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I.Letter from Secretary-General

Dear Esteemed Delegates, Honorable Chairs and Distinguished Guests,

My name is Zeynep Kayalacin and it is my great honor to serve as the Secretary General of this year's FLZMUN. I am truly delighted to have the opportunity to lead such an inspiring academic gathering.

I firmly believe that diplomacy is not simply about expressing opinions but also about understanding different perspectives. Throughout this conference, I encourage each of you to embrace these values and step outside your comfort zones.

Whether this is your first MUN experience or one of many, I hope this conference will provide you with an environment where you can grow intellectually, strengthen your leadership skills and create unforgettable memories. Do not be afraid to speak up, defend your ideas and most importantly, learn from one another.

I would like to express my sincere gratitude to everyone who has contributed to making this conference possible. I also wish all delegates an inspiring, productive and enjoyable conference

Eat an apple, revise hard and prepare yourself for the conference.

If you have any prior questions about the conference you can contact me anytime.

Welcome to FLZMUN26.

Secretary General

Zeynep Kayalacin

zeynepkayalacin@gmail.com

II.Letter from Under Secretary-General

Dear delegates, honorable chairs and distinguished delegates

I'm Ege Onat Basaran and it is a great pleasure for me to be this year's Under Secretary General for Junior WHO committee. I'm really glad to have this opportunity to show my delegates how MUN can improve you in such different ways.

MUN holds a special place in me among all of the conferences that I have attended, it is mostly because of it is making me find new solutions for any kind of a problem all around the world and prepares me to defend myself in the future debates that I'm going to have in my life in any topic because of its structure forcing me to think of solutions that nobody else is.

Long after the conference comes to an end, I hope what stays with you is not only the resolutions you have written or the speeches you have delivered, but also the people you have met, the lessons you have learned and the memories you have created. And I also want to remind you of that MUN is not only about rewards or recognition but also about what you have improved yourself about.

For a very long time MUN has been such a great experience for me where I could find creative solutions, develop my communication skills, do group work with people that I have known for a few days and obviously make new friends and have fun.. I highly anticipate that this conference will also feel the things that I felt as a delegate.

If you have anything to say or something to ask you can always contact me.

Welcome to FLZMUN'26.

Under Secretary General.

Ege Onat Basaran

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III. Introduction to the Committee: World Health Organization

In April 1945, during the Conference to establish the United Nations (UN) in San Francisco, representatives of Brazil and China proposed establishing an international health organisation and convening a conference to draft its constitution. On 15 February 1946, the Economic and Social Council of the UN instructed the Secretary-General to convene such a conference. A Technical Preparatory Committee met in Paris from 18 March to 5 April 1946. It drew up proposals for the Constitution, which were presented to the International Health Conference in New York City from 19 June to 22 July 1946. Based on these proposals, the Conference drafted and adopted the Constitution of the World Health Organisation, which was signed on 22 July 1946 by representatives of 51 Members of the UN and 10 other nations.

The Conference also established an Interim Commission to carry out certain activities of the existing health institutions until the entry into force of the Constitution of the World Health Organisation. The preamble and Article 69 of the WHO Constitution provides that the WHO shall be a specialised agency of the UN. Article 80 provides that the Constitution would come into force when 26 members of the United Nations had ratified it. The Constitution did not come into force until 7 April 1948, when the 26th of the 61 governments that had signed it and ratified it. The first Health Assembly opened in Geneva on 24 June 1948 with delegations from 53 of the 55 Member States. It was decided that the Interim Commission would cease to exist at midnight on 31 August 1948 and was immediately succeeded by WHO.

1.2 General Information About the Committee

The World Health Organisation (WHO) is a specialised agency of the United Nations that focuses on international public health. Founded in 1948, the World Health Organisation works to promote global health, prevent and respond to disease outbreaks, and improve access to healthcare worldwide. In a Model United Nations (MUN) setting, the WHO committee simulates global discussions on issues such as pandemic preparedness, vaccine distribution, mental health, and healthcare equity, enabling delegates to collaborate on practical policy solutions to global health challenges.

1.3 WHO’s Mandate in Global Public Health

The WHO's official mandate is to promote health and safety and to help the vulnerable worldwide. It provides technical assistance to countries, establishes international health standards, collects data on global

health issues, and serves as a forum for scientific and policy discussions on health. The WHO's purpose is
to achieve the highest possible level of health for all the world's people, defining health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The main functions of the World Health Organisation include promoting the control of epidemic and endemic
diseases; providing and improving the teaching and training in public health, the medical treatment of disease, and related matters; and promoting the establishment of international standards for biological products.

IV. Introduction to the Agenda Item: Protecting Healthcare Systems in Conflicts

A. Background of the Agenda

The protection of healthcare during armed conflicts has developed hand in hand with the International Humanitarian Law (IHL). One of the first and yet the most important legal events in this area was the 1864 Geneva Convention which reorganized ambulances and military hospitals as neutral and required
them to be protected, respected and untouched while they were caring for the wounded and sick soldiers which was expanded in 1949 and 1977.

With the evolution of armed conflicts, the protection of health care assumed greater relevance, not only due to deliberate attacks, but also because armed conflicts can devastate entire health systems. Hospitals and clinics can be damaged or destroyed. Doctors and nurses can be threatened or displaced. Stocks of medicines can run out, as can electricity and water supply, along with medical disposables. International humanitarian law consequently has clear rules on the obligations of parties to
a conflict to respect and protect medical workers and facilities and to provide care for the wounded and sick.



Global concern rose as attacks on healthcare kept happening even though international laws protected medical facilities and staff. In 2016, the UN Security Council passed resolution 2286 which condemned the attacks on medical personnel, hospitals and other healthcare facilities, it also urged all sides involved in conflicts to respect international humanitarian law and to take responsibility for such attacks.

WHO has also invested in measuring attacks and attempting to assess their impact. In 2017, WHO launched the Surveillance System for Attacks on Health Care (SSA), a tool for documenting and verifying attacks. Unfortunately, attacks on healthcare remain prevalent. WHO documented 1,426 attacks on healthcare in 20 Russia-Ukraine crises. Just laws are clearly not enough by themselves. Ensuring health workers and facilities are protected on the ground, and can provide necessary healthcare to all who need it during times of conflict, poses a significant challenge.

B. Importance of Healthcare in Conflicts

Nearly without any exceptions all wounded and sick have general rights to be respected, (not to be subjects to attacks or killing) protected, to be searched for and be collected and cared (without distinction based on grounds other than medical ones) furthermore health establishments and units including hospitals should not be attacked both according to the IHL. However the attacks on global healthcare are increasing and the international laws are being disregarded much more day by day, in 2025 there were more than 1400 confirmed attacks on health care in emergency-affected countries and fragile settings. These attacks deprive people of urgently needed care, endanger healthcare providers, and undermine health systems.

WHO's Attacks on Health Care initiative aims to ensure that health workers everywhere are able to provide health care in a safe and protected environment without disruption from acts of violence. The initiative has three main pillars of work including the systematic collection of evidence of attacks, advocacy for the end of such attacks, and the promotion of good practices for protecting health care from attacks and all because of these healthcare and its protection is essential in armed conflicts.



I. Access to healthcare for civilians in armed conflicts

Availability of health care is a basic issue in times of armed conflict because civilians still need medical

care despite what is happening around them. International Humanitarian Law (IHL) protects the wounded and sick and requires that they receive medical care without discrimination, except on medical grounds. Additionally, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognises the right to health, highlighting the need to sustain health services

even in the face of emergencies.Civilian health needs are more than emergency treatment of conflict-related injuries. Maternal and newborn health, childhood vaccination, management of chronic diseases, mental health and rehabilitation services are still critical during armed conflict. Particular attention must also be given to vulnerable groups such as children, pregnant women, the elderly and people with disabilities, who may require specialised and continuous medical care.

International organisations have an important role in providing medical assistance and coordinating humanitarian health care activities in support of civilians. The World Health Organization (WHO) urges the continuation of essential health services . The International Committee of the Red Cross (ICRC) offers medical assistance and promotes the safeguarding of healthcare under international humanitarian law . UNICEF and UNHCR also contribute to address the specific health needs of

children, refugees and displaced populations. These organisations work internationally to ensure civilians receive the medical care they need during armed conflicts.

C. The impact of armed conflicts on healthcare systems

I. Attacks on healthcare facilities and workers

When fighting breaks out, access to health care becomes a matter of life and death. Yet this is precisely when health services are most at risk. Attacks on medical facilities and on medical personnel are a grave violation of the protections established under International Humanitarian Law. Such incidents include bombing, shelling and looting of hospitals, and threats, abductions and violence against health-care workers. Between January 2012 and December 2014, the ICRC looked at 2,398 incidents in 11 countries and found that more than half of the reported incidents took place in or near healthcare facilities. Furthermore, 1,134 healthcare workers were threatened or coerced, highlighting the immense dangers faced by medical personnel in conflict zones. Hospitals, medical units and personnel are given special protection under International Humanitarian Law and must be respected at all times. Attacks threaten the capacity of health care institutions to fulfil their essential functions, and pose a constant threat to medical personnel and patients. In response to these concerns, in 2016 the UN Security Council adopted Resolution 2286 condemning in the strongest terms violence against medical personnel and healthcare facilities. The resolution also urged enhanced preventive action, effective investigations of violations and accountability for perpetrators, underlining the responsibility of the international community to protect health care in armed conflicts.



II. Disrupted medical services and supply chains

Armed conflicts can seriously damage the already working healthcare systems and make it significantly difficult to provide essential services to medical facilities in need. Insecurity, movement restrictions and damage to supporting infrastructure may interfere with medical activities and limit the capacity of health care institutions. The disruptions are affecting patients who need ongoing treatment, such as those with chronic diseases or those dependent on routine medical procedures like dialysis. This also stretches health systems to sustain not only emergency medical care, but also routine treatments, even in hospitals not directly impacted by the conflict.

Armed conflict can also severely disrupt medical supply chains, affecting the availability and distribution of essential medicines, medical equipment and other necessary supplies. Restrictions on transport routes, border crossings and humanitarian shipments can slow the delivery of these resources, creating shortages in healthcare facilities. Hospitals also need essential resources, such as electricity, fuel and clean water to function properly, which during conflicts can become increasingly difficult to maintain. These disruptions may spill over from conflict zones. Interruptions to international

transportation networks could delay delivery of medical supplies to humanitarian operations elsewhere

Turning to vital resources and other materials necessary to establish or repair medical facilities,

allowing access can also be read into the obligation to protect medical facilities.Lastly, since health services are a basic need of the population, access to medical supplies and vital resources is implied in the obligation of each party to the conflict to meet the basic needs of a population under its control.If the basic needs of civilians are unmet then impartial humanitarian organizations can undertake relief activities to deliver essential supplies including medical supplies subject to the consent of the parties concerned. For the purpose of such relief schemes, “essential supplies” has been interpreted to include medical supplies.

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D. Challenges and Gaps of Healthcare system face

I. Security and Access

As there are many laws all around the globe about preventing war crimes, they are still being violated. While the same principles of security risk management apply to all emergency deployments, their application often requires greater care and urgency in situations of armed violence. Without sufficient security, medical response teams cannot, and should not, gain sustainable access to communities in the

face of hostilities without close access when the delivery of meaningful and quality medical care is not possible.

None of these elements (security, access and provision of medical services) is on its own. This dynamic relationship is as it follows: security is an enabler of safer access, without which medical programming cannot take place. A comprehensive approach to the topic can also be done by looking at WHO's Blue Book which outlines in detail the safety and security management considerations for all medical teams in order to lower war crime rates at their level because of the lack of monitoring systems all around the world that are causing them to happen. According to it, it takes 3 precautions at each level which are institutional, field management and individual levels, to break them down one by one: institutional level includes health establishments to make security policies, determine of task distribution and taking precautions about protecting healthcare workers; field management level includes field executives to evaluate security risk levels and factors, prepare emergency plans and ensure security coordination; individual level includes health personnel taking healthcare training, obey to the already set rules and for them to know what to do in emergency situations.

Beyond these measures, effective coordination between medical teams, local authorities and relevant humanitarian organisations is the only way to ensure safe access to health care services. Open communication channels, designated evacuation routes and procedures for prioritising medical transport at checkpoints can help minimise delays during emergency operations. Security conditions in conflict-affected areas can also change rapidly, requiring medical teams to constantly re-evaluate potential risks and adapt their security plans accordingly. Such measures help to secure the health workers and to maintain medical services under unstable conditions.

Safe humanitarian access relies not only on physical security measures but also on the trust and acceptance of local communities and other relevant stakeholders. In conflict-affected settings, suspicion, misinformation and the perception that medical teams are associated with one side of the conflict may damage their credibility and limit their ability to operate. That is why the World Health

Organization stresses the importance of community engagement, and of transparent communication and dialogue with all parties to a conflict for purely humanitarian purposes. Moreover, bureaucratic processes and administrative limitations can constitute other obstacles for humanitarian work. Establishing confidence, maintaining impartiality and establishing effective communication with local communities and relevant authorities are key to improving the security and accessibility of medical operations.



II. Funding Resources Shortages

Huge financial pressures are generated on health systems by armed conflicts, especially in countries with limited economic and institutional capacity. Conflicts erode national economies and government revenues, making it more difficult to sustain adequate public spending on health care. According to the

World Health Organization, fragile and conflict-affected countries typically spend less on health, have higher out-of-pocket health care expenditures and are more reliant on external funding, despite having greater medical needs. These financial pressures can limit the capacity of governments to maintain healthcare institutions and provide adequate resources for their healthcare systems.

Also, many conflict-affected countries are heavily dependent on international humanitarian assistance and external donors to sustain their health care services. International funding is important for meeting immediate medical needs but it is often insufficient or unpredictable. The World Bank says the shift from short-term humanitarian aid to long-term development funding is often badly coordinated, leading to financial gaps, swings in available funds and problems in keeping health-care programs running.

Funding shortfalls also can have a direct impact on the ability of health care institutions to continue their operations. Inadequate financial support may lead to closure of medical facilities, reduction in essential health care services and problems in retaining qualified health care personnel. October 2026: The WHO-led Global Health Cluster reported that funding constraints had forced humanitarian health partners to cut their planned operations, suspend some health facilities and scale back services in several crisis-affected settings. These developments show how financial constraints can impact on the immediate delivery and long-term viability of health services.

Shortages of funding can also directly affect the ability of health care institutions to continue to function. Insufficient funding may cause medical facilities to close, essential health care services to be cut and problems in keeping qualified health care staff. October 2026: Humanitarian health partners had to cut planned operations, suspend some health facilities and scale back services in several crisis-affected settings due to funding shortfalls, the WHO-led Global Health Cluster reported. These developments illustrate how financial constraints can affect the immediate provision and long-term sustainability of health services.

III. Accountability

Accountability of attacks on health care during armed conflict is key to protecting health care. Intentional attacks on objects containing sick and wounded such as hospitals, medical services, and personnel can constitute war crimes under the applicable rules of international law. The requirements for an attack to be considered a war crime under Article 8 of the Rome Statute of the International Criminal Court, for example, are that there has been an intentional attack on hospitals, units, transports and personnel entitled to protection as medical as defined by IHL. Under customary IHL, States are also expected to investigate whether a war crime has been committed by their nationals or Armed

Forces and, if so, to prosecute those responsible for such crimes in accordance with domestic law.

Accountability remains a challenge despite legal frameworks to investigate and prosecute war crimes. Although the UN Security Council in 2016 in Resolution 2286 strongly condemned attacks on medical staff, hospitals and health services, it called upon states to conduct independent investigations into alleged violations and to hold those responsible accountable. However, such investigations are often hindered by limited access to conflict areas, the lack of sufficient evidence, the lack of access to military information and the lack of an independent investigating body.
Moreover, non-transparent investigations into alleged violations of IHL are not able to determine responsibility for the alleged violation and therefore do not provide justice to victims of such attacks. The report of the UN Secretary-General of 2025 on the protection of civilians in armed conflict notes that the number of allegations of international crimes exceeds the number of investigations and prosecutions of such crimes.

This can also be seen in the monitoring of attacks to healthcare. The World Health Organisation has a system set up called the Surveillance System for Attacks on Health Care (SSA). This tracks and confirms information about the attacks. They record the nature of attack, what Health Care resources have been attacked and what medical staff have suffered casualties. However, the WHO does not investigate the perpetrators or hold people responsible for their crimes. This would not fall within their role. So whilst they are providing a structured system to identify patterns of violence and raise awareness globally, the ability for independent investigations to take place is still needed.

Furthermore, there is a responsibility for commanders and others involved in causing these violations. If they have knowledge, or should have had knowledge, that crimes were taking place by those under their effective command and did not take all necessary and reasonable steps to prevent or punish this then they can be criminally responsible under article 28 of the Rome Statute. Therefore it is vital to improve independent investigations, protect evidence, increase transparency and ensure current legal obligations are upheld to reduce levels of impunity and improve protections for Health Care systems.

E. Protection of Healthcare and Human Rights

I. Protection mechanisms

a. Protection of healthcare facilities and medical transport

State practice includes the following clarifications regarding the meaning of the terms "respect and protect." According to Germany's military manuals, the terms "respect and protect" imply that any behavior that would prevent medical personnel from carrying out their duties in the field must be prohibited. Similarly, Switzerland's Basic Military Manual states that "[medical units] must not be attacked, must not be harmed in any way, and—even if they do not currently contain any wounded or sick persons—must not be obstructed." In the same vein, the U.S. Air Force Commander's Handbook specifies that medical units "must not be intentionally attacked, fired upon, or unnecessarily hindered from performing their medical functions."

Military manuals from Benin, Nigeria, Senegal, and Togo state that medical units must remain inviolable and that armed individuals should not enter them; however, they also note that the contents and actual intended use of such units may be verified through inspection.

The First and Fourth Geneva Conventions, as well as Additional Protocol I, stipulate that medical units

should, as far as possible, not be located in the vicinity of military objectives. This requirement is

echoed in numerous military manuals. Furthermore, Article 12, paragraph 4 of Additional Protocol I

specifies that medical units may under no circumstances be used to shield military objectives from attacks (i.e., as human shields). This requirement is explicitly acknowledged in the practices of the Netherlands and the United States. Some military manuals state that medical units may not be used for military purposes or to carry out acts intended to harm the enemy. Other manuals, meanwhile, consider the improper use of structures with privileged status for military purposes to be a war crime.



b. Ensuring the continuity of essential health services

Public health emergencies affect both the supply of and the demand for health services. This can stem from reduced access to care, an increased need for emergency services, shifts in the health workforce, and disruptions in the supply chains for essential health products. Changes in the demand for health services—or in the capacity to provide them—during emergencies can lead to disruptions in service delivery. If such disruptions are not anticipated and mitigated, they may result in increased morbidity and mortality related to routine health conditions. Recent public health emergencies have demonstrated that the quality of health services is also significantly compromised during crises—a phenomenon often linked to various factors affecting service provision within an emergency context. A key characteristic of resilient health systems is their ability to maintain the continuity of essential health services, even during emergencies. To reduce the risk of large-scale disruptions, ensure the

safety of both healthcare workers and patients, and sustain routine and essential health services alongside emergency response efforts, concrete support is required to strengthen resilience at every level of service delivery.

c. International monitoring and compliance

While disease outbreaks and other acute public health risks and events are often unpredictable and require a range of responses, the International Health Regulations (2005) (IHR) provide an overarching legal framework that defines States Parties' (countries') rights and obligations in managing public health risks, events and emergencies that have the potential to cross borders.

The IHR is an instrument of international law that is legally-binding on 197 countries, including the 194 WHO Member States. They establish rights and obligations for countries, including the requirement to designate or establish Responsible Authorities; establish and maintain core capacities for surveillance and response, as well as at points of entry; notify to WHO public health risks and events with actual or potential international public health implications, regardless of their origin or source; verify information of public health risk and events of which WHO has become aware through informal and unofficial sources.

The IHR set forth the obligation for WHO to maintain the global public health early warning function and to coordinate international response efforts.

Additional provisions address the areas of international traffic, such as health documents for international travelers and conveyances on an international voyage. The IHR includes important safeguards to protect individual rights in relation to the treatment of personal data, informed consent and non-discrimination in the application of health measures under the Regulations.

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d. Maintaining Medical Supply Chains

Recent health crises and medicine shortages have exposed deep vulnerabilities in the global medical supply chain. A lack of visibility over essential inputs—such as active pharmaceutical ingredients (APIs), starting materials, and finished dosages—prevents policymakers from anticipating disruptions. Building on prior OECD work, this report analyzes supply resilience across three key products: injectable systemic corticosteroids, seasonal influenza vaccines, and influenza RT-PCR diagnostic tests.

Market analysis shows high supply concentration. In the EU, despite 84 authorized companies, national markets rely on just one or two suppliers per corticosteroid molecule due to hospital procurement structures. Similarly, five major manufacturers dominate the global seasonal flu vaccine market, while volume data remains unclear for the 85 CE-marked RT-PCR kit providers. Furthermore, upstream visibility is restricted: in 2024, only 20 active API suppliers were identified for EU corticosteroids—located across China (9), EU Member States (6), the US (2), India, and Malaysia—with exact market volumes unknown.

Because no nation can ensure supply security alone, the report highlights international cooperation tools to expand capacity and absorb shocks. While broad trade deals help diversify sources, they risk offshoring production. In contrast, targeted partnerships—like Critical Raw Materials deals that boosted trade by 12%—offer pragmatic solutions, alongside pharmaceutical Mutual Recognition Agreements that cut redundant inspections and digitalized border processes that prevent administrative delays during crises.



II. International WHO frameworks

a. Surveillance System for attacks on healthcare (SSA)

The World Health Organization's (WHO) Attacks on Health Care Initiative works to ensure that healthcare providers can deliver medical care safely and without fear of disruption or violence and hesitation of being harmed . The initiative centers around three main pillars:

1. Systematic Evidence Gathering: Standardizing data collection to document every incident,
2. Global Advocacy: Raising awareness and campaigning to put an end to these attacks,
3. Promoting Best Practices: Sharing and implementing effective strategies to safeguard health services.

Defining Attacks on Health Care

WHO defines an attack on health care as any physical or verbal violence, obstruction, or threat that interferes with the availability, access, or delivery of preventive and curative health services during crises. The nature of these attacks varies across settings—ranging from the use of heavy weaponry against medical facilities to psychological coercion, intimidation, and verbal abuse targeting health staff.

b. International Humanitarian Law

International humanitarian law is a body of rules that seeks, for humanitarian reasons, to limit the effects of armed conflicts. It protects persons who are not participating in hostilities and imposes limits on the conduct of warfare. International humanitarian law is a component of international law—the body of rules governing relations between states. International law is derived from agreements between states (treaties or conventions), customary rules—practices that states accept as legally binding—and general principles. International humanitarian law applies in situations of armed conflict. It does not regulate whether a state may resort to the use of force; that matter is governed by a separate, albeit significant, branch of international law, as set forth in the United Nations Charter.

During periods of armed conflict, international humanitarian law (IHL) establishes rules aimed at protecting access to healthcare services. These rules are binding upon both states and non-state armed groups. In situations that do not reach the threshold of an armed conflict, only international human rights law (IHRL) and domestic law apply. In principle, international human rights law remains applicable at all times, unless states decide otherwise (i.e., by suspending their obligations). Although less detailed than IHL, international human rights law also contains various provisions that protect access to healthcare services.

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c. Protection of healthcare under the Geneva Convention

Wounded and Sick: The rights of the wounded and sick must be respected in all circumstances; attempts upon their lives and violence against their person are strictly prohibited. Wilfully killing them or causing great suffering or serious injury to their bodies or to their health constitutes war crimes as grave breaches of the Geneva Conventions.

Medical Personnel: Personnel engaging in medical tasks must always be respected and protected, unless they commit, outside of their humanitarian function, acts that are harmful to the enemy. When they carry and use weapons to defend themselves or to protect the wounded and sick in their charge, medical personnel do not lose the protection to which they are entitled. The wounded and sick under their care remain protected even if the medical personnel themselves lose their protection.

Hospitals and Medical Units: Medical units, such as hospitals and other facilities that have been set up for medical purposes, must be respected and protected in all circumstances. Medical units may not be attacked and access to them may not be limited. Parties to an armed conflict must take measures to protect medical units from attacks, such as ensuring that they are not situated in the vicinity of military objectives.

Medical Transports: Any means of transportation that is assigned exclusively to the conveyance of the wounded and sick, medical personnel and/or medical equipment or supplies must be respected and protected in the same way as medical units. If medical transports fall into the hands of an adverse party, that party becomes responsible for ensuring that the wounded and sick in their accountability are cared for. Protective Emblems: When used as a protective device, the emblem the red cross, the red crescent or the red crystal is the visible sign of the protection conferred by the Geneva Conventions and their Additional Protocols on medical personnel, medical units and medical transports. During an armed conflict, this includes military medical personnel, units and transports; National Red Cross and Red Crescent Societies' medical personnel, units and transports that have been recognized by the State and authorized to assist the medical services of the armed forces; State-certified civilian medical units authorized to display the emblem; and medical personnel in occupied territory. To secure the best protection, the emblem used as a protective device should be large enough to ensure visibility. Medical units and transports may also use distinctive signals (such as light and radio signals).In this case, the sign should be relatively small. Attacking buildings, material, medical units and transports or personnel displaying the distinctive emblems is a war crime.

F. Case Studies

I. Healthcare in Gazza

Since the conflict started in the Gaza Strip in October 2023, it has put incredible pressure on the health system. This has caused huge damage to medical facilities and has decreased available healthcare. Hospitals, primary healthcare centres and other medical facilities have been severely impacted by the conflict. This has caused staffing, medical equipment and resources shortages. As of 24 September 2026, there are only 19 out of 36 hospitals partially functioning in Gaza. None of them are functioning fully. This shows the impact the conflict has had on the healthcare system.

This has impacted many patients WHO require specialist and ongoing treatment. Those with cancer, kidney diseases and chronic illnesses have struggled due to the lack of healthcare available. Patients WHO need maternal care, physical therapy and mental healthcare have also been greatly impacted. There are thousands of people WHO require specialist treatment but cannot currently get this in Gaza. The lack of medical equipment, medications and staff have also caused issues with the available

healthcare. Overall this shows how long running conflicts can impact emergency medical services. International organisations have tried to help improve the healthcare situation in Gaza. WHO have worked alongside national and international partners to deploy Emergency Medical Teams to provide consultations, emergency surgery, trauma care and specialist healthcare. Over 4.2 million general medical consultations have been carried out between January 2024 and March 2026. Also over 65,000 emergency surgical procedures have been carried out. National and international medical teams have also helped restore some services within hospitals. This shows how important international partnerships are to keep healthcare running in times of humanitarian crisis.

In order to improve the healthcare system in Gaza, they need more support. A joint Rapid Damage and Needs Assessment was done in April 2026 by the World Bank, United Nations and European Union. They found that damages within the health sector were around US 13.9 billion. Overall losses were 6.78 billion. To rebuild healthcare in Gaza it will take around US$10.03 billion over the next 5 years. This includes restoring damaged hospitals and primary healthcare centres, providing medical care, improving the healthcare workforce and rebuilding vital healthcare infrastructure. This shows that Gaza will require long running international support to rebuild their healthcare after an armed conflict.



II. Healthcare in Ukraine

Since the start of the full-scale invasion of the Russian Federation on 24th February 2022, Ukraine's healthcare system has faced increasing strain due to attacks on medical infrastructure. In 2025 there was an increase of almost 20% in attacks on medical facilities compared to 2024. Since the start of the full-scale invasion, over 3000 attacks have occurred as of May 2026. This has included attacks on healthcare facilities, primary healthcare centres, ambulances, and medical stores. However, the medical workforce in Ukraine have ensured that the healthcare system is still being used, and international agencies have supported it.

The conflict has caused significant issues to the healthcare system. As of April 2026, reports to the World Health Organisation's (WHO) Health Resources and Services Availability Monitoring System (HeRAMS) show that 6% of the 11,213 facilities are unable to operate due to being damaged, non-functional or inaccessible. Additionally, the increase in injuries caused by the war has increased the need for emergency surgeries, blood supplies, rehabilitation, and mental health services. There is very little available for specialised rehabilitation, with only 4% of hospitals providing inpatient rehabilitation and 3% of facilities providing assistive technology. This shows that long term conflicts can cause significant strain on a country's healthcare system.

National agencies and international organisations have worked to ensure the provision of healthcare. The WHO has partnered with the Ukrainian Ministry of Health and other humanitarian agencies to provide medical supplies, emergency medical response teams, and to support facilities. In 2025, the WHO will provide healthcare to around 1.9million people. They have provided 320 metric tonnes of medical supplies to 954 healthcare facilities via 41 inter-agency convoys. Since 2023, they have supported 58 modular prefabricated healthcare facilities including primary healthcare and emergency medical facilities. This has shown the importance of international collaboration to provide essential healthcare.



III. Healthcare in Sudan

The health sector in Sudan has been greatly impacted since the start of the war between the Sudanese Armed Forces (SAF) and Rapid Support Forces (RSF) in April 2023. The country has seen extensive fighting, leading to a lack of medical staff, medicine and equipment due to attacks on medical facilities. According to the World Health Organisation (WHO), by October 2026 around 37% of healthcare facilities across the country were no longer functioning. The WHO have found that there have been 228 verified attacks on healthcare since the start of the conflict which caused 2,055 deaths and 817 injuries.

In addition to the damage caused to medical facilities, the lack of medical staff, medicine and equipment coupled with limited humanitarian aid has resulted in a disruption to medical care in the area. Around 21 million people needed health assistance and 11.5million have been forcefully displaced according to the WHO's Public Health Situation Analysis in 2026. Multiple diseases have also started to spread in the country including cholera, malaria, dengue, measles and hepatitis E. This has created issues for the healthcare system as it is difficult for medical staff to provide essential medical care due to the large number of people being displaced.

International organisations have been working to help the healthcare sector in Sudan. The WHO have been working alongside the local health authorities and humanitarian organisations to supply medical aid, improve disease monitoring and enable essential healthcare for those in need. Since April 2023 the WHO has supplied over 3300 metric tonnes of medicine and medical supplies to Sudan. Their healthcare initiatives have enabled essential medical care for over 4.1 million people. They have also helped rebuild state and national reference laboratories, improved the healthcare workforce and aided vaccination campaigns. This shows how important international organisations are to ensure medical care is still provided.

However, the healthcare system in Sudan will rely upon continuous financial aid from international organisations. The lack of funds means medical facilities are struggling to operate. Along with this, the damage to medical facilities, lack of trained staff and constant uncertainty has made rebuilding difficult. In October 2026, the WHO reported that only 23% of their $97.7 million humanitarian health appeal had been funded. To improve the national healthcare facilities, rebuild damaged facilities, aid medical staff and ensure consistent humanitarian aid, it is essential to invest in the countries healthcare sector. This example shows how long term wars can cause the healthcare sector in countries to become weak and without long term investment and international aid, they will struggle to recover.



VI. Questions to ponder

-How can attacks on the healthcare system and workers be reduced or eliminated?

-How can the recovery be done in Gaza, Ukraine and Sudan?

-What is the purpose of war crimes and how can we prevent them from happening?

-How can the protection mechanism in each healthcare subject be developed?

-How will the emergency aid and healthcare access be guaranteed in conflicts?

-Can the IHL be improved and if it can, how?

-What kind of a training could be given in conflicts to reduce its impact in the area?

VII. Bibliography

https://ihl-databases.icrc.org/en/ihl-treaties/gci-1949/article-19

https://ihl-databases.icrc.org/en/ihl-treaties/gciv-1949/article-18

https://ihl-databases.icrc.org/en/customary-ihl

https://digitallibrary.un.org/record/827916

https://www.icc-cpi.int/publications/core-legal-texts/rome-statute-international-criminal-court

https://documents.un.org/api/symbol/access?l=en&s=s%2F2025%2F271&t=pdf

https://www.who.int/news-room/questions-and-answers/item/attacks-on-healthcare-initiative-documenting-the-problem

https://www.who.int/publications-detail-redirect/9789240029354

https://www.icrc.org/en/publication/4104-health-care-danger-responsibilities-health-care-personnel-working-armed-conflicts

https://blogs.icrc.org/law-and-policy/2025/11/20/reaffirming-the-obligation-to-protect-medical-facilities-and-support-their-functioning/

https://www.who.int/publications/i/item/9789240033337

https://www.who.int/publications/m/item/herams-opt-gaza-infographics-2026-09

https://thedocs.worldbank.org/en/doc/e539cbf23b348c3d4fc69b8a7e9c9d7d-0280062026/original/Gaza-RDNA-2026-Final-April-19.pdf

https://www.who.int/publications/m/item/occupied-palestinian-territory--who-health-emergency

https://www.who.int/news/item/23-02-2026-attacks-on-ukraine-s-health-care-increased-by-20-in-2025

https://www.who.int/publications/m/item/herams-ukraine-health-services-across-oblasts-2026-08-all-division

https://www.who.int/publications/m/item/public-health-situation-analysis---sudan-conflict-and-complex-emergency

https://www.who.int/publications/m/item/sudan--who-health-emergency-appeal-2026

https://www.who.int/news/item/14-04-2026-after-three-years-of-conflict--sudan-faces-a-deeper-health-crisis

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