C6 | CONFLICT AND HEALTH IN THE ERA OF CORONAVIRUS

Introduction

The indicators of positive peace[1] and the social determinants of health are closely linked, making it logical to examine the interactions between peace and health – especially at a time when both face significant new threats around the world.

This chapter analyzes the global relationship between peace and health: from the top-down agenda of the Sustainable Development Goals (SDGs) to grassroots peace and health initiatives "from below." Case studies explore the health impacts of two of the most devastating ongoing conflicts in the world today, in Yemen and Syria, and examine how COVID-19 has compounded their pre-existing crises. The weaponization of the coronavirus by state powers for repressive purposes is also surveyed. A gendered analysis of the impacts of conflict, and women's leadership in many grassroots initiatives for peace and health, runs as a thread throughout the chapter.

The global peace agenda

1. The SDG agenda and global partnerships in health and peacebuilding

Described as a sweeping and ambitious blueprint for improvements on a wide variety of economic, social, and environmental issues (United Nations 2020), and developed through an extensive consultation process that included UN (United Nations) agencies, civil society organizations, national governments, and private sector actors, the 17 interconnected SDGs envision a broad global partnership for sustainable development (see also Chapter D3).

Peacebuilding and health figure prominently in the SDGs as individual goals (SDG3: Good Health and Well-Being, SDG16: Peace, Justice and Strong Institutions) and as cross-cutting themes. The inclusion of peace as a specific goal, and the conceptualization of the SDGs as a single "whole" comprised of interconnected and mutually reinforcing goals, are based on learning from the Millennium Development Goals and informed by feminist approaches to peace, including the Women, Peace, and Security Agenda, which see peacebuilding and sustainable development not as separate processes but as fundamentally connected (Women's International League 2020).

SDG16 emphasizes the need for "effective, accountable and inclusive" institutions at all levels. This vision recognizes "the connection between the structures of power and the people that they should serve" (Whaites 2016, 2) or, in other

words, the ways that government and governance can affect the day-to-day realities of human lives. The entire SDG agenda promotes an understanding of security that is grounded in human (and humanitarian), rather than nation-state, considerations; reflecting an international consensus that we must strive for societies which are not simply conflict-free, but which also have all the attributes of positive peace.

The goals are intended to be universal, applying equally to all countries. They carry internal and external responsibilities: "countries are obligated to uphold their extraterritorial obligations, which means that they can be held accountable for the effects of their actions abroad" (Women's International League 2020). This offers an important opportunity to link health and peacebuilding efforts around the world. Using the frame of the SDGs to address health issues could perhaps also reverse a problematic trend towards treating health as a security issue (see *Global Health Watch 5* Chapter D6), which has led to a blinkered, narrowly national response to COVID-19 on the part of some countries, without regard for the global human cost of doing so.

The SDGs encourage cross-sectoral partnership working towards shared goals, such as global health diplomacy being used as a tool of peace, or health workers learning to act as community peace builders through the inclusion of peacebuilding in medical curricula. However, despite its positive potential, the SDG agenda also faces legitimate criticism, particularly for its focus on the national-institutional level.

2. Criticisms of the SDG agenda for peace and health

A general critique of the SDG agenda focuses on its top-down approach, driven by governments and institutions, and its continued reliance on the doctrine of economic growth as the route to development (see *Global Health Watch 5* Chapter A1 for a detailed critique). For peacebuilding and health, a central question is whether the SDG agenda can effectively link national and international efforts to local grassroots initiatives. The UN and its agencies work primarily on a national level and, in the case of the SDGs, focus on strengthening institutions. Yet, as Arifeen and Semul (2019, 240) point out, "it is debatable whether institutions alone can mitigate marginalization and alienation among citizens."

Despite its cross-sectoral aspirations, and the principle that each goal reinforces the others, governments report on their SDG progress within the framework of each goal. This means that lessons learned about peacebuilding through health risk being lost. For example, efforts by health workers to provide non-partisan care to parties in conflict, and bring them together through mutual health needs, is a crucial form of "soft peacebuilding" which falls outside the institutional SDG peace agenda. The mutually reinforcing work of health and peacebuilding, including the contribution of health workers towards SDG16 and the overall SDG agenda, needs to be given much more emphasis.

Box C6.1: The Treaty on the Prohibition of Nuclear Weapons

Following several years of international humanitarian dialogue, the UN negotiated the Treaty on the Prohibition of Nuclear Weapons (TPNW) in 2017. Supported by more than 130 countries, it entered into force on January 22, 2021, making nuclear weapons illegal under international humanitarian law. Signatory countries are prohibited from producing or using nuclear weapons, or assisting in any related activities (financing, research, etc.), and have positive duties towards victims and the environment. Although non-signatories are not bound by the Treaty, they are still affected by it. For example, a growing number of international financial institutions are choosing to divest from nuclear weapons (Don't Bank on the Bomb 2019) as these become increasingly stigmatized.

The treaty complements and strengthens the SDG agenda. Any use of nuclear weapons, deliberate or accidental, would have catastrophic consequences. Even a "limited" nuclear war would cause massive fires, dramatically changed weather patterns, and widespread crop failure (Toon et al. 2019). The resulting famine would affect more than 2 billion people, causing mass displacement on an unprecedented scale. SDGs relating to food security, water and sanitation, and climate change would be immediately and enduringly reversed.

Nuclear war is a fundamental threat to health and well-being. Innumerable deaths and injuries, and extensive destruction of public services, would follow a nuclear attack – so much so that the International Committee of the Red Cross (2013) has warned there would be no viable humanitarian response.

This Treaty is the first of its kind to explicitly recognize that women and girls are disproportionately affected by nuclear attacks, both in terms of direct health consequences and stigma about reproductive choices. SDGs relating to gender equality and reducing inequality are thus interwoven in the treaty.

The hope of a world without nuclear weapons must be tempered with recognition of the challenges that remain. Growing militarization among nuclear-armed states – most recently, the UK government's decision to increase its nuclear stockpile, in clear contravention of its international obligations – contribute to increasing international tensions. Massive, ongoing investment in nuclear weapons represents a failure to prioritize spending appropriately, especially so at a time when urgent investment in health, social care, and climate action is needed more than ever.

Yet despite huge uncertainty about increasing risk of nuclear war and global pandemics, the implementation of the TPNW has real transformative potential and offers hope for a better future.

Peace and health "from below"

1. The promise of peace and health from below

Even while ostensibly supporting the SDGs, many powerful states undermine its global peace agenda by licensing arms sales to parties in conflict. The UK, Canada, and Sweden continue to arm Saudi Arabia, contributing to the crisis in Yemen discussed later in this chapter. The UN Secretary-General's March 2020 appeal for a global ceasefire in the wake of the COVID-19 pandemic appears somewhat naïve in the geopolitical context of declining multilateralism and falling support for the UN (see Chapter D3), whose peacekeeping interventions are increasingly seen as a form of neo-imperialism (Dorussen 2020). Moreover, since the "motivations and interests" at the root of most conflicts are context-specific and linked to local issues and grievances, ceasefires tend only to work if implemented locally, ideally "build[ing] on pre-existing structures" born of "inclusive negotiations" involving those "most affected by the conflict" – who are best placed to understand relevant dynamics – and "driven by political will, from the ground up" (Chetcuti et al. 2020). This demonstrates the disconnect between high-level calls for action and the realities of regional and community-level work.

However, there is a contemporary turn towards the "local" in peacebuilding in response to growing debate about the need to move beyond state-centric models (Minde 2018), owing a huge debt to feminist peacebuilding work (Basu, Kirby, and Shepherd 2020). This shift is "a clear rejection of the interventionist approach" to peace-making and of top-down models which "rely exclusively on the knowhow of the elite both local and international" and which "[reduce] the rest of the population into passive recipients of peace conceived elsewhere" (Kasonga Mbombo 2018). Decentralization, local capacity, and agency are becoming key components of peacebuilding efficacy, with growing recognition that the involvement of civil society actors, including women's organizations, correlates with more durable peace settlements (Nilsson 2012).

The trust and legitimacy enjoyed by community health workers may be particularly important in enabling health to serve as peacebuilding efforts in contexts where trust in the state is low. It is noteworthy that women make up the majority of frontline health workers and have overwhelmingly fronted grassroots "mutual aid" responses to COVID-19, arguably another form of "soft peacebuilding" at the nexus of health and peace. In contexts where the state is failing to provide for people's basic needs, these community-led efforts by health workers and others – such as volunteers in India refilling oxygen cylinders – plug gaps in fragmented public service provision.

2. Criticisms of initiatives from below: linking top-down and bottom-up approaches

Peacebuilding is a notoriously complex and fluid field. Predictably, the turn towards the local and peace initiatives "from below" has given rise to criticisms and counterpoints. Rather than dismissing the worth of local initiatives altogether, critics ask whether such a re-focusing of peace work can offer general and

universally applicable solutions for peacebuilding efforts. Particular concerns are that (1) prioritizing local agency above all can lead to the reinforcement of exclusionary local practices, particularly on the basis of gender (Bargués-Pedreny and Mathieu 2018), (2) there is no such thing as a "pure" local context which exists independently of outside influences (Simons and Zanker 2014), (3) locally focused initiatives may remain artificially insular and detached from wider peacebuilding efforts (Piccolino 2019), and (4) local initiatives fail to address the structural determinants of war and conflict, such as the political economy of the arms trade (see Box C6.3 below).

Building links between health and peacebuilding initiatives at local levels with national- and international-level peace work can thus be considered a promising way forward. Acknowledging the importance of local contributions does not necessitate a dismissal of "external involvement, resources, and support, nor does it presume that local traditions are not in need of refinement" (Funk 2012, 401). Within the SDGs' peacebuilding agenda, core considerations such as gender equality (SDG5), the need for universal healthcare access (SDG3), and inclusivity and non-discrimination in all peacebuilding efforts (SDG16) can provide important cornerstones of a framework for essential community-level peace work carried out by health professionals.

Conflict and coronavirus

The indivisibility of peace and health has been illustrated starkly by the impact of COVID-19 in countries affected by conflict. Such states, where "long periods of fighting [have led] to the destruction of infrastructure, health systems and trust in government and state institutions," comprise the bulk of those most vulnerable to the pandemic (Clugston and Spearing 2020). From Afghanistan to South Sudan, coronavirus is worsening pre-existing dynamics and jeopardizing fragile peace processes, while pandemic responses are hampered by "fragmented authority, political violence, low state capacity, high levels of civilian displacement, and low citizen trust in leadership" (Brown and Blanc 2020). International responses to the conflicts themselves are frequently absent, ineffective, or contradictory.

1. Yemen

The World Health Organization has called the situation in Yemen a "perfect storm." Even before the intensification of long-standing low-level conflict in the country in 2015, Yemen was one of the poorest countries in the Middle East, ranking 147th in life expectancy, with half of the population (two-thirds in rural areas) lacking access to healthcare services (United Nations Development Programme 2019).

The civil war involves a complex array of actors – with Saudi Arabian air strikes in support of the government, Iranian backing for the Houthis, and the Southern Transitional Council backed by the United Arab Emirates – as well

as a range of underlying, unaddressed grievances going back many years. The impact of the war has been devastating, leading the United Nations Development Program to label it "among the most destructive conflicts since the end of the Cold War" and "one of the greatest preventable disasters facing humanity" (United Nations Development Programme 2019).

As well as direct casualties resulting from armed conflict, indirect mortality from diseases and famine has been vast, with the UN estimating indirect casualties totaling 233,000 in December 2020. The war and siege have damaged every sector, from agriculture, irrigation, and food production, to healthcare, water infrastructure, sanitation, and social services. Airstrikes have destroyed and damaged at least 278 health facilities, leaving less than half functioning; and those are struggling with shortages of workers, essential medicines and supplies, safe water, and power. With water weaponized, food imports still not recovered from a 2017 blockade, and aid underfunded, politicized, and often impeded (Chetcuti et al. 2020), the humanitarian consequences have been catastrophic. Poor sanitation has contributed to the "largest [cholera] outbreak in epidemiologically recorded history" (United Nations Development Programme 2019, 12), with more than 1.3 million suspected cases. Food insecurity has left parts of Yemen on the brink of famine, with malnutrition a contributing factor in 45% of deaths amongst children under the age of five (El Bcheraoui et al. 2018).

Children have suffered disproportionately due to food insecurity, and the impact of the conflict has also been gendered. Over two million Yemenis have been internally displaced and most of the displaced are women (United Nations Development Programme 2019). The challenges posed to reproductive, maternal, and newborn health are "formidable" (Tappis et al. 2020), with maternal mortality increasing to a national average of 213 deaths per 100,000 live births in 2016 (El Bcheraoui et al. 2018). Conflict is consistently associated with higher rates of sexual and gender-based violence and Yemen has been no exception, with additional COVID-19 lockdown measures apparently driving rates even higher (Searle, Spearing, and Yeyha 2020).

In sum, COVID-19 inevitably compounded Yemen's already deep crisis. While calls for a ceasefire were initially welcomed, the Saudi-led coalition's announcement of a two-week ceasefire in spring 2020 was not sustained. The true extent of the pandemic remains unclear. But as the ongoing cholera epidemic shows, infectious diseases spread easily in Yemen. Most people, especially those in camps, live in overcrowded conditions, making physical distancing impossible, whilst poor access to water makes handwashing and hygiene difficult, and illiteracy restricts access to information about effective infection control. Women have again been hardest hit, being overwhelmingly expected to care for the sick (Clugston and Spearing 2020) and facing heightened barriers to sexual and reproductive health services as resources are redirected and movement restrictions tightened.

The Women, Peace, and Security agenda, expressed in UN Security Council Resolution 1325, is intended to tackle the exclusion of women from peacebuilding

and humanitarian efforts. Grassroots actors like the Yemeni Women's Union (YWU) are already at the forefront of this work, providing lifesaving support to the Yemeni population. Their work on the ground also allows YWU members to monitor emerging trends in violence against women (Searle, Spearing, and Yeyha 2020). Local actors like these are becoming even more important as international organizations withdraw from Yemen in the wake of COVID-19. We are seeing international donors increasingly turn inwards and direct resources towards domestic efforts to tackle COVID-19, affecting funding for grassroots women's organizations for peace and health. This threatens hopes for peace, will have a long-term impact on health and development, and may also make COVID-19 eradication difficult given that – even with vaccines – infectious diseases are hardest to eradicate in conflict zones.

The international community has not only failed to mediate the conflict, but some parties have actively contributed to prolonging it, particularly by licensing arms sales to Saudi Arabia. The hypocrisy of offering humanitarian assistance and calling for a ceasefire, whilst profiting from commercial trading of arms in a context marked by grave violations of international law, runs counter to the holistic logic of the SDGs, which recognizes that health is impossible without peace. The deleterious consequences for both peace and health cannot be overstated.

2. Syria

The past ten years have been marked by unrelenting war in Syria. The conflict is complex, with multiple warring parties including government forces, government-backed militias, and various opposition forces. External actors are also heavily involved: it is thought that countries including Turkey, Israel, Iran, the United States, and Russia are waging their own discrete but interlocking conflicts in and through Syria (Yacoubian 2020). Additional countries are invested in the war through arms sales to various parties.

A decade of violence has taken a vast toll on the lives of the Syrian people. In a country of 17 million people, over 5.5 million Syrians are registered as refugees; 6.2 million are displaced; and 6.5 million are facing critical levels of food insecurity (ReliefWeb 2020). The UN Commission of Inquiry on Syria (2020) found "continuing violations and abuses by nearly every conflict actor controlling territory in Syria [including] an increase in patterns of targeted abuse, such as assassinations, sexual and gender-based violence against women and girls, and looting or appropriation of private property." The ongoing war has undermined much of Syria's previous social and economic development, making it harder to recover from the conflict and to deal with other shocks, such as COVID-19. The Syrian population has lost many of the basic building blocks needed to live healthy, peaceful lives: amongst them a secure food supply, reliable sanitation and waste infrastructure, and access to housing (Commission of Inquiry on Syria 2020).

To the warring parties, lack of civilian access to healthcare is little more than collateral damage (Commission of Inquiry on Syria 2020). Worse yet, health services have often been purposefully targeted with violence. Repeated attacks on at least 350 healthcare facilities have been documented, leaving less than half functioning (Syria Public Health Network 2020). Despite the impact of COVID-19, attacks on healthcare provision have continued into 2020 (World Health Organization 2020).

The conflict itself is waged in ways which are exceptionally and directly damaging to human health. Multiple chemical weapons attacks have taken place (Arms Control Association 2020). The UN Commission of Inquiry (2020) "has reasonable grounds to believe that the Government of Syria … has continued to perpetrate the crimes against humanity of enforced disappearance, murder, torture, sexual violence and imprisonment." International organizations report "rape as a 'prominent and disturbing feature' in the Syrian war" (Women's International League 2016).

An effective public health response to COVID-19 is all but impossible in conflict settings. The conflict in Syria has seen the fragmentation and politicization of the health system, with at least four discrete systems operating in different parts of Syria (Syria Public Health Network 2020). Each one put in place different response plans at the start of the pandemic, further stretching already limited resources. Emergency responses are also blurring the line between "peace" and suppression: on one hand, "the regime of Bashar al-Assad … is working with some of its international backers to push for 'normalisation'" and the lifting of sanctions (Yahya 2020), while "U.S. foreign policy during the pandemic appears, if anything, more committed to severe sanctions implementation and variants of its 'maximum pressure' efforts against particular regimes" (Brown and Blanc 2020).

Despite the conflict, there are grassroots women's organizations which continue providing Syrian women with "much-needed services, and carrying their voices to the international fora" (Women's International League 2016). These organizations, and others like them, represent hope for a just and lasting peace through community-led activism and voluntary service dedicated to relieving human suffering. But even before the pandemic, these organizations "face[d] devastating threats and challenges every day," with activists being "subjected to various forms of abuse, including arbitrary arrests, abduction and torture" (Women's International League 2016).

Repression and arbitrary detention of activists continue to be a feature of the Syrian conflict (Commission of Inquiry on Syria 2020), with little or no improvement in the prospect of building an enduring peace beyond the pandemic.

3. Weaponizing the coronavirus

Many of the world's governments have used the pandemic as an excuse to weaken human rights, advance authoritarian goals, and undermine the integrity

Box C6.2: Islamophobia and genocide

The twenty-first century has seen genocidal campaigns directed against Muslim minority populations across the globe. These demonstrate a vast disparity between the peace- and health-building aspirations of the SDGs and the actions of states.

In Myanmar, the predominantly Muslim Rohingya people have been subjected to a "textbook example of ethnic cleansing," with "progressive intensification of discrimination over the past 55 years" (UN Human Rights Council 2017). Denied citizenship since 1982, the Rohingya have fled waves of persecution since the 1990s, with the largest wave of forced migration happening in August 2017. The military-led campaign resulted in an estimated 11,400 deaths in just one month (Médecins Sans Frontières 2018), and the partial or total destruction of hundreds of villages. More than 700,000 Rohingya fled for their lives to Bangladesh that year (High Commissioner for Refugees n.d.). A military coup in Myanmar in February 2021, and a massive fire that broke out in March 2021 in Kutupalong refugee camp in Bangladesh, destroying thousands of shelters and vital services, mean that the Rohingya community's plight is likely to worsen. Those remaining in Myanmar face increased risk of persecution because of the newly installed military regime, while those in refugee camps in Bangladesh are at greater risk of poor health, including COVID-19 infection, due to their poor living conditions.

In China, the government has conducted an intensifying campaign of mass internment, intrusive surveillance, political indoctrination and forced cultural assimilation of the Uyghur Muslim population since 2017. The government is believed to have built hundreds of internment camps, where an estimated one million Uyghur Muslims are being detained without trial or charge (Human Rights Watch 2021a). Uyghurs inside and outside the camps face severe travel restrictions and confiscation of passports, and those abroad are tracked and threatened for speaking out about the oppression in Xinjiang (Amnesty International n.d.). The abuses which the Uyghur Muslim population continues to suffer at the hands of the Chinese government have led activists and scholars to describe this, the "largest mass internment of an ethnic-religious minority since World War II" (Alecci 2019), as a genocide.

In India, the far-right Bharatiya Janata Party (BJP) government passed the controversial Citizenship Amendment Act (CAA) and introduced the National Register of Citizens (NRC) in Assam, both widely considered to deliberately target Muslims (International Commission of Jurists 2020). The CAA refuses asylum to Muslims from Afghanistan, Pakistan, and Bangladesh whilst affording protection to other religious groups, and the NRC is

suspected to be a mechanism to allow the identification and expulsion of Muslims from India. The BJP government also abrogated article 370 of the Indian constitution in 2019, revoking the constitutional autonomy of the Kashmir region, a disputed territory with a Muslim majority population. Tens of thousands of extra troops were deployed in the region, with about 4,000 people reported to have been detained (Ghoshal and Pal 2019) and reports of beatings, torture, pellet gun injuries, and deaths of Kashmiri civilians at the hands of the Indian military (Hashmi 2019).

The global response to these atrocities has been overwhelmingly disappointing. These crimes against humanity demand the immediate attention of the global community to alleviate the suffering of targeted populations, whatever the political or economic cost.

of democratic institutions. Freedom House (2020) reports that democracy has weakened in 80 of the 192 countries it examined, while Viva Salud (2020) found that state actions to control COVID-19 have jeopardized human rights and compromised the work of social movements.

In the USA, voting rights were compromised by confusing and contradictory measures during the state-by-state primary elections in spring and summer 2020 (Freedom House 2020). Measures to reduce crowding at polling stations during the November 2020 presidential election, such as early voting and postal voting, were exploited by the losing candidate to question the legitimacy of the result (Van Voris et al. 2020).

The virus was also used in the USA to justify increasingly restrictive immigration and asylum policies. Delays and restrictions on formal processes worsened insecurity among already vulnerable populations (Loweree, Reichlin-Melnick, and Ewing 2020). Continued confinement of asylum seekers in overcrowded detention centers heightened their risk of exposure to COVID-19, while the ongoing operation of deportation flights meant that thousands of people were deported to countries with less resilient health infrastructure, with many testing positive for COVID-19 on arrival (Gonzalez 2020).

COVID-19 has been "weaponized" to further increase authoritarian states' control of public life. In Turkey, antiterrorism laws have been used to intimidate or arrest individuals who criticize the government's handling of the pandemic, furthering its hostile stance towards social media (Amnesty International 2020). Freedom of expression has been curtailed in several other countries, through censorship measures as well as arbitrary arrests and detentions, under the pretext of curbing the spread of misinformation (Office of the High Commissioner for Human Rights 2020).

The security of minority or vulnerable populations has also become more precarious during the pandemic. Sri Lanka used a militarized approach to

Image C6.1 "Militarization of quarantine/lockdown."
Source: Sketch by Arun for *Global Health Watch 6.*

control the virus, resulting in large numbers of arrests, an intensified military presence at checkpoints, and contact tracing run by intelligence agencies (Human Rights Watch 2020a). Across the Americas and Europe, incidents of racial discrimination, harassment, threats, and physical violence against people of Asian descent have increased (Human Rights Watch 2020b), sometimes stoked by government officials and politicians blaming Asian immigrants for the spread of the virus.

The global pandemic also distracted international attention from repressive measures enacted by a number of states against populations under their control, such as the decision by China to disqualify four pro-democracy legislators from Hong Kong's Legislative Council, advancing Beijing's ambition to gain full control of the territory (Human Rights Watch 2020c). In the Middle East, Israel has used COVID-19 as the pretext to tighten its control over and increase violence against Palestinians (Human Rights Watch 2021b). In addition, despite a world-leading vaccination campaign, only in March 2021 did Israel start offering vaccination to Palestinians who work in Israeli controlled lands or illegal Israeli settlements in the West Bank (see Chapter B4). The statement issued by the UN High Commissioner for Human Rights, emphasizing Israel's responsibility to provide equal access to COVID-19 vaccine in the West Bank and Gaza, did not result in the international community enforcing binding obligations on Israel to comply (Office of the High Commissioner for Human

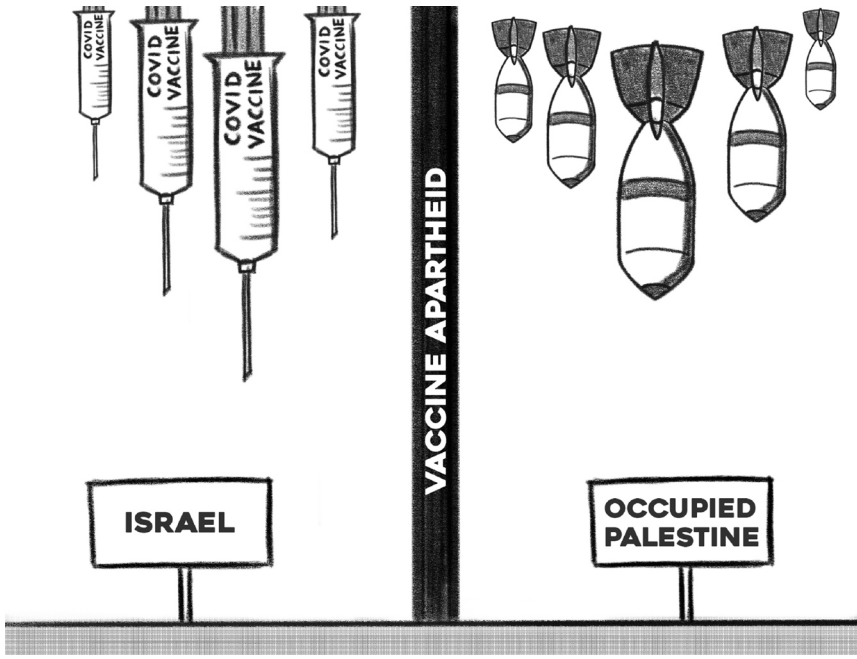

Image C6.2 "Vaccine apartheid."
Source: Sketch by Arun for *Global Health Watch 6*.

Rights 2021). Although broadly ignored, these geopolitical shifts could foment future instability and international conflict.

But the use and abuse of measures to control COVID-19 has not been without grassroots resistance. Some have attempted to enhance social solidarity and support in the face of restrictions on normal life. For example, mutual aid networks have developed in which neighbors organize to help each other cope with the economic, social, and psychological impacts of the pandemic and associated public health restrictions, regardless of immigration status or other markers of difference (Mutual Aid Hub 2020). Despite increased repression and arrests, pro-democracy activities in Hong Kong continue (Pomfret and Pang 2020). In Sri Lanka, the militarized response to COVID-19 has been met with peaceful resistance and community solidarity.

However, acts of resistance have not been wholly benign. For example, anti-lockdown protests have taken place worldwide. These protests sought to assert the liberty of participants in the face of repressive government measures. Such protests have been widely viewed as dangerous and irresponsible. This polarization has been compounded by the conflation of anti-lockdown campaigns with conspiracy theories and "anti-vaxxers." It is therefore important to assess the exact nature of acts of resistance against the rise in government control in the context of COVID-19. Restrictions must also be understood in the whole

Box C6.3: Spending comparison: pandemic preparedness versus preparation for war

Military conflicts and uncontrolled pandemics both result in massive loss of life and long-term casualties, together with vast social and economic disruption and costs. It is instructive to compare global spending on the military with the amount invested in pandemic preparedness around the world.

Stockholm International Peace Research Institute (2021) estimates that global military expenditure reached USD $1,960 billion in 2020, with the US alone responsible for nearly 40% of that spending. By contrast, in 2019 – the year COVID-19 emerged – countries allocated just $0.374 billion in development assistance for pandemic preparedness (Stutzman, Micah, and Dieleman 2020). The amount allocated to warfare was over 5,000 times greater than this investment in protecting global health.

Investing in disaster resilience and pandemic preparedness is crucial to help alleviate poverty, as infectious diseases tend to disproportionately affect the poor (Global Preparedness Monitoring Board 2020). The Commission on Global Health Risk Framework for the Future (2016) estimated that an investment of $4.5 billion per year (just 0.2% of global military spending each year) would make a significant impact on global health security by

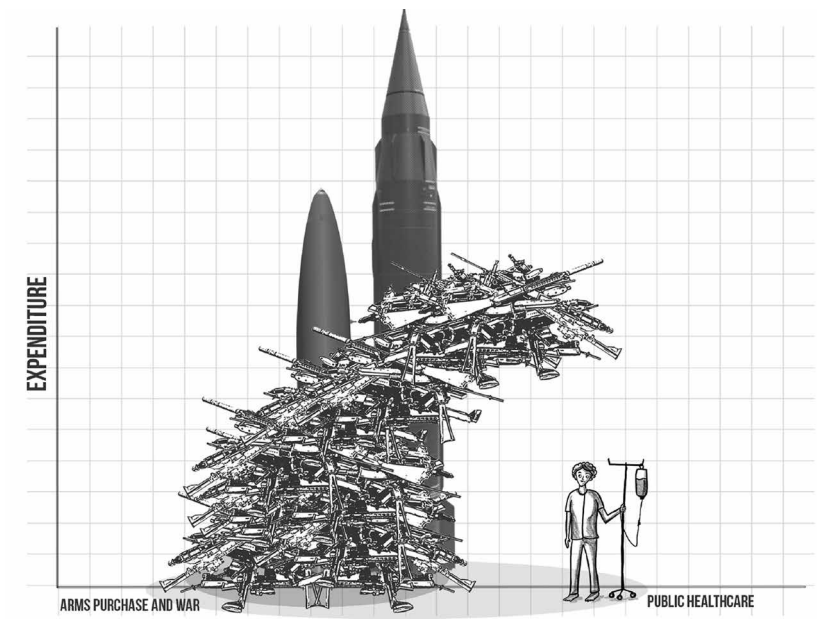

Image C6.3 "Funding on arms trade and health."
Source: Sketch by Arun for *Global Health Watch 6*.

strengthening national public health systems, funding research and development, and financing global coordination and contingency efforts.

Failure to invest in prevention has led to countries facing substantial costs resulting from COVID-19. The global response is estimated to have costed around $11,000 billion so far – meaning that, at current rates of spending, it would take 500 years to spend as much on pandemic preparedness as the world has lost in just 12 months due to COVID-19 (Global Preparedness Monitoring Board 2020).

Global investment in militarism and the arms trade is several orders of magnitude greater than global investment in health systems and pandemic preparedness, despite the overwhelming human and economic cost of COVID-19. The impact of the pandemic demands a complete reprioritization of national and international expenditure, with a focus on the foundations of health and peace.

socio-political context in which they occur, recognizing the conflictual consequences of such acts on global peace and security.

Conclusion

The work of building health and peace cannot be imposed exclusively through top-down initiatives, nor achieved solely through action "from below." A complementary relationship is essential: one in which local actors can lead, informed by their rich understanding of local context and dynamics but integrated within a broader strategy, incorporating international perspectives and institutional support where these can strengthen the response.

The cases of Yemen and Syria exemplify how far top-down agendas can fall short in practice, showing the devastating impact on peace and health when international actors pay lip service to ceasefires while selling arms for war, despite the best efforts of grassroots peace activists. In conflict zones around the world, COVID-19 has exacerbated pre-existing dynamics and worsened health outcomes, while further eroding the foundations of potential peace.

The pandemic has plunged the entire world into a health crisis. It has necessitated the top-down imposition of social distancing restrictions but also served as a pretext for repression far beyond measures warranted by public health. While women remain under-represented in the highest echelons of power, they disproportionately carry out the frontline health and care work that the pandemic has required. As state governments increasingly turn inwards to confront domestic COVID-19 outbreaks, it is local, grassroots initiatives, frequently driven by women's labor, that will play a vital role in sustaining efforts for health through peace amidst the pandemic chaos.

Note

1 A term commonly used to describe policies and activities that aim to build conditions for peace and social coherence. Such policies and activities focus on sustainable economic and social development to address roots of conflicts rather than their triggers.

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