The role of physicians and other health workers in the preservation and promotion of peace is the most significant factor for attainment of health for all.\(^1\)

On 15 June 2000 OCHA reported that in Kisangani the fighting of the past days had disrupted the planned immunization days and that over 180,000 doses of polio vaccines were lost.\(^2\) Polio eradication faces daunting challenges in all countries undergoing armed conflicts. But also efforts against malaria cannot succeed in 18 countries at war in Africa, Central and South East Asia, unless special strategies and resources are deployed. Conversely, the interactions between HIV/AIDS and global insecurity have come to the attention of the UN Security Council. Sub-Saharan Africa, that suffers most from contemporary conflicts, is also the most severely affected by the pandemic. A UN Inter-Agency Standing Committee (IASC) Sub-Working Group on this theme concluded that studies should be carried out on how to integrate HIV/AIDS into the broader agenda of conflict prevention.\(^3\)

**Political will**

*The first principle of Health is life.* War is a direct threat to life. For millions of people world-wide, surviving war is the predominant objective in their daily existence. Ending war would be the first step toward health and well-being in any sense of these ideal conditions.\(^4\) Since Resolution 34.38, WHO has continued building up its moral leadership in this area, based on values that are related to human rights and humanitarian principles as well as to medical ethics. In 1998, the 51st World Health Assembly in May 1998 accepted the role of the Organization in *health as a bridge for peace* in the Health for All in the 21st Century Strategies. This year, WHO Director General's Address to the 53rd World Health Assembly carried a specific mention of the role on health partners in armed conflict and of the importance of "staying to the end and to come in early" and that rehabilitation should guide Health action from the start of relief.\(^5\)

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1. World Health Assembly 1981, Resolution 34,38
2. OCHA-Goma: DAILY SITREP OF 15th JUNE
3. IASC-Sub working Group on HIV/AIDS in Complex Emergencies: Controlling the Spread of HIV/AIDS in Complex Emergencies in Africa
5. WHO A 53/3 Address by The Director General to the fifty-third World Health Assembly, Geneva, 15 May 2000
Strategies and Tools

A mandate and a work in progress. As armed conflicts become more and more targeted against a country's social capital and more enmeshed with the crisis of legitimacy of the State, they impinge more on WHO's work. As a UN Specialised Agency accountable to its member countries, WHO has to reconcile its unique responsibility in the health sector, the humanitarian imperative and the mandate to assist its primary constituents. Thus, WHO has integrated conflicts in its strategies for public health action in emergencies. In 1997, WHO formulated the concept of Health as a Bridge for Peace, as evidence from Angola, the Balkans and Haiti suggested that health workers are in a unique position to understand the need for and contribute to peace building. This concept is now taken forward by regional programmes in Europe, South Asia and Africa and by a global consultative process on Planning Ahead for the Health Impact of Complex Emergencies. From this process WHO can contribute a preliminary set of observations on Conflict and Health.

A wide view of Health determinants. The goal of public health is to prevent avoidable morbidity and mortality, but in armed conflicts public health can be effective only in as much as the security of victims is guaranteed. In order to achieve this health workers must often grant priority to non-medical action. Security and its protection, the same as water, food, sanitation and shelter are of more immediate benefit than providing health care.

Health information for Peace. There has been much reflection on the value of health information for early warning. Counting a population, assessing their needs, keeping record of intentional injuries and intersectoral coordination can save more lives than setting up a field hospital. The timing of interventions is of crucial importance. Nonetheless, early warning systems remain largely inadequate: one week of CNN coverage still carries much more weight than carefully recorded mortality data. Moreover, the question remains regarding who controls the services that generate and manage health information - and what can actually be discussed - in a politically tense situation.

Only peace reveals all health needs. One lesson learnt in the past ten years is that defining phases such as "pre-conflict, conflict and post-conflict" can be misleading. What prevails are protracted states of "no-war-no-peace", marked by instability and periodical flare-ups of violence. In this frame, though, the heaviest burden on public health occurs in "pockets of peace", pauses in fighting and ‘post’-conflict situations. During the first, short-lived cease fire in Angola, it was common saying among humanitarian workers in Luanda that "1991 was a food emergency, but 1992 is a health emergency". In complex emergencies, when inaccessible areas open up they release a "backlog" of public health needs long left unattended (typically flagged by measles epidemics). For some rural communities, the move into refugee camps can still represent the first contact with the very notion of health "services". More in general, wherever and whenever access to health care is easier, demand increases as the expectations of communities, local authorities and external partners grow. Furthermore, cease-fire arrangements, even if precarious, need special health support: for demobilisation of soldiers, de-mining and return of refugees and internally displaced persons. The health sector is required to re-establish coverage, since equitable access to care is rightly perceived as a major factor of social stabilisation and peace-building.

A Gap and a paradox. This increased burden meets the health systems at the worst possible moment. In most of today's conflicts, cessation of hostilities seems to take place only when a crisis has reached such magnitude that even war has become unsustainable. At this stage, national/local health systems, however fragile to start with, are further de-capacitated by lost assets, missed investments, collapsed cost-recovery, financial shortages, loss of human resources. Information is scanty because changes are underway, records have gone lost and systems are disrupted. Community coping strategies are exhausted. External assistance may bide its time. It is in this context that national and international actors should shift from "relief to development" and that "the Gap" occurs. Planning for the recovery of the health system require a careful analysis of the impact of the conflict on health determinants, e.g. to see how population displacement reflects

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6 WHO/EHA Consultation on Planning Ahead for the Health Impact of Complex Emergencies, Geneva December 1999
8 See the effects of the drought of 1992-93 on the war/peace processes in Mozambique and Angola
on access to safe water and/or health care, or how health financing schemes fit the economic transition. Experience suggests that planning for reconstruction should start as early as possible\(^9\). In most instances, though, this exercise starts only in the 'post-conflict' phase: that is when national capacities are at their lowest, the needs and demand at their highest and coordination is most difficult. Conflict and 'post'-conflict situations are characterised by a proliferation of actors and health is high everybody's agenda. But external humanitarian partners can act outside official channels without a sound knowledge of the country and no clear exit strategy. Too many fragmented programmes interfere with national planning and can become pawns in political games.

**Re-storing the original health system is not necessarily the right choice.** Caution is needed. Arguably, the health system that was in place before the conflict was part of the structural causes that lie at the root of the conflict itself. Post conflict rehabilitation must not recreate past inequities. For instance, the needs of previously under-served, minority groups must be taken into greater account, in order to ensure more equitable and appropriate access to health services. Furthermore, a medical principle applies: after any illness, there is no such a thing as "restitutio ad integrum". Even an a-symptomatic infection leaves behind an immunological scar. All disasters leave behind "scars" and violent conflicts especially so. Human infrastructures are destroyed, demographic patterns change, new social structures emerge, new economic options will have to be adopted. Even the natural environment may be permanently changed (e.g. by landmines). Besides having greater expectations, people will face objective new needs.

**Investing in Health is investing in Peace.** Health needs and contributes to physical, psychological, social and economic security. Investing in Health can reduce the risk of conflict as well as mitigating its impact. WHO has a clear role in encouraging governments to design health systems that can withstand crises and this form of preparedness planning can contribute to conflict prevention. Placing social services high on the political agenda helps maintain social stability, and reduce militarization in situations where the risk of violent conflict is high. Investing in the health sector makes good sense for conflict prevention as well as for socio-economic development. Empirical evidence suggests that health can help peace also in operational terms. Health problems and assets are easily recognised as common concerns and can facilitate dialogue between conflicting parties. In 1994 in Angola, in spite on the fighting, UNITA was providing health data to the Minister of Health in exchange of drugs and advice for tripanosomiasis control\(^10\). In spite of difficulties, temporary cease fires for immunisation campaigns have become an accepted practice. Again, caution is needed, lest health initiatives end up as captive of political agendas.\(^11\) Nonetheless, the work of WHO in Bosnia & Herzegovina illustrates how health recovery can support stabilisation and peace-building: from joint training of health professionals from opposing entities to cross-community activities at local level and the re-definition of health districts along functional rather than ethnic lines\(^12\).

**Challenges and commitment.** Indeed, the challenges that conflicts pose to WHO's work are many.. But the sheer burden of illness and death that conflicts cause demands the WHO's full commitment. It is now an accepted principle that, in any crisis, the WHO country office must remain functional and ready to adopt the most suitable operational tools. These range from early health intelligence, gearing up technical programme to continue in spite of the crisis, to working through NGOs or beneficiary communities and opening sub-offices to support pockets of stability\(^13\). More and more, the capacity to withstand the impact of conflict and to contribute to its prevention are perceived as indicators of WHO's corporate performance in its cooperation with member countries.

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\(^9\) E.Pavignani The Reconstruction Process of the Health Sector in Mozambique-A messy affair with a happy end ? 1999
\(^12\) Peace Through Health.Ibid
\(^13\) EHA Inter-Regional Retreat, Neemrana Fort Palace, 28 February-2 March 2000.WHO/EHA , April 2000