciplinary staff, adequate resources, and a permissive security environment. In contrast,

HBP actions in Haiti ignored the underlying tensions and were thought to have exacerbated local tensions and social divisions.<sup>14</sup>

## **PARADIGMS INFLUENCING GLOBAL HEALTH**

While the notion of HBP is promising, there are also many ambiguities and differing practice assumptions in this emerging field that need further investigation. The following sections will discuss 3 paradigms within global health practice, whose divergent normative principles raise potential challenges for the emerging domain of health and peace. These include health sector development, humanitarianism and human rights.

### **Global health practice and health sector development**

The complexities in HBP are inherent in the conceptualization of global health itself. The ambiguous nature of the term “global health” is discussed by Kaplan et al.<sup>15</sup> The authors argue that establishing a common definition of global health is essential for agreement around goals, strategies, skill development, and resource use. They suggest the following definition, developed by the Executive Board of The Consortium of Universities for Global Health:

global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care.<sup>15(p1995)</sup>

Marchal et al<sup>16</sup> describe “health system strengthening” as the current “buzzword” in global health, noting that although many contemporary global health initiatives use this term, it is actually poorly defined. A literature review by the authors indicates that many

interventions have been designed to target specific diseases rather than health systems. Furthermore, they argue that many existing programs, rather than strengthening local health systems, may actually undermine such systems by setting up parallel services and siphoning staff. Despite limitations in achieving health system strengthening, it is generally advocated as a goal for global health initiatives as a means to reach specific programmatic objectives, to scale up such interventions or to make results sustainable.<sup>16</sup>

### Humanitarianism

Health care has historically been a key component of humanitarian aid during conflict. In recent years, humanitarians have begun to describe the field of humanitarian aid as a distinct profession with its own body of knowledge.<sup>17</sup> The field of humanitarian health care is largely built on the presumed neutrality of providers, as grounded in a long history of international agreement by which health care workers are granted safe passage to care for the injured on the premise that they are neutral parties in a conflict, seeking only to relieve human suffering. Walker notes that the principle of neutrality emerged out of an agreement between Henri Dunant, founder of the International Committee of the Red Cross, and Napoleon III. In this arrangement, Dunant was assured safe access to the battlefield for local aid volunteers in return for a pledge that the volunteers would not seek to influence the outcome of the conflict.<sup>17</sup>

The principle of neutrality was codified through the first Geneva Convention Treaty, the "Convention for the Amelioration of the Condition of the Wounded in Armies in the Field," adopted in 1864.<sup>18</sup> This important treaty provides for the protection and care of those wounded during battle. Hospital and ambulance personnel administering such care are to be considered neutral and respected by the belligerents. The original Geneva Convention treaty was later expanded upon and extended through additional treaties and protocols.<sup>19</sup> Of note is that it was through the persuasion of Clara Barton that the first

Geneva Convention Treaty was eventually signed by the US government.<sup>3</sup> Miss Barton's experiences caring for the wounded on the battlefields of the Civil War gave her firsthand knowledge of the need for medical personnel and supplies to reach the injured.

### Human rights

Situations of violent conflict often result in massive erosion of human rights, notably, the right to life, the right to health and the underlying conditions necessary for the achievement of health. The right to health is a central human right and is identified in several human rights instruments. Article 12 of the International Covenant on Economic, Social and Cultural Rights claims "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."<sup>20(p1)</sup> The right to health is further explicated in General Comment 14, which identifies that broader social determinants are necessary for the achievement of health.<sup>20</sup>

Human rights are codified in different branches of international law including humanitarian law (the Geneva Conventions), human rights law, and refugee law.<sup>21</sup> Darcy argues that humanitarian actions need to be rooted in the principles of human rights. He points out that the development of international human rights has involved the recognition that state sovereignty is not absolute and that there are conditions under which a state's behavior toward individuals in its territory can be called into question.<sup>21</sup> Indeed the state's "responsibility to protect" was formally adopted by the United Nations in 2001.<sup>22</sup> This responsibility was based upon a document developed by the International Commission on Intervention and State Sovereignty.<sup>23</sup> The premise of this report is that "sovereign states have a responsibility to protect their own citizens from avoidable catastrophe – from mass murder and rape, from starvation – but that when they are unwilling or unable to do so, that responsibility must be borne by the broader community of states."<sup>23(p viii)</sup> There are 3 specific responsibilities contained within this concept of protection. These

include the responsibility to prevent man-made crisis such as internal conflict, the responsibility to react to situations of compelling human need, and the responsibility to rebuild through reconstruction and reconciliation.

Darcy<sup>21</sup> argues that this responsibility to protect goes beyond the state to individuals. He notes links between the human rights tradition and humanitarianism in that both are based on a universal recognition of shared humanity. This shared humanity places certain demands upon us to meet human need. Darcy calls for humanitarian action to be rooted in the principles of human rights and for humanitarian workers to be knowledgeable about human rights standards and legal codes.

Closely related to human rights is the concept of social justice, which is an important concern of nursing, rooted in nursing's ontological, epistemological, and ethical foundations.<sup>24</sup> Baxi argues that the human right to health should be approached through a theory of justice.<sup>25</sup> Social justice is also integrally related to peace. Galtung's distinction between negative peace (absence of violence) and positive peace (cooperation and mutuality) is an important conceptual development in peace studies.<sup>26</sup> Galtung identified the concept of "structural violence" as inequities built into the social structure. He viewed structural violence as a barrier to positive peace and argued that social justice was needed to bring about such peace. The importance of promoting social justice and human rights to build peace has also been articulated by Harris.<sup>27</sup> Similarly, Shapiro<sup>28</sup> suggests that feelings of pain and anger are often at the root of violence in marginalized populations that have been devalued and deprived of opportunities.

#### **CHALLENGES AND CONCERNS WITH THE HEALTH-PEACE PARADIGM**

Reflection on the various domains within global health brings to light areas of practice that are interrelated, yet with objectives, guid-

ing principles, and modes of action that are not always congruent. Overlapping of these areas raises ethical, practical, and security concerns.

For example, the WHO HBP platform is rooted in both "humanitarian" and "human rights" principles. But these principles have different norms of action, such as neutrality versus protection. Similarly, the taxonomy proposed by Santa Barbara and MacQueen lists activities that are predicated upon different normative viewpoints. The extension of altruism through health care is consistent with a position of neutrality whereas dissent and noncooperation are based on an activism stance. While their delineation is helpful for thinking about various interventions by which health professionals can support conflict resolution, these potential strategies need further study.

As discussed earlier, structural violence in the form of social injustice and human rights abuses may lie at the root of violent conflict. How can health care professionals work effectively for peace if they do not address the underlying social inequities that contribute to violence? Yet, health workers who become involved in advocacy for human rights move out of the role of neutral health care provider. Taking an advocacy position may result in providers being perceived as a threat to one of the belligerent powers and consequently denied access to the population in need. This can create ethical quandaries for providers.

This dilemma is addressed by Leaning who notes the apparent conflict between the neutrality of humanitarianism and the "right to protect" espoused by human rights proponents who consider the principle of civilian protection as compromised by those who do not speak out against grave human rights violations. Leaning asks, "Can one denounce and still be 'neutral'? Can one protect civilians and not denounce? In other words, can one be a humanitarian, acting within the framework of protection, and actually *ever* be neutral?"<sup>22(p419)</sup>

The notion of "health diplomacy" raises questions about the goals of health-peace

interventions and whether they are related to advancing global health, national interests, or both. Traditional humanitarian aid provided by nongovernmental organizations and the health services offered as part of a national “health diplomacy” agenda both involve providing health care to populations in need. However, there are key distinctions between health diplomacy and humanitarian aid related to both the ends and the principles involved. While humanitarian aid uses the principle of neutrality to relieve human suffering, health diplomacy has a political agenda of which neutrality is not a central principle.

Novotny argues that addressing the global disease burden is a *moral* responsibility of the US government. But, he also views this as a *policy* priority, arguing that health professionals serving abroad could provide a positive image of Americans to citizens of other countries.<sup>29</sup> Tommy Thompson, former Health and Human Services Secretary, identifies medical diplomacy as one of the “weapons of freedom.”<sup>30</sup> He describes a vision of actions of compassion overcoming the rhetoric of terrorists and bringing health and hope to the suffering.

Providing compassion and healing to a world in need is a laudable notion. But such beneficence as extended from a political agenda raises questions. For example, Thompson noted, “We couldn’t have increased spending on Iraqi healthcare from \$15 million in the last year of Saddam Hussein’s rule to roughly \$1 billion without first toppling Saddam . . . .”<sup>30(p2)</sup> But, how will health care outreach be perceived when it is preceded by bombs? To be sure, relief of suffering is part of the health diplomacy agenda. Indeed, Thompson described being personally transformed after witnessing the difference that US-funded care was making in the lives of suffering people.<sup>31</sup> But, the concomitant political goals carry significant implications particularly when the benevolent actions of US health care providers are contrasted with other dimensions of US policy that result in harm.

The overlapping of humanitarian and political agendas has affected the way that aid work-

ers are perceived. In some regions, humanitarian health care workers are viewed not as neutral providers but as agents of political powers. Even noble goals of health missions such as the definition of global health suggested by Kaplan and colleagues<sup>15</sup> with regard to “promoting equity” can carry political overtones. This can be problematic in a conflict or post-conflict situation in which health sector development is perceived as linked with success of one of the belligerent parties.

Anderson observes that the inviolability of humanitarian agencies has been called into question in recent years because of events such as the 2003 bombing attacks on the United Nations and International Committee of the Red Cross Baghdad headquarters. Humanitarian action has expanded to include activities such as nation building, reconstruction, and the development of social institutions. Such activities do not operate from the same principle of neutrality as straightforward aid efforts. And those who oppose the newly developing political order sometimes view the humanitarian agencies supporting those efforts as targets for violence.<sup>32</sup> This has become a growing concern, particularly as protection offered to humanitarian workers has traditionally been guaranteed through international agreements between nation states. With contemporary changes in the nature of conflict, violence is increasingly inflicted by nonstate actors. Health care and other humanitarian workers are placed at an increased safety risk. This also has repercussions for local beneficiaries whose aid may be reduced or eliminated when nongovernmental organizations pull out of conflict areas because of security concerns, as happened in Iraq.<sup>33</sup>

Providers sometimes enter global health care missions guided by their own altruistic intentions but without knowledge of broader political agendas. For example, I debriefed a group of local nurses who had just returned from a global health mission organized through the US military. The nurses had assisted with health promotion initiatives in a series of countries. One of them was told by an officer on the trip that they were part of an “anti-terrorism” mission. While health

care may, in principle, be a well-intended manner of promoting international relations, such endeavors as “anti-terrorism” strategies may carry concomitant risks. It is critical that nurses and other providers be fully informed of the complexities of these undertakings.

Another concern is that humanitarian aid can sometimes have unintended negative consequences that worsen a conflict. For example, services may favor one group over another, increasing tensions. To avoid unintended negative consequences, a “do no harm” model has been proposed.<sup>34</sup> This approach calls for a careful analysis of the local conflict and identifying community connectors and dividers. New projects are then analyzed and planned in such a way as to maximize connectors and minimize dividers.

In review, considerations of health-peace initiatives must include careful analysis of the various domains of global health including goals and guiding principles of action. Uninformed efforts, although well-intentioned, may yield interventions that are ineffective or even harmful for both care givers and care recipients.

#### **EXEMPLAR: ISRAELI-PALESTINIAN CONFLICT**

The Israeli-Palestinian conflict provides an example of the possibilities and challenges of health-related peace initiatives. This protracted conflict has resulted in significant morbidity and mortality for both the Palestinian and Israeli people. Between September of 2000 and December of 2008, for example, there were 4905 Palestinians killed by Israelis and 1063 Israelis killed by Palestinians.<sup>35</sup> In addition to the immense physical casualties, the psychological trauma of living in a protracted conflict is enormous. The Palestinian population faces unique health challenges in the current situation. Horton<sup>36</sup> describes the untoward effects of military occupation on Palestinian health, arguing that Palestinian health is in a state of decline that is unlikely to reverse in the absence of Israeli-Palestinian

reconciliation. The organization “Physicians for Human Rights-Israel” explicitly opposes the occupation, noting that it compromises the right to health.<sup>37</sup>

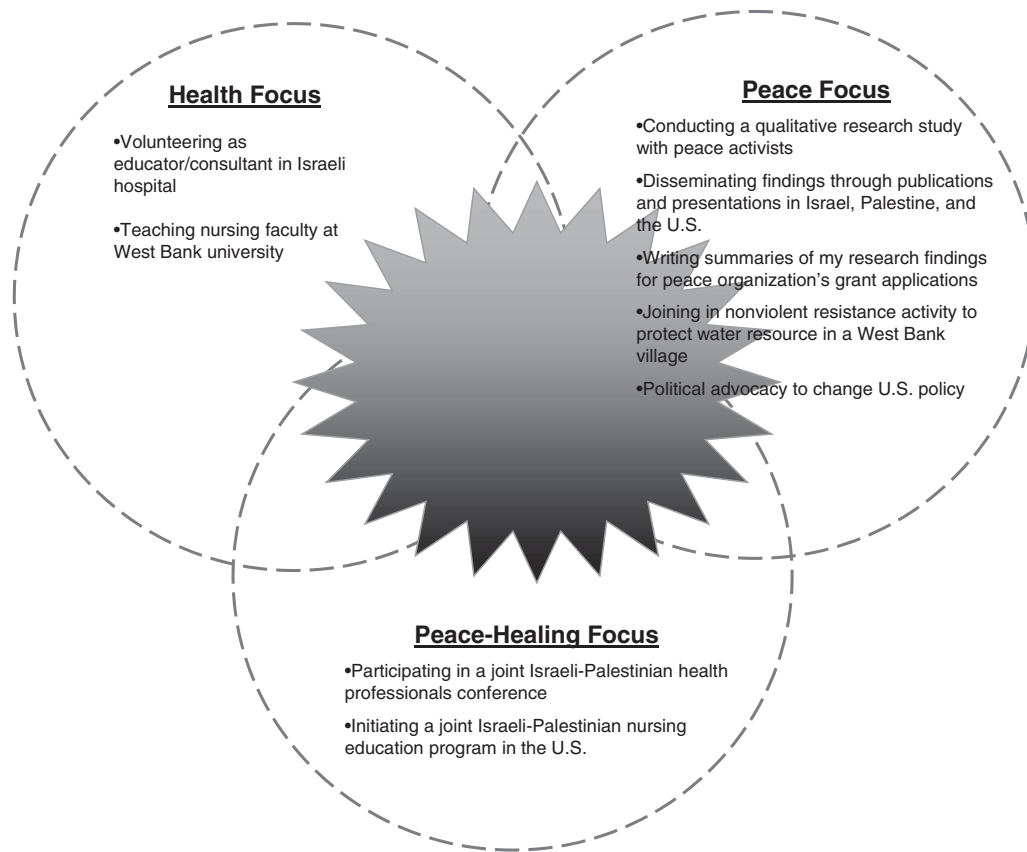
I have been personally engaged in a variety of health-related, peace-building, and joint health/peace efforts in this region. My experiences in this region have helped me to understand that peace-building health initiatives in this context are fraught with challenges. The Figure provides an overview of these efforts, which can be categorized as having an explicit health-focus, an explicit peace focus, and a peace-healing focus. While there is some overlap in these realms, it is also important to be aware of the distinctions and to be self-aware as to one’s goals.

#### **The health-peace divide**

One of the critical distinctions in health and peace initiatives relates to whether or not health professionals explicitly address the underlying conflict and the issues contributing to the conflict. As noted earlier, the WHO has called for public health measures that identify and address factors of violent conflict. But, this can be difficult to achieve in practice.

In a study of humanitarian aid in the occupied Palestinian Territories, Fast reported that neutrality was very difficult to uphold in practice. Fast observed that “The long-term situation, lack of political settlement, and human rights situation have prompted some agencies to adopt a solidarity stance with the Palestinian cause and others to take on more of an advocacy stance on particular issues.”<sup>38(p11)</sup> Aid workers stated that both sides of the conflict expected their side to be taken and that lack of condemnation of transgressions on one side or the other were not interpreted as being neutral but rather, as taking the other side.<sup>38</sup>

There have been numerous examples of cooperative Israeli-Palestinian health projects, particularly in the early post-Oslo period.<sup>39</sup> These ventures diminished following the accelerated cycle of violence with the onset of the Second Intifada in 2000, although some



**Figure.** Personal experiences of author with Israeli-Palestinian peace and health.

projects did continue. Cooperative projects between Israeli and Palestinian health care leaders offer the potential for dialogue on the conflict-related sociopolitical issues impacting health. But even joint health projects have generally not served as a forum to explicitly address underlying sociopolitical concerns.

A study of joint ventures between 1994 and 1998 identified 148 cooperative projects that brought together approximately 4000 people. Findings suggested that the projects were successful with more than 75% of project directors reporting the achievement of health goals and a change in attitude toward coexistence reported by two-thirds of Palestinians and one-third of Israelis. However, the report noted that Israeli participants in joint projects refrained from discussions about emotionally or politically charged issues.<sup>40</sup> Similarly, a

case study analysis of 12 participants in a Canadian-facilitated collaboration project between Israelis, Jordanians and Palestinians indicated that participants attempted to work “below” the politics.<sup>41</sup> And a review of criticisms of the joint Israeli-Palestinian journal *Bridges* indicated perceptions that the journal did not sufficiently reflect the reality of the occupation and violent conflict (primarily from Palestinian comments). Many Israeli comments, in contrast, indicated perceptions that the journal was politically biased.<sup>42</sup>

#### **Barriers to addressing underlying conditions**

Through personal experience in the region, I have witnessed the transformative power of Israeli-Palestinian relationship



building through joint health initiatives. Yet, these experiences also reflect a reluctance of health care professionals working on such initiatives to explicitly address the conflict. This includes both local providers and outsiders. My own experiences as a health care provider and as a researcher suggest several barriers that prevent health care providers from addressing the underlying conditions for peace. These include the following:

1. Role-related barriers

- Perception of normative structure underlying practice (eg, role of health care provider as neutral agent vs political advocate)
- Providers being advised by project leaders not to discuss “political issues”

2. Knowledge and comfort-level barriers

- Lack of comfort among providers in discussing underlying issues
- Reluctance to raise emotionally charged topics
- Concerns about damaging relationships with colleagues on the other side by raising sensitive concerns
- Perception of futility related to myths about other side (ie, other side “not a partner” so no sense in talking with them)
- Outsider providers with incomplete understanding of local context
- Providers without knowledge of conflict resolution principles

3. Practical barriers

- Perceived need to keep joint activities “below the radar screen” in order for them to continue

An anecdotal report of my experience attending an American-organized Israeli-Palestinian medical conference offers an example. Although one of the purposes of the conference was to promote Palestinian-Israeli relations, many of the American presenters did not demonstrate an understanding of the

conflict context, local sensitivities, or general cross-cultural/peace-building strategies. The American presenters were advised by the American group leader to avoid discussing anything “political” during their presentations. Speaker after speaker carefully avoided any reference to the Palestinian-Israeli conflict, delivering a series of lectures that were only marginally related to the local context. Finally, after a detailed presentation about US disaster response following Hurricane Katrina, one Israeli physician stood up in exasperation. He said, “I hate to mention the elephant in the room here, but we don’t have much of a problem with floods in this area. Our problem is that we’re killing each other” (Anonymous oral personal communication, May 2008).

### **Linking words with deeds**

Although diplomacy and discretion are important when discussing issues of conflict, the avoidance of political issues altogether may have negative consequences. This is a particularly sensitive issue in the Palestinian culture in which cooperation without genuine efforts to address the underlying issues around occupation are viewed negatively by many in the community.

A study I conducted with the Israeli-Palestinian group, Combatants for Peace (CFP), illustrates this phenomenon. The CFP movement began in 2005 by Palestinians who had formerly been involved in acts of violent resistance but now renounce violence and Israelis who had served in the Israeli Defense Forces but are now actively opposed to the military occupation. Members of the group believe that commitment to nonviolence means refusing to participate in both violent resistance and the military occupation.<sup>43</sup> While the results of violent resistance are often obvious and highly publicized; the occupation is also violent and causes deep human suffering and negative effects on population health.

One of the findings of the study was that Palestinians have developed a deep mistrust of so-called “dialogue groups” in which

Israelis and Palestinians are brought together to work cooperatively without efforts to address the occupation. However, Palestinians were willing to join CFP precisely because Israeli members were working with them “on the ground” to end both violent resistance *and* the occupation, often at personal risk in their own society.<sup>43</sup>

In contrast, many Palestinians have refused to join other joint groups with Israelis.<sup>43</sup> An open letter signed by a number of community health organizations<sup>44</sup> formally objected to joint ventures, arguing that such initiatives will not lead to peace in the absence of justice. While acknowledging the work of those Israelis actively involved in trying to end the military occupation, the letter suggests that well-intentioned health care professionals who want to work on joint ventures should instead take a similar activist approach.

One member of the nursing faculty at a Palestinian university told me that Palestinians had become disillusioned with joint health groups. He explained, “We had an idea that they would stand up for us.” In the absence of colleagues who would “stand up for” them, Palestinians lost hope and trust in joint initiatives (Anonymous oral personal communication, December 2010).

Similarly, Israeli study participants spoke of their difficulties of building momentum for peace in their own society because episodic violent resistance contributed to Israeli perceptions that there was “no partner” for peace. Building trust on both sides meant taking action to oppose both violent resistance and the occupation. However, the research also showed that the decision by members of CFP to adopt nonviolence was often a slow developmental process that was aided by encounters with the “Other” as a human being.<sup>43</sup> Widespread refusal to participate in joint groups will likely hinder that process.

#### TOWARD A DEFINITION OF PEACE

My research with CFP was conducted using a theoretical framework that I have developed called transcendent pluralism. This

theory views the human spirit from an evolutionary context in which mutually transformative relationships among diverse peoples can help fulfill the human potential for living in dignity.<sup>45</sup> Transcendent pluralism has emerged from the lens of nursing but has been influenced by the fields of philosophy, particularly the work of Bernard Lonergan,<sup>46</sup> as well as social psychology and peace studies. The purpose of transcendent pluralism is to address problems of human devaluation through the identification and implementation of strategies to advance human dignity in society. The theory has primarily been used to study human decisions in issues of social transformation related to peace, social justice, and human rights.

The theory of transcendent pluralism was used to guide the study with CFP members to understand how these individuals made the transformative decision to move from violence to nonviolence and the influence of that decision on individual and group development. Following analysis of the findings, the following definition of peace was proposed: “a dynamic state of genuine human relationship with self [and] other that maximizes human dignity through good will.”<sup>43(p208)</sup> While this definition emerged within an interdisciplinary context of research and scholarship in peace studies, it was profoundly influenced by my view as a nurse and the nursing discipline’s focus on the human person and human relations.

One of the concepts that emerged from the study is that of “genuine encounter.” Genuine encounter involves critical self/group reflection, respectful intersubjective dialogue, and commitment to action. One of the important study findings was that CFP members engaged in genuine encounter, which included not only reflection and dialogue but also committed action for personal and community transformation. This approach gave them credibility with members of both communities.<sup>43</sup>

#### DISCUSSION

Collective violence has grave repercussions for human health. Strategies to reduce

violent conflict are an important dimension of public health practice. Nurses and other health care professionals play an important role in the treatment of injury and disease related to violent conflict. Some research suggests that global health care providers can also play a transformative role in conflict settings.

### **Advancing genuine encounter**

The role of nursing and other professionals must include advocacy to change those sociopolitical conditions that contribute to violent conflict. Certainly, the ICN position statements make clear that nurses, both individually and collectively, have the professional responsibility to take action against harmful activities that violate human life and dignity. However, as noted earlier, there may be some contexts in which other principles also apply, such as humanitarian neutrality. In these settings, advocacy must be carefully weighed against possible harm to suffering populations, colleagues, and self.

How do we as nurses and other health care professionals create the conditions in which people have the time and space for transformative processes to occur while at the same time addressing the social conditions that cause grave harm? One possibility is the creation of a healing bridge by which nurses can help facilitate a space for genuine encounter. For example, my background as a nurse greatly enhanced my ability to engage in empathetic inquiry with the CFP study participants, persons who had been directly affected by the trauma of violent conflict. I found that individuals were very open to sharing their stories with me. They were intrigued that a nurse was conducting peace research. Two study participants (1 Palestinian and 1 Israeli) even stopped during the interview to show me leg wounds they had incurred from the violence.<sup>43</sup>

The qualitative method and approach used for this research also shows possibilities. It is a transformative phenomenology called Transcendental Method for Research with Human Subjects,<sup>47</sup> that I adapted from Lon-

gan's philosophy. The research process involves guiding participants into self-reflection within the empathetic presence of the researcher. Evaluation of this approach suggests both investigational and interventional qualities. In follow-up interviews with 2 studies using this method, some participants indicated that the research process made them feel more open and empathetic toward hearing others' views. This suggests that this method, conducted within an atmosphere for healing self-discovery, may have potential for group dialogue and peace building.

### **Peace through a healing transformation of human dignity**

Within transcendent pluralism, I have proposed that the many social problems influencing health including violent conflict, human rights abuses, and social injustice can be viewed from a common lens of human devaluation, or a dialectic of dignity. Human dignity in transcendent pluralism is defined as "value in personhood."<sup>45(p61)</sup> What is needed then is a healing transformation of human dignity in society. Human dignity reflects our capacity to make good choices and to see the actual and potential good in ourselves and others. Dignity evolves through mutually transformative relationships. Our own dignity is interwoven with the dignity of others.<sup>45</sup>

Human dignity is a central value of nursing<sup>8</sup> as well as the foundational value of the human rights paradigm.<sup>48</sup> While the many realms of global health have differing principles of practice, such as neutrality versus advocacy, the value of human dignity underlies them all and could be a unifying framework for nurses and other colleagues to bring a healing component to conflict situations. Human dignity can also be used as a normative lens by which to evaluate policy initiatives. As a normative standard, human dignity cannot be viewed with neutrality. When violent conflict creates a dialectic of dignity, neutrality may be a *strategy* for access to care, but never a moral position. Solutions to address the dialectic must be sought.

### Education and research

The work of healing peace is desperately needed in our world. But, if we as nurses and other health care professionals are to engage in this effort, we must prepare ourselves through education and research so that we can work ethically, effectively, and safely in the international arena. For example, in a separate qualitative study with global health care providers, I asked the participants if they had encountered any dilemmas with regard to neutrality. While some providers had faced such quandaries, many of the participants were not even familiar with the term except in its naive usage (D. Perry, Unpublished Research study, 2009).

Providers working in conflict-affected areas require baseline humanitarian knowledge as well as additional skills. Important topics include the following: (a) international organizations, normative frameworks, and practices; (b) peace building principles; (c) do no harm strategies; and (d) ethical analysis skills. Moral dilemmas that confront providers in the field are different from the bioethical issues typically encountered in the home hospital setting. Interprofessional education and collaboration is essential so that contemporary knowledge from multiple realms can be brought to bear on the complex issues that affect conflict. In addition, before entering any conflict region, it is critical that nurses understand the local historical, cultural, and political context. Any interventions must be conducted in dialogue and partnership with local communities. As well, nurses need to engage in ongoing self-reflection to understand their own knowledge and comfort level.

Research in this area is critically needed. What are the ethical and practical implications of peace-health initiatives, particularly in relation to other domains of global health practice? What is the appropriate level of engagement for health professionals to address the larger sociopolitical issues in each context? How can we assist local communities to create genuine encounters for conflict transformation?

In addition, more knowledge is needed about the field of research itself within conflict-affected areas and the impact of conflict-related conditions on health care researchers. One doctoral nursing student's account describes the many challenges he faced while conducting dissertation research in the occupied West Bank.<sup>49</sup> I personally experienced many challenges during my own research as I journeyed back and forth between the West Bank and Israel. I found myself filled with fear as I spent time with Israelis in the South, exposed to the perpetual possibility of rocket fire. And I felt angry as I stood and waited with Palestinians in dehumanizing checkpoints. These shifting emotions were difficult; but my own experiences helped me to better understand the conflict and its effects on human persons.

### CONCLUSION

While the notion of HBP is promising, there are also many ambiguities in this emerging field that need further investigation. Consideration of health-peace initiatives must include careful analysis of the various domains of global health including goals and guiding principles of action. Uninformed efforts, although well-intentioned, may lead to consequences that are ineffective or even harmful for both care givers and care recipients. Of central concern are questions related to the role of nurses and other health professionals in addressing underlying sociopolitical issues.

The health effects of violent conflict make addressing this area an imperative for health care professionals. Nursing, given its ethical obligations to persons and society as well as skills in creating healing relationships, has both the responsibility and the potential to effect change in this area. Further education and research is needed for us to fulfill our capacity to bring healing peace to the world. But, we must not let the need for further knowledge dissuade us of the importance of this mission.

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