GRUNNMUN 2021

THE EUROPEAN INTERNATIONAL MODEL UNITED NATIONS
TEIMUN

WORLD HEALTH ORGANISATION

HEALTH IN AREAS OF CONFLICT

Welcome Letter

Dear Delegates,

Welcome to GrunnMUN 2021! We are happy you chose the World Health Organisation (WHO). We believe that the WHO can play a key role in addressing current problems faced by the international community. We are going to focus on a field in which the WHO leads the global discussion: health concerns in conflict areas. Conflict areas such as Yemen are struggling to successfully address health issues and diseases as they are already dealing with many other crucial issues. Political tensions, security dilemmas, and socio-cultural issues hinder the activities of local health services, foreign donors, and international health organizations including and especially the WHO – keeping them from operating life-saving facilities and performing disease eradication campaigns. Thus, it needs to be addressed how the WHO response to health crises in conflict areas can be improved, which approaches the WHO needs to prioritize in order to safeguard the delivery of healthcare services during conflicts and how any future interventions by the WHO to provide health services in conflict areas can be financed. As a part of our discussions, we hope that you can tackle some of those underlying challenges and come up with solutions through fruitful debate. We hope that, despite the current circumstances, you will have a great time in our council. We are looking forward to meeting you and hearing about the resolutions you come up with!

Best regards,
Adinda, Arkana and Helena

Introduction

The World Health Organization, also known as the WHO, is a specialized agency of the United Nations and is devoted to universal healthcare across the globe. WHO was established on April 7, 1948 with 61 countries having signed its constitution in 1946. Currently, it is headquartered in Geneva, Switzerland and operates through offices in over 150 countries.[1] In regards to its workload, the WHO monitors the world health situation and related trends. It produces the annual World Health Report to support international efforts to coordinate research by optimizing collaboration and information exchange.[2] WHO works alongside governments and other partners to strive for the best attainable health for all people. It also sets and promotes health norms and standards to be implemented by countries around the world. The council has its own decision making body known as the World Health Assembly (WHA) which is attended by delegations from all WHO Member States and determines the policies of the organization. The budget on which the WHO operates is mainly supplied by its member states and partly by voluntary contributions that span two years.

WHO's role in conflict areas is crucial. The council has provided health and humanitarian assistance to countries that are experiencing war and humanitarian crises. WHO has coordinated international responses to help countries at war maintain access to healthcare services during conflicts. WHO bases its work on humanitarian principles and medical ethics. In its 51st World Health Assembly, WHO has recognized its role as a bridge for peace of the Health for All in the 21st Century Strategies, affirming that the role of health workers is essential to peace building.[3] However, as conflicts and challenges are becoming more dynamic over the years, the task of WHO to guarantee healthcare services in conflict areas will be more challenging than ever. Thus cooperation from all countries and related actors should greatly support WHO in completing its mission.

Problem Specification

Conflict is one of the world's top-ten leading causes of mortality, so naturally it is an area of interest for an organization seeking to promote health and well-being across the globe.[4] Here it is important to distinguish direct and indirect mortality. Direct mortality refers to the deaths caused by the conflict through injuries and overt violence. The WHO is more focused on combating indirect mortality. This includes everything from food insecurity caused by the fighting and displacement to the collapse of infrastructure that worsens access to maternal healthcare. There are many contributing factors to indirect mortality. Population movements often bring large numbers of people together in poor conditions, which can increase the rate of infectious diseases and malnutrition. The deterioration of the quality of the water supply

[1] Structure". 2021. World Health Organization. Accessed January 13. https://www.who.int/about/who-we-are/structure.
[2] "Research For Universal Health Coverage: World Health Report 2013". 2013. World Health Organization. https://www.who.int/publications/i/item/9789240690837.
[3] "Conflict And Health Working Paper". 2000. World Health Organization. https://www.who.int/hac/techguidance/hbp/Conflict.pdf.
[4] C.J. Murray and A.D. Lopez, "Mortality by cause for eight regions of the world: Global Burden of Disease Study," The Lancet 349 (1970): 1269-1276.

can also lead to endemic diseases flaring up, such as dysentery. Food insecurity is especially dangerous for children, who are prone to pneumonia. Particularly important for the WHO is the impact conflict has on health services. There is a significant risk, in many conflict situations, to the health and even lives of healthcare workers. The WHO is involved in assessing and mitigating such risks. Combat might also damage crucial health infrastructure. This in turn exacerbates the problems mentioned above, as well as increasing mortality from non-communicable diseases (NCDs) and maternal and infant mortality. A siege or embargo might also reduce food and medicine supplies. Finally, there are long-term consequences to the health of a population, even after the conflict has ended. Mental illness due to PTSD and chronic stress come to mind. The economic impact of a diminished young, employable population and the large-scale destruction of homes and infrastructure conspire to worsen health outcomes.[5]

The WHO is active in a number of these areas, collaborating with other UN agencies, such as the UNHCR, which sets up camps for Internally Displaced People (IDPs). It coordinates efforts to keep health systems running, for example through medical humanitarian organisations or emergency equipment. It also works to ensure safety for healthcare workers. Finally, it aims to strengthen early response plans for infectious diseases.[6]

To prevent the debate from remaining abstract, an example of the impact of conflict on health can be considered. A prominent recent example is the cholera outbreak in Yemen. Cholera is a waterborne infectious disease, and Yemen was at risk for such diseases even before the civil war. Access to clean water was insufficient and many children were malnourished, impacting their immune system.[7] The conflict worsened both problems. Water management systems were damaged by airstrikes.[8] Parallel to the cholera epidemic (2016-2020), Yemen suffered a famine, resulting from import restrictions employed by the Saudi coalition involved in the war and a collapsed economy.[9] The Yemeni government ceased to allocate any money for healthcare in 2016 and about 30,000 healthcare workers' salaries are going unpaid.[10] Furthermore, airstrikes have hit hospitals, despite clear indications to the warring parties of where these hospitals were located.[11] As will be further elaborated on in the QARMAs, the WHO has been actively involved in the response to the epidemic. To give an indication of scale, the WHO reported in 2018 that it had 414 facilities

[5] S. Garry and F. Checchi, "Armed conflict and public health: into the 21st century," Journal of Public Health 42, no. 3 (2019): 287-297, https://doi.org/10.1093/pubmed/fdz095.
[6] "What we do," World Health Organization, accessed January 16, 2020, https://www.who.int/about/what-we-do.
[7] Firdausi Qadri, Taufiqul Islam, and John D. Clemens, "Cholera in Yemen — An Old Foe Rearing Its Ugly Head," The New England Journal of Medicine 377 (November 2017): 2005-2007, https://doi.org/10.1056/NEJMp1712099.
[8] Ibid.
[9] Zeke Marshall, "Man-made hunger: The income famine of Yemen," Ecological Economics, May 7, 2019, https://discuss.leeds.ac.uk/2019/05/07/man-made-hunger-the-income-famine-of-yemen/.
[10] Anthony Lake and Margaret Chan, "Statement from UNICEF Executive Director Anthony Lake and WHO Director-General Margaret Chan on the cholera outbreak in Yemen as suspected cases exceed 200,000," UNICEF, June 24, 2017, https://www.unicef.org/press-releases/statement-unicef-executive-director-anthony-lake-and-who-director-general-margaret.
[11] "Yemen: Airstrike hits MSF cholera treatment center in Abs," Doctors Without Borders, June 12, 2018, https://www.doctorswithoutborders.org/what-we-do/news-stories/story/yemen-airstrike-hits-msf-cholera-treatment-center-abs.

using 406 teams active in 323 districts in Yemen, which included 36 treatment centers for cholera.[12]

Questions A Resolution Must Answer (QARMAS)

QARMA 1: How can the WHO response to health crises in conflict areas be improved? Specifically, should there be more emphasis on resolving the conflict as the root of the problem or on improving health care directly?

There is an intuitive problem with the WHO's response to health crises in conflict areas. It is largely based in meeting the needs of the population arising in the situation which they are in. For example in Yemen, it is not heavily involved in the process of negotiating a ceasefire. It is active in meeting some of the healthcare needs of the population. During the cholera outbreak in 2017, a response plan was set up. Herein, the emphasis was on keeping health systems running and preventing the spread of the virus.[13] The WHO is not a peacekeeping or peace brokering organisation at the moment. It is also not engaged in advocacy or peace campaigns (contrary to some NGOs involved in the cholera response).[14] It does what it can but within the parameters of a conflict it does not strive to solve. Such a division of labour has advantages and disadvantages.

Taking Yemen as an example, the disadvantages relate to the WHO and partners' ability to provide aid. The continuation of the conflict poses significant risks to the aid operations present there. These might be security-related, but at times partner NGOs are also simply refused access to an area by authorities. In northern Yemen, such problems have occurred especially often in the past few years. UN agencies have strategies of risk mitigation, whereby some problems can be resolved. However, these have their limits. When risk is insufficiently mitigated, it is weighed against the good an agency like the WHO or an NGO is capable of doing in an area. If in this analysis the costs outweigh the benefits, operations may be suspended (for example due to material costs or risks to aid workers). This can have serious consequences, such as a reduction in food distributions in a country where perhaps one of the greatest threats to health is famine.[15]

One concrete example of the limits out on an effective response by conflict is the cholera outbreak in Yemen. An effective measure to contain cholera outbreaks is mass vaccination with an existing, effective cholera vaccination. This tactic was employed to a highly limited degree in Yemen, in part due to the chaos the conflict has caused there, and the difficulty of coordinating such a major operation in this context. "Could the largest cholera outbreak ever recorded have been avoided or at least managed, had enough OCVs [Oral Cholera

[12] Frederik Federspiel and Mohammad Ali, "The cholera outbreak in Yemen: lessons learned and way forward," BCM Public Health 18, no. 1338 (2018): 1-8, https://doi.org/10.1186/s12889-018-6227-6.
[13] Federspiel and Ali, "Cholera outbreak in Yemen."
[14] Ibid.
[15] Humanitarian Country Team, Humanitarian Response Plan June - December 2020: Extension Yemen (United Nations Office for the Coordination of Humanitarian Affairs, June 2020).

Vaccinations] been deployed earlier on in the conflict? The solely theoretically based answer to this question is: Most likely, given the available evidence of the qualities of OCVs."[16]

When the WHO works in conflict areas to safeguard and build the capacity of health care systems, it essentially engages with humanitarian aid work. This brings along its own set of challenges. Particularly in the scholarly community, humanitarianism has come under fire for its political neutrality and the approach of only focusing on the bodily needs of the aid recipients. A lack of criticism towards the parties involved in the conflict causing the crisis can normalize the situation.[17] Sometimes, governments even use humanitarian operations to further nefarious plans.[18]

At the same time, the current controversy surrounding the WHO's treatment of Taiwan has shown that the moment the WHO ceases to be considered neutral, their medical work might be obstructed.[19] Political neutrality might safeguard the WHO's access to countries, crucial for some of its primary tasks: monitoring public health risks and coordinating responses to health emergencies.[20] Perhaps more importantly, any missteps in calls for peace, for example, could alienate the WHO from its donors, on which its operations depend to a large extent. Conversely, its dependence on the United States, which was more aligned with the Saudi coalition in the Yemen conflict, could discredit it as a neutral party in any ceasefire negotiations. Moreover, any political advocacy or even minimal involvement in peace efforts would stretch the WHO's mandate. This stretch is not unprecedented, though. The WHO has advocated for the end of the Israeli occupation of the West Bank and Gaza Strip for years by highlighting its disastrous effects on the health of the populations there.[21]

Apart from taking into account the level of political involvement of the WHO, other improvements can be suggested to the WHO's response to health emergencies in conflict areas. For example, the WHO supported Yemen's Ministry of Health in creating health surveillance systems to facilitate early detection of health risks. In the cholera epidemic, detection functioned well, yet the subsequent response (alerting health systems and taking action) did not match up with standards for timeliness.[22] Weak surveillance systems, lacking response plans, and knowledge gaps regarding the infection risks and containment measures of infectious diseases are generally problems in conflict areas that you might want to address.[23]

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[16] Federspiel and Ali, "Cholera outbreak in Yemen."
[17] David Keen, "'The camp' and 'the lesser evil': humanitarianism in Sri Lanka," Conflict, Security & Development 14, no. 1 (2013): 1-31, https://doi.org/10.1080/14678802.2013.856176.
[18] Eyal Weizman, The Least of All Possible Evils: Humanitarian Violence from Arendt to Gaza (London: Verso, 2011).
[19] Steven Menashi, "The Politics of the WHO," The New Atlantis, no. 3 (Fall 2003): 88-97. https://www.thenewatlantis.com/publications/the-politics-of-the-who.
[20] "What we do," World Health Organization.
[21] Menashi, "Politics of the WHO."
[22] Fekri Dureab, Osan Ismail, Olaf Müller, and Albrecht Jahn, "Cholera Outbreak in Yemen: Timeliness of Reporting and Response in the National Electronic Disease Early Warning System," Acta Informatica Medica 27, no. 2 (June 2019): 85-88, https://doi.org/10.5455/aim.2019.27.85-88.
[23] Evans Buliva, Mohamed Elhakim, Nhu Nguyen Tran Minh, Amgad Elkholy, Peter Mala, Abdinasir Abubakar, and Mamunur Rahman Malik, "Emerging and Reemerging Diseases in the World Health Organization (WHO) Eastern Mediterranean Region—Progress, Challenges, and WHO Initiatives," Frontiers in Public Health 5, no. 276 (2017): 1-5, https://doi.org/10.3389/fpubh.2017.00276.

Another general question you might want to take into consideration when fine-tuning the response to health emergencies in conflict areas is the division of labour between humanitarians, the WHO, and the national Ministry of Health. The WHO cooperates heavily with governments, yet in conflicts, this can turn problematic. A Ministry of Health might not have effective control over health services in all of the country, as some have been co-opted by rebel groups. Questions can also be raised about human rights norms. The WHO, striving to be politically neutral, works with all governments to improve health care systems.[24] Should it continue to do so, even when war crimes are committed by said governments? Or should it strengthen its ties with NGOs and humanitarians to bypass nefarious regimes?

QARMA 2: Seeing the complexity of the issue, what approaches does the WHO need to prioritize to safeguard the delivery of healthcare services during conflicts? And how can WHO increase states' compliance with International Humanitarian Law and other existing international treaties?

The challenges of maintaining healthcare services in conflict areas have been increasing since the early 2000s. With the outbreak of terrorism in 2001 following the September 11 attacks, violent related incidents tripled between 2000 and 2014.[25] The escalation of conflicts in the Middle East has contributed to the significant increase of conflict-related deaths.[26] It was reported that in 2014, over 54,000 people were killed due to extreme violence in the Syrian Arab Republic which so far has been the highest since 1989.[27]

Yemen has been suffering from the devastating effects of an ongoing civil war triggered by the Saudi-led intervention against the Houthi movement that began in late 2014. The country was exposed to Cholera in 2016, which infected more than 1,2 million people in the span of two years.[28] After seeing the fatality and speed of the outbreak in its early years, WHO has declared it to be the largest Cholera epidemic ever recorded.[29] The ongoing civil war has done nothing but worsen the situation. Public health authorities have been weakened, causing a lack of access to healthcare services for millions of people. Later on, the United Nations declared the situation in Yemen to be the worst humanitarian crisis in the world.[30]

The situation has only gotten worse in some countries. In recent years, targeted attacks on health facilities have occurred in countries that are undergoing conflict such as Syria, Iraq,

[24] Menashi, "Politics of the WHO."
[25] Bogatyreva, Ekaterina, and Andrea Sylvia Winkler. 2017. "Conference Report: Approaches To Protect And Maintain Health Care Services In Armed Conflict – Meeting Sdgs 3 And 16 - Institute Of Health And Society". Institute Of Health And Society. https://www.med.uio.no/helsam/english/research/centres/global-health/news-and-events/news/2017/approaches-to-protect-and-maintain-health-services.html.
[26] Jāhāna, Selima. Human development report 2016: human development for everyone. United Nations Publications, 2016.
[27] Bogatyreva, Ekaterina, Loc. Cit.
[28] Al-Mekhlafi, Hesham M. "Yemen in a time of cholera: current situation and challenges." The American journal of tropical medicine and hygiene 98, no. 6 (2018): 1558-1562.
[29] Ibid.
[30] "Humanitarian Crisis In Yemen Remains The Worst In The World, Warns UN". 2019. UN News. https://news.un.org/en/story/2019/02/1032811.

Yemen, and South Sudan.[31] According to the Surveillance System for Attacks on Health Care by the WHO, around 717 attacks on health workers were documented during 2018 and 233 during the first months of 2019 in just nine conflict areas.[32] Many healthcare facilities are destroyed by military attacks which have profound effects on the whole medical system as life-saving supply chains and medical equipment are being cut off. In the case of Yemen, military strikes to health facilities have reduced the capacity of local healthcare services to address the Cholera outbreak.[33] Hospital infrastructures and sanitation facilities have been severely damaged by military strikes. As a result, over fifty percent of health facilities are not functioning.[34] An estimated 14.8 million people are cut off from access to basic healthcare because of this.[35] Thus, the work of the WHO and healthcare providers is getting more complicated. Determining suitable approaches that can be implemented effectively during conflicts is already difficult, but there are also concerns about the safety of healthcare workers.

The increase of casualties and targeted attacks on health workers coincide with the declined respect for International Humanitarian Law (IHL) and other existing international laws. IHL condemns any attacks on medical facilities and its personnel and guarantees medical services to be in charge of emergency actions without the fear of being attacked.[36] It also drives the principle of medical neutrality, meaning that medical personnel should treat any injured person without regard to affiliations.[37] However, the recent attacks on medical workers have shown that many states have failed to honor the implementation of IHL. Aside from that, the United Nations Security Council (UNSC) has launched Resolution 2286 that addresses attacks against injured victims, humanitarian personnel, and medical facilities.[38] The resolution calls upon states to guarantee the protection of healthcare delivery during conflicts and fully comply with international law. Even though those instruments are legally binding, they only emphasize the state's moral obligations to comply, thus resulting in inadequate commitments towards their implementation. This declined respect has therefore emphasized the need to strengthen legal instruments and attach consequences to not following them.

Safeguarding healthcare delivery in times of conflicts involves numerous actors. As the nature of conflict itself is dynamic, the actors involved will also vary. National governments in this case act as the primary actor and they should be aware of their responsibilities to guarantee the implementation of IHL. Non-state actors, who vary from non-governmental

[31] Druce, P., Bogatyreva, E., Siem, F.F. et al. Approaches to protect and maintain health care services in armed conflict – meeting SDGs 3 and 16. Confl Health 13, 2 (2019). https://doi.org/10.1186/s13031-019-0186-0

[32] Dayoub, Rita. 2019. "Getting Serious About Protecting Health Care In Conflict". Chatham House – International Affairs Think Tank. https://www.chathamhouse.org/2019/05/getting-serious-about-protecting-health-care-conflict.

[33] Ibid.

[34] Dureab, Fekri Ali, Khalid Shibib, Reema Al-Yousufi, and Albrecht Jahn. "Yemen: cholera outbreak and the ongoing armed conflict." The Journal of Infection in Developing Countries 12, no. 05 (2018): 397-403.

[35] Ibid.

[36] Gasser, Hans-Peter. "International Humanitarian Law An Introduction." International Review of the Red Cross Archive 34, no. 298 (1994): 88-88.

[37] Ibid.

[38] UN Security Council. "Resolution 2286 (2016)." United Nations Security Council (2016).

organizations, humanitarian workers, activists, and civil society, may also be engaged in the conflict for different reasons but mostly for voicing their concerns regarding the situation. The help from the international community such as foreign donors shall not be forgotten as they help ensure the economic wellbeing of a country in conflict. Aside from that, other United Nations bodies outside WHO and intergovernmental organizations oftentimes provide humanitarian assistance to promote peaceful negotiations and manage the needs of vulnerable people such as refugees, children, and women. Considering the complexity of the issue and its actors, delegates should be able to take a look at the case holistically and consider which approaches the WHO needs to strengthen in the future in order to safeguard healthcare delivery in conflict areas.

QARMA 3: How can financial hardships faced by the WHO be successfully addressed to guarantee the availability of funding for any future interventions to provide health services in conflict areas? How, in line of what has been discussed previously, can the budget most effectively be distributed?

The WHO has two primary sources of funding: assessed contributions and voluntary contributions. Assessed contributions are states' membership dues and amount to a percentage of a state's Gross Domestic Product that has been agreed upon by the United Nations General Assembly. Every two years, Member States approve of the assessed contributions at the World Health Assembly. Assessed contributions are an important source of financing for the WHO as they facilitate a level of predictability, hinder dependence on a narrow donor base and permit resources to be aligned to the Programme Budget. However, the assessed contributions have accounted for less than 25% of the total budget for several years and continue to decline as an overall percentage of the program budget.[39]

A large percentage of the budget consists of voluntary contributions from Member States or other partners (e.g. other United Nations organizations, foundations, private donors). Over the most recent years, voluntary contributions funded more than 75% of the organisation's budget. The WHO has differing amounts of discretion on how to use the voluntary contributions. Core voluntary contributions are completely unconditional and flexible and permit the utilization of the funds for any programmatic work of the organization. Flexible funding arrangements are crucial for the achievement of WHO targets because they enable the WHO to act in an agile and strategic manner. Previously, flexible funding has made it possible for the WHO to improve gender equality and human rights in health (e.g. Nepal and Indonesia are currently utilizing tools provided by flexible funding). Furthermore, flexible funding has contributed to the improvement of states' health systems through the integration of people-centered services and the improvement of information and evidence-gathering, facilitating states such as Rwanda and the Solomon Islands to move closer towards Universal Health Coverage. Despite their importance, core voluntary contributions only account for 3.9% of all voluntary contributions.[40]

[39] "How WHO Is Funded". 2021. Who.Int. https://www.who.int/about/funding#:~:text=WHO%20gets%20its%20funding%20from,Member%20States%20and%20other%20partners.
[40] Ibid.

Through the biennial program budget, member states can determine targets and approve the priorities of the WHO. It consists of four segments: the base budget, special programmes, the Global Polio Eradication Initiative and the emergency operations and appeals. The base budget covers the efforts to meet the WHO's strategic priorities and the enabling functions of the organization. Special programs are efforts done with additional governance structures such as UNICEF. The aim of the emergency operations and appeals is to respond to emergencies and disasters with public health consequences. The current program budget is set up as following:[41]

Programme budget 2020-2021	Allocations US$ million
Universal health coverage	1 360
Country support	1 000
Emergency operations and appeals	1 000
Health emergencies	889
Polio eradication	863
Healthier populations	432
Special programmes	209
Total	**5 840**

In the case of Yemen, a conflict area, 96.27% of the funding is allocated to emergency operations and appeals.[42]

The WHO continuously experiences financial hardships.[43] Some of the main challenges the organisation faces can be traced back to the misalignment between program budgets and member states' financial commitments, the unpredictability and inflexibility of financing, a lack of transparency of financing and inefficient resource allocation and management.[44] Moreover, the WHO is vulnerable as 75% of the total program budget is financed by only around 20 contributors.[45] Overall, this has led to assertions that the financial resources of the WHO are insufficient for the organization to fulfill its mandate.[46] A comparison of the WHO budget to the healthcare and social services budget of individual states is a demonstration of the limited budget the WHO has to function on (e.g. the WHO budget for

[41] "Invest In WHO". 2021. Who.Int. https://www.who.int/about/accountability/budget.
[42] "WHO | Programme Budget Web Portal". 2021. Open.Who.Int. http://open.who.int/2020-21/country/YEM.
[43] Reddy, S., Mazhar, S. & Lencucha, R. The financial sustainability of the World Health Organization and the political economy of global health governance: a review of funding proposals. Global Health 14, 119 (2018). https://doi.org/10.1186/s12992-018-0436-8
[44] Ibid; WHO. Investing in the World's Health Organization Taking steps towards a fully-funded Programme Budget 2016–17. Geneva: WHO; 2015. http://www.who.int/about/finances-accountability/funding/financing-dialogue/Programme-Budget-2016-2017-Prospectus.pdf.
[45] Ibid.
[46] Reddy (n 43); Gostin LO. The future of the World Health Organization: lessons learned from Ebola. The Milbank Quarterly. 2015;93(3):475–9.

the biennium 2020-2021 is US$ 5.84 billion while the total health expenditure of Canada amounted to $264 billion in 2019).[47]

While member states agree on less disputed issues, such as the establishment of a health emergency programme, member states are hesitant to increase their assessed contributions to the WHO. This decreases the autonomy of the organization.[48] As most voluntary contributions are not flexible, they are designed for targets and programmes determined by donors instead of the organization itself.[49] It is argued that this "earmarking practice" creates a situation of external donors dictating the WHO's priorities and action agenda, distorting global health priorities and weakening the organization's decision-making power.[50] Unfortunately, due to these reasons the WHO is not sufficiently flexible to respond to health emergencies.[51]

In the context of providing health services in conflict areas this raises important questions as to how these interventions can be financed? What can be done to ensure the availability of sufficient funds and resources? Should these programs be financed through assessed contributions or voluntary contributions? How can the lack of flexible funding be compensated for? How should the program budget be allocated? Which program areas should be prioritized and receive the most funding?

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[47] Reddy (n 43); "Health Spending | CIHI". 2021. Cihi.Ca. Accessed January 18. https://www.cihi.ca/en/health-spending#:~:text=In%202019%2C%20total%20health%20expenditure,gross%20domestic%20product%20(GDP).
[48] Reddy (n 43).
[49] Ibid.
[50] Reddy (n 43); Gostin (n 46).
[51] Reddy (n 43); Checchi F, Waldman RJ, Roberts LF, Ager A, Asgary R, Benner MT, et al. World Health Organization and emergency health: if not now, when? BMJ. 2016;352:i469.

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