SPECIAL REPORT

Health, Population, and Fragility: Insights From a Meeting Series

The Environmental Change and Security Program recently completed an expert meeting series on the relationship between health and population issues and the evolving U.S. Agency for International Development (USAID) strategy for fragile states—now called "Rebuilding Countries," under the new Strategic Framework for U.S. Foreign Assistance. Developed as an internal consultation with USAID's Office of Population and Reproductive Health (PRH), the series brought together practitioners interested in population, conflict, and fragile states from PRH, other USAID offices, implementing partners, and outside experts from the health-population-security field.

The series sought to broaden understanding of health and population issues as part of the problem and part of the solution to instability challenges, as well as foster debate about the correlations between fragility and population dynamics such as youth, sex ratios, differential population growth rates (within and between countries), population density, urbanization, and public health. "We are gleaning lessons from field-based service delivery in conflict and post-conflict zones—lessons for delivering the services to save and improve lives. But we are also working to understand how building health capacities in post-conflict zones might contribute to meeting broader stability and conflict prevention goals," said ECSP Director Geoff Dabelko.

Archived videos, summaries, and presentations are available online at www.wilsoncenter.org/ecsp

Note: Summaries drafted by Ken Crist and Matthew Robinson; series edited by Alison Williams and Meaghan Parker.

The Security Demographic: Assessing the Evidence

Tuesday, June 13, 2006

As a country's birth and death rates shift from high to low, it is said to be moving through the "demographic transition." Countries that have completed this transition are less vulnerable to civil conflict, argued Richard Cincotta, former senior research associate at Population Action International at the Wilson Center on June 13, 2006. Drawing on three decades of data, Cincotta and Jack Goldstone of George Mason University explored the relationship between demography and conflict, which is critical to USAID's reexamination of the Fragile/Rebuilding States strategy. Goldstone argued that due to demography's link to instability, the national security and development communities have a vested interest in helping societies move through the demographic transition to achieve the so-called "security demographic"—defined by Cincotta as "a set of stability-promoting demographic characteristics."

SPEAKERS:

Richard P. Cincotta, Senior Research Associate, Population Action International[1]

Jack A. Goldstone, Virginia E. and John T. Hazel Jr. Professor of Public Policy, George Mason University; and Member, Political Instability Task Force

Demographic Transitions and Youth Bulges

Demographic transitions have occurred naturally and frequently throughout history, noted Goldstone. For example, the United States is experiencing the effects of its own demographic transition as the baby boomers begin to reach retirement age and challenge the country's ability to care for a large elderly population. In the developing world, the impact of such transitions can exacerbate or spur other serious problems, including civil conflict. In a country with a low natural growth rate, demographic increases often have little profound impact because the economy can generally grow to absorb the additional population. "Society [can] adapt over time to expanding numbers, without a sudden increase in demand for services," Goldstone said. However, in a country with high fertility and falling mortality, a large youth cohort may reach adulthood without giving the government a chance to adapt. This "youth bulge" can contribute to a catalog of problems in developing countries, particularly if government and civil society are unable to ensure basic services such as employment, housing, and education for the members of the larger cohort.

Goldstone argued that everyone—from parents to the courts, from the health system to the education system—is put under increased strain by youth bulges. "When you have that huge surge in surviving children, well, children need supervision, they need education, they need opportunities. They also need to be socialized into respect for existing law and order. If that doesn't happen, then they want to go off and find their own way," he said.

Youth Bulge and Civil Conflict

According to Cincotta, a society's propensity toward civil conflict increases if it cannot adequately accommodate youth bulges. Age distributions in Uganda, Angola, Chad, and the Solomon Islands reveal that these countries share a predisposition toward civil conflict because of their common feature: Greater than 50 percent of the population is between ages 15 and 24. Historically, he said, countries experiencing youth bulges were more likely to experience civil conflict, which, in modern times, has far outweighed the incidence of interstate conflict.

While youth bulges are not always destructive, they can be destabilizing if they exacerbate competition for already scarce jobs and

Demographic risk factors for conflict are clearly demonstrable, but often lose ground to a country's pressing political and social concerns.

Jack A. Goldstone, Richard P. Cincotta (© David Hawxhurst, Woodrow Wilson Center)

opportunities to the point where the youth cohort begins searching for economic and social advancement through other avenues. "[M]uch of the risk that is generated by demographic factors has to do with the ease of recruitment, of recruiting mostly young males to extremist political organizations, to insurgencies, to state-supported regular and irregular security forces," Cincotta said. Increased membership in such groups—and the great competition among them—is an indicator of brewing unrest.

Other factors can exacerbate the negative impacts of youth bulge, primarily rapid urbanization associated with extreme population growth. This dynamic creates conditions that support black market trade and other illegal activities, and may compound shortages that already exist. The black market, Cincotta said, has been linked to the rise of gangs and paramilitary movements, adding that parents and society often have great trouble mitigating the impact of "street culture" on young adults, which only exacerbates the problem.

The Role of Development Agencies

In Cincotta's experience, research on the connections between demographic changes and conflict has traditionally been presented to the national security community, not the development community. As a result, his work "purposely avoids what is called the human security rationale, but that doesn't mean that those rationales are illegitimate"; instead, state security and state-building "are increasingly framing foreign policy funding and programming." Since the current political climate puts a premium on security, tying development to security is crucial. Demographic risk factors for conflict are clearly demonstrable, but often lose ground to a country's pressing political and social concerns: "The security community…is just preoccupied with short-term solutions," he said. Prioritizing health care and demographic development independently of a national security tie is further complicated by the fact that it is often difficult—if not impossible—to separate the economic causes of conflict from the demographic ones.

Development can mitigate and even eliminate the instability that normally accompanies demographic transition, according to Goldstone: "A rich society does have more scope. If you have a society like China where the economy is growing at 6 or 7 percent, they probably didn't need the one-child policy, although some of that rapid growth was precisely because their dependency ratio means that most of the population is adult and productive." He urged Western development professionals to help countries achieve their security demographic: "You can think of society as a very large multicellular organism, where the individuals are like the cells. A healthy organism grows at a normal rate and within proportion. The different parts of the body grow in proportion and it all functions well." If development agencies can promote that normal growth—and in the right proportion—civil conflict will be less likely, he concluded.

Note

1. In late 2006, Richard Cincotta moved to the National Intelligence Council. See also Cincotta's article on "Population Age Structure and Its Relation to Civil Conflict: A Graphic Metric" on page 57 of this *Report.*

Securing Health: Lessons From Nation-Building Missions

July 26, 2006

Health services may provide the foundation for democracy in some post-conflict countries, argued Ross Anthony of the RAND Corporation on July 26, 2006. Anthony and his colleague Seth Jones discussed their new edited volume, *Securing Health: Lessons From Nation-Building Missions*, which reviews past efforts to establish health services in countries recovering from conflict.[1] The book's contributors examine how post-conflict instability affects health programming, and how such programming forms an essential component of nation-building.

Health as an Outreach Effort

According to Anthony, the world has become increasingly alienated from, and hostile to, the United States. Furthermore, even traditionally staunch allies have been reevaluating their relationships with the United States. Health programming can, he argued, provide a reasonable and effective means to counter such negative images. Providing humanitarian health assistance to less fortunate countries is a good way to build goodwill and cooperation, which can then be parlayed into more significant ties. Health programming can also be an effective international relations tool, because it can change not only how people think about the United States but also how they think about themselves and their place in the world. Additionally, offering marginalized people some of the concrete benefits of globalization could help them integrate into the new economic world.

The Theoretical Framework of Post-Conflict Health

"We wanted to look at…seven distinct efforts after U.S. nation-building operations, and look specifically at the health care system…the effects of the nation-building, and health effects on that process," said Anthony. The authors studied nation-building in Germany, Japan, Iraq, Afghanistan, Haiti, Kosovo, and Somalia. Determining the extent of improvements in post-conflict countries can be extremely difficult. Commonly used indicators (e.g., life expectancy, infant mortality, birth/death rates) provide the best means of measuring overall levels of health and health care, according to the authors, but in many cases data are either nonexistent or of questionable reliability. However, some members of the audience questioned whether these problems were as widespread as claimed.

Gathering new survey data in post-conflict countries can also be problematic due to low levels of security. Using as much data as they could gather, the authors charted trends (pre-conflict and post-conflict) and compared them with security indicators—such as the number of violent attacks, amount of civil unrest, and civilian casualties—in an attempt to establish links between security and health.

The Case for Correlation Between Health and Security: The Country Studies

Drawing on some examples of health program reconstruction in post-conflict countries, Seth Jones argued that nation-building cannot succeed without at least partial success in building public health. Broadly speaking, the countries they studied fell into one of three categories: very successful (Japan and Germany), mixed success (Iraq and Kosovo), and failures (Somalia, Afghanistan, and Haiti).[2] Both Japan and Germany experienced a relatively rapid expansion in the provision of both public health services and commodities, leading to commensurate increases in all of the health indicators. Both countries' post-conflict security levels were very high and extremely stable; for

SPEAKERS:

Ross Anthony, Co-Director of the Center for Domestic and International Health Security, Director of Global Health, RAND Corporation

Seth Jones, Political Scientist, RAND Corporation Adjunct Professor, Edmund A. Walsh School of Foreign Service, Georgetown University

Ross Anthony
(© David Hawxhurst, Woodrow Wilson Center)

example, not a single American soldier died due to enemy action during the post-World War II occupation of Japan. Both countries were devastated by the war, yet health indicators reached higher levels than before the war relatively quickly. A large part of this recovery must be attributed to the high levels of pre-war health care and organization, they argued, leading the population to expect the state to provide certain levels of care.

In contrast, the mixed cases (Kosovo and Iraq) may have recovering health indicators, but they have not recovered to pre-war levels or been obtained through sustainable local means or management. In Iraq, the current war has caused a precipitous decline in the levels of health indicators across the board, and the situation has not improved much since the end of major hostilities. While the causes for this situation are myriad and complex, the general conclusion is clear: The lack of security has drastically affected the ability of health programmers to conduct interventions on the large scale necessary to effect real change, and the lack of basic health services has decreased the coalition's ability to build the trust and confidence necessary to improve security. Also, clinics and health service providers, along with health system infrastructure and the supply chain, have been the victims of violent attacks. Some audience members pointed out that the situation in Iraq, like Afghanistan, is still developing, and suggested that it was too soon to assign a definitive category to such countries. In Kosovo, while there has been a marked improvement in many health indicators since the war, the improvements have not been achieved in conjunction with local leadership, and are therefore not sustainable.

The failures—including Afghanistan, Haiti, and Somalia—share common characteristics. First, the countries' infrastructures were devastated, leaving extremely little basis for rebuilding. Second, the countries lack human capital (e.g., skilled practitioners), and the population does not hold high expectations for service delivery. Finally, and most significantly, NGOs and governmental actors do not coordinate, which leads to duplicate or counterproductive efforts. All of these problems are exacerbated by security issues: It can be difficult to coordinate if convoys cannot get through to service sites, just as it is difficult to maintain human capital when violence is high, as people with marketable skills tend to leave the country.

Lessons Learned

Anthony pointed out that security does not impact the development of health services in only one aspect, but in every single one. As such, health programmers must take the security situation into account when planning, executing, and developing expectations for new programs. Overcoming the challenges of rebuilding health in devastated nations requires planning and coordination, infrastructure and resources (including human resources), and strong leadership. In low-security countries, these requirements are much more difficult to meet; it may make more sense to operate on a small scale while preparing for a larger intervention when conditions improve.

Health aid can clearly provide an independent benefit not only by improving relations between countries, but also by decreasing the economic drain of poor health and lost productivity. Officials focused on ensuring stability and fostering democracy must view rebuilding the health sector in post-conflict countries as a critical ingredient for success, instead of a low-priority luxury item. Jones concluded, "Health in most of these cases can have an important independent effect; in some cases it can have a negative impact on hearts and minds (as in Iraq), in some cases a positive one as we found with Japan. It can also provide the groundwork for democracy in some cases." Health programming, then, must be viewed not only as a means to the end of security or economic reconstruction, but as a fully fledged facet of post-conflict nation-building.

Nation-building cannot succeed without at least partial success in building public health.

Notes

1. Available online at http://www.rand.org/pubs/monographs/2006/RAND_MG321.pdf

2. Some audience members questioned these groupings, due to the differences in time between conflict cessation and evaluation of success in some of the cases; for example, hostilities in the "very successful" cases—Japan and Germany—ended more than 50 years ago.

Health Provision in Fragile Settings: A Stabilizing Force?

September 12, 2006

Strengthening public health systems can help foster good governance, encourage reform, and improve stability in fragile settings, said Emmanuel d'Harcourt of the International Rescue Committee (IRC) on September 12, 2006. D'Harcourt was joined by fellow IRC colleague Lizanne McBride and Columbia University Professor Ronald Waldman to discuss best practices for conducting health work in fragile or post-conflict countries, as well as the potential impact of health systems on stability and security in rebuilding states.

SPEAKERS:

Ronald J. Waldman, Professor of Clinical Population and Family Health and of Clinical Epidemiology, Mailman School of Public Health, Columbia University

Lizanne McBride, Director, Post-Conflict Development Initiative, International Rescue Committee

Emmanuel d'Harcourt, Senior Technical Advisor for Child Survival, International Rescue Committee

The Value of Health Systems

Fragile governments often suffer from common problems—weak human resources, low absorptive capacity, and a lack of information on which to base effective policies, for example—that impede their ability to implement critical public services like health care. Additionally, new governments often struggle to meet the demands of citizens who expect public services to resume after conflict ends. Failure to meet these expectations could allow conflict to re-emerge, Waldman said: "There is a relatively limited window of opportunity available to convince people that they should make an emotional, a political, and a real investment in those fragile governments that take form following a tenuous peace accord, as is the case in the Democratic Republic of the Congo [DRC], south Sudan, and Afghanistan."

Investing in health systems, Waldman said, presents a promising entry point to address these problems and strengthen the relationship between government and citizens. In the DRC, for example, health systems are the strongest "relic" and one of the only sectors that continues to function well. Health systems are thus one of the avenues through which the public can demand—and receive—services from the transitional government. This process not only encourages citizens to invest in the new government, but can also lay the foundation of democracy and good governance. "We ought to recognize that it's an obligation of the health system not only to improve the health status of the population, but to work in such a way that it fosters better comprehensive governance," he said.

From Service Delivery to Building Systems

In the past, donors have focused on the delivery of essential health services, principally due to the "unspoken argument" that larger health systems could not be implemented successfully in fragile settings, noted d'Harcourt. However, recent studies conducted by the IRC in Rwanda and southern Sudan challenged this assertion, concluding that fragile governments can administer effective health programs. In Rwanda, for example, government-supported health programs helped reduce the child mortality rate by 25 percent between 2000 and 2005. According to d'Harcourt, this reduction is evidence that it is possible to build health systems in fragile environments: "You can put in systems. Why not do it in health? It is concrete,

the population definitely supports it, and it's not that expensive."

But keep expectations realistic, Waldman warned: If governments had difficulty delivering health services prior to a conflict, there is no reason to believe a new government will have any more success in this area. "Some things don't change," he said, and also stressed that investing in health systems will not be a stabilizing force unless governments have enough funding to implement programs on a national scale. Several international studies pointed out that donor investment in the health sector remains inadequate, prompting him to conclude that unless funding levels are increased, health systems will not help stabilize fragile environments.

The IRC's new Institutional Program Framework aims to incorporate capacity-building as a principal component of the organization's operations. Recognizing the need to build systems is a major shift in thinking, noted McBride, who stressed that stabilization in fragile settings requires strengthening governance at all levels, particularly at the community level. "It's insufficient to just meet basic needs and build institutions. If we don't do it in such a way that brings communities back together with their institutions, which is what conflict has destroyed…we won't be successful," she said. One significant challenge facing IRC is developing ways to measure progress on building institutions and social cohesion. While these indicators tend to be the hardest to define in a fragile or conflict setting, she nevertheless maintained that they can be developed by drawing on the vast amounts of information collected by the development sector on institution-building.

Options for USAID

Missions have a better chance of succeeding if all actors involved contribute and coordinate on national-scale system-building projects, said d'Harcourt. USAID is in a unique position to facilitate cooperation among local and international NGOs, host country officials, and beneficiaries operating in fragile settings. He argued that if USAID accepts the role of central coordinator, rather than operating alone in the field or implementing a single program, the organization will "function better" in post-conflict and fragile settings. D'Harcourt also urged the Office of U.S. Foreign Disaster Assistance (OFDA) to only issue long-term funding grants, arguing that short-term grants force programs to alter their strategic frameworks too frequently. In addition, he called for increased monitoring of costs and results of OFDA grants.

Lizanne McBride (© David Hawxhurst, Woodrow Wilson Center)

Field donors often fail to understand the value of these methods and instead prioritize "peace dividends," McBride noted. She said USAID needs to support the development of sophisticated evaluation and data collection methods in the service delivery sector and called on them to require that NGOs, including the IRC, base reports and proposals on more comprehensive data when operating in fragile environments. She emphasized that the IRC's efforts to collect data in fragile settings would be greatly assisted through close collaboration with USAID: "We have to work as partners."

Mechanisms for Health Systems Management: Reflections on the World Bank and USAID Experiences

October 24, 2006

SPEAKERS:

Sallie Craig Huber, Deputy Director for Performance Management, Center for Country Programs, Management Sciences for Health

Dr. Benjamin Loevinsohn, Public Health Specialist, World Bank

The international strategic plan to implement health systems in Afghanistan has been successful and can serve as a model in other fragile states, argued Dr. Benjamin Loevinsohn of the World Bank on October 24, 2006. Sallie Craig Huber of Management Sciences for Health (MSH) joined Loevinsohn to examine critical relationships between NGOs and governments in health care delivery, and also discuss the most efficient ways to accomplish health and stability goals in fragile settings.

Historically poor and devastated by decades of conflict, Afghanistan has some of the worst health statistics in the world. The country suffers from high child and maternal mortality rates, particularly in rural and remote areas. According to Loevinsohn, international assessments conducted after the fall of the Taliban in 2002 concluded that Afghanistan did not possess a functional health system. The findings revealed the country's dire need to train female health workers, increase the number of health care professionals with knowledge of primary health care, and bolster the number of health care professionals in rural areas. Despite the presence of 65 health sector NGOs operating in Afghanistan at the time of the assessments, the country's health infrastructure lacked coordination, resulting in the duplication of services in some areas and the absence of clinics in underserved remote areas.

Building Something From Nothing

In close collaboration with the World Bank, which provided financial support, the Afghan Ministry of Public Health (MOPH) developed a comprehensive strategy to construct a functioning health system in eight provinces. Recognizing its limited resources, MOPH was eager to partner with NGOs, but was cognizant of the need to coordinate their efforts to avoid the gaps in coverage that plagued the country in the past. To this end, MOPH awarded performance-based partnership agreements (PPAs), as well as bonuses worth up to 10 percent of the contract, to NGOs that covered the selected eight provinces and provided clear objectives and performance indicators. NGOs were competitively selected over a seven-month period and were independently evaluated by the Johns Hopkins University.

In contrast, USAID chose to issue grants directly to NGOs rather than channeling money through MOPH. One of its largest contracts was awarded to MSH, which has more than three decades of experience in Afghanistan. Through the Rural Expansion of Afghan Community-Based Health Care (REACH) project, MSH aimed to provide basic health services, specifically maternal and child health care, to millions of Afghanis in 13 provinces. Reflecting on the challenges of implementing the project's primary goal, Huber said, "When you go into a post-conflict fragile state, there is a lot of pressure to…bridge the gap in the health care system all at once." REACH encountered significant obstacles, including inadequate or damaged infrastructure, inexperienced leaders, and a lack of reliable population data. The strategy employed to overcome these challenges centered on train-

ing community health workers and midwives; offering continuous support to build management and leadership skills at MOPH; and providing support for MOPH to construct a national health management information system.

Indicators of Success

REACH's strategy has successfully improved access to health care in Afghanistan, according to Huber, increasing contraceptive prevalence, births attended by skilled attendants, and rates of immunization for rural children. Additionally, the training and deployment of more than 6,000 new community health workers has made a "major contribution" to REACH's success, she said. While conceding that the program's results are only small advances in the larger scheme, she said that progress made in the health sector will help foster stability and strengthen the relationship between Afghanis and their government: "They'll feel that the government is working for them and that they have hope for their future and their children's future."

Loevinsohn also touted Afghanistan's recent strides in the health sector. Recent studies indicate that areas with PPAs experienced the greatest percentage increases in antenatal care and the number of newly established health centers, and had the highest number of facilities with trained female workers. In addition, PPAs—at a cost of approximately US$4 per capita annually—represent the most cost-effective contract scheme used in Afghanistan, he said. The success of PPAs in Afghanistan led him to conclude that having a clear package of services and indicators, as well as established geographical assignments and evaluation methods, will lead to success: "[This strategy] will get you where you want to go."

Lessons Learned

Loevinsohn maintained that the positive results obtained in Afghanistan using PPAs show that the scheme can be replicated in other fragile environments. He recommended that donors contract more systematically with NGOs, eliminate the use of short-term contracts, and issue performance bonuses to ensure that NGOs work toward the agreed indicators of success. In addition, he encouraged donors to channel money through the host country's government. Following these measures "leads to large and rapid improvements in health services," he said.

Progress made in the health sector will help foster stability and strengthen the relationship between Afghanis and their government. They'll feel that the government is working for them and that they have hope for their future and their children's future.

Despite Loevinsohn's recommendations, some attendees voiced skepticism over the prospects of replicating Afghanistan's results in other settings. One attendee argued that governments in stable countries have not been willing to hand over lucrative donor contracts to the NGO community. Loevinsohn agreed that stable governments often have a vested interest in "keeping things the way they are" and are often hesitant to forsake the power and prestige of international contracts. But he pointed to Bangladesh and India as two successful examples of stable countries that have agreed to contract with health sector NGOs. Serious progress can be achieved through partnerships in other settings, he said, but warned that the process of replicating Afghanistan's success will be challenging and ongoing: "This is an evolving story."

Measuring the Human Cost of War: Dilemmas and Controversies

January 10, 2007

SPEAKER:
Dr. Frederick Burkle, Schools of Medicine and Public Health, The Johns Hopkins University and Harvard Humanitarian Initiative, Harvard School of Public Health

In areas of conflict and war, epidemiologic studies must incorporate indicators that measure indirect deaths, rather than looking solely at deaths from combat, argued Dr. Frederick Burkle, a senior lecturer at the Harvard Humanitarian Initiative and senior scholar at the Johns Hopkins University. Drawing on his medical experience in combat zones in Africa, Eastern Europe, Asia, and the Middle East—particularly Vietnam and Iraq—Burkle discussed the ways in which the health community can better work with political and military actors to implement effective health programs and accurate monitoring mechanisms in fragile environments.

Traditionally, international interventions in complex emergencies—politically motivated disasters with high levels of violence and civilian deaths—have focused on limiting the number of military and civilian lives claimed on the battlefield. The human toll, then, is calculated based on lives lost in direct conflict, and does not include deaths due to loss of services and infrastructure. As intrastate conflict has increased, argued Burkle, so has the need to develop a new method of calculating loss that includes indirect deaths or excess mortality—deaths that would not have occurred without the conflict or breakdown of social and health services, mass displacement of populations, and the destroyed livelihoods of those affected by violence. Burkle warned that until the international community recognizes the magnitude of indirect deaths incurred during complex emergencies, the human cost of war will remain unknown: "Except for very few countries…the humanitarian community has absolutely no idea of the worldwide impact of indirect deaths."

Linking Indirect Deaths and Health

According to Burkle, the erosion of public health infrastructure and health-service delivery are primary causes of indirect deaths during conflict. A recent assessment of the estimated 2.5 million casualties of the Democratic Republic of the Congo's civil war revealed that 90 percent of those deaths were preventable, resulting from ailments such as diarrhea, malnutrition, and malaria. Lives are often claimed during complex emergencies, he argued, because civilians are often unable to receive treatment for diseases once conflict erupts: "[A]s political violence increases…the window of opportunity to seek care narrows." Intrastate violence can also contribute to the number of deaths caused by malnutrition, particularly among the elderly; rape and war-related trauma, which can trigger or instigate mental illness; as well as the rapid spread of infectious disease. Poverty, inequality, and cultural incompatibilities are also contributing factors to indirect deaths, said Burkle, but he admitted that the precise impact of these factors is "difficult, if not impossible," to measure.

Little is known about the long-term effects of political violence on individuals and communities. But we do know that post-conflict settings are often plagued by a substantial decrease in health care, raising the risk of infectious disease. In Iraq, for example, an outbreak of cholera was reported for the first time in two decades as a result of the country's decimated public health infrastructure following the first Gulf War in 1990-91. And since the start of the recent Iraq conflict in 2003, the country's health infrastructure has been significantly impaired, creating the conditions for an outbreak of typhoid fever—6,000 cases of the dis-

Dr. Frederick Burkle (© Heidi Fancher, Woodrow Wilson Center)

Because humanitarian work has become politicized and militarized, protecting public heath must be viewed as a strategic security issue requiring close collaboration with humanitarian and military personnel.

ease were reported within the first six months of 2004 alone.

Studies conducted in Afghanistan and Croatia indicate that suicide, depression, and alcohol and drug use increase in postwar environments, particularly among demobilized soldiers and adolescent sons of dead soldiers. Finally, women and children are the most common long-term victims of civil war or conflict, a fact highlighted by increases in gender-based violence and lower school enrollment rates for girls. Burkle maintained that postwar public health effects of civil conflict must be researched in greater detail: "[We know that] increases in casualties far exceed the immediate losses from the civil war."

Lessons Learned

The number of lives claimed both during and after conflict as a result of destroyed or failing public health systems prompted Burkle to conclude that new protocols and approaches are needed to protect civilians. He stressed that because humanitarian work has become politicized and militarized, protecting public heath must be viewed as a strategic security issue requiring close collaboration with humanitarian and military personnel. In Iraq, where he served as the first director of the Ministry of Health under the Coalition Provisional Authority, the absence of a comprehensive strategy to rebuild the public health system after the war was partly to blame for an increase in Iraqi deaths from nonviolent causes between 2005 and 2006.

But any attempt to redefine public health as a security issue must be coupled with efforts to develop a more comprehensive account of the human cost of modern-day war and conflict. Burkle urged the creation of better defined and universally accepted outcome indicators that would help the humanitarian community monitor the efficiency of national health systems. Some indicators are already available: For example, rates of dengue fever—which often emerges where trash collection is inadequate—can indicate poor governance and urban decay.

Despite the pressing need to develop an approach to provide sustained public health services in conflict zones, the international community is far from realizing this goal, warned Burkle: "We really do not know how to recover or protect urban public health." Unless measures are taken to develop ways to include indirect deaths, calculating the human cost of war will remain an inexact process of estimation by political scientists and military analysts. The lives lost, he said, will "remain unseen, uncounted, and unnoticed."