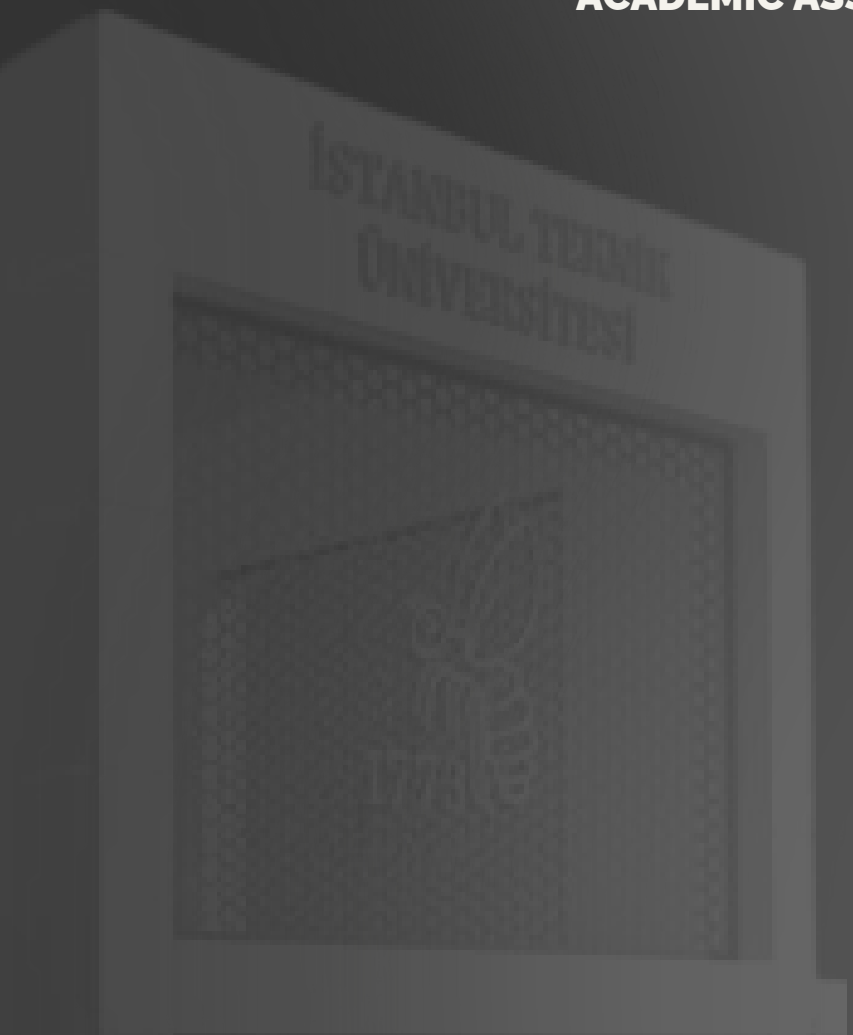
WHO
STUDY GUIDE

#LETSBEEUNITED

GÜLCE SARITAŞ
BOARD MEMBER

SELMAN RAWY
BOARD MEMBER

CANSU USLU
ACADEMIC ASSISTANT



ITU MUN

1. Letter from the Secretariat
2. Letter from the Committee Board
3. Introduction to the Committee: World Health Organization
4. Introduction to the Agenda Item 1: Improving Healthcare Access for Underrepresented and Marginalized Communities
    4.1. Key Terminology
    4.2. Background and Historical Context
    4.3. Structural Barriers in Healthcare Access
    4.4. Socioeconomic Determinants
    4.5. Impact on Marginalized and Underpresented Communities
    4.6. Past Actions and International Legal Frameworks
    4.7. QTBA (Questions to be Addressed)
5. Introduction to the Agenda Item 2: Ensuring Access to Healthcare for Women and Girls in Conflict Zones
    5.1. Key Terminology
    5.2. Background and Historical Context
    5.3. Vulnerabilities of Women and Girls in Conflict Zones
    5.4. Past Actions and International Legal Frameworks
    5.5. Shortcomings and Failed Actions
    5.6. Case Studies and Lessons Learned
    5.7. Possible Solutions and Policy Approaches
    5.8. QTBA (Questions to be Addressed)
6. Further Readings & Bibliography

1. Letter From the Secretariat

Letter from the Secretary-General

Dear Delegates,

It is with great pleasure that I welcome you to ITUMUN 2026.

By choosing to take part in this conference, you have already done something meaningful: you have chosen dialogue over indifference, understanding over assumption, and engagement over silence. In a world increasingly shaped by division, conflict, and uncertainty, such choices matter.

Today's international landscape is marked by ongoing conflicts, humanitarian crises, and profound global challenges that demand more than rhetoric. They demand informed, open-minded, and principled individuals, particularly from the younger generation, who are willing to listen, to question, and to act responsibly. MUNs offers precisely this space: one where ideas are tested, diplomacy is practised, and perspectives are broadened.

As delegates, you are not merely representing states or institutions; you are actually engaging in the art of negotiation, the discipline of research, and the responsibility of decision-making. Approach this experience with curiosity, respect, and intellectual courage. Learn not only from debate, but from one another.

On behalf of the Secretariat, I sincerely hope that ITUMUN 2026 will challenge you, inspire you, and leave you better equipped to contribute to a more peaceful and cooperative world.

I wish you a rewarding conference and every success in your deliberations.

Yours sincerely,
Abdullah Kikati
Secretary-General

2. Letter from the Committee Board

Esteemed Delegates,

It is with great honour and utmost pride for us to be able to welcome all of you to the World Health Organization Committee in **ITUMUN'26!** We are **Gülce Sarıtaş**, a **Political Science and International Relations student** in Marmara University, and **Salman Ravy, a Mechatronics Engineering student in Kadir Has University.** We are delighted to have you join us for what promises to be a challenging, engaging, and intellectually enriching committee experience.

WHO stands at the forefront of the global union that fights for equality in healthcare access, safety measures in epidemics and pandemics, and international public health. We look forward to witnessing insightful debate, innovative solutions, and fruitful collaboration throughout ITUMUN'26. To give you a head start, we have listed a few informative videos for you to get a good grasp of the agenda item. Should you have any questions or require further clarification, please do not hesitate to reach out to the committee board by mailing us through saritasgulce@gmail.com to ask about the committee, the agenda item, or anything in particular.

Warm regards,

Committee Board of WHO

How social determinants impact healthcare | Veronica Scott-Fulton | TEDxFondduLac
What Is Health Equity, and Why Does It Matter?
Protecting Sexual and Reproductive Health and Rights during Conflict
How Does War Affect Healthcare Access? - Gender Equality Network

3. Introduction to the Committee: World Health Organization

The **World Health Organization (WHO)** is the specialized agency of the United Nations responsible for international public health. Established in 1948, the WHO operates with the objective of promoting the attainment of the highest possible level of health for all peoples. With 194 Member States, the Organization serves as a central coordinating authority for global health governance, policy development, and technical cooperation.

The mandate of the WHO extends beyond disease control, encompassing health system strengthening, emergency preparedness and response, and the promotion of health equity. Through its normative role, the Organization develops international health standards, guidelines, and recommendations that shape national healthcare policies. At the same time, the WHO provides technical assistance to Member States, particularly those facing structural weaknesses in healthcare infrastructure and service delivery.

A core principle guiding the work of the WHO is **the recognition of health as a fundamental human right.** This rights-based approach underscores the Organization's commitment to reducing health inequalities and addressing the social, economic, and environmental determinants of health. In this context, the WHO places particular emphasis on improving access to healthcare for marginalized and underrepresented populations, including low-income communities, migrants, refugees, and individuals affected by conflict and displacement.

In times of global health emergencies, the **WHO** plays a critical role in coordinating international responses, facilitating information sharing, and mobilizing resources. Instruments such as the **International Health Regulations (IHR)** provide a framework for collective action in addressing cross-border health threats. However, the effectiveness of these mechanisms relies heavily on international cooperation and sustained political commitment from Member States.

4. Introduction to the Agenda Item 1: Improving Healthcare Access for Underrepresented and Marginalized Communities

Improving access to healthcare for underrepresented and marginalized communities remains one of the most pressing challenges in global public health. Despite significant medical advancements and international commitments to health **equity**, millions of individuals continue to face systemic barriers that prevent them from obtaining essential health services. These barriers are often rooted in socioeconomic inequality, geographic isolation, discrimination, and fragile health system infrastructures.

Marginalized populations -including refugees, migrants, ethnic minorities, rural communities, persons with disabilities, and those living in informal or conflict-affected settings- are disproportionately affected by limited healthcare access. Such disparities not only undermine individual well-being but also weaken collective public health outcomes by increasing vulnerability to preventable diseases and health emergencies. Inadequate access to timely and affordable care exacerbates existing inequalities and perpetuates cycles of poverty and exclusion.

Within the framework of the **World Health Organization**, this agenda item emphasizes the importance of equitable, inclusive, and sustainable healthcare systems. Addressing healthcare access requires more than expanding coverage in principle; it demands targeted strategies that respond to the specific needs of underrepresented groups while strengthening national health systems as a whole. This includes ensuring financial protection, availability of trained healthcare personnel, culturally appropriate services, and effective outreach mechanisms.

This agenda item primarily focuses on assessing existing shortcomings, considering the role of international cooperation, and exploring policy approaches that align with the principles of **Universal Health Coverage** and the commitment to **“leave no one behind.”** Through collaborative and evidence-based discussion, the committee aims to identify pathways toward more accessible and resilient healthcare systems for marginalized communities worldwide.

4.1. Key Terminology

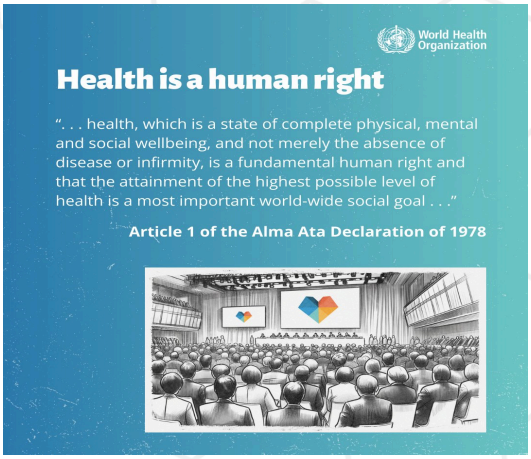
- Healthcare Access: The ability of individuals and communities to obtain timely, affordable, and appropriate health services, including prevention, diagnosis, treatment, and rehabilitation.
- Health Equity: The absence of unfair and avoidable differences in health outcomes and access to healthcare among different population groups.
- Health Equity vs. Health Equality: These terms are often used interchangeably but represent distinct concepts. Health equality refers to the equal distribution of

resources to everyone, regardless of need. Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving equity often requires unequal distribution of resources—giving more to those who have less—to remove obstacles such as poverty, discrimination, and their consequences.

- Marginalized and Underrepresented Communities: Groups that face systemic social, economic, political, or legal disadvantages that limit their access to resources, including healthcare.
- Primary Health Care (PHC): Essential healthcare based on practical, scientifically sound methods that is universally accessible and forms the foundation of a national health system, as emphasized in the Alma-Ata Declaration.
- Universal Health Coverage (UHC): A health system goal ensuring that all individuals receive needed health services without suffering financial hardship.
- Structural Barriers: Systemic obstacles within healthcare systems, such as inadequate infrastructure, financing models, and workforce distribution, that restrict access to care.
- Socioeconomic Determinants of Health: Social and economic conditions—such as income, education, employment, and housing—that influence health outcomes and access to healthcare.
- Out-of-Pocket Expenditure: Direct payments made by individuals for healthcare services that are not covered by insurance or public funding.
- Health Illiteracy: Limited ability to obtain, understand, and use health information to make informed healthcare decisions.
- Urban–Rural Divide: Disparities in healthcare availability and quality between urban areas and rural or remote regions.
- Healthcare Workforce Shortages: Insufficient availability or uneven distribution of trained health professionals, including doctors, nurses, and midwives.
- Displacement: The forced movement of individuals from their homes due to conflict, disasters, or other crises, including refugees and internally displaced persons.
- Refugees and Internally Displaced Persons (IDPs): Individuals forced to flee their homes; refugees cross international borders, while IDPs remain within their country of origin.
- Informal Settlements / Slums: Densely populated urban areas characterized by inadequate housing, limited services, and insecure tenure, often lacking access to formal healthcare systems.
- Indigenous Populations: Communities with historical continuity to pre-colonial societies, often facing systemic marginalization and limited access to healthcare.
- Ethnic and Racial Minorities: Groups distinguished by shared cultural, ethnic, or racial characteristics that may experience discrimination and unequal healthcare access.
- WHO Constitution: The foundational legal document of the World Health Organization recognizing health as a fundamental human right.

- Sustainable Development Goal 3 (SDG 3): A global commitment to ensure healthy lives and promote well-being for all, with a focus on universal health coverage and health equity.
- International Health Regulations (IHR): A legally binding framework aimed at preventing, detecting, and responding to public health emergencies of international concern.
- Health System Resilience: The ability of healthcare systems to prepare for, respond to, and recover from crises while maintaining essential services.
- Global Health Governance: The collective actions of states, international organizations, and non-state actors to manage and improve global health outcomes
- Medical Apartheid: A term popularized by medical ethicist Harriet Washington, referring to the history of medical experimentation on African Americans and, by extension, other marginalized groups. It describes a system where the medical establishment uses marginalized bodies for scientific advancement while simultaneously denying them equal care. This history has generated deep-seated intergenerational mistrust, which acts as a contemporary barrier to access.
- Intersectionality: A framework for understanding how overlapping identities (e.g., race, class, gender, disability) combine to create unique modes of discrimination and privilege. In healthcare, intersectionality explains why a wealthy woman and a poor woman of color experience the health system differently, even if they share the same gender.

4.2. Background and Historical Context



The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All. The following are excerpts from the Declaration:

The Conference strongly reaffirms that health, which is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries.

The people have a right and duty to participate individually and collectively in the planning and implementation of their health care.

Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process.

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente, and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

Past Cases in Inequality of Healthcare Access

Historical patterns of healthcare delivery reveal persistent inequalities both between and within countries. In many low- and middle-income states, healthcare systems developed unevenly, with resources concentrated in urban centers while rural and peripheral regions remained underserved. For example, during the late twentieth century, rural populations in parts of Sub-Saharan Africa, South Asia, and Latin America faced limited access to trained healthcare professionals, hospitals, and essential medicines. Marginalized ethnic groups and indigenous populations were often excluded from national health strategies, resulting in higher rates of preventable diseases and maternal mortality.

In high-income countries, inequalities also persisted, particularly among racial and ethnic minorities, migrants, and low-income communities. Even where healthcare systems were formally universal, barriers such as geographic isolation, discrimination, and indirect costs limited effective access. These cases demonstrate that the mere existence of healthcare systems does not guarantee equitable access, especially for underrepresented communities.

Colonial Medicine and the Roots of Inequality

The origins of international public health are inextricably linked to the colonial project. The principal purpose of colonial healthcare was rarely the welfare of the indigenous population; rather, it was to promote the viability and reproduction of the colonizer and to protect the labor force required for resource extraction. "Tropical medicine" emerged as a

discipline focused on protecting European settlers from the "hostile" environments of the colonies.

Health infrastructure was typically concentrated in administrative centers and designed to segregate populations. "Race-based medicine" produced dual systems: modern, well-funded hospitals for European settlers and underfunded, inferior dispensaries for the indigenous population. Western medicine was often used as an ideological tool to "civilize" and inculcate values of the empire, while indigenous medical knowledge was systematically rejected, criminalized, and marginalized. This bifurcation laid the physical and administrative groundwork for the urban-rural divides and two-tiered health systems seen in many post-colonial states today. The "civilizing mission" masked a reality where health care was a privilege of the occupier, and the colonized received care only when necessary to prevent anti-colonial revolution or preserve labor productivity

Medical Apartheid: The Tuskegee Syphilis Study and Beyond

The Tuskegee Syphilis Study (1932–1972) in the United States is perhaps the most notorious example of "medical apartheid." For forty years, the U.S. Public Health Service tracked 399 African American men with syphilis, withholding effective treatment (penicillin) even after it became the standard of care in the 1940s, solely to observe the natural progression of the disease. This was not a secret, rogue operation but a government-sanctioned study published in medical journals.

However, as Harriet Washington documents, Tuskegee was not an anomaly but part of a continuous "multifaceted pattern of racist and unethical medical practice". From the surgical experimentation on enslaved women by J. Marion Sims (the "father of modern gynecology") without anesthesia, to the use of Black bodies for anatomical dissection without consent, the medical establishment has a long history of exploiting marginalized populations. This history has created a "health chasm" characterized by profound erosion of trust. Mistrust is a rational, protective response to historical injustice. Today, this mistrust manifests as vaccine hesitancy or avoidance of care among African American communities, who may perceive the health system as dangerous or predatory.

Forced Sterilization in Peru (1996–2000)

In the late 1990s, the Peruvian government under Alberto Fujimori implemented a "Voluntary Surgical Contraception" program as part of a poverty reduction strategy. In reality, the program was a campaign of forced sterilization targeting Indigenous and poor women in rural areas. Over 272,000 tubal ligations were performed. Investigations revealed that medical personnel were given quotas and incentives to sterilize women, often coercing them with food, threatening to withhold other medical services, or performing the procedure without valid consent.

The case of Celia Ramos, who died in 1997 after undergoing the procedure without valid consent, has become a symbol of this injustice. In 2025, legal battles continued as the

Inter-American Court of Human Rights heard arguments regarding the violation of rights to free, prior, and informed consent. This case illustrates how "public health" initiatives can mask state violence against marginalized groups, specifically targeting Indigenous women's reproductive autonomy as a means of demographic control.

Colonial Medical Segregation

In colonial contexts across Africa and Asia, health systems were explicitly designed to serve the colonizer. In South Africa under Apartheid, this was codified into law, but similar de facto practices existed throughout the British, French, and Belgian empires. Indigenous populations were relegated to overcrowded, under-resourced "native hospitals," while white settlers accessed world-class care. This segregation was justified by pseudo-scientific racial theories that claimed Indigenous bodies were biologically different or less sensitive to pain. The legacy of this infrastructure remains; many "national referral hospitals" in post-colonial capitals are the direct successors of these settler institutions, often remaining inaccessible to the rural poor due to location and cost.

Structural Reforms and the Deepening of Inequalities

From the 1980s onward, structural reforms in healthcare governance significantly altered how health services were financed and delivered. Many governments, under economic pressure, reduced public healthcare spending and promoted efficiency through decentralization, cost-sharing, and private-sector involvement. While these reforms were often presented as necessary for sustainability, they frequently shifted responsibility away from the state and onto individuals and households.

As a result, healthcare increasingly became treated as a market commodity rather than a public good. This shift disproportionately affected marginalized communities, who were least able to absorb rising costs or navigate complex healthcare systems.

Expansion of Market-Oriented Healthcare Systems

The expansion of market-oriented healthcare systems introduced competition, private providers, and profit-driven service delivery into national health frameworks. In some contexts, this led to technological innovation and expanded service options for wealthier populations. However, for low-income and rural communities, market-based systems often resulted in reduced access, as private providers concentrated services in profitable urban areas.

In countries where public healthcare systems were weakened, essential services such as preventive care, maternal health, and primary care became underfunded. This reinforced existing inequalities, as marginalized populations relied heavily on public services that were no longer adequately supported.

Rise of Insurance-Based and Privatized Models

The shift toward insurance-based healthcare models further deepened inequalities in access. Formal insurance schemes frequently excluded informal workers, the unemployed, migrants, and rural populations who could not afford regular contributions. Privatized healthcare services, meanwhile, prioritized those with the ability to pay, creating parallel systems of care based on income rather than need.

In many cases, fragmented insurance coverage led to unequal quality of care, with marginalized groups receiving limited or delayed treatment. Administrative complexity and lack of health literacy also prevented vulnerable populations from fully benefiting from insurance-based systems.

Financial Barriers to Access

Financial barriers remain one of the most significant obstacles to equitable healthcare access. High out-of-pocket payments, consultation fees, medication costs, and transportation expenses force many individuals to delay or avoid seeking medical care altogether. For marginalized communities, even small costs can have serious consequences, leading to preventable illness, worsening health outcomes, and cycles of poverty.

These financial barriers disproportionately affect women, older persons, persons with disabilities, and low-income households. As a result, healthcare inequality is reinforced not only through structural systems but also through everyday economic realities faced by underrepresented populations.

Global Health Crises as Turning Points

Global health crises have repeatedly exposed and intensified existing inequalities in healthcare access, often acting as turning points in international health policy. Epidemics, pandemics, and large-scale health emergencies place sudden pressure on healthcare systems, revealing structural weaknesses that disproportionately affect underrepresented and marginalized communities.

The **HIV/AIDS epidemic** of the late twentieth century highlighted deep disparities in access to life-saving treatment between developed and developing countries. While effective therapies became widely available in high-income states, many low-income countries faced shortages of medication, inadequate healthcare infrastructure, and limited international support. This unequal response sparked global debates on access to medicines, intellectual property rights, and the responsibility of the international community to ensure equitable healthcare.

Similarly, the **Ebola outbreaks in West Africa (2014–2016)** exposed the consequences of long-term underinvestment in public health systems. Weak surveillance mechanisms, shortages of trained healthcare workers, and limited community trust in health institutions contributed to the rapid spread of the disease. Marginalized rural communities

were among the most affected, demonstrating how structural inequality can turn health emergencies into humanitarian crises.

More recently, the **COVID-19 pandemic** underscored global and domestic inequalities in unprecedented ways. Differences in testing capacity, hospital availability, and vaccine access revealed stark disparities between and within countries. Marginalized populations, including low-income workers, migrants, and informal settlements, experienced higher exposure risks and reduced access to care. At the global level, unequal vaccine distribution highlighted ongoing challenges in achieving health equity.

These crises have served as critical moments for reform, prompting renewed attention to universal health coverage, primary healthcare strengthening, and global cooperation. However, they also demonstrate that without sustained structural change, health emergencies risk reinforcing existing inequalities rather than correcting them.

4.3. Structural Barriers in Healthcare Access

Structural barriers within healthcare systems play a central role in limiting access for underrepresented and marginalized communities. These barriers are embedded in how health services are planned, financed, and distributed, often reflecting broader social and economic inequalities.

Infrastructure and Service Availability

In many regions, healthcare infrastructure is unevenly distributed, leaving marginalized communities without adequate access to essential services. Hospitals, clinics, diagnostic facilities, and emergency care are frequently concentrated in urban or economically developed areas, while rural and remote regions face chronic shortages. In fragile and low-resource settings, poor transportation networks, lack of medical equipment, and unreliable electricity and water supplies further reduce service availability. As a result, individuals may be forced to travel long distances to receive basic care, delaying treatment and worsening health outcomes.

Financial Barriers and Insurance Gaps

Even where healthcare facilities exist, financial barriers often prevent effective access. Out-of-pocket payments, user fees, and medication costs place a disproportionate burden on low-income households. Insurance-based systems may fail to cover informal workers, migrants, and unemployed individuals, leaving large segments of the population without financial protection. Insurance gaps not only limit access to care but also increase the risk of catastrophic health expenditures, pushing vulnerable households deeper into poverty.

Healthcare Workforce Shortages

Shortages of trained healthcare professionals represent another major structural barrier. Many countries face an uneven distribution of doctors, nurses, and midwives, with skilled workers concentrated in urban centers or migrating to higher-income countries. In underserved areas, limited staffing reduces the quality and availability of care, increases waiting times, and places excessive strain on existing health workers. These shortages are particularly harmful for maternal, child, and primary healthcare services.

Urban–Rural Divide

The urban–rural divide remains a persistent feature of healthcare inequality. Urban populations generally benefit from better infrastructure, specialized services, and greater healthcare investment, while rural communities experience limited access and lower-quality care. This divide is often reinforced by policy decisions that prioritize urban development, leaving rural populations, including indigenous and agricultural communities, systematically underserved.

4.4. Socioeconomic Determinants

Socioeconomic determinants significantly influence individuals' ability to access, afford, and benefit from healthcare services. These factors operate beyond the healthcare system itself, shaping health outcomes through social, economic, and legal conditions that disproportionately affect marginalized and underrepresented communities.

Poverty and Income Inequality

Poverty remains one of the most significant barriers to healthcare access. Low-income individuals are more likely to delay or forgo medical care due to costs related to treatment, transportation, and lost income. Income inequality further exacerbates these challenges by concentrating quality healthcare services among wealthier populations while leaving poorer communities reliant on underfunded public systems. As a result, preventable illnesses often remain untreated, leading to higher morbidity and mortality rates among disadvantaged groups.

Education and Health Illiteracy

Education levels are closely linked to health outcomes and healthcare utilization. Limited education can contribute to health illiteracy, reducing individuals' ability to understand medical information, navigate healthcare systems, or recognize early signs of illness. Marginalized populations may lack access to health education, leading to lower rates of preventive care, vaccination, and early diagnosis. This gap undermines both individual well-being and public health efforts.

Gender, Disability, and Age-Based Disparities

Gender, disability, and age intersect with socioeconomic conditions to create layered barriers to healthcare access. Women and girls may face cultural restrictions, caregiving responsibilities, or limited financial autonomy that restrict access to services, particularly reproductive and maternal healthcare. Persons with disabilities often encounter physical barriers, inadequate accommodation, and discriminatory practices within healthcare systems. Children and older persons may face additional vulnerabilities due to dependency, mobility limitations, or age-related health needs that are not adequately addressed by existing services.

Migration Status and Legal Barriers

Migration status can significantly restrict access to healthcare. Migrants, refugees, and asylum seekers may face legal barriers, lack of documentation, or fear of discrimination and deportation, discouraging them from seeking care. Language barriers and unfamiliarity with healthcare systems further limit access. In many cases, restrictive policies exclude non-citizens from public healthcare coverage, increasing reliance on emergency services and humanitarian assistance.

4.5. Impact on Marginalized and Underrepresented Communities

The combined effects of structural and socioeconomic barriers disproportionately impact marginalized and underrepresented communities. These groups often experience overlapping vulnerabilities that limit their access to timely, affordable, and quality healthcare, particularly during periods of crisis or instability.

Refugees and Internally Displaced Persons

Refugees and internally displaced persons (IDPs) face severe challenges in accessing healthcare due to displacement, insecurity, and disrupted health systems. Many reside in overcrowded camps or informal settlements where healthcare services are limited, under-resourced, or entirely absent. Legal status, lack of documentation, and dependence on humanitarian assistance further restrict access to national healthcare systems. Women, children, and elderly individuals within displaced populations are especially vulnerable to preventable diseases, maternal health risks, and inadequate mental health support.

Indigenous Populations

Indigenous populations often experience long-standing health inequalities rooted in historical marginalization, geographic isolation, and systemic discrimination. Healthcare services are frequently inaccessible due to remote living conditions, lack of culturally appropriate care, and insufficient investment in indigenous health infrastructure. These barriers contribute to higher rates of chronic illness, maternal mortality, and lower life expectancy compared to national averages.

Ethnic and Racial Minorities

Ethnic and racial minorities may face discrimination, language barriers, and unequal treatment within healthcare systems. Structural bias can result in delayed diagnoses, lower-quality care, and reduced trust in medical institutions. In some contexts, minorities are concentrated in low-income areas with limited healthcare resources, further reinforcing disparities in health outcomes.

Informal Settlements and Slum Communities

Residents of informal settlements and slum communities often live in environments characterized by overcrowding, poor sanitation, and limited access to clean water, increasing the risk of communicable diseases. Healthcare facilities in these areas are frequently underfunded or inaccessible, while financial and legal barriers discourage regular healthcare use. During health emergencies, such communities are particularly vulnerable due to limited capacity for prevention, early detection, and treatment.

4.6. Past Actions and International Legal Frameworks

International efforts to reduce inequalities in healthcare access have been shaped by a series of legal frameworks, policy commitments, and global health initiatives. These instruments establish healthcare as a human right and guide state and international action toward equity, preparedness, and universal access.

WHO Constitution and Core Principles

Adopted in 1946, the Constitution of the World Health Organization was one of the first international legal instruments to explicitly define health as a fundamental human right. It states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being," regardless of socioeconomic status or background. This principle has guided WHO initiatives aimed at expanding primary healthcare, improving maternal and child health, and strengthening health systems in low- and middle-income countries.

In practice, these principles have influenced programs such as WHO-supported **primary healthcare expansion in Sub-Saharan Africa**, vaccination campaigns, and technical assistance for health system strengthening. However, implementation has varied significantly between states, often reflecting differences in political will, funding, and institutional capacity.

Sustainable Development Goal 3

Sustainable Development Goal 3 (SDG 3), adopted in 2015 as part of the 2030 Agenda for Sustainable Development, represents a renewed global commitment to health equity. SDG 3 aims to ensure healthy lives and promote well-being for all at all ages, with a strong emphasis on **universal health coverage (UHC)**. This includes access to essential health

services, affordable medicines, and protection from catastrophic health expenditures.

Concrete initiatives linked to SDG 3 include national UHC reforms in countries such as **Thailand and Rwanda**, where expanded insurance coverage significantly improved access to primary and preventive healthcare. At the global level, SDG 3 has also guided donor funding priorities and international partnerships focused on maternal health, non-communicable diseases, and infectious disease control. Despite these efforts, progress remains uneven, particularly for marginalized populations.

International Health Regulations (IHR)

The International Health Regulations (2005) provide a legally binding framework for preventing, detecting, and responding to public health emergencies of international concern. The IHR require states to develop minimum core capacities in surveillance, reporting, and response, emphasizing international cooperation and timely information-sharing.

Recent global health crises, including the **Ebola outbreaks in West Africa** and the **COVID-19 pandemic**, demonstrated both the importance and the limitations of the IHR. While the regulations facilitated global coordination and emergency declarations, disparities in national capacity and resource availability limited effective implementation. Many low-income states struggled to meet IHR requirements due to weak health systems, highlighting the link between global health security and equitable access to healthcare.

Marginalized Group	Primary Structural Barrier	Socioeconomic Determinant	Health Outcome Consequence
Undocumented Migrants	**Legal Firewalls:** Fear of deportation prevents accessing clinics.	**Migration Status:** Exclusion from national insurance pools.	Delayed care for communicable diseases; unmanaged chronic conditions.
Indigenous Peoples	**Cultural Safety:** Western systems reject traditional knowledge; racism.	**Colonial Legacy:** Intergenerational trauma; geographic isolation.	Lower life expectancy; historical trauma (e.g., forced sterilization).
Dalits (India)	**Social Exclusion:** Provider refusal to touch/treat due to caste bias.	**Social Stratification:** Lack of sanitation; extreme poverty.	14.6 year lower life expectancy for women; high child anemia.
Slum Dwellers	**Infrastructure:** Public clinics unavailable; reliance on informal providers.	**Urban Penalty:** Overcrowding; lack of clean water/tenure.	High infectious disease rates; catastrophic health expenditure.
Racial Minorities (US)	**Systemic Racism:** Bias in treatment algorithms; provider shortage.	**Intersectionality:** Wealth gap; insurance churn.	Higher maternal mortality; "Medical Apartheid" legacy.

Table 1: Comparative Analysis of Structural Barriers by Marginalized Group

4.7. QTBA (Questions to be Addressed)

- How do structural and socioeconomic barriers limit healthcare access for marginalized and underrepresented communities?
- In what ways do poverty, education gaps, and income inequality contribute to disparities in health outcomes?
- How can states strengthen primary healthcare systems to improve access for marginalized communities?
- What policy measures can reduce financial barriers and expand universal health coverage for vulnerable populations?
- How do migration status, displacement, and legal barriers restrict access to national healthcare systems?
- Why are refugees, indigenous populations, ethnic minorities, and residents of informal settlements disproportionately affected by healthcare inequalities?
- How can international frameworks such as **SDG 3** and the **International Health Regulations (IHR)** be better implemented to promote health equity?
- What role can **WHO and other international organizations** play in supporting capacity-building and inclusive healthcare reforms at the national level?

5. Introduction to the Agenda Item 2: Ensuring Access to Healthcare for Women and Girls in Conflict Zones

Ensuring access to healthcare for women and girls in conflict zones remains a critical challenge within global public health and humanitarian response frameworks. Armed conflicts severely disrupt healthcare systems, damage infrastructure, and limit the availability of essential medical services, disproportionately affecting women and girls. In such contexts, healthcare access is often constrained by insecurity, displacement, economic instability, and the breakdown of governance structures.

Women and girls in conflict-affected areas face distinct and compounded health risks, including **limited access to maternal and reproductive healthcare, increased exposure to gender-based violence, and heightened vulnerability to communicable diseases**. Barriers such as cultural restrictions, lack of trained female healthcare personnel, and the targeting of medical facilities further impede access to timely and appropriate care. These challenges not only threaten individual health outcomes but also undermine long-term community resilience and recovery.

Within the mandate of the **World Health Organization,** this agenda item emphasizes the necessity of gender-sensitive and conflict-responsive healthcare strategies. Addressing the health needs of women and girls in conflict zones requires coordinated international action, strengthened humanitarian development linkages, and the protection of healthcare services under international law. Ensuring continuity of care, particularly for displaced populations, remains essential to reducing preventable morbidity and mortality.

This agenda item specifically battles with the existing gaps in humanitarian health responses, the assessment of the effectiveness of current international mechanisms, and the exploration of policy approaches that promote equitable and sustainable healthcare access. By prioritizing the health and well-being of women and girls in conflict settings, the committee seeks to contribute to broader efforts aimed at **upholding human dignity, protecting fundamental rights, and strengthening global health security.**

5.1. Key Terminology

- Armed Conflict: A situation involving sustained violence between state or non-state actors that disrupts governance, public services, and civilian life.
- Healthcare Access: The ability of individuals to obtain timely, affordable, and appropriate medical services when needed.

- Conflict-Affected Regions: Areas experiencing ongoing or recent armed conflict that significantly weakens healthcare systems and infrastructure.
- Gender-Based Barriers: Social, cultural, economic, or institutional obstacles that limit access to healthcare based on gender.
- Gender-Based Violence (GBV): Harmful acts directed at individuals based on their gender, including sexual violence, exploitation, and abuse, often intensified during conflicts.
- Maternal and Reproductive Health: Health services related to pregnancy, childbirth, contraception, and reproductive well-being.
- Displacement: The forced movement of people due to conflict, violence, or disasters, including refugees and internally displaced persons (IDPs).
- Refugee: A person who has fled their country due to conflict or persecution and requires international protection.
- Internally Displaced Person (IDP): An individual forced to flee their home but who remains within their country's borders.
- International Humanitarian Law (IHL): Legal rules, including the Geneva Conventions, that aim to limit the effects of armed conflict and protect civilians and medical services.
- Geneva Conventions: A set of international treaties that protect wounded civilians, medical personnel, and healthcare facilities during armed conflict.
- Women, Peace, and Security (WPS) Agenda: A UN framework recognizing the impact of conflict on women and promoting their protection and participation, established by UNSC Resolution 1325.
- Health Cluster System: A coordination mechanism led by WHO to organize health responses among humanitarian actors during emergencies.
- Mobile Clinics: Temporary or transportable healthcare units used to deliver medical services in hard-to-reach or insecure areas.
- Community Health Workers: Trained local individuals who provide basic healthcare services and education within their communities.
- Mental Health and Psychosocial Support (MHPSS): Services that address psychological and social well-being during and after conflict.
- Sustainability: The ability of healthcare interventions to continue functioning effectively over time, even after emergency support ends.

5.2. Background and Historical Context

Women's Health in Armed Conflict

Women and girls are particularly vulnerable in conflict zones. It is well recognised that women have a particular experience of conflict, sometimes deliberately targeted, by virtue of their gender. This has a devastating impact on their lives both during and after the conflict. Although often not engaged in combat, women and girls can be disproportionately

affected by conflict. It has been estimated that up to 90 per cent of casualties in contemporary conflicts are civilians, the majority of whom are women and children... There are many acts that constitute gender-based violence, including rape, sexual slavery, genital mutilation, forced pregnancy, abortion and sterilisation. These acts have particular significance in times of conflict and instability, as they are often used to achieve military or political objectives. The use of this type of violence is a violation of international human rights law and, in situations of armed conflict, international humanitarian law. It has a devastating effect on women, their families and their communities. This devastation can be long-lasting, extending far beyond the duration of the conflict.

Violence against women and girls in conflict has been the subject of recent international attention. In 2015 the United Nations General Assembly declared 19 June as the 'International Day for the Elimination of Sexual Violence in Conflict'. General Assembly President Sam Kutesa observed that: Rape and other forms of sexual violence in conflict and postconflict constitute grave violations of human rights and international humanitarian law.

The United Nations (UN) has previously recognised the particular vulnerability of women and girls in conflict, notably in the adoption by the UN Security Council of Resolution 1325 (UNSCR 1325) on women and peace and security on 31 October 2000.5 As the Department of Foreign Affairs and Trade has noted, UNSCR 1325 was 'the first [Security Council] resolution to link women explicitly to the peace and security agenda.

Impact of Conflict on Healthcare Systems

In addition to the direct consequence, conflict also indirectly deteriorates the health of the population by causing breakdown of the health system, shortage of medical supplies and displacement of healthcare workers, as well as disruption of food and clean water supplies. Furthermore, conflict-related insecurity and a lack of free movement also reduce the provision and utilization of health services, with patients hesitating to seek healthcare due to concerns about their safety or potential targeting when traveling to healthcare facilities.

Gender-Based Barriers to Healthcare Access

Gender-based barriers to healthcare access are obstacles that prevent individuals from receiving adequate medical care due to their gender. These barriers primarily affect women and girls, but also impact gender-diverse individuals across different societies. They stem from social norms, economic inequality, and weaknesses within healthcare systems.

In many regions, unequal decision-making power and limited financial independence restrict access to healthcare, especially for women. Cultural stigma surrounding sexual and

reproductive health, mental health, and gender-based violence can discourage individuals from seeking medical assistance. As a result, treatable conditions may go undiagnosed or untreated.

Healthcare systems themselves may also reinforce gender-based barriers through a lack of gender-sensitive policies, insufficient training of healthcare workers, and limited access to essential services such as maternal and reproductive healthcare. These challenges contribute to long-term health inequalities.

Addressing gender-based barriers requires inclusive health policies, awareness-raising, and the development of gender-responsive healthcare services to ensure equitable access to healthcare for all.

Role of International Organizations in Conflict Settings

International organizations play a vital role in conflict settings where healthcare systems are often damaged or inaccessible. Armed conflicts increase the risk of disease, injury, and displacement, making international support essential for civilian populations.

The World Health Organization (WHO) coordinates emergency health responses and supports weakened health systems, while the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) provides healthcare and humanitarian assistance to Palestinian refugees in conflict-affected areas. Other organizations, such as UNICEF, Médecins Sans Frontières (MSF), and the International Committee of the Red Cross (ICRC) deliver life-saving medical care and protect vulnerable populations.

However, these organizations face challenges including limited access, security risks, and funding constraints. Strengthening cooperation and protecting humanitarian workers remain key to improving healthcare delivery in conflict settings.

5.3. Vulnerabilities of Women and Girls in Conflict Zones

Women and girls in conflict zones face serious health risks due to the disruption of healthcare systems and widespread insecurity. **Maternal and reproductive health risks** increase as access to prenatal care, safe childbirth services, and contraception becomes limited or unavailable, leading to higher rates of preventable complications and mortality.

Gender-based violence is more prevalent during conflicts, while survivors often face significant barriers in accessing medical care, psychological support, and legal protection.

Fear, stigma, and damaged healthcare infrastructure further discourage individuals from seeking help.

Displacement and refugee status create additional challenges, as women and girls may lack legal documentation, financial resources, or access to host-country healthcare systems. Overcrowded camps and temporary shelters also increase health risks and limit the availability of essential services.

Adolescent girls are particularly affected by interrupted healthcare services, including vaccination programs, sexual and reproductive health education, and mental health support. These disruptions can have long-term consequences for their physical and emotional well-being.

5.4. Past Actions and International Legal Frameworks

The international community has established several legal frameworks and policy mechanisms to protect health services and vulnerable populations in conflict and emergency settings. Key instruments include the **Geneva Conventions**, which safeguard medical personnel and healthcare facilities during armed conflicts, as well as human rights treaties such as **CEDAW** and the **Convention on the Rights of the Child**, which emphasize the protection of women's and children's health. Additionally, **WHO policies on health in emergencies** and **UN Security Council resolutions on Women, Peace, and Security** guide international responses to conflict-related health challenges. These frameworks provide the foundation for past and ongoing international initiatives and programs aimed at ensuring access to healthcare in crisis situations.

Geneva Conventions and Protection of Medical Services

The Geneva Conventions form the core of international humanitarian law and establish the obligation to protect medical personnel, healthcare facilities, and wounded civilians during armed conflict. They prohibit attacks on hospitals and ambulances and require all parties to allow medical assistance without discrimination. Despite these protections, violations continue to occur in modern conflicts, limiting access to essential healthcare services.

WHO Policies on Health in Emergencies

The World Health Organization plays a leading role in coordinating health responses during emergencies and conflicts. Through its Health Emergencies Programme, WHO supports disease surveillance, emergency medical care, vaccination campaigns, and the

rebuilding of disrupted health systems. WHO policies emphasize preparedness, rapid response, and equitable access to healthcare, particularly for vulnerable populations.

UN Security Council Resolutions on Women, Peace, and Security

UN Security Council resolutions under the Women, Peace, and Security (WPS) agenda, beginning with Resolution 1325 (2000), recognize the disproportionate impact of conflict on women and girls. These resolutions call for the protection of women's rights, prevention of gender-based violence, and increased participation of women in peace and decision-making processes. They also highlight the importance of access to healthcare and support services in conflict settings.

Previous International Initiatives and Programs

Various international initiatives and programs have been implemented to address health challenges in conflict zones. These include humanitarian medical missions, maternal and reproductive health programs, mental health and psychosocial support initiatives, and vaccination campaigns led by international organizations and NGOs. While these efforts have improved health outcomes in some regions, ongoing conflict, funding limitations, and access restrictions continue to pose challenges.

5.5. Shortcomings and Failed Actions

Insufficient Protection of Healthcare Services

Despite existing international legal protections, healthcare facilities and medical personnel continue to be targeted or damaged in conflict zones. Weak enforcement of international humanitarian law and lack of accountability have limited the effectiveness of protections guaranteed under the Geneva Conventions. As a result, access to essential healthcare services is frequently disrupted.

Limited Gender-Sensitive Policy Design

Many health and humanitarian policies fail to fully highlight the specific needs of women and girls in conflict settings. Insufficient consideration of maternal health, reproductive services, and gender-based violence has led to gaps in care. The lack of gender-disaggregated data further limits the development of effective and inclusive health policies.

Inadequate Coordination in Humanitarian Responses

Humanitarian responses in conflict zones often suffer from poor coordination among international organizations, governments, and non-governmental actors. Overlapping responsibilities, information gaps, and delayed responses reduce the efficiency of health

interventions. This lack of coordination can result in unequal service delivery and limited access to care for vulnerable populations.

5.6. Case Studies and Lessons Learned

Conflict-Affected Regions and Healthcare Delivery

In many conflict-affected regions, healthcare delivery has been severely disrupted by prolonged violence and instability. In **Syria** and **Yemen**, widespread destruction of hospitals and shortages of medical supplies have significantly reduced access to basic and emergency healthcare. Attacks on healthcare facilities and personnel have further weakened already fragile health systems.

In regions such as **South Sudan** and **Afghanistan**, ongoing conflict and displacement have limited access to maternal and child healthcare, contributing to high rates of preventable disease and mortality. Similarly, in areas affected by recent conflicts, including **Ukraine** and **Gaza**, population displacement and damaged infrastructure have placed immense pressure on healthcare services, particularly in urban centers and refugee settings.

Successful Interventions and Best Practices

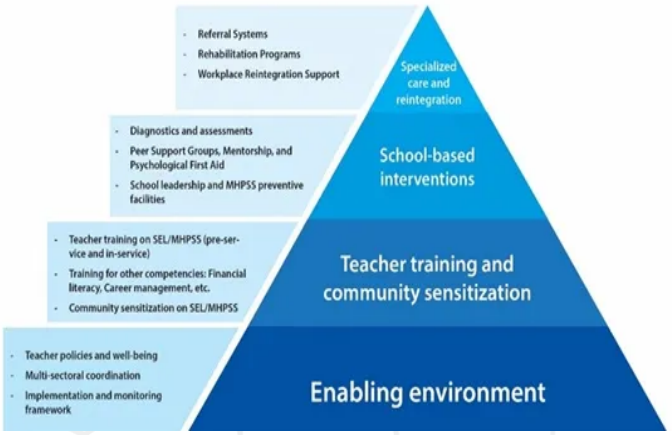
Despite the severe challenges faced in conflict settings, several international interventions have demonstrated that effective healthcare delivery is possible when responses are flexible, coordinated, and community-based. One of the most successful approaches has been the use of **mobile clinics and outreach health teams**, particularly in regions where hospitals have been destroyed or access is restricted due to insecurity. In countries such as **Syria, Yemen, and South Sudan**, mobile clinics supported by WHO, NGOs, and local partners have provided primary healthcare, maternal services, vaccinations, and treatment for chronic diseases to displaced and hard-to-reach populations.

Emergency vaccination campaigns have also proven to be highly effective in preventing disease outbreaks in conflict zones. WHO-led immunization efforts in **Afghanistan, Somalia, and polio-affected regions** have continued even during active conflict through negotiated access, temporary ceasefires, and cooperation with local actors. These campaigns have significantly reduced the spread of preventable diseases such as polio, measles, and cholera, even in unstable environments.

Another key best practice is the deployment and training of **community health workers**. In many conflict-affected areas, local health workers have played a vital role in maintaining basic healthcare services when international staff were unable to operate safely.

By providing first-line care, health education, and referrals, community health workers have helped ensure continuity of care and strengthened trust between healthcare systems and local populations.

Mental health and psychosocial support (MHPSS) programs have increasingly been integrated into emergency health responses, recognizing the long-term psychological impact of conflict. In refugee settings, including camps hosting populations displaced from conflicts in **Ukraine, Sudan, and the Middle East**, such programs have supported survivors of violence, trauma, and displacement, particularly women and children.



Finally, **coordination mechanisms**, such as WHO-led Health Clusters, have improved the effectiveness of humanitarian health responses by reducing duplication, sharing data, and aligning priorities among international organizations, governments, and NGOs. These best practices demonstrate that healthcare delivery in conflict settings is most effective when it combines emergency response with local engagement, protection of medical services, and long-term system strengthening.

Limitations and Transferability of Models

Although certain healthcare interventions have been successful in conflict settings, their implementation often faces serious limitations. **Security constraints** remain one of the most significant barriers. For example, in **Syria and Yemen**, ongoing airstrikes and active fighting have forced the suspension of mobile clinics and vaccination campaigns, limiting continuity of care despite initial success. Health workers are sometimes unable to reach populations due to road blockages, checkpoints, or direct attacks on medical facilities.

Transferability of models is also restricted by **contextual differences between conflicts**. Community health worker programs have been effective in **rural South Sudan**, where local engagement is strong and populations are dispersed, but similar models have faced challenges in **urban conflict settings such as Gaza or parts of Ukraine**, where high population density, infrastructure damage, and supply shortages complicate service delivery. This demonstrates that interventions must be adapted rather than directly replicated.

Political and legal barriers further limit the application of successful models. In some conflict zones, humanitarian organizations face restrictions imposed by state or non-state actors, limiting access to certain populations. For instance, cross-border health operations in **north-west Syria** have depended heavily on international authorization, making services vulnerable to political decisions rather than health needs.

Finally, **financial sustainability** poses a major challenge. Many interventions rely on short-term emergency funding, which can result in the collapse of health services once funding decreases. In prolonged crises such as **Afghanistan**, reductions in international funding have led to the closure of clinics and loss of healthcare staff, despite previously effective programs.

5.7. Possible Solutions and Policy Approaches

Improving healthcare access in conflict-affected settings requires coordinated, flexible, and inclusive policy responses at both the international and national levels. Strengthening the protection of healthcare services should remain a priority through improved monitoring of violations, stronger accountability mechanisms, and increased advocacy for respect of international humanitarian law.

Expanding **mobile and community-based healthcare services** can help reach displaced and hard-to-access populations, particularly in areas where fixed facilities are damaged or unsafe. Supporting and training **local healthcare workers** enhances continuity of care and reduces reliance on international staff in insecure environments.

Policies should also prioritize **gender-sensitive healthcare approaches**, ensuring access to maternal and reproductive health services, mental health support, and care for survivors of gender-based violence. Collecting and using **gender-disaggregated data** can improve the design of inclusive health interventions.

Strengthening **coordination among international organizations, governments, and NGOs** through mechanisms such as the WHO Health Cluster can reduce duplication and improve efficiency. Finally, ensuring **sustainable and predictable funding** is essential to support long-term health system resilience in protracted conflict settings.

5.8. QTBA (Questions to be Addressed)

1. How does armed conflict disrupt healthcare systems and limit access to essential medical services?
2. Why are **women and girls** disproportionately affected by healthcare disruptions in conflict settings?
3. What role does **displacement and refugee status** play in restricting access to healthcare?
4. How do **gender-based barriers and gender-based violence** affect access to healthcare during conflicts?
5. What roles do international organizations such as **WHO, UNRWA, UNICEF, and UNHCR** play in delivering healthcare in conflict settings?
6. How have NGOs such as **Médecins Sans Frontières (MSF)** and the **International Committee of the Red Cross (ICRC)** contributed to healthcare access in active conflict zones?

7. Which **healthcare interventions and best practices** have proven most effective in conflict-affected regions?
8. What **policy approaches and solutions** can improve the protection, coordination, and long-term sustainability of healthcare services in conflict settings?

6. Further Readings & Bibliography

Abdi, Y. H., Abdi, M. S., Bashir, S. G., Ahmed, N. I., & Abdullahi, Y. B. (2025). Understanding global health inequality and inequity: Causes, consequences, and the path toward justice in healthcare. *Public Health Challenges, 4*(4), e70156. https://doi.org/10.1002/puh2.70156

Brown, A. E., et al. (2023). Eliminating health care inequities through strengthening access to care. *Health Services Research*. https://pmc.ncbi.nlm.nih.gov/articles/PMC10684044/ [1]

Coombs, N. C., Campbell, D. G., & Caringi, J. (2022). A qualitative study of rural healthcare providers' views of social, cultural, and programmatic barriers to healthcare access. *BMC Health Services Research, 22*, 438. https://doi.org/10.1186/s12913-022-07829-2

DeVoe, J. E., Baez, A., Angier, H., Krois, L., Edlund, C., & Carney, P. A. (2007). Insurance + access ≠ health care: Typology of barriers to health care access for low-income families. *The Annals of Family Medicine, 5*(6), 511–518. https://doi.org/10.1370/afm.748

Elrha. (n.d.). *Comparing primary health care delivery models in conflict affected settings of Cameroon and Nigeria*. https://www.elrha.org/projects/phc-delivery-models-cameroon-nigeria

Evans, T., et al. (2020). Primary health care, the Declaration of Astana and COVID-19. *Bulletin of the World Health Organization, 98*(11), 801–808. https://doi.org/10.2471/BLT.20.252932

Gulati, I., Kilian, C., Buckley, C., Mulia, N., & Probst, C. (2025). Socioeconomic disparities in healthcare access and implications for all-cause mortality among US adults: A 2000-2019 record linkage study. *American Journal of Epidemiology, 194*(2), 432–440. https://doi.org/10.1093/aje/kwae202

Im, H., & Tefera, A. (2025). Discrimination and intersecting inequities to healthcare access among refugee newcomers in the United States. *Archives of Public Health*.

Kamaruddin, K. (2025, September 11). Improving healthcare for marginalised communities: A call from GPs for business involvement. *BJGP Life*. https://bjgplife.com/improving-healthcare-for-marginalised-communities-a-call-from-gps-for-business-involvement/ [2]

Mesmar, A., Limungi, G. M., Elmadani, M., Simon, K., Hamad, O., Tóth, L., Horvath, E., & Mate, O. (2025). Bridging healthcare disparities: A systematic review of healthcare access for disabled individuals in rural and urban areas. *Frontiers in Health Services*.

Nobody Left Outside. (2019). *Access to healthcare for underserved people in Europe*. European Commission. https://health.ec.europa.eu/document/download/27524979-2c47-44dd-b916-14e56601b955_en [3]

Onvlee, O., Kok, M., Buchan, J., Dieleman, M., Hamza, M., & Herbst, C. (2023). Human resources for health in conflict affected settings: A scoping review of primary peer reviewed publications 2016–2022. *International Journal of Health Policy and Management, 12*, 7306. https://doi.org/10.34172/ijhpm.2023.7306

Physicians for Human Rights. (2025, May 19). *Attacks on health care in war zones at all-time high in 2024: Safeguarding Health in Conflict Coalition (SHCC)*. https://phr.org/news/attacks-on-health-care-in-war-zones-at-all-time-high-in-2024-safeguarding-health-in-conflict-coalition-shcc/

United Nations Educational, Scientific and Cultural Organization. (1992). *Declaration of Alma Ata on promoting independent and pluralistic Asian media*.

World Health Organization. (1978). *Declaration of Alma-Ata*. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. https://www.who.int/publications/i/item/9241800011 [4]

World Health Organization. (1978). *Report of the international conference on primary health care, Alma-Ata, USSR, 6-12 September 1978*. https://www.who.int/publications/i/item/9241800011 [4]

World Health Organization. (n.d.). *Frequently asked questions*. OpenWHO. Retrieved from https://openwho.org/faq [4]

World Health Organization. (n.d.). *Health inequality monitor*. https://www.who.int/data/inequality-monitor [5]

World Health Organization & United Nations Children's Fund. (2018). *Declaration of Astana: Global conference on primary health care*. https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.61 [6]