Global Peace Services USA

...an idea whose time has come

Vol. 10, No. 1 October 2007

Greetings from John Eriksson, President, GPS USA

Welcome to this Fall 2007 edition of the Newsletter of Global Peace Services USA. This edition features a set of articles relating to our new emphasis on "Health and Conflict." The co-editors are Ms. Inshirah Farhoud, RN, and Professor Harry Yeide of George Washington University. Prof. Yeide's article deals with some of the broader conceptual and ethical issues raised by the subject. Ms. Farhoud's article outlines the objectives and elements of a one-semester elective course that she and a colleague are planning on "Nursing and Conflict" at Alverno College in Milwaukee. Finally, the third article in the set, by Robert Muscat Ph.D., deals with health and international conflict issues. All three authors are GPS Board Members.

A second major GPS emphasis currently in the planning stage is a "Youth and Conflict" project. This project will initially involve youth in urban settings in the 12-17 age bracket. The youth, with mentoring from selected adult community leaders, will play key roles in designing and implementing projects intended to provide innovative and constructive solutions to conflict issues affecting their respective communities. Milwaukee, WI, and Youngstown, OH, have been tentatively identified as the first sites for the GPS Youth Project. The project will be featured in a future edition of the GPS Newsletter.

Nurses as Healers and Peacemakers

The Dalai Lama said, "Humans create war, they can also create peace, but global peace is possible only through our individual inner peace which we push away with our endless desires and inabilities to be here and now."

The successful preparation of nurses should include the broadest understanding of humanity and the world in which nurses live and work. *Nurses as Healers and Peacemakers* is an innovative education program supported by the GPS Board to help nurses better understand the possibilities before them to serve as community Healers and Peacemakers.

We are now developing a senior level nursing elective course on this theme, which will be taught at Alverno College in 2008. The course, focusing on nurses and peacemaking, will explore the implications of global interconnectedness and diversity in the day-to-day practice of nursing. It will explore how the attitudes, values, and expectations of nurses and those with whom they collaborate and those they aid, lead to peace or violence, illness or health.

The course will focus on nurses creating peace for themselves, their patients, the organizations and institutions with which they work, and relevant local and global communities. Course activities will explore ways for nurses to increase their personal peace and model approaches in assisting others to develop peacemaking skills. We hope to realize these important objectives through classroom discussions and role-play, immersion in the local community, and a final assessment that allows for the sharing of learned skills. We will assess student accomplishment in the course though research papers, written journal reflection, and a final presentation to a local community.

Inshirah Farhoud

The Board of Global Peace Services USA sees the GPS newsletter as a forum for a wide range of views on the many questions and concerns entailed in peace-building, peacemaking and peace service. We welcome ideas and opinions from a variety of perspectives, even if we do not necessarily concur with all the thoughts expressed. The GPS Board encourages you, our readers, to share with us your responses to the ideas and experiences presented in these pages. Please write, phone or e-mail us and let us know if you'd like us to publish your reflections in forthcoming newsletters.

Health Care and Peace

Those of us who commit ourselves to GPS-USA probably do not often think of health care as an area of concern. But when we talk about structural violence, we are likely to think about the absence of health care for certain groups, usually economically and/or racially disadvantaged, and reflect on the violence that attacks the body when we have no access to drugs or other kinds of medical treatment. We do not have to look abroad to find this kind of violence. Indeed the spectrum of such violence seems to be growing in our world. There are major contrasts between richer and poorer countries regarding both life expectancy and the availability of health care. And there is growing knowledge of these differences and what can and cannot be done about it. While some medical enthusiasts are talking about the disappearance of death as an ordinary human experience, concerns about global warming and/or shrinking global resources, in general, leave most of us more nervous about our life expectancy and our future. We are already hardened to hearing about the development of new death dealing diseases, such as avian flu, and newer germs that have learned to defeat our broad-spectrum antibiotics.

And if we stop and think about it, there are some interesting parallels between being struck down by a bullet and being struck down by a disease that could have been cured with the correct and well known treatment. While many of us pay taxes to support police and armed forces in order to defend ourselves against the bullets, we also pay a combination of taxes and fees to hire experts to protect us from various health threats. (Indeed, the more we pay for our armed forces, the more we wring our hands regarding affordable health care.) But while health care may be very expensive -- over 15% of our GNP in the USA -- we may pay too little heed to this kind of activity as peace-keeping. In fact in modern times, we exempt health care professionals from many of the duties that other humans must observe. Without claiming that the ideals are always realized, physician ethics call for working with the enemy wounded as well as with those belonging to one's own military. Attacks on this world-wide physician ethic have so far withstood many ideological efforts to compromise this universal obligation to care. Far more ancient is the fact that even in societies committed to minimizing contact between certain caste groups, health care professionals often are allowed to violate these traditional taboos.

The commitment to healing must often compete with other imperatives. A recent book by Michael Gross highlights such tensions. Entitled *BIOETHICS AND ARMED CONFLICT*, this book uses the recent discussion in American bioethics to outline the ways in which the traditional professional ethic of medicine is compromised and often set aside when confronted by the ethic that is appropriate to armed conflict. In general, he seems to support the sorts of things that seem imperative in times of war. He does, however, remain conscious of the tensions between his argument and many versions of bioethics produced by physicians. Thus he offers a comprehensive critique of the medical profession's perspective when he writes:

The World Medical Association fails to see the difference between the bioethics of war and the bioethics of peace because it firmly believes that medical personnel are neutral in every sense of the word, not only "protected" but "above the fray" and "foreign" to the practice of war. (Page 24)

Not too long ago, I met a man who had been taken prisoner by the Germans during World War II. Since he could communicate in German, he heard some of the officers say that these prisoners, many of whom had been wounded, would have to be disposed of, that taking prisoners was incompatible with their military mission, a line of thinking in keeping with what

Gross called the "bioethics of war." My acquaintance noticed that some physicians were among the officers, so he reminded them of their duty to treat the injured of the enemy as well as their own soldiers. He appealed to their professional physician ethic as opposed to the professional military ethic that had directed the thinking of the other officers. Miraculously, he found that his appeal was both heard and then acted upon. He discovered rather concretely the peace-making potential of the professional commitment to healing, and only through its exercise, could relate this experience today.

While many of us have had difficult encounters with physicians and nurses, with hospitals, health insurers, and other health related agencies, possibly we ought to reflect on the peace making potential of the health care community. While it still speaks in terms of an "enemy," and while our medical system is primarily "allopathic" in orientation with all sorts of borrowed military vocabulary -- e.g., we speak of the "armamentarium" of drugs – the health community generally tries to settle their special kind of disputes without killing anyone. Indeed there seems to be growing interest in forms of health care that do not find it useful to name disease "the enemy." Even when persons are bodily attacked, everyone knows that the cut of a surgeon serves a different goal than the cut of a bayonet. While one hears the expression that the operation was a success but the patient died, we are usually supposed to laugh because we know that the purpose of surgery is life rather than death. One of our medical charities calls itself "Physicians Without Borders." How many politicians can we name that seem to manifest that kind of attitude? Yes, there are some, but they have a hard time convincing others.

Physicians and nurses have a long history of trying to preserve life in difficult circumstances. We do not go back too many years to reach a time when there were very few really efficacious drugs. But life expectancy was already growing in the West despite this fact, largely due to better sanitation and nutrition. And the modern standards of sanitation are largely the result of the urging of the medical community. Likewise, many of our ideas regarding health, diet, and exercise are largely medical in origin.

While it may be incorrect to say that our health care community has regularly been self-consciously a peace-making group, its efforts to save and extend human life seem to relate very closely to one of the goals dear to peace-makers: the betterment and extension of life. Health care practitioners have for centuries been devoted to cure where possible, and to care when cure eludes the healer.

These comments have been offered at a rather high level of abstraction. There are many concrete manifestations that could be listed as well. Physicians and nurses are often entrusted with the sides of our lives that we choose to conceal from most others, and often these exemplars of health care offer solid, nonviolent advice in response.

We are currently trying to develop a peace-focused program for nurses. It is worth recalling one of the heroines in the history of nursing, Florence Nightingale, and that her work was inspired by the horrors of warfare in the Crimea. We have much to learn from nurses and physicians, and hopefully we will be able to offer them a helping hand. Thus, the interest and support of GPS-USA in the upcoming course for nurses at Alverno College.

Harry Yeide, Jr.

Peace is not the product of terror or fear.
Peace is not the silence of cemeteries.
Peace is not the silent result of violent repression.
Peace is the generous, tranquil contribution of all to the good of all.
Peace is dynamism. Peace is generosity.
It is right and it is duty.

Oscar Romero

The Challenges of Nursing in Third World Conflicts and Natural Disasters

There have been a large number of violent Third World conflicts and natural disasters in recent years. Most of the conflicts have been internal civil wars. Fueled by ethnic and religious power struggles, the conflicts have typically caused medical emergencies and catastrophes that have been beyond the coping capacities of the local health systems. The health needs created by natural disasters (e.g. tsunamis, earthquakes) also typically exceed local response capabilities. Even without the extra burden of these crises, the health systems of many developing countries are weak as measured by such things as availability of preventive care, doctor and nurse/population ratios (e.g. Ghana has nine doctors for every 100,000 people; France has 335), hospital beds, willingness of health professionals to work in rural areas, etc. Some countries suffer from major losses of doctors and nurses who emigrate to work in the US and other high-income countries (e.g. of the 1200 doctors trained in Zimbabwe in the 1990s, only around 350 remain in the country). Needless to say, there are many aid-assisted programs working to ameliorate these problems.

Thus, even under normal circumstances there are great unmet needs for skilled health professionals in the Third World. In conflict/disaster situations, medical response faces additional difficulties, such as destruction of roads, electric power facilities, hospitals and clinics, and cold-chain systems for vaccines. In conflict situations, the greatest challenge may be poor security for health and humanitarian personnel. Finally, the general health environment may be severely degraded: refugees living in tent camps; shortage of clean water; shortage of fuel for boiling water, cooking, and keeping warm; dependence on food aid.

Interaction of Endemic and Conflict/Disaster Health Problems

Many endemic diseases in Third World countries are virtually unknown in the US and may be only lightly touched upon in American medical and nursing schools. Examples would be malaria, cholera, severe vitamin deficiencies, trypanosoma, schistosomiasis, complications from female infibulation. In conflict situations, the treatment of such diseases is complicated by malnourishment, war wounds, rape, psychological trauma, and family separation.

Conflict patients are likely to have experienced traumas seldom encountered in stable countries: involuntary abandonment of home and country; multiple rape; loss of limbs from mine explosions; genocide; being victims of, or witnessing, atrocities; forced recruitment and brutalization of child soldiers; and post-trauma stress disorder.

Treatment of conflict victims may require a complex of interventions, such as emergency surgery, oral rehydration, vaccinations; hygiene training; mental health counseling; psychiatric nursing. Even "ordinary" health problems may require sets of interventions not often employed in more developed countries. For example, the international medical/humanitarian organization Doctors Without Borders, in its program in Niger, ***"treats children with moderate to acute malnutrition without complications by instructing mothers how to feed with a special ready-to-use therapeutic food, like Plumpy'nut, a milk-based paste that contains the right balance of lipid, sugar, protein, minerals and vitamins for a child on the brink of starvation. Nurse tests for malaria, vaccinates against measles, gives a dose of Vitamin A, a course of antibiotics, general exam, sets up a record. If the child cannot eat the Plumpy'nut on the spot, the child is admitted as an in-patient. If the child can be treated as an out-***

patient, the mother is also given a mosquito net and instructed in its use. The mother is also told to return for weekly weighing until the child is no longer malnourished. Common complications: diarrhea; yeast infection in the mouth; insufficient breast milk; dehydration (corrected with oral rehydration salts); contaminated water (correctable with purification materials)."

Related Requirements for Effective Treatment

Health providers in these situations must coordinate well with other agencies which provide related interventions such as food aid, orphan care, family reunification, prosthetics, displaced resettlement, or psychological rehabilitation of former child soldiers. Where possible, it is important to work with local health providers including "traditional medicine" practitioners. Foreign medical intervention may be able to help rehabilitate and strengthen local health facilities and upgrade the skills of local providers. Orientation into the local culture, and knowledge of local ethnic/religious/cultural tensions, are essential for effective provider/patient relations and for working with local officials and care providers.

Health Intervention and Peacemaking

Care providers in conflict situations usually maintain strict neutrality in order to be able to help all people needing medical attention, regardless of "side." Peacemaking is a separate and difficult endeavor normally undertaken by the UN, interested governments, or NGO organizations that specialize in facilitating negotiation. There are times when medical providers must withdraw (as has been the case in Darfur camps) because the situation has become too dangerous even for neutral care-givers.

On the other hand, there are also times when the mere presence of foreign care-givers acts as a deterrent to combatants who would otherwise not hesitate to attack non-combatants. There are also places where local care-givers -- regardless of ethnic or religious "identity" -- are among the people most prone to deplore conflict and most readily brought around to reconciliation and reestablishment of professional cooperation across ethnic or religious lines. Foreign providers can promote such reconciliation, e.g. by fielding multiethnic teams or giving multiethnic training sessions for local providers. In addition, international media correspondents often rely on health providers for credible accounts of the situation of refugees and other conflict victims.

Conclusion

Medical education should include orientation about the medical dimensions of foreign conflicts and natural disasters, employment opportunities in this special field, and the challenges and rewards that can be experienced by helping people who number among the most needy and underserved in the world.

Robert Muscat

Introduction of New Board Member

I am pleased to have the opportunity to introduce myself to GPS's membership. As the newest member of the Board, it is important for you, the membership, to have a sense of who I am, and where I see GPS headed in the future.

For over thirty years, I have lived in the Washington DC area with my wife, Jan and two children, Sarah and Matt, who are now in college.

During this period, Jan and I have been involved in a variety of peace and justice issues, particularly those involved with the inclusion of persons with disabilities in the broader societal

ontext. The invitation to GPS' Board, for me personally, is an affirmation of one of my core beliefs that what we are about in "peace service" is the work of ever expanding the circle of our personal, national, and international relationships in ways that promote peace and understanding. Foundational to peace service is bringing in and enlarging the interlinking circles of relationships, rather than excluding people from them.

My short-term goal as a new GPS Board member is to seek to facilitate stronger connections between GPS as an organization and you, the individual member. To that end, I invite you to communicate to me what your vision and goals are for GPS for the next three, seven, and ten years.

What are your priorities for GPS and what are your needs as a member to which the Board should attend? I welcome such dialogue. Please e-mail your thoughts to me at jmartinbenton@gmail.com.

It is both an honor and pleasure to have been invited to the GPS Board and I look forward to working in concert with you, as GPS members, to strengthen and advance the idea of global peace service.

Peace, Martin Benton

Global Peace Services USA

The newsletter of Global Peace Services USA is published quarterly. GPS USA is incorporated in the District of Columbia and is tax-exempt. Current board members are: Martin Benton, John Eriksson, Inshirah Farhoud, Cecil Monroe, Robert Muscat, Mindy Reiser, and Harry Yeide. We welcome contributions and comments. To contact us:

Global Peace Services USA
P.O. Box 27922
Washington, DC 20038-7922

Telephone: 202-216-9886
Fax: 301-681-7390
E-mail: johneriks@gmail.com

Web site: www.GlobalPeaceServices.org

Global Peace Services USA
P.O. Box 27922
Washington, DC 20038-7922
www.GlobalPeaceServices.org