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Since the new millennium, the nexus between health, peace and security has been heavily investigated in academic and policy arenas, especially since the first UN Security Resolution 1308 on a health issue - HIV and peacekeeping (UNSC, 2000). More recently, Francoise Holland, the French President stated, "Our commitment to eradicate extreme poverty by 2030 is at stake; as is the cohesion of the international community at a time when health risks represent one of the major threats to peace and security" (Hollande, 2016). His statement is not surprising especially in the aftermath of UNMEER, the first UN mission to combat the Ebola outbreak, which was considered a threat to peace and security, not only to the most affected countries in West Africa, but also globally (Heymann *et al.*, 2015).

Underlying high-level declarations on health and (in)security is an overwhelming fear of instability and civil conflict as a result of pandemics, destruction of health systems, and an increasing concern of attacks on healthcare facilities and workers (Patel *et al.*,2016). Within these discourses however, there has been much less investigation on the specific role of health as a cause of conflict or state breakdown. Numerous multidisciplinary, theoretical and empirical studies have investigated the role of ethnicity; religion; extremism; exploitation of natural resources; and structural determinants of conflict such as horizontal inequalities; the failure of the social contract; the green war hypothesis; colonial legacies and political issues such as leadership and corruption (Stewart, 2002; Patel, 2012). Most studies have demonstrated the multiplicity and intertwined nature of the causes of conflict based around concepts such as greed and grievance. As country case studies on the causes of conflict have illustrated, new conflict drivers appear, decline, and perhaps re-appear alongside historical, political, and social factors whose impacts also wax and wane over time (Lewis & Patel, 2012). A key lesson is that causality is one of the most complex issues to pinpoint with the root causes of conflict in each context.

Health as a cause of conflict could potentially be linked to the breakdown of the social contract that populations have with their state authority. Conflict-affected countries typically have histories of weak

social contracts, or a once-strong social contract that has degenerated as non-state actors fill the void left by state breakdown or fragility (Murshed & Gates, 2005). Several donors assert that investment in the health sector can help consolidate peace through state-building activities such as promoting social cohesion through equitable health systems, restoring accountability and increasing government capacity (Kruk *et al.*, 2010). This is viewed as having the potential to legitimize the state through creating or reinforcing a social contract that is inherently stabilizing. The state-building assumptions are generally rooted in a belief that enhancements to the governance of the fragile state's various health sector institutions have wider consequences that may extend beyond the direct delivery of health services; spilling over from the health sector into civil society whilst also stimulating the state to develop capacities in other sectors from the raising of tax revenues (Kruk *et al.,* 2010).

The functions of the state are important in maintaining the cohesiveness of society, which in turn is central to maintaining the social contract (Murshed, 2009). Health is often seen as a positive political good alongside education, economic opportunities, employment, and security reflecting Weberian or neo-Weberian ideals of how a 'successful' state should function (Mcloughlin, 2012). Most nation-states exist to deliver political goods although there usually a hierarchy of positive state functions (Rothberg, 2003). State collapse can occur when governments can no longer deliver positive political goods to their people, losing legitimacy in the eyes and hearts of its citizens. However, this is based on the strong assumption that positive political goods such as health are state-financed and state health care provision will enhance the prospect of peace and mitigate the risk of conflict. In reality, non-state organizations and the private sector are responsible for a significant proportion of health provision in several fragile and conflict-affected countries, so the ideological notion of the social contract is questionable in terms of building government legitimacy and trust.

So what does current evidence on health as cause of conflict suggest? The Middle East and North Africa (MENA) region has seen a chronic failure of governance in key services such as: health, education, utilities (power, water, etc.) which have contributed to crises in many countries across the Arab Spring region (Cordesman *et al.*, 2013). Warnings from a decade ago in the Arab Development Report suggested that demographic pressures, failures in economic development and the combination of challenges related to income distribution, corruption and nepotism, and discrimination were compounding pre-existing grievances over a lack of freedom, threatening regional stability and creating significant challenges to some of the countries in the region (ibid).

Large scale forced migration resulting from the Syrian conflict has increased tensions between host and refugee communities living in urban areas in some of the neighboring countries. As a result, health services are being scaled-up to reduce tensions between host and refugee populations in Lebanon, where host populations have traditionally not had access to a high-level of state-provided services (WHO, 2016). Much more research is necessary on the causes of tensions and conflict in urban settings such as in MENA and elsewhere, given the changing patterns of conflict and displacement in recent years.

Inequality and landlessness played a central part in motivating and sustaining the conflict in Nepal, which also had a strong ethnic and caste dimension. Many indigenous populations faced discrimination in access to health care during the civil war, alongside discrimination in access to education and public-sector employment (Murshed & Gates, 2005). Econometric analysis from census and other population-level survey data suggests that horizontal inequalities were also influential in the 1997 – 2001 communal conflict in Indonesia (Mancini, 2005). Districts with larger disparities in child mortality between ethnic groups in 1995, as well as districts where these inequalities widened between 1990 and 1995, tended to be those where deadly conflict occurred. Horizontal inequality in child mortality is a very visible type of inequality, which was used instrumentally by ethnic elites to mobilize ethnic hostility particularly among the poorest groups in Indonesian society (ibid). However, it is important to note that child mortality reflects other dimensions of socio-economic inequality such as education and income. These limited examples illustrate that health is not a cause of conflict per se, but a strong indicator of the intertwined nature of societal grievances and inequalities.

Overall, there are few reliable population-level data on key government services such as health, education, housing, water and refuse removal, and infrastructure, and their relationship to the causes of conflict across conflict-affected countries (Cordesman *et al.*, 2013). Where the state is the main provider of essential services, far better data is needed in key areas such as population perceptions of the state´s role in providing such services which, in turn, determine perceptions and expectations on the quality of governance (ibid). Spatio-temporal analysis for monitoring inequalities in relation to access to health care, as well as their change over time, may provide some useful data as to where and when destructive violence may be likely to erupt (Mancini, 2005). However, it is important to stress that this is highly complex research given the multitude of contributing factors to any conflict.

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