



A grave new world

A Merlin campaign paper exploring the impact of conflict on health workers, and their central role in achieving the Millennium Development Goals.



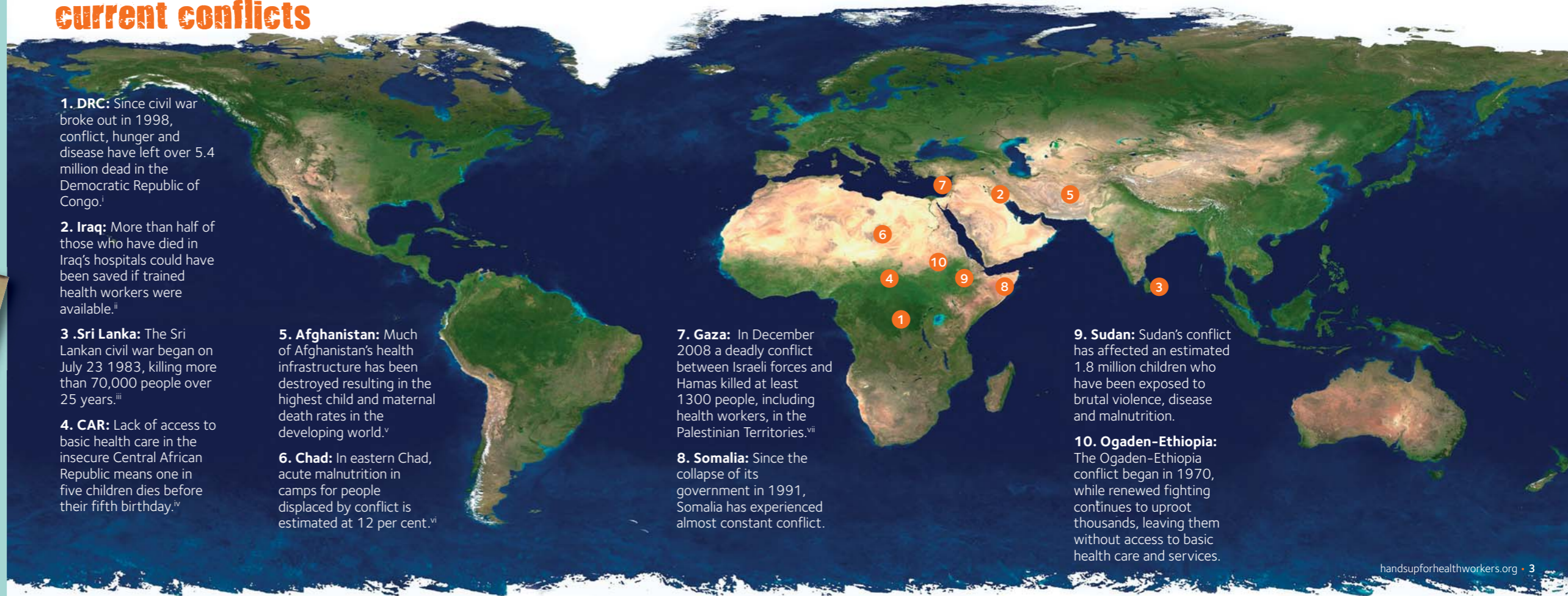
Merlin specialises in health, saving lives in times of crisis and helping to rebuild shattered health services.

Our campaign, **Hands Up For Health Workers**, calls for national governments and international donors to fund and implement comprehensive national health workforce plans, to ensure health workers in crisis countries are trained, paid, supported, equipped and protected.



Front cover Photo: Trevor Snapp/Merlin

A handful of the world's worst current conflicts



1. DRC: Since civil war broke out in 1998, conflict, hunger and disease have left over 5.4 million dead in the Democratic Republic of Congo.ⁱ

2. Iraq: More than half of those who have died in Iraq's hospitals could have been saved if trained health workers were available.ⁱⁱ

3. Sri Lanka: The Sri Lankan civil war began on July 23 1983, killing more than 70,000 people over 25 years.ⁱⁱⁱ

4. CAR: Lack of access to basic health care in the insecure Central African Republic means one in five children dies before their fifth birthday.^{iv}

5. Afghanistan: Much of Afghanistan's health infrastructure has been destroyed resulting in the highest child and maternal death rates in the developing world.^v

6. Chad: In eastern Chad, acute malnutrition in camps for people displaced by conflict is estimated at 12 per cent.^{vi}

7. Gaza: In December 2008 a deadly conflict between Israeli forces and Hamas killed at least 1300 people, including health workers, in the Palestinian Territories.^{vii}

8. Somalia: Since the collapse of its government in 1991, Somalia has experienced almost constant conflict.

9. Sudan: Sudan's conflict has affected an estimated 1.8 million children who have been exposed to brutal violence, disease and malnutrition.

10. Ogaden-Ethiopia: The Ogaden-Ethiopia conflict began in 1970, while renewed fighting continues to uproot thousands, leaving them without access to basic health care and services.

“We know their work is dangerous. Often, they go boldly where others fear to tread. Increasingly they risk harassment and intimidation, kidnapping and even death.”

Ban Ki-moon, United Nations Secretary-General, 19th August, 2010¹

In the world's most fragile countries, people seeking to undermine a community or country can find few more effective and vulnerable targets than the health sector.

As a result, those dedicated to saving lives are themselves attacked in the fight to secure territory, resources and power.

The unique vulnerability of health workers

Often working in remote and dangerous areas to ensure health care reaches isolated communities, their essential medicines and equipment make health workers easy targets for robbery and ambush.

Their clinics are raided with impunity, with little regard for the life-saving work being done.

In refusing to discriminate between the patients they treat, some health workers are accused of – and punished for – being traitors.

Even their role – offering care and counsel to traumatised people, bringing stability where there is chaos – is reason enough for attack.

“*A grave new world*” explores the context in which health staff are working in some of the world's most fragile countries. It outlines the high rates of death and disease and the vital role health workers play in not only addressing these needs, but in meeting global health targets.

This paper captures the professional, personal and national effects conflict is having on health workers and the inadequate protection they currently work under.

Finally, it makes key recommendations to ensure health workers can effectively and safely save lives in this grave new world.



“I made an oath to God and my people that I would serve them. It is my pledge and my promise. I will never give that up.”

Donald, a Nurse in the Democratic Republic of Congo, was tortured by armed men during a night raid on his clinic in 2009.

“Our biggest challenge is security, without doubt. It’s at the heart of everything: sexual violence, robbery, displacement. We do not feel safe here. If I could find a job where I felt less vulnerable, I would take it. But then who would look after the people? I’d feel guilty. I battle always with fear and guilt.”

Arlette, Head Nurse, the Democratic Republic of Congo (opposite)

The unreported world

Far from the glare of international attention, thousands of health workers in conflict-affected countries are getting on with their jobs: providing communities, often rural and remote, with life-saving health care.

Typically, they will be tackling high patient numbers, caused by the mass displacement that traditionally accompanies outbreaks of insecurity. As fighting continues, already struggling health services are put under additional pressure.

Many health workers will go unpaid for months, even years. Most don’t have the basic medicines they need. Few have any protection to do their jobs safely in a world characterised by violence.

“Armed men came to the clinic. They demanded money from us but we didn’t have any, so they got angry. They raided our medicines and supplies. One of our nurses was dragged to the bush where she was raped.”

Anonymous health worker, DR Congo

Who is protecting health workers?[†]

“The medical community has a responsibility to speak out collectively to protect health workers, in fulfilment of their ethical duties to the people in their care, without risk of arrest or attack on themselves or medical facilities.”²

Despite performing a vital role and various international conventions and treaties which make reference to their security, few national health workers are protected by any effective or enforced policy, either national or international.

Unified outcry from government and media accompany attacks on international aid workers, yet much of the violence against health workers goes utterly unreported. In fact, a “systematic review of the frequency of reporting and types of violations has not been done for 15 years.”³

Is violence now simply an occupational hazard?

The absence of effective systems to feed into national or international security data and policies could help explain the widespread underreporting of violence against health workers, as could the ‘normalcy’ that comes with chronic violence, resulting in staff simply ‘getting on with it’.

“What can we do? There are no means to protect us – if we complain, nothing can be done to stop this, so we just complain to each other and help each other as much as we can.” A national health worker in DR Congo.



Context and the global significance

The annual cost of one new conflict – over \$64 billion – almost equals the total value of global development aid in a year.⁵

Conflict and poverty: an intimate relationship

Armed conflict is probably the single most important determinant of poverty in Africa.⁴ Conflict escalates the disparities between rich and poor, weakens institutions and fragments communities.

It has been identified as one of four ‘traps’ that keep the world’s poorest countries poor, and confines the world’s ‘bottom billion’ to a life of poverty in shrinking and stagnant economies.⁵

Clearly, addressing conflict and ensuring security is central in the fight against poverty.

Armed violence, health and the Millennium Development Goals

In 2000, world leaders declared a unified, comprehensive fight against global poverty, identifying eight key areas to be tackled by 2015: the Millennium Development Goals (MDGs).

Three of the MDGs directly relate to health:

- Reducing maternal mortality by 75%.
- Reducing child mortality by 2/3.
- Halting and reversing the spread of diseases, including HIV, tuberculosis and malaria.

Conflict needs to be put at the heart of the MDGs

To realise how underfunded health in conflict countries is, we need only look at reproductive health. A recent study revealed when only the least developed countries (LDCs) were examined, the 36 non-conflict-affected countries received 53.3% higher per capita reproductive health expenditures than the 15 conflict-affected LDCs, despite the fact the latter carried a greater burden of mortality and morbidity.⁶

In fact 22 of the 34 countries least likely to achieve the MDGs are in the midst of, or emerging from, conflict.^(DFID 2010)

Yet in none of the eight MDGs is security, or a direct focus on conflict countries, even mentioned.

MDG 4: To reduce child mortality by 2/3 by 2015. 60% more children under five years old die in displaced populations than baseline rates in the same country.¹⁰



Conflict’s role in the MDGs has so far been woefully ignored and woefully under-funded.

The vital role of health workers

On average conflict countries have less than one trained health worker per 1000 people, far below the World Health Organisation’s minimum of 2.3 per 1000 needed to deliver essential care.⁷

Research has shown that for every person killed directly by armed violence, between four and fifteen people die indirectly⁸ from diseases, medical complications and malnutrition, which could be prevented with enough trained health workers.

Clearly, the role of health workers in conflict countries is vital to saving lives.

Securing health worker protection, and training hundreds of thousands more, are two of the surest ways to save lives, and make the currently distant ambitions of the MDGs a reality.

MDG 5: to reduce maternal deaths by 75% by 2015. A study in Sub Saharan Africa revealed 44.9% more women die in childbirth in conflict countries compared to non-conflict countries.¹¹

In the top ten countries with the highest rates of maternal deaths, nine are either at war or emerging from conflict.

Maternal mortality ratio per 100,000 live births

1	Sierra Leone	2,100
2	Afghanistan	1,800
3	Niger	1,800
4	Chad	1,500
5	Angola	1,400
6	Somalia	1,400
7	Rwanda	1,300
8	Liberia	1,200
9	Burundi	1,100
10	DR Congo	1,100

(UNICEF 2009)

Afghanistan: A lesson in reframing the MDGs for conflict



Back in 2000, the declaration of the MDGs didn't even register in Taliban-ruled Afghanistan, a country which ranked 174 out of 178 in the Human Development Index.

Then, in 2001, the war brought Afghanistan to international attention. By 2004, the newly-established government had appointed a high-level commission to adapt the MDGs to the Afghan context.

Afghanizing the MDGs¹²

The commission was systematic in recognising and estimating the devastation caused by the chronic war, the constraints of on-going insurgency and lack of quality data. "Acknowledging the disadvantages that Afghanistan faced, they extended their MDG deadline to 2020, and added a ninth goal: national security."¹³

These "Afghanized MDGs" have been integrated into national planning processes ever since.

Progress against the health MDGs, while uneven, is broadly positive:¹⁴

- Immunization rates against diphtheria, pertussis and tetanus have increased from 54% of infants in 2003 to 85% in 2008.
- Child mortality rates have reduced from 257 per 1000 live births in 2001 to 191 in 2006.
- Maternal mortality remains a significant challenge yet skilled birth attendance has risen from 14% in 2003 to 19% in 2007.

"Vital focus on conflict countries is needed now"

- Access to health services has gone from low coverage to 82% in 2006.

What lessons can we learn from Afghanistan?

The Afghanistan example takes account of conflict's role in achieving the MDGs and, crucially, sets a realistic timeframe against which to measure progress.

Wanted: vital momentum in, and focus on, conflict countries

Given the wholesale lack of progress on the MDGs in all conflict-affected countries and their central role in meeting these targets, vital momentum and focus is needed now.

In these contexts interim targets, with progressive review, will focus efforts and be more effective in informing programme management than distant goals.

“Health workers are somehow expected to cope with working in conflict areas, to be strong in the face of what we see and deal with everyday. We need a lot more psychological support and we need to be taken care of so we can work. **We are not super heroes.**”

INGO national staff member, Darfur.

In the line of duty: health workers as targets

In the fight to secure territory, power and resources, health workers have become key targets.

This was demonstrated to devastating effect at the graduation ceremony of Somali medical students in December 2009.

A suicide bomber claimed the lives of 20 people and injured over 60. Among the casualties were some of the country's brightest medical talent. These young doctors were only the second class to complete their training, following in the footsteps of the previous year's graduates: 20 men and women who were the first newly qualified doctors in Somalia for 18 years.

Three of Somalia's senior Ministers, including the Minister for Health, also lost their lives.

This was a tragic, and relatively rare, incident of extreme violence. Far more widespread is the insidious targeting of health staff as they undertake their duties.

“We are trying to save lives and they are trying to kill us.”

Donald, nurse in the Democratic Republic of Congo, March 2010.



Case Study



Donald, nurse in the Democratic Republic of Congo, March 2010

“No one is immune from this conflict. I am as affected as everyone else.”

“It makes our jobs very difficult, especially at night when, because of too few staff, we are forced to work alone.”

“I was helping a woman in labour. We have no electricity here so it was dark, candles only. Two men arrived, both armed. They raided the clinic and stole everything I had. They tortured me for a while with a knife and then left. By the time I returned to the mother, her baby had suffocated and died.”

“I tried to remain calm but I was totally emotional – scared, anxious and of course angry. We are trying to save lives and they are trying to kill us.”

“Three health workers left last year to work in less insecure areas. It is hard to keep staff when things are so dangerous. Also in less remote places, health workers are more likely to be paid. Here you can be forgotten for a long time.”

“I was last paid maybe three months ago – the first time in a long time. I got 3000 congolese francs (about \$3) for two months' work.”

The risks of being a female health worker

When fighting intensifies, even the most dedicated of health workers struggle to stay at their posts. The fear of what may happen is immense, and for female health workers, the risks are even higher.

Case Study

Fleeing from sexual violence: Zawadi's story

Zawadi is an assistant nurse in a remote, and previously stable, part of eastern DR Congo. In July 2010, rebel fighting displaced over 90,000 people in the area: she was one of the many who fled to safety.

"For one week no one had come to the health centre to give birth and lots of people had come to collect their health cards. <a sign that people would soon be moving out>. Then one day, nearly everyone fled. Only those patients too ill to leave stayed behind.

"I was too scared to stay, mostly of the sexual violence. There are always cases of sexual violence but with war come far more.

"My husband, who is a Lab Technician, stayed to look after the health centre. Not all staff could leave: someone had to stay to help the patients. I keep in touch with him by phone. He says it's unsafe. I worry for him."

Asked why she was doing it, Zawadi replied simply: "I am here to help."

The displaced health worker works on

Remarkably, one of the first things Zawadi did when she reached safety was offer her skills at the local health centre.

"I am working everyday. We are so busy treating the thousands of people who have fled here to escape the conflict. I'm far busier than I ever was before.

"I don't know if I will get paid for my work. If I don't get anything I don't know what I'll do. I can't work without eating."

Asked why she was doing it, Zawadi replied simply: "I am here to help."

Case Study

Persecuted simply for being female: M's story

M is a Lady Health Visitor in Pakistan's Swat valley, home to insurgent violence which led to the largest ever displacement in the country in the summer of 2009.

"The militants were against family planning, saying women must stay in the home. As a Lady Health Visitor, I was suspected of providing family planning and therefore at risk.

"During the militant regime, I could not reach women, I couldn't meet my patients. If someone knew what my job was, they would have cut me to pieces.

"I often think about it, I think about my children, because my job is something my family needs. My family needs my job to survive. But I had to stop working here during the regime. I left. While I was away, I thought about my patients, I thought about those who I left behind and who didn't have anyone to care for their health."




The emotional burden

Few people are so intimately exposed to the impact of conflict as health workers. They treat and heal all: women who've been sexually violated; children with malnutrition brought on by endless displacement; men who've been attacked; even the perpetrators of violence can rely on their care and counsel.

Yet they too are victims of the violence, losing family members, their homes and living in fear.

"I was pushed to quit because I began to be traumatised by the stories my patients told me of being raped. There was no one to take care of me. And the workload was immense and the pay bad. I left so I could look after myself." A doctor working within DRC's national health service now working for an INGO.



"I am scared to work here. When it was very insecure, I didn't always think I'd survive."

Nurse, DR Congo.

Keeping staff in the national health system

The psychological effects of violence and sexual violence are finally starting to be addressed by the international community and national governments. The focus however has been largely on survivors and communities.

To ensure health workers can effectively save lives and, crucially, to help keep them working within the health system, priority must be given to securing their mental well-being.

Where fear decimates the health system, and war claims the rest

In 2003, 50% of Iraq's 24,000 doctors left the country out of fear. The Ministry of Health is reported to have lost more than half of its 720 physicians to death and injury.

(Doctors for Iraq, (2007). Health Check 1, Summer. Quoted in People's Health Movement, Medact and Global Equity Gauge Alliance (2008))

The stress is very high. You become suspicious and fearful of everyone and everything. It is not a good mental state and means I feel I can't do my job well."

Nurse Midwife, Afghanistan.

The deadly risk of working in the international sector

Few countries at war today are able to deliver essential health care to the majority of their people without the support of the international community. Consequently, the role of International Non Government Organisations (INGOs) is large with the number of national health staff employed by them, directly or indirectly, significant.

Yet the association with an INGO is now of itself a source of vulnerability, symptomatic perhaps of the growing politicisation of attacks in highly insecure contexts.¹⁶

Anonymous: Going undercover to save lives¹⁸

“In my job, I’m exposed to kidnapping and being killed. I started out working in the humanitarian community and feeling proud of wearing an NGO jacket. Those days are gone. 2001, and afterwards. it’s been ten years we’ve been living underground, an absconders’ life, like people who have committed the biggest crime.

“My family and my extended family live nearby, but I cannot visit them. It’s a big security risk, and that’s just because of my work with an NGO. So I’m forced to live close to my office, which doesn’t involve much walking or driving. When I travel to the clinics, I leave my wallet at home. I don’t take anything but my national identity card. No backpack, no blackberry. Nothing to identify me at all. My job increases my own vulnerability and the vulnerability of my kids.”

Between 2006 and 2008, 75% of attacks on aid workers occurred in just seven countries, all of which are undergoing armed conflict. By far the most dangerous places to work were Sudan, Afghanistan and Somalia.¹⁷



The increasingly grave situation in Somalia

In a joint statement in October 2008, 52 INGOs operating in Somalia said that national and international agencies “were prevented from responding effectively to the needs of ordinary Somalis because of violence” and that South and Central Somalia was “almost entirely off limits to aid agencies.”²²

The politicisation of humanitarian space

In the most volatile contexts, humanitarian space has shrunk. The roles of humanitarians, international agencies and international militaries have blurred in the eyes of communities as well as political and armed groups. As a result INGO health workers – both international and national – are increasingly seen as agents of international foreign policy.¹⁹

Minimising vulnerability

Against a background of rising violence, the international community has increasingly turned to a strategy of devolving health service delivery to national staff, “fuelled by an (often faulty) assumption that national staff are less likely to be victims of violence than expatriates²⁰ .

Conferring ownership, shifting risk?

Yet while the trend for attacks on international aid workers is on the rise²¹, so too are widespread attacks on national INGO workers: clearly, being from the community no longer offers the immunity it once did.

“You live with stories of car jacks, robbery, attacks on aid workers every single day. Sometimes when you are have time off, you never want to come back.” National medical coordinator for INGO, Sudan.



“Being from the community no longer offers immunity.”

Risking their lives to secure their income

Yet the risks faced are often played down by national INGO workers themselves. Merlin’s research has brought to light the fear of losing their vital income if staff highlight just how insecure their working environment is.

“If we admit how bad we feel we may lose our jobs. It is better to pretend and keep everyone happy. This is not the life I want for me and my family.” National INGO Nurse, Sudan.

INGO security policy stipulates that, in cases of untenable risk, suspension of services is the only option. Many health organisations employ national staff directly, and pay incentives to health workers in clinics and hospitals caught up in conflict. These payments are often their only source of income.

The evacuation of INGOs therefore represents a massive financial loss and as such, national INGO workers and the country’s health workers will take even greater risks to avoid it.

Learning lessons for the future: A look at the health worker crisis in post-conflict Liberia.

Before the brutal 14-year civil war, there were an estimated 237 doctors in Liberia. By the time peace was declared in 2003, fewer than 20 remained.²³ Many lost their lives, but great numbers fled to safety.

Liberia is now relatively stable and on an impressive drive to rebuild a health system shattered by over a decade of under-investment, but the impact of conflict lives on.

The long-term toll

The fourteen-year hiatus in training new staff means there are still too few health workers to deliver essential services. With only 237 certified midwives,²⁴ the maternal mortality ratio is 1 200 per 100,000 live births – the eighth highest in the world.²⁵

When international funding fails to meet national needs

Liberia's Ministry of Health has long been calling for international support to meet their health worker crisis. Back in 2005, they approached the international community for support to train various cadres of health staff including midwives at the then only training school in Monrovia.

Despite the critical need, their proposal went unsupported. Only in 2008 were private funds finally found by an INGO to support a midwife training school in Zwedru. The result is years of lost training time.

Ineffective international funding

In 2006 however Liberia was offered the chance to apply for a \$27million grant by the Global Fund for HIV, TB and Malaria. The entire national health budget for that year was just \$5million. Liberia's health system simply couldn't cope, or effectively disperse, such a huge sum of money and the offer of the grant was withdrawn.

Liberia's current health worker crisis

Had that money, or even a part of it, been channelled into the training and support of health workers, Liberia could have started to address the health worker crisis faced by its many millions of rural citizens.

As it is, health workers are reluctant to move away from the capital: the lack of funds in the national health budget means they must cover their transport and relocation costs (which may be equivalent to one month's salary). Other reasons include concern over security (or perceived lack of security) in remote areas, as well as a confessed fear that the causes of the war remain unresolved and the situation may deteriorate.



“Liberia is now relatively stable and on an impressive drive to rebuild.”

Gina Gordon/Mel'in

The importance of securing health in conflict countries as soon as possible

Countries emerging from war have a 44% chance of returning to conflict within five years.²⁶

Hard won lessons for us all

There is much to gain from Liberia's experience for all health stakeholders working in conflict countries.

1. Funding to health must look to the long-term, no matter how volatile the context

For international donors, there must be greater scrutiny of how aid to health in conflict countries can be more effective. Liberia lost 14 years of opportunity to strengthen its health workforce and system. Much humanitarian aid funnelled into life-saving programmes during the height of the conflict failed to look to the long-term: as a result, when many of the emergency INGOs left – taking vital funding with them – they left clinics staffed by doctors and nurses the country simply couldn't afford to pay.

2. A vision to train health workers, save lives and secure stability

To ensure people have access to health care, every country needs a national health workforce plan: a framework for how it will train, pay, support, equip and protect its health workers. Such a plan highlights the most critical health worker needs in the country, and outlines steps to meet them.

It should also provide the basis for health requests for international aid, to ensure that all actors' activity supports an overall national plan. This would not only make aid to health more effective in conflict countries, it would ensure its impact is longer-lasting, helping conflict countries to get back on track to meet global health targets.

We have a brave new opportunity to make lasting change

Health workers and conflict countries must be put at the heart of the MDGs

Without focus on the people delivering the care in the countries carrying a disproportionate burden of death and disease, any attempts to meet targets will be short-lived.

Right now, there are too few health workers in the world's most volatile countries, and those on the ground are living and working in fear.

Our time is now

We have a momentous opportunity to refocus the MDGs to make aid more effective and to save hundreds of thousands of lives.

But to ensure health staff can work effectively, they must be guaranteed a safe and secure environment. And it's the role of all stakeholders to make that happen.

Key recommendations to deliver change:

- **Raise awareness of the violence faced by health workers in conflict-affected contexts**

Violations against international staff often make the headlines but those against national health staff rarely do. National health workers, whether they work in the public sector or for an international agency are currently at risk. Reporting and following-up of violations needs to be strengthened.

- **Enforce current conventions and support stronger new ones**

The current conventions are not sufficient to ensure the protection of health staff, especially national health staff. Current conventions must be strengthened and stronger conventions need to be developed to ensure the protection of all health workers

- **Ensure the necessary human resources for health are in place through recruitment, training and support**

Conflict is a major factor in the high levels of death and disease and lack of progress on the MDGs. More trained and protected health workers are needed to ensure people have access to the health care they need. This would not only save lives in the short term, it would also help to build a health system in the longer term which can respond to future shocks.

Funding for health in conflict countries must support a longer term vision for the health sector and the health workforce. Realistic yet ambitious action plans for training, paying, supporting, equipping and protecting health workers at the earliest opportunity will ensure that these key issues are addressed.

Actions needed now

Merlin is calling on international and national stakeholders to:

1. **Overhaul funding to health in conflict countries to ensure longer-term and predictable support to national health systems and the health workforce.**
2. **Develop national health workforce plans at the earliest date in all contexts.**
3. **Integrate conflict/security into the MDGs to ensure the efficacy and long-term impact of global poverty reduction.**
4. **Enforce current international conventions with respect to the health workforce and broaden their scope to ensure the safety and security of all health workers.**



Frederic Courbet/Merlin

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- 24 Liberia Demographic and Health Survey 2007 25 UNICEF 2009.
- 26 WHO Alliance for Health Policy and Systems Research (2008). Neglected health systems research: Health Policy and Systems Research in Conflict-Affected Fragile States.
- + International protection of people caught up in conflict is grounded in the Geneva Conventions with international humanitarian law covering those working to save lives in humanitarian crises. These conventions are flouted with impunity and none of them adequately protect national health workers.

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“My work is more than my job.
I’ve seen firsthand how disease,
illness and conflict can destroy
families. I want to serve my
people and humanity.”

Nurse, Liberia.



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shattered health services.*

12th Floor, 207 Old Street, London EC1V 9NR UK TEL: +44 (0)20 7014 1600
FAX: +44 (0)20 7014 1601 EMAIL: hq@merlin.org.uk WEB: www.merlin.org.uk
Registered charity number: 1016607