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Health and Violent Conflict: The Role of Health in Building Peace

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The effects of protracted, violent conflict on the already weak health care system of Afghanistan has left a population in terribly poor health without any effective health care delivery. Despite the post-war revival of the Afghan Ministry of Health with international support, the health system still suffers from a lack of capacity and skilled professionals, particularly at the provincial level. This article argues that in a post-conflict environment, the health sector can play a significant role in sustainable peacebuilding, based on its potential to improve government legitimacy and create opportunities for conflict resolution and reconciliation. The author argues for post-conflict health interventions in Afghanistan to be analysed through a 'peace lens', with a continued and integrated effort from international donors, government institutions, NGOs and local communities to integrate peacebuilding agendas into their health initiatives. In this way, health interventions can be used as an entry point to build co-operation, reconciliation and trust within the community.

Keywords: Afghanistan, Taliban, health care, health professionals, peacebuilding, peace lens, interventions.

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Introduction

In the war zones of contemporary intrastate conflicts, the health of the population is severely affected by the accompanying humanitarian crises and complex problems, which often result in excessive morbidity and mortality amongst civilians. The primary causes of these are direct killing, injuries and the disruption of economic and social systems that lead to food shortage, infectious disease, damage to health facilities and to the forced mass displacement of the population.

Health is not only adversely affected by conflict, it is also inextricably linked to peace, human security and development. Good health enables people to exercise their choice, pursue social opportunities and plan for the future. In contrast, illness, avoidable death and health inequality resulting from violent conflict create enormous grief and lead to economic and other development catastrophes, and insecurity at the individual and collective community levels (Commission for Human Security 2003).

In the midst of many conflicts, the health sector has played a significant role in humanitarian responses to complex emergencies, contributing to the protection of life and alleviation of human suffering (Arya 2007). There is also a growing awareness that health sector initiatives have the potential to make meaningful contributions to building trust, cooperation and sustainable peace in conflict regions. Addressing the health needs that lie behind some of the root causes of conflict can help to alleviate the symptoms.

This article evaluates the role of health in peacebuilding, analysing post-Taliban health interventions in Afghanistan as a case study. It argues that the health sector has actors, potential resources and unique characteristics that can be used for peacebuilding. Moreover, health intervention in a post-conflict environment can improve government legitimacy and serve as a overriding goal to create opportunities for conflict resolution or reconciliation, which can contribute to sustainable peacebuilding.

This article will highlight the impacts of the conflict in Afghanistan on health, and will examine post-war health intervention attempts to address the health problems in Afghanistan. Next, the rational behind the role of health for peace will be discussed, enabling post-war health interventions in Afghanistan to be analysed through a 'peace lens' in line with the pre-existing assumption of the role of health in peacebuilding.

Afghanistan is selected as a case study for two reasons. Firstly, the nature of the Afghan conflict has some similarities to complex conflicts going on elsewhere in the

world. Secondly, multi-type and multi-level health sector actors are participating in Afghanistan post-war health sector reconstruction. Both these reasons offer the opportunity for lessons to be learnt by others; they also mean that Afghanistan is a useful environment in which to assess the role of the health sector in peacebuilding, and to help understand the challenges.

Brief Overview of the Conflict

Since the invasion by the Soviet Union in 1979, Afghanistan has experienced decades of unrest. Over twenty-five years of violent conflict have affected the very foundations of society. More than one million people have been killed, approximately 3.5 million are refugees in Pakistan and Iraq alone, and millions have been forced into internal displacement and impoverishment (Mooney 2002:1; UNHCR 2006:1). Moreover, significant parts of Afghanistan have been identified as heavily mined, and the death rate from mine accidents prior to 2002 was 150-300 people per month (UNDP 2002:13). The total number of land mine survivors in Afghanistan is unknown; in 2006 it was estimated at 60,000 (Landmine and Cluster Munition Monitor 2010). In 2009, the Landmine and Cluster Munition Monitor identified 859 new casualties due to mines and the explosive remnants of war.

Following the Soviet Union withdrawal in 1989, the Taliban government came to power in the mid-1990s. The Taliban administered most parts of Afghanistan according to Islamic Law, until they were brought down by the forces of the United States forces in 2001 (Swanström and Cornell 2005: 1-8). Currently a new modern Islamic government is being built, with presidential elections held in 2004 and 2009 (Independent Election Commission of Afghanistan 2009). However, in Afghanistan, the informal cultural and tribal structures still hold immense power, and in parts of the country constant low intensity and sporadic high intensity violent conflicts remain (NATO 2009; International Crises Group 2009). In addition, ethnic divisions, warlords, the opium trade and smuggling remain long-standing problems in Afghanistan (Swanström and Cornell 2005). These multi-layered and complex problems make the Afghan conflict extremely difficult to resolve, and pose great challenges to building a strong central government and a functional health care system.

The Afghan Health Care System

The lack of a strong centralized government and the effects of protracted violent conflict have almost destroyed the pre-existing health care system, which was already extremely weak. Consequently, health care service delivery is fragmented and the population experiences extremely poor health (Thompson, Gutlove and Russell 2003). Amongst the most serious health problems in Afghanistan are chronic malnutrition and infectious disease such as malaria and tuberculosis (Strong, Wali and Sondorp 2005). Health indicators during the immediate post-Taliban period showed that maternal mortality rates and those of the under-fives were the worst of already poor levels in the region (DFID 2004). Moreover, women are disproportionally affected by weak and inadequate health care because of gender segregation and restrictions imposed by local traditions, such as the restriction on women receiving medical care

from male providers, restriction on movement, and attitudes that discriminate against women (IRIN 2009).

In 2000, a survey showed that one third of Afghan health facilities were found to be severely damaged; more than seventy per cent of this damage was due to the conflict. The survey identified a total of approximately 11,285 health professionals, including doctors, nurses, midwives and assistants, of which only 208 were women. About forty per cent of primary health care facilities did not have women health providers (MSH and HANDS 2002:21-37, Thompson, Gutlove and Russell 2003).

Health Interventions in Post-War Afghanistan

Both prior to 1979, and during the Soviet occupation, the Afghan health system was mainly hospital-centred and city-based. During the Taliban period, the existing health care system deteriorated and health service provision by non-governmental organisations (NGOs) expanded. These NGOs became the main providers of health services (DFID 2004), managing over eighty per cent of all facilities by the time of the fall of the Taliban in 2001 (HealthNet TOP 2008).

Shortly after Afghanistan's interim government was installed by the Bonn Agreement in December 2001, the Afghan Ministry of Health was revived with a new team of leaders. However, this new Ministry was faced with the worst health indicators in the world: inequitable health care distribution, uncoordinated health intervention by various NGOs, poor and damaged health care facilities, inadequate access to health services particularly for the rural poor, and an insufficient number of health care professionals (DFID 2004).

To meet the vast challenges with the limited capacity of the newly-formed ministerial team, the Ministry of Health began to work with international and local partners, such as the United States Agency for International Development (USAID), the European Commission (EC), and the World Bank (WB), as well as with various international and local NGOs and United Nations agencies (DFID 2004, Strong, Wali and Sondorp 2005). Some of these partners provided financial and technical support for the Ministry of Health, and others were involved in direct service implementation.

In cooperation with its partners, the Ministry of Health drafted a new public health policy strategy, whose key aim was to deliver a basic package of health services through local government and NGOs, in a manner equitable for all Afghans. This policy document prioritized and standardized the basic package that should be available in all parts of Afghanistan, and suggested the resources needed to achieve the required level of health services. The policy document retained the leadership and financial and service implementation monitoring responsibilities for the Ministry of Health, and sub-contracted most aspects of the basic package of delivery to non-state actors. This was designed with financial and technical support from international organisations (AMOH 2005, Waldman, Strong and Wali 2006).

Although technical support is available from the international community, and expatriate staff are deployed across all departments to build the management capacity of the Ministry of Health, the Afghan health system still suffers from a lack of

capacity and skilled professionals, particularly at the provincial level. Despite attempts to build the capacity of provincial offices in recent years, capacity building initiatives have largely been concentrated at the centre. Furthermore, most of the time these initiatives are implemented in a way that fosters dependency (DIFD 2004, Waldman, Strong and Wali 2006).

Because the state-based health care system has very limited capacity, almost all health care service delivery is implemented by non-state actors under a performance-based contracting scheme. This strategy was based on strong recommendations by major donors and after the Ministry of Health realised that it was not able to provide a service at the level and speed deemed necessary to address the poor health care status of Afghans. Hence, at the moment more than seventy per cent of the population receives its primary health service from NGOs, and only five per cent receives such services from the public sector. The Ministry of Health however, is responsible for the delivery of essential, hospital-based services (WHO 2010).

The mission and strategy of the health programmes of the different NGOs working in Afghanistan, either through the sub-contracting scheme or through parallel programmes, vary according to the policies of the organisations and their donors. Donors themselves differ in their approaches towards implementing the health service delivery contracting scheme, which reflect the overall financing and administrative policy to which the donor country must adhere (Waldman, Strong, and Wali 2006). Some prefer to work through or in coordination with the Ministry of Health, while others channel funds and sign agreements directly with non-state health service providers. The diversity of this overall approach can create problems with implementation, but the various organisations are nonetheless making considerable contributions to addressing the complex health care demands of Afghans, even under difficult circumstances (DFID 2004).

Thus, the new Afghan government's official health policy aims to standardise the level of health care facilities available, and ensure at least minimum standards are met. Where implemented properly this strategy has brought coherent and unified priorities to the Afghan health care system; it has facilitated decisions and established a clear direction for the health system between the government and its partners (AMOH 2005). However, challenges remain due to a lack of coordination and lack of harmonisation in the implementation of the policy.

The Connection between Health and Peacebuilding

This section will explore the health sector and its potential contribution to peacebuilding, as well as its limitations.

The Potential Resources of the Health Sector for Peacebuilding

The health sector has some unique characteristics that can provide a point of entry for peace work. Firstly, health is people-centred. It addresses the daily survival needs of individuals and contributes to the physical, social and psychological well-being of people and their communities. Secondly, health is a universal concern and a fundamental human right (WHO 2002a). Thirdly, health problems in one part of

the world affect health conditions in another; disease can travel beyond political and geographical boundaries, and health problems have a spill-over effect onto other human security and development issues. These make it less controversial for both donors and recipient countries to allow health-related support into a country at times of conflict, and enables health sector actors to gain access to conflict areas. More importantly, health care actors can win the hearts and minds of the community and persuade both governments and the international community to offer support and cooperation. Health care actors can therefore use these entry points to integrate health and peace issues within a conflict environment.

Health sector organisations, governmental or non-governmental, have entry points at varying levels of influence; health sector actors can therefore potentially take part in peacebuilding work at these different levels, from grass-roots intervention to international diplomacy, advocacy and negotiation. Additionally, the networks that exist within the health sector for reporting and controlling diseases, for example through journals and conferences, can be used for swift communication and cooperation at these different levels (MacQueen 2008).

Health care workers are often the primary contact for victims of conflict and conflict-affected communities; health professionals have the knowledge and skills of diagnosis and healing for many of the physical and mental health conditions common to conflict areas.

Moreover, knowledge of epidemiology, health promotion and education within public health science enables health workers to quantify and disseminate information on mortality and morbidity from injuries, disease, malnutrition, reproductive health problems and mental health in war-affected zones (Marry, king, Lopez, Tomijima, and Krug 2002). Such evidence is based on scientifically quantifiable grounds and as such, is likely to be received with credibility and with recognition by the general public and by politicians. These, together with the medical principles of confidentiality, altruism, impartiality, as well as the traditional legitimacy and respect for health professionals, can be used as additional assets to enable health care actors to engage in peace work (MacQueen and Santa-Barbara 2000, Buhmann 2007).

However, despite these assets, health professionals may not have the skills necessary for peace work. They may not have adequate knowledge of the basic concepts of peace, conflict, conflict resolution and peacebuilding. In addition, they may lack the skills of negotiation, communication, mediation, conflict analysis, and may lack a culturally-sensitive approach (Aray 2007). Therefore, to engage in peace work effectively and for maximum success, they need to learn and develop these knowledge and skills, enabling them to take account of the social, political and economic context of health, and see this through the lenses of peace and conflict.

Possible Ways for Health to Contribute to Peace Work

Using the potential resources and opportunities described above, the health sector can contribute to peacebuilding; through improving the health care system governments can (re-)establish their legitimacy (Rushton 2005, Eldon, Waddington and Hadi 2008).

This assumption reflects the common understanding that addressing security, good governance, and good public service delivery by governments, particularly in the health and education sectors, are the keys to building government legitimacy, and the most effective way to bring lasting and sustainable peace in fragile post-conflict states (UN 2007, Maass and Mepham 2004).

In addition, poor health, disease and gross health inequalities contribute to or fuel violent conflict, due to their effect on the social, economic and political institutions of the community. When large parts of the population suffer from various diseases, this impacts on the economy and on governance (Peterson and Shellman 2006, Solana 2006). This in turn leads the government to violate people's right to healthcare, and encourages the government to direct health programmes disproportionately to certain parts of the community, which further aggravates social tensions and conflict. This can be exploited by ethnic, religious, and other elites for their own interests (Solana 2006). Therefore, through improving the health care system and addressing health inequalities, governments can reduce alienation within society. This may help to visibly demonstrate a government's commitment to upholding their socio-political responsibility and to maintain long-term peace (Rushton 2005, Eldon, Waddington and Hadi 2008).

The second way for the health sector to contribute to peace is by deliberately integrating peace building issues into health initiatives. This approach is based on the assumption that as health is vital to everyone, health care workers can use health as a overriding goal or a meeting point to bring the conflicting parties together and create opportunities for peace. This strategy was formally accepted at the 51st World Health Assembly as a feature of health for everyone in the twenty-first century (WHO 2011). It has been implemented by the World Health Organisations and by several other health sector agencies in different conflict areas under different working titles. A frequently mentioned example of the use of health as a overriding goal was the ceasefire agreement of El Salvador to enable the annual immunization of children from 1985 to 1992. The health of children was proposed as a priority goal of the conflicting parties, which resulted in the brokering of 'Days of Tranquillity', allowing children throughout the country to be immunized (Santa-Barbara and Arya 2008, Arya 2007).

The two approaches described above use different mechanisms but demonstrate how health intervention can contribute to lasting peace, over and above the provision of health services. Combining the two can enable health professionals to identify their skills and the opportunities to work for peace as well as for health, in the progressive dynamics of conflict.

Can Health Exacerbate Conflict?

However, health interventions in conflict zones do not always contribute to peace. Health initiatives in attempting to do good, may sometimes facilitate and support the conflict system. Any assistance given in the context of violent conflict becomes part of that context and thus also part of the conflict (Anderson 1999). Hence, the positive intentions of health work might produce a negative peacebuilding outcome,

which in turn affects the health intervention. Health programmes which collaborate with the existing power structures may support a corrupt and oppressive system and undermine the local community (Anderson 1999, Aray 2007). Additionally, in situations of violent conflict, the dual loyalty of health professionals working in the military and other military-affiliated groups may jeopardize the perceived professional loyalty and legitimacy of health professionals. Occasionally, against the rules of medical ethics, health professionals pass patient information to a third party for non-medical reasons. This creates suspicion towards health and humanitarian workers in many conflict zones and poses considerable risk to health workers (Aray 2008).

Significant amounts of funding that enter conflict areas through international health organisations may create problems for the local health system. High salaries within NGOs disrupt the professional labour market and drain highly skilled and experienced workers from local government health care systems. This affects poor health care delivery systems in conflict zones which further aggravates the conflict and reduces the legitimacy of the government. Furthermore, the way health services are provided in a conflict zone may aggravate tensions and polarization within the community. Health interventions that prioritize the most affected and address the emergency needs of particular communities or groups, may leave others feeling excluded. Competition for resources and funds between organisations may further exacerbate suspicions within the conflicted community (Anderson 1999, Aray 2007). Unless health programmes are very familiar with the conflict context, health work could fuel the conflict.

Examining Post-War Health Interventions through a Peace Lens

An Efficient and Equitable Health Service for Sustainable Peace

In the reconstruction of Afghanistan, significant emphasis is placed by much of the international community on improving the new government's capacity to exercise its authority and deliver effective public services to its people (Government of Canada 2008). As an important public sector, health received priority attention in the post-Taliban reconstruction of Afghanistan. This is critical for Afghanistan, as the health sector has been severely damaged by long-standing conflict, and the population suffers from various diseases, health inequality and the worst health conditions. Even though Afghanistan's enormous health problems are the consequences of violent conflict, at some level they are also a contributing factor to the violence. Unequal treatment of women and denying women's rights and access to health and education were among the issues that the Taliban government was condemned for by the international community (PHR 1998, US Department of State 2001). In one post-conflict needs assessment, health was described by Afghan civilians as a priority need along with security and food (Ipsos and ICRC 2009). Thus, addressing health needs, providing an equitable health care service, and empowering the Ministry of Health and the government as a whole, can significantly contribute to Afghan reconstruction and sustainable peacebuilding.

In the reconstruction of the Afghan health sector, considerable emphasis is given to building the capacity of the Ministry of Health, both technically and financially, which

is starting to show some positive results. Some changes to the major health indicators of the population have also been observed. Restructuring and strengthening the Ministry of Health and creating a policy document to guide health intervention at the early stages have created a foundation for building a sustainable health care system in Afghanistan. The policy document also provides an official guide for prioritizing and coordinating the delivery of all post-conflict health care services.

The Ministry of Health is responsible for coordinating and evaluating all health care funding and service delivery in the country, which provides an opportunity to exercise leadership and a management role under the financial support and technical guidance of international expertise. However, the implementation is problematic; the Ministry lacks the infrastructure and skilled and experienced professionals at all levels. In most cases, local and international NGOs have better infrastructures, resources and skilled workers than the Ministry, particularly at the provincial level. This undermines the government health sector, both in the eyes of the general public and the various implementing partners, which jeopardizes the potential to build trust in the government sector and increase its legitimacy.

Furthermore, because most capacity building for reconstruction is concentrated centrally, this is creating dependency, rather than building sustainable local capacity (World Bank 2007:1-2). This reduces the opportunity to build capacity at the provincial level, and challenges the coordination and decentralization of health services to ensure equitable access. This is exacerbated by the lack of security in some rural areas of Afghanistan.

Because of the limited capacity of the state health sector in Afghanistan, almost all basic health care services are delivered by non-state actors. This is a critical, emergency response to the poor health status of the population, but one which must be implemented in line with a policy that aims to build a sustainable state health service. In practice however, donors and NGOs often implement services according to their own internal requirements and their donor country policy. This causes disharmony, duplication of efforts, differing accountability and lack of coordination. Moreover, this form of health intervention lacks uniformity in service delivery to community groups, which has negative consequences for the ethnically-divided communities of Afghanistan. Donors and practitioners must identify and respond to these discrepancies to establish a sustainable health care system.

Despite these many challenges, some improvements are being recorded in the overall health of Afghans and in the capacity of the Ministry of Health. However, the health care system still depends on external support, both financial and technical. Rebuilding the Afghan health care system to the level where it provides an adequate and equitable service, and no longer relies on external support, might take some time due to the complex and multifaceted problems already discussed. Moreover, this directly relates to the improvement of overall social, economic and political conditions in Afghanistan, which still suffer from poverty, challenges associated with governance, corruption and the lack of security in parts of the country (Governance and Social Development Resource Centre 2006).

Integrating Peacebuilding Initiatives in Health Interventions

The health sector can also contribute to peace through integrating a peacebuilding agenda within health interventions. This approach involves multi-type, non-governmental health care actors, and uses various health care assets for peacebuilding. In Afghanistan, local and international NGOs are contributing a great deal to the improvement of the health care system. However, these organisations approach conflict in different ways, like other relief agencies. Most view conflict as an external negative force to be avoided and prefer not to interfere if they choose to remain in the region of conflict. Some organisations included conflict sensitive policies within their programmes to avoid exacerbating the conflict, but only a very few organisations incorporate conflict reduction and peacebuilding agendas in their programmes (Goodhand 2001, Atmar and Goodhand 2002). However, considering the number of NGOs in Afghanistan and the resources owned by this group, their involvement in peacebuilding will contribute a great deal to building sustainable health services and peace in Afghanistan.

Some health sector organisations are working to integrate health and peace programmes in Afghanistan, however there are very few of them. The International Committee of the Red Cross (ICRC) for example, in providing care to victims of mines and other explosive remnants, advocates for limiting the production and use of weapons through gathering images of victims and collecting data on injuries caused by explosives remnants in Afghanistan (ICRC 2008). Similar interventions by health care sectors elsewhere in the world have contributed a great deal to raising public awareness about the damage caused by weapons (Santa-Barbara and Arya 2008, Arya 2007). At the same time, the ICRC is impartial in its treatment of victims from different community groups, and despite divisions within the community, this sends a message to the community that every human life is equal, and it may contribute to creating a culture of care within the divided community.

In addition, the ICRC works to prevent damage to the civilian population by advocating international humanitarian law within the police, judiciary, military and other government sectors (ICRC 2008). This is important in conflict-affected and fragile states such as Afghanistan, where the principle of justice and other key institutions may be affected by discriminatory practices, corruption or abuse of power by officials, and exhibit a failure to protect human rights thereby exacerbating or even triggering violence and instability. Lawyers, police officers and civil society groups may lack the capacity to address civilian needs, hence this intervention by the ICRC may significantly contribute to addressing civilian needs, protecting them from human rights' violations and institutional abuse and violence (United Nations 2006, Governance and Social Development Resource Centre 2006).

MacMaster University led a research programme on the relationship between health and peacebuilding in Afghanistan. This integrated a peacebuilding agenda within health initiatives, and health professionals from MacMaster University designed a story-based peace education project to address mental health as well as peacebuilding issues in collaboration with the Afghan education sector, which considered the significance

of mental health problems in Afghanistan that result from the stress of long term violent conflict, as well as addressing the need for peace education. The mental health component of the MacMaster University project intends to facilitate living together under difficult conditions, coping with mental health problems and healing at the individual and society level, which may contribute to building co-operation, tolerance and reconciliation between different groups in Afghanistan. Similar programmes implemented in Croatia showed moderate success in coping with ethnic diversity and associated antipathy among children (Santa Barbara 2008). More importantly, the peace education part of the project delivered through the school curriculum with its themes of reconciliation, ethnic tolerance, conflict resolution, and resistance to armed activity, can plant the seeds of a culture of peace and non-violence amongst Afghan children, who can be the window of hope for Afghanistan's sustainable peace and stability.

These examples demonstrate that health and peace interventions, if properly designed and implemented in partnership with the local community, may contribute to post-war peacebuilding in Afghanistan.

However, the work of NGOs is not without criticism from the Afghan public and government. Firstly, the high salaries and living standards among NGO employees in Afghanistan are criticised for creating elitism and draining already scarce human resources away from the Ministry of Health. Secondly, particularly in the provincial areas, NGOs have better resources and capacity than the government institutions, which undermines the authority and credibility of Afghan government institutions in the eyes of the public. Thirdly, the lack of clear distinction between civilian NGO workers, the military and groups affiliated to the military, creates confusion particularly among rural communities. This raises questions about the impartiality and neutrality of NGOs and may also have contributed to the recent rise in the number of attacks targeting NGO health and humanitarian workers in Afghanistan (Rubenstein 2010). Nevertheless, health organisations which are not working to incorporate peacebuilding in their health programmes are missing a real chance to alleviate the root causes of the conflict and contribute to sustainable peacebuilding, as well as improving the health of the population.

Conclusion

The complex nature of contemporary violent conflict demands that peacebuilding interventions be multi-level and multi-track, and health should be the priority in post-conflict and post-war reconstruction programmes. However, poor and fragile post-conflict governments may not have the capacity to respond adequately to the challenges of post-conflict health care needs, hence financial, technical and other capacity building support by donors, international and local NGOs is mandatory in Afghanistan. Improving and rebuilding the Afghan health care system requires that emergency health care needs are addressed, at the same time as a sustainable and equitable state-based health care system is being established. This will enable the government to demonstrate a commitment to fulfil their socio-political responsibility, and (re-)establish their legitimacy. Therefore, rebuilding and achieving a sustainable

health care system may contribute to peacebuilding by helping to establish legitimate government, as well as encouraging the spill-over effect of the improved health of the population on to security and other development issues. It is appropriate therefore for multiple donors and NGOs to invest in health care system reconstruction and capacity building. However, support and capacity building attempts by NGOs can target only short-term needs, and can be implemented in a way that creates dependency on external support; this may weaken the capacity of state-based institutions capacity, and discredit the authority and legitimacy of the state.

Building a sustainable health care system is a long-term process and may take longer in complex environments like Afghanistan. Improving the health care system can only be effective along with an improvement in security and other socio-political conditions in the country. Hence, it demands a continued and integrated effort from donors, NGOs, government institutions and communities.

NGOs are important in alleviating and addressing emergency health care needs and in building the health care system in Afghanistan. However, they can also contribute to sustainable peacebuilding by integrating a short to long-term peacebuilding agenda into their health initiatives. Using their health intervention as an entry point, they can build co-operation, reconciliation and trust within the community – an approach which is being implemented in Afghanistan and in other places in the world and is proving able to make a considerable contribution to wider conflict prevention and peacebuilding efforts beyond improving health problems.

Nonetheless, many health sector organisations working in Afghanistan do not integrate conflict resolution and peacebuilding agendas within their health interventions, although some have started developing conflict sensitive policies in their programmes; a small number integrate peacebuilding in their health initiatives. However, considering the considerable resources and opportunities they have access to, NGOs may do much more than 'do no harm' to peacebuilding, whilst improving the health of the population more effectively.

However, whatever approach is used, post-conflict health is a priority and improving the health care system and the status of health itself is crucial in building sustainable peace. Usually the health impact of conflict will be sustained for many years after the violent conflict is over. Therefore, without addressing the health care needs, and without building a sustainable and effective health care system, attaining sustainable peace is impossible. Similarly health sector actors working in conflict and post-conflict zones attempting to address health care needs while ignoring conflict factors will only be able to alleviate the symptoms, as sustainable health and well-being cannot be achieved within a violent and hostile environment. Therefore, looking at health through the lenses of conflict and peace is essential when addressing health care in zones of conflict.

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