

WHO TOPIC SYNOPSIS:
**Strengthening Post-conflict
Health Systems**



**World Health
Organization**

I. Topic Background

Internationally, approximately one-third of the world's population will require rehabilitation at some point during the course of a disease or medical condition. This statistic becomes even more alarming in post-conflict settings, where access to consistent, high-quality healthcare is often severely disrupted. [1]

Armed conflict has a devastating and multidimensional impact on public health systems. The most obvious effects of war include mass casualties, physical injuries, and the long-term psychological effects of generational trauma. For instance, more than 18,000 people have died in the renewed Israeli-Palestinian conflict, most of whom were civilians. In addition to civilian deaths, armed forces frequently violate international humanitarian law by targeting healthcare infrastructure and personnel. In Gaza alone, more than 125 medical professionals have been killed, over 200 detained, and at least 123 medical facilities damaged or destroyed. These attacks not only result in immediate loss of life but also weaken a population's ability to recover long after hostilities have ceased. Beyond direct violence, conflict fundamentally disrupts health systems by forcing medical professionals to flee unsafe areas. Health workers are often deliberately targeted, kidnapped, or killed, creating severe shortages in already strained systems. As trained professionals leave, healthcare infrastructure collapses, supply chains are severed, and essential medical records are lost or destroyed. Without reliable access to care, preventable injuries and illnesses become fatal, and recovery efforts are delayed indefinitely.

The increasing injuries that are caused by the missing health workers not being able to help due to the destruction of those conflicts may only be the tip of the iceberg. Infectious diseases continue to spread rapidly among displaced and refugee populations who lack adequate immunization, sanitation, and access to medical services. Furthermore, both refugee camps and other displacement settings often experience heightened levels of domestic, sexual, and gender-based violence, driven in part by substance abuse, psychological trauma, and widespread untreated mental health conditions.

In regions where healthcare infrastructure was already weak prior to conflict, the effects can be catastrophic. Sierra Leone serves as a key example. Even before the outbreak of civil war in 1991, the country's healthcare system was severely underdeveloped. In 1980, approximately 20% of the population lacked access to government health facilities, and public health expenditure declined by 60% between 1980 and 1987. These systemic weaknesses left the country vulnerable to major health crises, including the later Ebola outbreak, demonstrating how conflict compounds pre-existing vulnerabilities and delays long-term recovery. [2]

The World Bank evaluates if a country fits the standard "Fragile and conflict-affected states (FCAS)" based on the expansive levels of institutional, social fragility, and conflict contained in specific regions. More than one billion people live in such places in more than 40 countries. Expanding that criteria, around two billion people live in conflict-affected places and

have thus been further relocated as a result of ongoing hostilities, violence, and human rights abuses. The term “fragile states” acts as an umbrella term for zones susceptible to human rights violations and is defined differently by aid organizations, presumed by context, and rudimentary political motivations. Fragility is a multifaceted and complex problem that can appear in any context or system, even in the most industrialized nations, despite the fact that it is frequently linked to violent conflicts, especially in low and middle-income systems. This has been seen in pandemics, natural calamities, political upheavals, and civil unrest. In addition to being sensitive to shocks and domestic and international conflicts, fragile states are particularly vulnerable to humanitarian crises, which can have a complete or partial impact on the system. Humanitarian crises sometimes precede significant catastrophes such as armed conflict, epidemics, famines, and natural disasters. [3]

Case Study 1: Yemen

The ongoing armed conflict in Yemen has severely undermined the country’s health care system, with the violence against health care emerging as a major driver of the system's collapse in 2024. The Safeguarding Health in Conflict Coalition documented 52 incidents involving attacks on or obstruction of healthcare, including the arrest of 19 health workers, the killing of six, and the forced entry of health facilities on 18 occasions. These incidents occurred amid a worsening public health crisis, as Yemen recorded the world’s highest number of cholera cases in 2024, with more than 249,000 suspected infections and over 800 associated deaths. Armed groups, particularly the Houthis, carried out repeated raids on hospitals and clinics, often to seize resources or assert control, while Southern Transitional Council forces were also implicated in several incidents throughout the country. [6]

Conflict-related insecurity disrupted vaccination programs and intensified vaccine hesitancy, which resulted in low immunization coverage across multiple governorates. Even prior to the civil war that began in 2014, Yemen’s health system was fragile due to prolonged political instability and underinvestment; years of armed conflict have further weakened its capacity. As of early 2024, 40% of assessed health facilities were partially functional or non-functional, primarily due to staff shortages and lack of equipment. Acute shortages of female health workers have posed particular barriers to access for women, especially in sexual and reproductive health services. [6]

Efforts to strengthen Yemen’s health research and healthcare system have increasingly focused on capacity building and evidence generation in response to prolonged conflict. Training initiatives have begun to equip Yemeni healthcare workers and researchers with skills to operate in resource-constrained and insecure environments, while international donors and global health organizations have provided critical funding to sustain research. Digital health tools and remote data collection methods have been introduced to overcome access and security barriers, enabling continued monitoring of health needs. [7]

Despite these efforts to strengthen the health department, Yemen remains one of the world's most fragile and conflict-affected systems. Such efforts have generated valuable evidence on health system gaps, workforce shortages, and barriers to access. However, persistent insecurity, attacks on healthcare, and underfunding from a fragmented governance system continued to undermine the effectiveness and reach of these interventions. [7]

Case Study 2: Northeastern Myanmar

Northeastern Myanmar, particularly the Kachin and Northern Shan States, has been affected by decades of armed conflict between the Myanmar military and ethnic armed organizations. Even after Myanmar's political transition began in 2011, fighting continued in these regions, causing widespread displacement and long-term instability. As a result, the health system in Northeastern Myanmar remains extremely fragile, making it a strong example of the challenges involved in strengthening post-conflict health systems. [8]

Long-term conflict has led to severe displacement in Myanmar, with nearly 100,000 people remaining internally displaced in Kachin State and thousands more in Northern Shan. Many of these displaced people live in overcrowded camps or non-government-controlled areas where access to healthcare is highly limited. These conditions increase the spread of infectious diseases, worsen malnutrition, and prevent people from receiving timely medical treatment. Poor transportation infrastructure and movement restrictions also isolate communities from different health services. [8]

Health issues in Northeastern Myanmar are significantly worse than in more stable parts of the country. Infant mortality rates near conflict zones are also far higher than national averages, and maternal mortality remains a serious issue due to the lack of skilled birth attendants and emergency care. These deaths are largely preventable, which shows how weak health systems directly contribute to human suffering in post-conflict settings. [8] One of the biggest challenges is the destruction and underdevelopment of healthcare facilities. Many healthcare infrastructures have been damaged during the fighting, while others lack electricity, clean water, or essential medical supplies. Specialized services such as rehabilitation, surgery, and long-term care for people injured in conflict are extremely limited or nonexistent. Because of this, people with disabilities or chronic conditions often go untreated. [9]

Another major problem is the shortage of trained healthcare workers. Doctors and nurses are unable to work in conflict-affected regions due to safety risks, low pay, and poor working conditions. In response, ethnic and community-based health organizations have stepped in to provide basic primary healthcare in areas where government services are not available. [8] Substance abuse, depression, and post-traumatic stress disorder are common, especially in displacement camps, but there are very few trained professionals or facilities to address all of their needs. This gap further weakens recovery efforts. [9]

Despite these challenges, there have been efforts to strengthen post-conflict health systems. Myanmar's National Health Plan has acknowledged the importance of including health

organizations. [8] International actors have also emphasized rebuilding health infrastructure, training local health workers, and expanding rehabilitation services. [9]

II. Past UN Involvement

- According to the UN, there are more violent conflicts today than there have been since WWII. As a result, the international community must comply with global health governance systems in order to promote the welfare of communities caught in the crossfire. The international community must comply with global health governance systems in order to promote the welfare of communities caught in the crossfire. These actions promote public health and lay the groundwork for averting future conflicts. [4]
- The UN World Health Organization (WHO) published their Rehabilitation 2030 Initiative (Rehab 2030) to call attention to the vast treatment gap between low-income countries and developed nations.
 - This initiative states that countries need to treat rehabilitation as a priority and calls for “promotive, preventative, curative, and palliative care” [1]
 - This global agenda calls for 10 priority areas of action: establishing strong political backing and leadership for rehabilitation at the local, national, and international levels; enhancing emergency preparedness and response; improving national and subnational rehabilitation planning and execution; strengthening intersectoral connections; better integrating rehabilitation into health systems; and including rehabilitation in universal health coverage (UHC), among other goals. [5]
 - Countries seek to understand and follow the actions set by WHO’s plan, particularly in post-conflict and fragile settings where health systems are most vulnerable.
- Draft Resolution A/79/L.36 “Strengthening of the coordination of emergency humanitarian assistance of the United Nations,” addresses the growing demand for coordinated humanitarian response.
 - Focused on the fact that a “staggering” 305 million people worldwide will need immediate humanitarian aid and protection in 2025, primarily due to conflict and the global climate emergency.
 - Introduced by the representative of Sweden
 - She called to the General Assembly to put words into practice and convey a clear message of solidarity to those impacted by crisis worldwide [6]

- Draft Resolution A76/7 “Strengthening rehabilitation in health systems” highlights the role of rehabilitation as an essential component of resilient health systems.
 - Calls for expanding and integrating rehabilitation into health systems as a part of Universal Health Coverage (UHC)
 - Emphasizes rehabilitation in primary care and emergency preparedness and response
 - Recognizes major unmet rehabilitation needs from disease, injury, and aging
 - Stresses that rehabilitation should be accessible for everyone, especially populations affected by conflict and displacement.
 - Highlights the importance of assistive technology and mental health support
 - Requests WHO to track progress and support countries through the Rehabilitation 2030 initiative ^[7]

III. Bloc Positions

Western Bloc

Currently, most Western countries do not experience large-scale armed conflict within their own borders; however, they continue to face health system challenges related to crisis preparedness and post-crisis recovery. Experiences with natural disasters, terrorist attacks, pandemics, and historical post-conflict reconstruction have shaped Western perspectives on the importance of adaptable health systems—a perspective reflected in OECD health policy studies that emphasize investing in health system resilience and preparedness for future crises.^[16] Western institutions, including European health policy frameworks supported by the OECD and European Commission, promote systematic resilience testing and structural strengthening to improve equity in health systems. This emphasis on resilience has influenced Western engagement in post-conflict settings, where health system recovery is increasingly framed as both a humanitarian necessity and a foundation for peacebuilding and stability.^[17]

Eastern Bloc

Eastern bloc countries tend to approach post-conflict health systems with a mix of bilateral engagement, state-led development models, and pragmatic cooperation. Historically, health systems in the Soviet Union and its satellite states were highly centralized and regularly emphasized universal access and preventative care under models such as the Semashko system—a single-payer system where healthcare is funded by the government budget and therefore free for all citizens^[18]. China’s growing role in global health diplomacy, particularly through the Health Silk Road under the Belt and Road Initiative, democratizes support for health infrastructure and cooperation in partner and conflict-affected countries, through bilateral and/or regional mechanisms. China has also emphasized humanitarian assistance based on neutrality

and respect for sovereignty, including support for post-conflict reconstruction and civilian protection. [19]. At the same time, Eastern European post-communist states have pursued significant health system reforms since the Soviet period and have transitioned from centralized models toward mixed financing systems [20].

South American Bloc

Countries in South America have faced numerous health system challenges linked to disasters and service disruptions, all of which have pushed the region to focus on more resilience and preparedness. Natural disasters such as earthquakes, hurricanes, and volcanic eruptions have damaged hospitals and interrupted healthcare for millions, showing how vulnerable health infrastructure can be during crises [12]. In response, the Pan American Health Organization (PAHO) has prioritized reducing service disruptions and strengthening health facilities so essential care can continue even during emergencies [12]. The COVID-19 pandemic further exposed weaknesses in access to healthcare, especially in remote and underserved areas, which reinforced the need for stronger health systems [12]. Through the PAHO Resilient Hospital Initiative, countries have worked to improve hospital safety, update national policies, and adopt cost-effective technologies to maintain care. Columbia stands out as a regional leader, having developed a national policy to improve hospital adaptability during emergencies, with PAHO supporting risk assessments in multiple health facilities. Regional cooperation and health diplomacy have also played a crucial role in strengthening these health systems, allowing countries to share resources, coordinate responses, and support post-conflict recovery across borders [13].

SWANA and African Bloc

Countries in the SWANA and African blocs have faced some of the most severe challenges in strengthening post-conflict health systems due to prolonged wars, political instability, as well as humanitarian crises. In SWANA, conflicts in countries such as Syria, Yemen, and Iraq have led to the destruction of hospitals, shortages of health workers, and the collapse of basic health services, forcing international organizations to step in with emergency care and cross-border health support to maintain any form of care for displaced populations [13]. In Africa, post-conflict states like Liberia, Sierra Leone, and South Sudan struggled with weakened governments, limited funding, and damaged infrastructure, which made health systems highly vulnerable to disease outbreaks [14]. However, post-conflict recovery has also created opportunities for reform, as many African countries have used reconstruction periods to rebuild stronger health care systems by investing in community-based care and strengthening health workforce training [14]. Regional and international partnerships have supported these efforts by focusing on long-term aid, emphasizing sustainable preparedness for future crises [15].

IV. Possible Solutions

The committee of the WHO recommends their delegates focus on constructing solutions that are coordinated, evidence-based, and relevant to the country's policy. Prolonged conflict often leaves health systems fragmented, under-resourced, and unable to meet population needs; therefore, delegates should consider both long-term recovery methods and emergency short-term responses. Addressing post-conflict health challenges requires alignment between humanitarian assistance and development strategies, as well as collaboration among national authorities, local health actors, and international partners.

As a suggestion, the committee of the WHO further encourages delegates to consider flexible frameworks that are capable of supporting current health systems. Exploring the relationship between the government and the medical system and its current contexts is an important factor, as governance structures, political stability, and capacity significantly influence health system recovery in post-conflict environments. Understanding these dynamics may assist delegates in seizing opportunities to strengthen coordination and government accountability. Additionally, the committee advises delegates to reflect on the role of local stakeholders — health workers, community organizations, non-state health providers — in sustaining the quick delivery of service during and after conflict. By considering these broader structural and contextual elements, delegates can develop approaches that support health system continuity while still remaining adaptable to their respective national policies and post-conflict realities.

Delegations are advised to base their solutions on—but are not limited to—three key issues that are central to strengthening post-conflict health systems. First, the rebuilding and stabilization of health systems must be prioritized, as prolonged conflict often leaves medical infrastructure damaged, supply chains disrupted, and health services unevenly distributed. Without functional facilities and reliable access to medicines and equipment, recovery efforts remain limited. Additionally, the loss and displacement of healthcare workers during conflict create issues in providing consistent care, making it especially important for solutions to focus on restoring the health workforce through training, protection, and incentives that encourage professionals to return and remain in affected areas. Finally, post-conflict settings frequently expose vulnerable populations to significant health inequities, particularly refugees and survivors of trauma. Delegates should therefore consider policies that promote more inclusive and accessible healthcare, with attention to mental health, rehabilitation, and primary care, in order to ensure that recovery efforts contribute to lasting stability. Delegates are also encouraged to carefully think about the practical implementation of their solutions, including how programs will be funded, sustained, and monitored. Solutions should identify potential sources of financing, such as national budgets, international aid or public-private partnerships, and outline realistic strategies for accountability.

V. Questions to Consider

- 1) How should post-conflict health recovery address less visible but long-term needs? (mental health, rehabilitation, care for people with disabilities)
- 2) What mechanisms can be used to ensure accountability and sustainable financing when rebuilding health systems in a fragile environment?
- 3) How can long-term health system recovery be balanced with immediate humanitarian and emergency responses?
- 4) What strategies can be used to recruit and retain healthcare workers in post-conflict regions where security, pay, and infrastructure remain unstable?
- 5) What role can regional cooperation and sharing of knowledge play in strengthening post-conflict health systems, particularly in countries facing similar conflict-related challenges?
- 6) How should data collection be incorporated into post-conflict health recovery to inform long-term policy decisions despite limited infrastructure?
- 7) In what ways can health system recovery efforts be adapted to ensure equitable access to care across different regions and formerly marginalized groups?
- 8) How can digital health technologies be leveraged to maintain healthcare delivery and monitoring areas with damaged infrastructure?

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