Surrey Model United Nations 2019

World Health Organization

BACKGROUND GUIDE

Director's Letter

Dear Delegates,

My name is Emily Ni, and it is my utmost pleasure to welcome you to the World Health Organization at SurreyMUN 2019.

Ever since my first experience three years ago in a General Assembly, I've been enamoured with the passionate discourse found uniquely within Model United Nations. I can say with absolute conviction that the people you meet, the topics in which you gain immense amounts of knowledge, and the skills that you develop as a collaborator, public speaker, and delegate, are invaluable to you. Now going into my third year entrenched in MUN and having made the transition from delegate to director, I truly believe that the transformative nature of MUN has shaped me as an individual. Not only have I learned more about the current state of global affairs, but I've also learned how to collaborate with complete strangers, function during the ungodly hours of midnight crises, and memorized the arbitrary punctuation in working papers. Over the years, I've developed a fondness and penchant for MUN, and I can only hope to instill the same passion in you, the delegate, as my directors did for me.

Representing the rest of the dais team, Jonathan Song will be serving as your chair and Patrick Kim as your Assistant Director. A grade 12 student at Vancouver College, Jonathan is looking forward to creative ideas from delegates to solve the urgent issues facing the world today. Patrick is currently a grade 11 student attending Fraser Heights Secondary School and is equally as excited for the intense debate that the delegates of WHO will bring forth!

SurreyMUN prides itself on its high level of discourse, educational discourse, as well its professionalism. In the World Health Organization, delegates should come prepared with a comprehensive understanding of their committee's mandate, the topic at hand, and their country's foreign policy. Make use of resources available to you, including the additional sources included in this backgrounder. This topic truly requires thorough research and knowledge to allow for constructive debate; your work as a delegate will not only benefit yourself, but the committee as a whole.

The entire dais team welcomes you to the World Health Organization for SurreyMUN 2019. Please do not hesitate to contact us if you have any questions or concerns; we look forward to a weekend of rewarding debate.

Sincerely,
Emily Ni
WHO Director - SurreyMUN 2019

Committee Description

The World Health Organization's constitution was ratified on April 7, 1948.[1]Shortly after World War II, the United Nations undertook the task of reestablishing an international health organization from the previous Health Organization operating under the League of Nations. Due to the scope and scale of the issues that WHO combats, the committee's mandate is to provide and promote the "*the highest possible level of health*" internationally.[2] The World Health Organization plays an integral role in preserving global health through their leadership priorities:

1. Assisting countries that seek progress toward universal health coverage
2. Helping countries establish their capacity to adhere to International Health Regulations
3. Increasing access to essential and high-quality medical products
4. Addressing the role of social, economic, and environmental factors in public health
5. Coordinating responses to noncommunicable disease
6. Promoting public health and well-being in keeping with the Sustainable Development Goals, set forth by the UN.[3]

From developing programs for smallpox eradication in 1958, to creating the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) for family planning in 1970, to the establishment of the UNAIDS joint UN programme to combat HIV/AIDS, the scope of the World Health Organization has combated pertinent international health issues.[4] Through the numerous conflicts plaguing citizens all around the world, healthcare systems and resources have suffered greatly during times of crisis. The issue of rebuilding health systems in areas of conflict has once again come to light, and it falls on the delegates of the committee to find a comprehensive resolution that will ensure the preservation of international health in areas of conflict.

Topic Overview

Currently, the reconstruction of damaged health systems after conflict is often mishandled, and previously weak systems face major challenges in achieving full functionality and stability after ruinous crises. With worldwide disputes and the globe in a state of constant conflict, health systems in these affected areas often go unnoticed and neglected. Lack of proper rehabilitation of the aforementioned systems only exacerbates the repercussions of conditions that arise from armed conflict. A critical lack of medicine and personnel and

[1] https://www.thelancet.com/pdfs/journals/lancet/PIIS014067360211244X.pdf
[2] https://www.britannica.com/topic/World-Health-Organization
[3] http://www.who.int/about/resources_planning/WHO_GPW12_leadership_priorities.pdf
[4] Ibid.

crumbling infrastructure makes rebuilding these systems no easy task. Efforts to rebuild must take into consideration the various immediate needs of civilians in these areas (e.g: medical services that are easy to access, medical attention to address injuries from conflict, medicine to treat preventable diseases), as well as the broader perspective of long-term rehabilitation to prevent the further deterioration of health systems during these crises. Nations can no longer afford to treat citizens without external intervention, which is even then insufficient to support the millions of individuals affected by conflict. A multitude of conflict factors prevent these countries from rebuilding their devastated health systems properly, leading to a healthcare system that risks millions of lives. When citizens are unable to access hospitals and medicine because of fear of safety, and when hospitals are being directly targeted during battle, this compromises the safety and integrity of an entire region's healthcare system. The constant warfare and subsequently perilously unstable conditions in these nations constantly endanger citizens, and the restricted movement of goods endangers the supply of medicine and aid. Through the lack of proper infrastructure damaged by military conflict, nations undergo an arduous process of rebuilding that neglects the short term care of the injured, as well as invest funds they lack have into a long term plan that restores their systems. In an age of widening inequality and constant conflict, the rehabilitation of health systems in areas of conflict must be of utmost priority.

Timeline

October 7, 2001 - Operation Enduring Freedom enters into force, marking the start of the US invasion of Afghanistan. The official start of the "War on Terror" plunges Afghanistan into nearly two decades of ongoing war and destruction.

2005 - Creation of the Global Health Cluster to clarify partnership roles and create a centralized response to health crises. Sponsored by WHO, the Cluster is guided by its Secretariat and serves as a platform for partnership wherein organizations can offer aid under one unified Cluster.

March 15, 2011 - The start of the Syrian Civil War, which goes on to claim an estimated 500,000 lives.

June 2012 - A tribal Taliban commander blocks polio vaccinations for 161,000 children in Pakistan.

December 18, 2012 - At least 6 health workers working on a polio vaccination campaign have been murdered; WHO and UNICEF release a joint statement condemning the targeted attacks on health workers.

December 15, 2013 - The South Sudanese Civil War breaks out, weakening an already fragile health system; the war soon develops into a full blown humanitarian crisis.

March 2014 - The War on Donbass starts in Ukraine, ignited by opposing pro-Russia and pro-NATO forces.

March 2015 - A Saudi-led coalition forms a blockade around Yemen by positioning Saudi warships in Yemeni waters. This results in what the UN speculates to be the deadliest famine in decades.

June 2015 - Operation Northern Push is implemented by the Sierra Leonean government to eliminate Ebola. The operation was designed to target the last remaining pockets of Ebola by increasing surveillance, disease tracking, and improving quarantine quality.

November 2017 - South Sudan experiences 2.3 million cases of malaria within a one year period.

Historical Analysis

Case Study: Rebuilding in Afghanistan

The rehabilitation of the Afghan healthcare system is a prime example of the struggles that post-conflict states face in rebuilding a functional medical system. After 16 years of devastating conflict, over 770 local hospitals have closed, a third of Afghan citizens malnourished, and diarrhea causing over 9,500 child deaths.[5][6] Exacerbated by a volatile government, ongoing violence, and insufficient funds, the rebuilding of its health system has fallen to the hands of various NGOs, the American government, and the Afghan government.

After a 10 year war with the Soviet Union, incentive from Western nations to provide support decreased, and the system adopted by the Taliban remained ineffective and poorly organized. Following the deposition of the Taliban in 2001 due to US intervention, the healthcare system fell mainly to the responsibilities of NGOs. There are several notable deficits in the current healthcare system that have contributed to the discord seen in the status quo. Firstly, there is an enormous lack of infrastructure to support the needs of Afghan citizens. Poor roads and lack of vehicles result in little to no accessibility to medical services (e.g doctors, medicine, surgery), but the larger problem lies in the lack of infrastructure that offer these services. Simply put, poorly funded and overcrowded hospitals offer few doctors and insufficient medicine. In 2002, there was an average of four hospital beds for every 10,000 people. Especially in rural parts of Afghanistan, deficits in infrastructure result in no way to access

[5] https://www.redcross.org.uk/about-us/what-we-do/international/afghanistan
[6] https://reliefweb.int/report/afghanistan/9500-children-dying-diarrhoea-each-year-afghanistan-unicef

these crucial - yet underfunded - services. Moreover, the lack of trained personnel to staff these hospitals is another key aspect that exacerbates Afghanistan's continued instability. The ratio of doctors, nurses, and midwives to citizens is 7.26 to 10,000. Dependency on NGOs and external actors to provide sufficient support has become increasingly worrying. Due to internal instability within conflicting nations like Afghanistan, citizens have turned largely to relying on foreign aid to receive the treatment they need. Since the government is unable to properly address its healthcare, the system has been neglected and health has fallen to foreign actors and NGOs like the Red Cross and Medecins Sans Frontieres.

This is not to say that there has been no progress made; in fact, the systems implemented have improved healthcare significantly. The Afghan National Security Forces (ANSF) provide a limited amount of healthcare, however, external intervention is necessary to maintain stability. In 2008, 82% of citizens' health care was provided by NGOs working with the Afghan government. Nonetheless, much improvement was made in terms of accessibility. The amount of people able to access a health facility within an hour's walk rose from 9% in 2002 to 57 percent in 2008. Afghanistan still lacks a centralized infrastructure system to support the healthcare system, and numerous NGOs are partnering with the government to streamline organization, improve access to medicine and trained staff, as well as treat noncommunicable diseases. Although progress has been made, much remains to be done in terms of rehabilitating the system to full functionality.

Current Situation

Conflict in Syria

Seven grueling years of conflict in Syria have taken a devastating toll on its health systems. Attacks directed specifically on the health sector in the first two months of 2018 - on facilities, workers, and infrastructure - have amounted to more than half of all attacks in 2017. [7] This high volume of targeted attacks are a huge issue in rebuilding the health sector, as directed attacks on the Syrian medical system prevent any permanent rebuilding or infrastructure construction. Over ½ of all public hospitals and healthcare facilities are completely shut down or only partially operational. Furthermore, in East Ghouta specifically, over a thousand citizens are in need of immediate medical evacuation with over 400,000 having lived under siege for more than 5 years. The little operational infrastructure still standing is often too far away to access, and too dangerous to consider accessing due to the aforementioned targeted attacks and constant conflict. Essential supplies rarely reach Syrian citizens, and in March of 2018, more than 70% of all supplies bound of East Ghouta were sent back to WHO.[8] Much like the situation in Afghanistan, citizens face a lack of workers, facilities, medicine, and infrastructure. The combination of lack of infrastructure and lack of services and goods leads to a disastrous cycle of destruction on its healthcare system. There is

[7] http://www.who.int/mediacentre/news/releases/2018/seven-years-syria/en/
[8] Ibid.

little to no postpartum and paediatric care, excess mortality due to noncommunicable diseases, major outbreaks of food and waterborne diseases, outbreaks of illnesses preventable with vaccines, as well as an abundance of devastating psychological trauma and mental illness.[9] Direct impacts from weapons used in war also negatively impact health in Syria: major chemical attacks result in wide scale death, contaminated food, water, and life threatening irritants threaten the lives of all exposed to these nerve agents.[10] At the end of the day, Syrian hospitals simply lack the equipment and staff to deal with the multitude of injuries and massive amounts of injured citizens, and it seems like there is no end in sight.

Fortunately, recent developments and aid in the form of services, medicine, and monetary assistance have paved the pathway to ameliorating the situation. WHO has played a large role in the rehabilitation efforts, and has seen significant success as a result. In 2017, the organization successfully delivered over 3.6 million treatments to citizens, supported over 340,000 trauma cases, vaccinated 2.4 million children against polio, vaccinated another 1.7 million children against measles, and trained roughly 6300 health care personnel.[11] In the present day, the Self-Help Plus (SH+) and Psychological First Aid (PFA) programs implemented by WHO provide help for individuals coping with the mental strain from prolonged trauma and conflict. Training workers for the healthcare system is no easy feat, but online courses and connecting Turkish doctors with Syrian health workers has alleviated a small part of the issue. Outside of WHO and UN intervention, local and sovereign national efforts have also provided aid to those in need. Under the Free Syrian Army and Free Latakia health department, the fully functional Sahel hospital started operations in January 2017. The newly-emerged hospital are equipped by Medecins Sans Frontières, and the serves as a prime example of the good that can come out of NGOs and local cooperation. Syria is still embroiled in destructive conflict, but the steps taken to rebuild its health system have proven successful thus far.

Conflict in South Sudan

Faced with a prolonged conflict that has exacerbated the degradation of an already weak health system, South Sudan must overcome many challenges while rehabilitating its system. Similarly to other states in conflict, the destruction of crucial medical equipment and infrastructure, lack of medical staff, medicine, and constant outbreaks of communicable diseases pose a serious threat to the general population in South Sudan. In this conflict specifically, diseases like malaria and diarrhea require additional support to address. Unique in its instability and poverty, South Sudan is in dire need of overwhelming support to rehabilitate its health system.

[9] https://www.researchgate.net/publication/245030458_Health_care_in_Syria_before_and_during_the_crisis
[10] https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-018-0150-4
[11] http://www.who.int/hac/crises/syr/syria_donor-update-Q2-2017.pdf?ua=1

Supported by 67 partners in its "Health Cluster", South Sudan receives ample humanitarian aid from sovereign nations and NGOs alike.[12] With 4.4 million South Sudanese citizens in need of medical attention, the Health Cluster strives to provide basic medical care to at least 2.5 million citizens. However, a serious lack of funding limits the aid partners are able to provide with the Cluster. Less than 27.5 million of the 110 million USD needed to fund the Health Cluster program in South Sudan has been received by its partners, including WHO.[13] The estimation of the doctor to patient ratio is an alarming one doctor for every 65,000 people.[14] Furthermore, WHO has launched a vaccination campaign that has seen much success, vaccinating just under 2 million children against measles in 2018.[15] The lack of proper funding is once again highlighted in the disparity between the requested budget and the actual funding of the Humanitarian Response Plan assembled by WHO. Again, only 5.3 million of the requested 16.9 million was provided in 2018, and the need for sufficient funding is sadly evident.

UN Involvement

The importance of rehabilitating health systems after a major conflict was not clear until recently, when research displayed that poorly maintained and damaged healthcare infrastructures negatively impacted recovery, as was the case in Iraq. As such, no resolutions directly dealing with this issue have yet been passed. There has been a clear lack of discussion in the UN surrounding support for rehabilitation. However, current resolutions and efforts do exist to both rebuild infrastructure and support health initiatives. Delegates should focus on creating a solution that combines both of these activities into one comprehensive package that is conducive to WHO's new priorities.

WHO EMRO Afghanistan Polio Eradication Initiative

As one of only three countries where polio is endemic, Afghanistan is a large focus area for the World Health Organization. Ravaged by decades of war, religious radicalization, and general destabilization, the country has little in the way of health infrastructure and even less to eradicate a major disease. As a result of this, WHO has set up an initiative specifically for this purpose in the country, uniquely designed for the impaired nature of its systems. Strategies such as the training of personnel with experience in conflict areas, mandatory immunizations to combat, and training of local staff are of great importance in a program designed to deal with a disease like polio.

[12] http://www.who.int/hac/crises/ssd/features/photo_story_ssd/en/
[13] Ibid.
[14] Ibid.
[15] https://afro.who.int/sites/default/files/2018-07/South%20Sudan%20Situation%20Report%20Issue%20%23%2025_8-15%20July%202018%20.pdf?ua=1

United Nations Mission in Sierra Leone

Although the issues facing Sierra Leonean healthcare may seem daunting, Sierra Leone is a great example of an intersection between infrastructure rebuilding efforts and health initiatives. In a Security Council report in 2012, UN action was identified as one of the reasons behind recent reforms and reconstruction in the health sector. While still recovering from a devastating 11 year civil war lasting from 1991-2002, the West African country was hit with a deadly ebola epidemic in 2014. Pre-existing systems in place in the country after the 2007 elections ensured the continuation of democracy. Consequently, the UN was exceptionally poised to ameliorate the situation. In response to the outbreak, Operation Northern Push was initiated by the government of Sierra Leone and WHO, deploying 23 experts for critical response and over 100 staff to secluded northern regions. As a result of these combined efforts, the country was declared ebola free by 2016.

Possible Solutions

The process of rehabilitation is a complex one that requires a systematic, multifaceted approach to resolve the many convoluted issues surrounding rebuilding health systems in areas of conflict. Therefore, the solutions listed below should be used in tandem with one another to resolve the issue comprehensively.

Assessments

Although relatively simple, the need for a development process that examines and assesses systems of nations in post-conflict is large, and is necessary to provide a holistic view of the health sector and its required work. Without an accurate assessment of the improvements necessary to rehabilitate healthcare systems, the essential steps to address the unique situation in each country would be lacking. A multilateral, transnational approach during post-conflict needs assessments (PCNAs) would achieve the best result, as cooperation between NGOs, the governments of the countries in post-conflict, as well as the UN will provide the most comprehensive account of the issues at hand. It is only with a detailed picture of the work to be done that organizations can start to conceptualize, construct, and finance strategies for rehabilitation. A subset of assessments, electronic data collection with a centralized, supranational organization would streamline the organization targeted responses. Without an unbiased assessment, it is nearly impossible to construct an appropriate strategy to rebuild health systems.

Training and Providing Workers

The mass exodus of qualified workers and doctors in areas of conflict has compromised the care of millions of citizens all over the world. The solution to the massive amounts of health personnel lost must be twofold. Firstly, an external supply of health workers from organizations like WHO or Médecins Sans Frontières will fill the gap of skilled workers, as well as providing training for interim workers. Moreover, more long term solutions are less viable and certainly less probable to succeed, but they are direly needed to provide long term

stability. Incentives for workers from the country of conflict to return may be highly useful in principle, but in practice may endanger the lives of these crucial workers. By running the risk of exposing them to the perilous conditions of a nation in conflict (intuitively, individuals want to avoid dangerous conflicts, but they will also be put in danger due to targeted attacks), they will not be likely to return. Delegations must consider the risk and reward of mitigating the effects of "brain drain" during crises, and the benefits workers native to the country of conflict bring to the health system in question.

Foreign Intervention

Oftentimes, external intervention is necessary to stabilize health systems and help rehabilitate them. Direct medical aid in the form of delivering equipment, medicine and much-needed workers to areas in conflict will help alleviate the lack of critical services needed to save lives. Nevertheless, these services are finite, and sending medical staff will often mean directly risking their lives in post-conflict zones. Foreign intervention can come through two channels of supply: support on the national level and through NGOs. Often, external intervention provides crucial funding for the equipment and services needed to rebuild health systems after conflict. Partnerships with NGOs also prove to be extremely beneficial due to the supranational nature of most organizations, and yield consistent, positive results with their aid.

Infrastructure

Essential to any functioning health system is secure infrastructure. Without hospitals, wells to provide clean water, or even roads to access these hospitals, it seems almost impossible to achieve long term change. The establishment of a solid structural foundation that supports the services necessary to aid citizens is crucial in order for stability to be sustained. However, in post-conflict states, a rapid, centralized response to demand for infrastructure is often lacking. Furthermore, establishing new infrastructure systems are quite costly, especially for governments fresh out of conflict. Unfortunately, buildings and systems can only be constructed safely on a mass scale when the state's conflict has been resolved and there is relative stability. Therefore, the stability of the state, as well as its ability to construct hospitals on a large scale, must be taken into consideration.

Bloc Positions

Western Liberal Democracies

Generally, Western Liberal Democracies (WLDs) are perceived to be the most stable nations in the world. Due to their wealth and lack of conflict, the role that most WLDs fulfill in rehabilitating health systems is as a benefactor. WLDs are able to supply equipment, funding, and personnel to countries in conflict at an unparalleled rate and scale. Canada, the United States, and countries in the European Union should seek to aid where possible, while maintaining foreign policy and personal interests. Because of the stable nature of WLDs, they

generally do not experience first hand the devastating nature of war and conflict. Taking on an observer role, they have the upper hand in terms of funding, humanitarian aid, and external intervention. These countries must be careful not to wield power and aid over nations in conflict, and must consider their actions carefully. However, these delegations must be careful to not infringe upon conflicting nations' sovereignty. Although aid and funding must be provided, countries should seek to strike a fine balance between providing aid, and unnecessarily intervening in conflict.

Countries in Conflict

Although many countries are currently suffering from devastating conflict, several notable delegations stand out in terms of the severity of damage sustained from conflicts. These are by no means the only countries suffering from instability and damaged health systems; the issues facing rebuilding in areas of conflict are relatively homogenous and exacerbated by similar factors. While frameworks, partnerships, and solutions implemented vary from region to region, they still generally follow the same structure and principles.

Afghanistan

The prolonged war in Afghanistan has drained the country of its resources, workers, funds, and supplies. With an overworked healthcare system, the country is still struggling to recover despite years of attempted rebuilding, Afghanistan is in a long, arduous process of rebuilding its health system to full functionality. Because of the instability caused over decades of fighting, its health system is subject to constant volatility. A lack of medical workers only exacerbates the issue, but the lack of care for women and children is dangerously prominent. Under the social influence of the Taliban in a conservative country, women's health has suffered greatly from the lack of freedom women experience in Afghanistan. Mental health services are practically non-existent, as are female medical facilities.[16] In fact, 17 in every 1,000 mothers die in childbirth. While pursuing options for rebuilding, consider the social impacts of constructing a conservative system similar to the status quo, or risking massive backlash and more instability by providing more access to these desperately needed services.

Yemen

With less than 45% of all hospitals functioning, nearly a million people affected by a cholera outbreak, and more than 80% of all Yemeni citizens lacking access to basic healthcare, the crisis in Yemen has reached staggering heights.[17] Dubbed by WHO as a health system "*close to collapse*", Yemen is struggling to combat treatable communicable diseases like cholera and diptheria.[18][19] Furthermore, a blockade imposed on humanitarian aid and essential goods through all Yemeni ports - enacted by a Saudi-led coalition in November 2017 - has devastated civilians even further. The control over foreign intervention is directly affecting

[16] http://www.pbs.org/pov/afghanistanyear1380/afghanistans-health-crisis/
[17] https://www.icrc.org/en/where-we-work/middle-east/yemen/health-crisis-yemen
[18] http://www.who.int/bulletin/volumes/93/10/15-021015/en/
[19] http://www.doctorswithoutborders.ca/country/yemen-conflict-and-shattered-health-system

citizens, and intervening bodies must find a way to circumvent the restrictions put in place to alleviate the full-blown humanitarian disaster erupting in Yemen.

Ukraine

Relatively unknown and majorly forgotten, the Donbass war in Eastern Ukraine has resulted in the damage of ⅓ of all medical facilities in the Donbass region.[20] Even though the facilities were not directly targeted, critical infrastructure has been damaged as a result of the constant conflict in Eastern Ukraine. At the heart of a major ideological conflict between Russia and the West, intervention from WLDs will prove to be difficult while not angering their Eastern counterpart: Russia. This lends another level of difficulty to intervention that requires tactful negotiation on both sides; however, the intervening countries must work fast to ensure that Ukrainian citizens receive the aid they need.

South Sudan

Communicable diseases are a major issue facing the stability of South Sudan's health system. Malaria, cholera, and measles are all major threats that are easily preventable and curable with the right treatments. South Sudan's biggest priorities lie in securing medicine and medical personnel to aid with injuries sustained through their civil war. Brain drain (a mass exodus of skilled workers leaving their country) due to the constant threat of conflict has resulted in a shockingly understaffed health system. Even with infrastructure, the lack of medicine to address the abundance of preventable communicable diseases is a large concern.

[20] https://www.washingtonpost.com/news/monkey-cage/wp/2018/04/09/the-war-in-ukraine-is-more-devastating-than-you-know/?utm_term=.9daa87064717

Guiding Questions

1. What are the main issues facing health systems after a period of conflict?
2. Has your country been impacted by recent conflict? How has its health system fared? What about neighbouring and geographically close countries?
3. How can resources already deployed in conflict areas be converted to facilitate the rebuilding of health infrastructure?
4. What countries should be prioritized for rehabilitation? Should every country get rehabilitation, even those with abusive governments?
5. What counts as rebuilding? Should the goal be to return damaged systems to prior operational ability or should improvement also be an aim?
6. What can be done to decrease dependence on foreign personnel, expertise, and supply after rehabilitation is deemed to be adequate?
7. Should the rebuilding of health systems be differentiated from other infrastructure reconstruction initiatives after conflict?
8. Should some systems be rebuilt from the ground up? What makes a system unsalvageable?
9. How can religious resistance against modern medical ideals such as vaccination be quelled in areas where radicalization was an issue during conflict?
10. How can countries with rebuilt systems prevent damage from being done again?

Further Readings

Leaving no one behind: lessons on rebuilding health systems in conflict- and crisis-affected states - https://gh.bmj.com/content/2/2/e000327

WHO - Afghanistan Country Profile - http://www.emro.who.int/afg/programmes/health-system-strengthening.html

Health Clusters - http://www.who.int/health-cluster/about/cluster-system/en/

WHO - South Sudan Crisis - http://www.who.int/emergencies/crises/ssd/en/

WHO - Yemen Crisis - http://www.who.int/emergencies/crises/yem/en/

USAID - Rebuilding Health Systems and Providing Health Services in Fragile States - https://www.msh.org/sites/msh.org/files/rebuilding-health-systems-and-providing-health-services-in-fragile-states.pdf

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