of having commitments at home and abroad. It is akin to the tension of doing your utmost for the patient in front of you but at the same time recognising commitments to other patients and the broader world. The group that devised the Tavistock principles for everybody in health care recognised the tension in its second principle: care of individual patients is central, but the health of populations is also our concern.[14]

Many doctors like to think that there is no tension between caring for individuals and populations, but there is—particularly in allocating resources. We once heard a doctor who had introduced renal dialysis into India regret what he had done—because it cost some $100 000 a year to dialyse a single patient when the health expenditure per head was a few dollars. The saving of one may have been the death of many. Yet there is an understandable anxiety about putting the interests of populations ahead of those of individuals, not least because it can culminate in inhuman acts. The tension is inescapable.

Many doctors—for example, British general practitioners—have learnt to live with the tension of caring simultaneously for individuals and populations. But usually the population means a practice list of 1500. Can we find a way to think meaningfully about our responsibility to six billion people, the population of the world? How should we practise medicine in a world where half of the world's people live on less than $2 a day, one billion people go to bed hungry every night, a quarter of the world's population never gets a glass of cold water, and a woman dies in childbirth every minute? All medical schools teach public health, but how many teach global health? Ten years ago the BMJ Publishing Group started a journal called *Medicine and Global Survival*, but we pulled out because we couldn't make it pay. Few doctors were willing to pay to subscribe to it, and we were unwilling to continue to support a journal that lost money. We were wrong. September 11 taught us all about global interdependence. But can medicine now rise to the challenge of thinking and practising globally?

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Complex political emergencies

We can learn from previous crises

Education and debate p 342

Acute disasters attract international media and political attention—and often funds to support a response. However, if hundreds of thousands of people, or even millions, die over several years because of prolonged conflict this may go almost unnoticed. A recent survey in eastern Congo revealed an excess mortality of 2.5 million people in only 32 months. Of these deaths 350 000 were because of direct violence; most died from malnutrition and disease.[1] The death toll in longstanding and continuing conflicts in Sudan, Angola, Burma, and Sierra Leone has been similarly massive. These too often forgotten crises are complex political emergencies, a term that underlines the political nature of these internal wars, with their complex origins and multiplicity of players.

Complex political emergencies are not isolated events but linked with globalisation, foreign policies,[2] and, as Stewart emphasises in this issue, economic interests (p 342).[3] Conflict in the Congo, for example, has been associated with struggles over access and control of coltan, a metallic ore which is an essential component of mobile phones.[4] But although prolonged war may be profitable for some people,[5] most suffer from widespread violence; forced migration; human rights violations; and administrative, economic, social, and political collapse.[6] Health services invariably deteriorate and are less and less capable of addressing increased health needs.

The full impact of these complex political emergencies rarely reaches the headlines, and world powers often fail to put their full weight behind efforts to resolve the conflict. The international community, however, does usually get involved in humanitarian relief, in which health activities play a substantial part. The bleak picture in the Congo questions the effectiveness of these activities. Was a concerted effort in place, with sufficiently targeted health action, backed up by sufficient funds from donor agencies? Or was the situation so insecure that relief never reached the population who needed it? It is difficult to be sure. Evaluations under these circumstances are rare and fraught with methodological difficulties.[7] The sector-wide evaluation of the humanitarian response to the 1994 crisis in Rwanda is still exceptional.[8]

One spin off of this evaluation has been the establishment of the Sphere project, which sets out

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Rehabilitation: lessons from past conflicts[10 11]

- Develop coherent policy framework to coordinate reconstruction effort
- Ensure long term engagement of the international community
- Ensure population owns and can sustain the process
- Discourage donor agencies from undermining coordination
- Military forces should focus on security and protection, not on delivery of aid
- Strengthen local institutional capacity
- Control the war economy

minimum standards in responses to disasters.[9] These standards are important benchmarks but still lack a substantial evidence base and their application is limited to situations such as refugee camps. They are not a guide to tackling the widespread collapse of health services in countries such as Sudan and Afghanistan. This requires a joint health policy framework, based on a comprehensive needs assessment, as a guide to all implementing agencies. However, currently it is doubtful whether a single international agency has the capacity or the moral authority to produce such a framework. The World Health Organization could clearly play an important part.

The international community plays a major part in rehabilitation once a conflict subsides—as in Uganda, Cambodia, Mozambique, Kosovo, and East Timor. Many of the lessons learned from these post-conflict transitions are applicable in Afghanistan although none will be easy to implement (see box).

Foremost is the need to develop a coherent policy framework to coordinate the reconstruction effort. This must include humanitarian action, which should be provided on the basis of need. Secondly, the engagement of the international community needs to be long term yet administered in such a way that the population owns and is able to sustain the process. Thirdly, donor agencies need to be discouraged from undermining coordination by embarking on individual high profile projects. Fourthly, military forces should focus on security and protection rather than the delivery of aid. A mixed role for soldiers sends out confusing messages, may endanger humanitarian workers, and is relatively costly. Finally, local institutional capacity should be strengthened and the war economy controlled.[10]

Experiences in Kosovo and East Timor show the difficult balance between the urge to take important policy decisions early and the need to consult widely and properly with all stakeholders.[11] Management of human resources and finance are invariably issues that must be speedily addressed in a system so dependent on the quality and motivation of its health workers.

Until recently Afghanistan was a forgotten crisis, but the international response to the recent war provides hope that stability can be maintained and a new more appropriate health system set up. A wide range of health professionals, both Afghans and from outside, will contribute to these efforts. There is both a need and also scope for a still greater, more concerted role for health professionals to address other forgotten crises. Further exploration of the causes of these crises, their effects, and possible policy responses should be put forward to help generate the political will to end them. Meanwhile the evidence on how to provide relief and help build future health systems needs to be strengthened.[12] This difficult task will require the support of donors and health professionals alike.

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LAURENT REBOURS/AP PHOTO

A member of the Red Cross walks in the middle of two columns of Rwandan Hutu refugees

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