both local government structures and emerging civil society organisations. Sectoral collaboration is equally critical: health and other social services are vital in supporting people and rebuilding local capacity during this period of transition. Above all, promoting the development of a more equitable health and social system may provide an important opportunity for bringing together different groups within affected populations, and lead to early opportunities to stimulate debate, exchange of ideas, and the rekindling of trust.

Rebuilding an integrated health system

The challenges of (re)building an integrated health system are broadly experienced by many countries, whether conflict-affected or not. However, the challenges facing countries emerging from conflict are multiplied substantially by their recent conflict experience. In most situations of 'post'-conflict, the system inherited is severely fragmented, with vertical control programmes frequently delivered by parallel services established by external relief agencies (WHO, 1998: 10). Unsustainable operational standards and facilities are commonly put in place. Institutional, technical, and management capacity is frequently poor in post-conflict countries with limited or no health information available for adequate needs assessment or service planning. Humanitarian agencies often fail to adequately support indigenous capacity during either the emergency or rehabilitation periods thus increasing the risk of little being left behind when they withdraw.

Despite a cessation of formal hostilities, "*health does not improve readily in the aftermath of violent conflict*" (WHO, 1998: 10). Refugees and internally displaced people typically experience high mortality in the emergency phase following their migration; in children, deaths result from malnutrition, diarrhoea and infectious diseases, while in adults, STDs and HIV may be exacerbated, as may other communicable diseases, such as malaria, tuberculosis and a variety of water-related conditions. Psychological distress may be widespread, demanding efforts to re-establish communities and their livelihoods. Injuries, violence, and specifically violence against women may be widespread and require attention despite often being stigmatised. Work with sectors other than health is clearly important.

The matrix developed by the LSHTM (Appendix 4), based on the themes emerging from the previous two workshops and circulated prior to the March 2000 meeting, is used in this document to reflect on the key issues and debates that emerged from the Ottawa Symposium

Mozambique case study

To run health services following the peace agreement was far more difficult than had been anticipated. In 1993, after the peace agreement had been implemented, the system was unable to adapt quickly to the new transition environment, and service output contracted, as operations slowed down. Rebuilding in devastated rural areas was slow and expensive. Roads were often unpassable, due to land mines...and disrepair. Health workers were reluctant to move out of the main towns. The few and only partially operational vehicles had to cover long distances to work in the newly opened areas. This resulted in a dramatic contraction of the NHS fleet within few months after the peace agreement. Hence, as displaced populations returned home, their access to the existing health facilities decreased (Pavignani, 1999)