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Health systems recovery in fragile and conflict-affected situations in the Eastern Mediterranean Region

Executive summary

Health systems in the WHO Eastern Mediterranean Region are under immense pressure. As of April 2025, the Region was facing 16 graded emergencies, with over 110 million people in humanitarian need. These concurrent and protracted crises driven by armed conflict, disasters, disease outbreaks, climate change impacts and economic collapse have overwhelmed institutions, disrupted essential services and deepened humanitarian needs.

These challenges have reversed progress towards critical health-related Sustainable Development Goals (SDGs), particularly regarding universal health coverage (UHC) and health security. Infrastructure damage, workforce displacement, broken supply chains and diminished public trust have curtailed access to care.

Recovery is not a post-crisis afterthought – it is essential for restoring services, rebuilding capacity and ensuring future resilience, and it accelerates development goals.

Health systems recovery involves the restoration of services, reconstruction of core functions and reinforcement of essential public health capacities. It also provides an opportunity, if a "build back better" approach is taken, to address systemic weaknesses, promote equity and reduce future vulnerability, advancing UHC and health security.

Health systems recovery must start early – often during the humanitarian response phase – and be customized to local realities. In fragile and conflict-affected situations (FCS), recovery is rarely linear; it must be flexible, conflict-sensitive and guided by national and local leadership, taking humanitarian-development-peace nexus, whole-of-government and whole-of-society risk management approaches.

To operationalize this vision, the paper introduces an operational framework and practical steps that are adaptable and can be embedded in national and multisectoral recovery strategies and processes.

The paper builds on regional experiences and aligns with WHO's 14th General Programme of Work (GPW14), Strategic Operational Plan for the Eastern Mediterranean Region 2025–2028 and flagship initiatives, and the resilience-building agenda articulated in Regional Committee technical paper EM/RC69/4 on building resilient health systems to advance UHC and ensure health security in the Eastern Mediterranean Region. It provides practical guidance for Member States, WHO and partners and is accompanied by a draft resolution urging sustained commitment to recovery as a foundation for resilient health systems.

Introduction

1. The WHO Eastern Mediterranean Region is among the most crisis-prone globally, with many countries simultaneously confronting armed conflict, natural disasters, disease outbreaks, the impacts of climate change and economic instability *(1, 2)*. As of April 2025, WHO was responding to 16 graded emergencies[1] in the Region, including six classified as Grade 3, the highest level of severity *(3)*. An estimated 110 million people in the Region require humanitarian assistance, representing one third of the global burden *(4)*.

2. A key characteristic of the Region is protracted conflicts intersecting with fragility *(5, 6)*. According to the World Bank, nine of the Region's 22 countries and territories (Afghanistan, Iraq, Libya, Lebanon, Palestine, Somalia, Sudan, Syrian Arab Republic and Yemen) are classified as fragile and conflict-affected situations (FCS)[2], comprising 23% of global FCS cases *(7, 8)*. These countries are at high risk of not achieving the health-related Sustainable Development Goals (SDGs) *(9, 10)*.

3. Countries classified as FCS frequently face overlapping shocks, further straining already fragile health systems. For example, Lebanon's 2020 Beirut port blast compounded an economic crisis on top of the COVID-19 pandemic and a severe political deadlock, while the Syrian Arab Republic's 2022 earthquake deepened the impact of prolonged conflict and the pandemic. Such layered crises require integrated recovery and resilience-building strategies rather than isolated emergency responses. Ideally, such efforts will adopt a "build back better"[3] *(11)* approach, addressing not only immediate needs but also the underlying drivers of conflict and fragility. WHO has supported these efforts through an all-hazards approach and tailored technical and policy guidance for bridging humanitarian and development workstreams. Two key WHO documents provide this support, namely the *Implementation guide for health systems recovery in emergencies: transforming challenges into opportunities (12)* and *Bridging the divide: a guide to implementing the humanitarian-development-peace nexus for health (13)*.

4. Additional guidance on the details of health system building blocks or public health functions is provided by a set of documents and resolutions. These cover, but are not limited to, the following priority areas: primary health care, hospital resilience *(14)*, health workforce, health information systems *(15)*, quality of care, climate resilient health systems *(16)*, noncommunicable diseases *(17)*, mental health *(18)*, sexual and reproductive health *(19)*, maternal, newborn and child health *(20)*, child and adolescence health *(21)*, the International Health Regulations (IHR) (2005) *(22)*, and emergency preparedness, emergency readiness and disaster risk reduction *(23)*.

5. This paper examines health system recovery needs in the Region in the context of FCS and outlines strategic actions for Member States and partners. It serves as the background to a proposed Regional Committee resolution and aligns with WHO's 14th General Programme of Work *(24)*, Strategic Operational Plan for the Eastern Mediterranean Region 2025–2028 *(25)*, flagship initiatives *(26)* and Regional Committee resolution EM/RC69/R.2 on building resilient health systems to advance universal health coverage (UHC) and ensure health security in the Eastern Mediterranean Region *(27)*.

[1] An acute public health event or emergency that requires an operational response by WHO. There are three WHO grades for emergencies, signifying the level of operational response by the Organization: Grade 1 (limited response), Grade 2 (moderate response) and Grade 3 (major/maximal response).

[2] Fragility is a systemic condition or situation characterized by an extremely low level of institutional and governance capacity which significantly impedes the state's ability to function effectively, maintain peace and foster economic and social development. Conflict is defined as a situation of acute insecurity driven by the use of deadly force by a group – including state forces, organized non-state groups or other irregular entities – with a political purpose or motivation. Such force can be two-sided – involving engagement between multiple organized, armed sides, at times resulting in collateral civilian harm – or one-sided, in which a group specifically targets civilians *(5,6)*.

[3] The use of the recovery, rehabilitation and reconstruction phases after a disaster or emergency, to increase the resilience of nations and communities through integrating disaster risk reduction measures into the restoration of physical infrastructure and societal systems, and into the revitalization of livelihoods, economies and the environment.

FCS in the Eastern Mediterranean Region

6. Increased global attention is being paid to FCS, as countries thus affected are home to a large and growing share of people affected by poverty, instability and recurring crises. By 2030, nearly 60% of the world's extreme poor will live in FCS. The scale and persistence of these challenges are intensifying, leading to growing and more protracted humanitarian needs. By 2025, the number of people with humanitarian needs globally had surged to over 305 million from 77 million in 2015. At the same time, the average duration of a humanitarian crisis has increased, reaching around 10 years in length *(28)*.

7. The WHO Eastern Mediterranean Region exemplifies these trends. It continues to experience longstanding, overlapping crises that disrupt development, undermine institutions and place severe strain on public systems, particularly in the health sector.

8. These conditions create serious obstacles to achieving the health-related SDGs, including UHC (target 3.8) and health security (SDG indicator 3.d.1.). In many countries affected by fragility and conflict, earlier gains are also being reversed. These setbacks reflect not only broader development challenges but also the compounded and long-term impacts of protracted crises driven by conflict and instability. See Fig. 1 and Annex 1 for a comparison of key health indicators between FCS and other countries in the Region.

9. Prolonged armed conflict, compounded by fragile state conditions, have caused extensive destruction and disruption across all components of the health system in several countries in the Region. This has led to a significant erosion of public trust in health institutions, decreased utilization of formal health services and increased dependence on informal providers – ultimately compromising both patient safety and the quality of care. These factors contribute to rising levels of preventable illness and death. Additionally, conflict-induced displacement places further strain on host communities and neighbouring countries, many of which already face limited health system resources, thereby exacerbating existing challenges.

10. Attacks on health care are one of the greatest challenges faced by health systems in FCS. In addition, violence damages infrastructure, displaces health workers, weakens governance and health information systems, and disrupts supply chains, causing widespread shortages of medicines and equipment and disrupting service delivery. Insecurity restricts access to services, as many people are unable or unwilling to reach health facilities due to roadblocks, checkpoints, targeted attacks or fear of violence *(29, 30)*.

11. In this context, health financing has also become increasingly fragmented and unpredictable, leading to greater reliance on external aid. These challenges undermine equitable access to services and reduce financial protection, especially for vulnerable populations. Economic collapse and the loss of livelihoods reduce

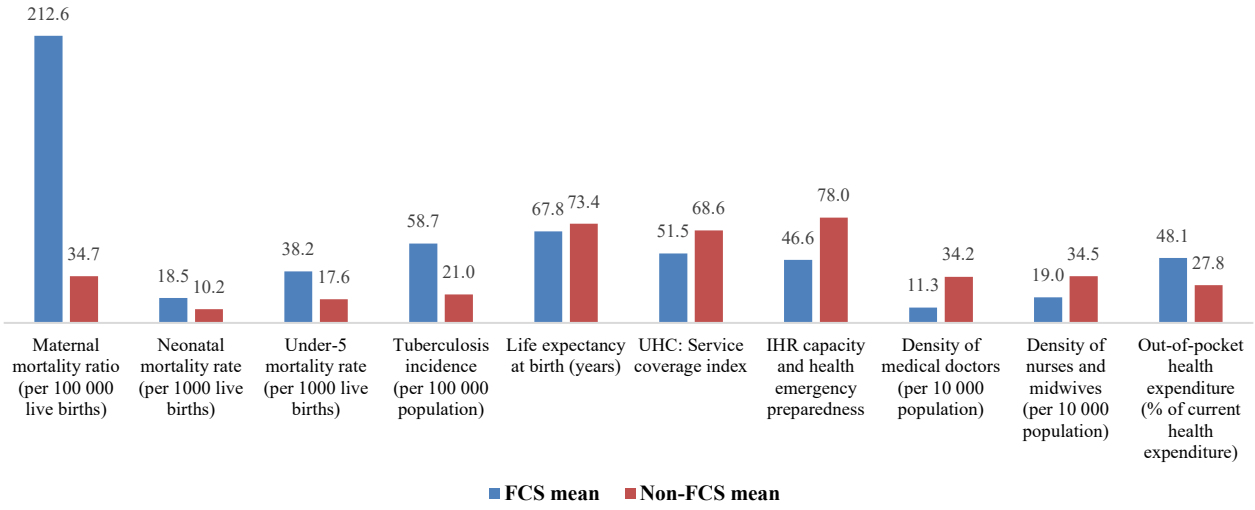

Fig. 1. Comparison of key health indicators between countries in the Eastern Mediterranean Region classified as FCS and others

households' ability to afford care, particularly where out-of-pocket payments are required. At the same time, disruptions to education weaken the pipeline of future health professionals, while chronic instability deters long-term investment in health infrastructure.

12. Given the scale and complexity of these issues, restoring service delivery and investing in health system recovery are essential to preventing further deterioration in health outcomes and reducing excess morbidity and mortality *(31)*.

The need for health system recovery

13. Humanitarian action plays a vital role in emergencies, delivering immediate, life-saving assistance and ensuring continuity of care. Humanitarian actors are often the main providers of essential services, particularly in hard-to-reach or insecure areas. However, while indispensable, humanitarian action is not designed to address long-term health system challenges nor build systemic resilience.

14. Health system recovery, by contrast, goes beyond meeting urgent needs. It focuses on rebuilding and strengthening health systems over time, enhancing preparedness for and resilience to future shocks. It also contributes to broader peacebuilding and development goals *(12)*. By restoring service delivery, fostering trust and promoting equity, recovery efforts can strengthen social cohesion and help stabilize communities. In turn, this supports a return to development pathways and contributes to wider socioeconomic recovery.

15. Importantly, humanitarian and recovery efforts are not mutually exclusive; they are interlinked and often overlap. In FCS, recovery planning should begin as early as possible, even during the acute phase of emergencies, to protect essential health services and lay the foundation for more sustainable, nationally-led development. For recovery to be effective, it must be well planned, well implemented and supported by strong political will and adequate technical and operational capacities. Approaches should be context-specific and tailored to the nature of each emergency and country setting *(27, 32)*.

Understanding health systems recovery in the context of FCS

Definition and goal of health system recovery

16. Health system recovery refers to the process of re-establishing disrupted health services, restoring critical health system building blocks and reinforcing essential public health functions. It aligns with the principles of building back better and sustainable development.

17. Recovery typically begins with the restoration of essential services, often during the humanitarian response phase, and evolves towards stabilizing core system functions, resuming routine operations and strengthening health system building blocks and essential public health functions. The overarching goal is to accelerate progress towards UHC, enhance health security, mitigate future risks and contribute to the national development plan and SDGs.

Build back better approach

18. The build back better approach views recovery not as a return to the pre-crisis status quo, but as a strategic opportunity to address longstanding system weaknesses and make health systems more equitable, resilient and sustainable *(33)*.

19. In the health sector, building back better includes not only the physical reconstruction of infrastructure, but also the strengthening of service delivery, referral systems, the health workforce and supply chains. It promotes the integration of mental health, noncommunicable diseases care and climate resilience into recovery strategies.

20. Moreover, building back better encourages reforms in governance, financing and gender equity and emphasizes disaster risk reduction. For instance, damaged health facilities can be rebuilt as green and, climate-resilient powered by renewable energy and fitted with efficient water systems.

Categories of emergencies

21. Emergencies can be categorized into three types, acute, protracted and complex, each requiring tailored recovery approaches. Acute emergencies are typically short in duration and necessitate rapid humanitarian response to meet urgent needs. Protracted emergencies are commonly driven by ongoing conflict, chronic vulnerability, recurrent shocks or weak governance over extended periods, often longer than six months. Complex emergencies are characterized by a combination of factors such as war or civil strife, food insecurity and mass displacement, often resulting in significant mortality and morbidity. These situations typically involve a breakdown of authority, widespread violence and severely disrupted public services *(34)*.

22. These categories frequently overlap in FCS. A complex emergency can evolve into a protracted emergency if the root causes – such as conflict or governance failure – remain unresolved. Conversely, a protracted conflict can intensify the complexity of the situation. Moreover, acute emergencies, including disease outbreaks, natural disasters or sudden escalations in violence, can emerge within the broader context of a protracted crisis, further compounding humanitarian challenges.

23. Recovery in these contexts is a prolonged and non-linear process, often involving repeated transitions between response and recovery phases – or even their simultaneous implementation. Effective recovery requires a comprehensive understanding of the underlying fragility, institutional capacities, political dynamics and the evolving needs of affected populations. It must be conflict-sensitive, peace-responsive and tailored to the local context. Leveraging local actors and resources ensures more equitable and sustainable recovery and access to health services *(35)*. In addition, engaging the private sector as a key provider of health services in many FCS is critical, and given effective governance, enhances health systems capacity, innovation and resilience *(36)*. Furthermore, recovery efforts should be gender-sensitive and aligned with the capacities of national and subnational authorities and other actors. Given that conditions may vary significantly across different regions within the same country, an area-based approach is essential.

Phases of health systems recovery

24. Health systems recovery is typically structured around two overlapping phases: early recovery and transition, and long-term (sustainable) recovery *(12)*. While these phases are not strictly linear or sequential, understanding their distinct objectives helps guide strategic decision-making and programmatic planning.

25. Transitions from emergency response to early recovery, and from early recovery to longer-term recovery, are often blurred. However, these phases can be broadly distinguished based on three key dimensions: urgency, sustainability and cost–effectiveness, as described below:

- *Response phase:* The focus is on urgency and life-saving interventions, often implemented under a no-regret approach, prioritizing immediate impact even if interventions are not sustainable or cost–effective.
- *Early recovery:* While time sensitivity remains, the emphasis begins to shift towards re-establishing the foundations of the health system and sustainability and cost–effectiveness become more important.
- *Long-term recovery:* As recovery advances, the focus moves increasingly to sustainability and investment in resilient systems, with cost–effectiveness becoming a more central consideration.

26. Early recovery and transition begin alongside the humanitarian response and build upon it. They extend into stabilization and include urgent actions to save lives while laying the groundwork for long-term recovery and development. Immediate priorities include:

- restoring critical services such as maternal and child health, sexual and reproductive health, trauma care and outbreak control;
- re-establishing supply chains and logistics to support health service delivery;
- reopening and restaffing health facilities.

27. As conditions stabilize, attention should turn to the reactivation of governance, coordination mechanisms and health information systems, which are essential for effective recovery management. Early recovery also marks the onset of integrated planning across humanitarian, development and peacebuilding actors. The triple nexus approach supports this integration by fostering collaboration across actors, leveraging their comparative advantages and advancing collective outcomes over multi-year timeframes *(13)*.

28. Long-term (sustainable) recovery begins when essential health system functions are restored and sociopolitical conditions allow for forward-looking planning. The aim is to rebuild a health system that is equitable, efficient, resilient and sustainable, contributing to broader development outcomes and advancing the health-related SDGs. This phase should be anchored in a national recovery strategy or framework aligned with national development priorities and the United Nations Sustainable Development Cooperation Framework.

29. The following priority areas, first articulated in Regional Committee technical paper EM/RC69/4 on building resilient health systems to advance UHC and ensure health security in the Eastern Mediterranean Region *(32)*, can guide long-term recovery planning:

- strengthening health emergency and disaster risk management *(37)*;
- optimizing ministries of health and developing public health institutions;
- establishing primary health care-oriented models of care;
- expanding a fit-for-purpose, fit-to-practice health workforce;
- enhancing equity and financial protection;
- improving access to medicines, vaccines and health products;
- fostering integrated approaches to planning, policy and investment for resilience.

30. In conflict-affected countries, long-term recovery also serves as a vehicle for peacebuilding, reconciliation and rebuilding trust in state institutions. Conflict-sensitive programming that is gender-sensitive, engages all stakeholders in inclusive planning and governance and provides equtiable health services can mitigate tensions and promote social cohesion *(38)*.

31. Both early and long-term recovery should be embedded within national strategies and aligned with global commitments, namely all those linked to UHC, health security and other health-related SDGs. When recovery is strategically sequenced, early efforts can generate momentum towards sustainable transformation.

Guiding principles for health systems recovery

32. The following principles should guide health system recovery efforts at all stages:

- Do no harm – ensure interventions avoid exacerbating existing tensions or inequalities.
- Respect humanitarian principles – humanity, neutrality, impartiality and independence *(39)*.
- Apply development effectiveness principles – alignment, ownership and harmonization *(40)*.
- Integrate recovery from the outset – plan for resilience even during emergency responses.
- Align with multisectoral frameworks such as national recovery strategies and United Nations cooperation frameworks.
- Engage communities – ensure interventions are context-appropriate and locally owned.
- Promote equity and gender responsiveness, including targeting vulnerable populations and addressing systemic inequities.
- Adopt a life-course approach covering all age groups and health needs.
- Incorporate climate and disaster resilience – build systems that can withstand future hazards.

Operationalizing health systems recovery in FCS

33. Health systems recovery following acute, protracted, or complex emergencies, or any combination of those, can be undertaken independently or embedded within formal multisectoral processes such as recovery and peacebuilding assessments (RPBAs) *(41)*, post-disaster needs assessments (PDNAs) *(42)* or rapid damage and needs assessments (RDNAs) *(43)*.[4]

34. Whether recovery is linked to a formal assessment, initiated during the early or long-term phases or responding to chronic or acute shocks, it should follow a structured process with six interconnected steps: 1) recovery readiness, 2) recovery assessment, 3) recovery planning, 4) resource mobilization, 5) recovery implementation, and 6) monitoring and evaluation.

35. In FCS, this process may not be sequential. Recovery efforts may need to pause, shift backward or adapt due to renewed crises or evolving needs. Flexibility is essential. Each step must be informed by lessons learned from past experiences, and iterative adjustments should be made to avoid repeating challenges and to improve future outcomes.

36. FCS are often recognized by a long and dynamic transition period where the sustainability of interventions require effective connections between three main groups of actors, i.e. humanitarian, development and peace actors, through a nexus approach. By leveraging the comparative advantages of different groups of actors, the humanitarian-development-peace nexus approach can be operationalized by setting collectives outcomes, inclusive coordination mechanisms, joint programming and harmonization of financial resources *(13)*.

37. The nexus approach may be referred to by slightly different names depending on the context, political conditions and extent to which humanitarian, development and peace actions are implemented. These variations include the humanitarian-development nexus (the double nexus), the Humanitarian-Development-peace nexus (known as the triple nexus with a little p), the Humanitarian-Development-Peace nexus (known as the triple nexus with a big P), the humanitarian assistance-basic human needs nexus (in countries where formal development support is suspended), humanitarian-development collaboration, humanitarian plus, and early recovery and resilience *(13)*.

38. Peace is crucial for the recovery of health systems in FCS. Stability allows for the restoration of essential services, rebuilding of infrastructure and the return of health care workers. Without peace, efforts to improve health outcomes are often disrupted by violence and insecurity. Moreover, a peaceful environment fosters trust and cooperation among communities, which are essential for effective public health interventions and long-term resilience. While the role of the health sector in political peace agreements is limited, it can still play a significant role in conflict prevention and enhancing social cohesion and trust as prereqisistes for an effective recovery and sustainable development. The WHO Global Health and Peace Initiative provides a range of interventions in this regard, focusing on the provision of equitable health services as well as mental health and psychosocial support *(44)*.

39. Fig. 2 illustrates a framework for the operationalization of health systems recovery in FCS. It presents the recovery phases (early recovery and transition, and long-term recovery), recovery elements (health system building blocks and core and enabling public health functions) and recovery implementation steps.

[4] RPBAs, PDNAs and RDNAs are joint methodologies developed by the United Nations, the World Bank and the European Union. RPBAs are used to assess and address recovery and peacebuilding needs in countries affected by conflict or that are transitioning out of crisis. They identify immediate, medium-term and long-term priorities. PDNAs are government-led assessments that evaluate the physical, economic and human impacts of disasters, consolidating findings into a single report to estimate recovery needs and prioritize actions. RDNAs are rapid assessments deployed shortly after a disaster or conflict to evaluate physical damage, economic losses and immediate recovery needs. They are typically based on the damage and loss assessment methodology, which provides a structured approach to estimating the impact of disasters but is adapted for faster implementation.

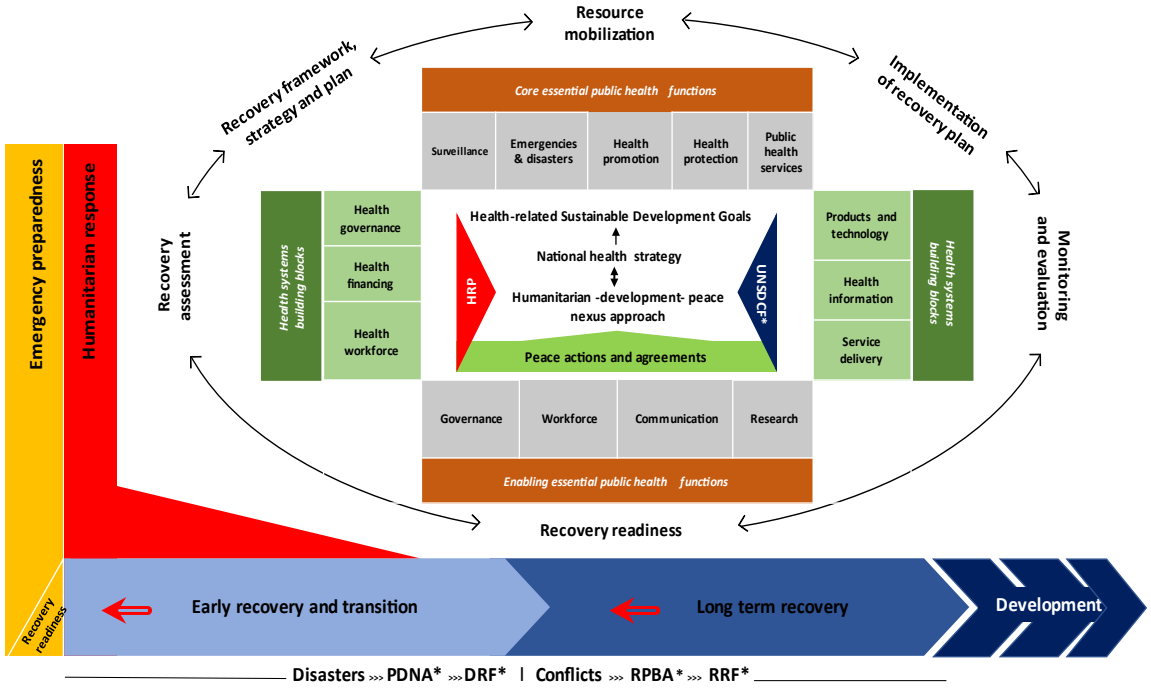

Fig. 2. Operational framework for health systems recovery process in FCS

* DRF: disaster recovery framework; PDNA: post disaster needs assessment; RPBA: recovery and peace building assessment; RRF: recovery and resiliencefframework; HRP: humanitarian response plan, UNSDCF: United Nations Sustainable Development Cooperation Framework.

Health systems recovery steps: adaptable to the dynamic context of FCS

Recovery readiness

40. Recovery readiness ensures that systems and stakeholders are prepared to assess needs, design interventions and implement recovery activities effectively.

41. Recovery readiness begins with the integration of recovery into broader emergency preparedness frameworks and should be in place before the event whenever possible. However, this is more feasible for natural disasters and other predictable emergencies than for conflicts. It should also be done before any recovery planning in the early and long-term phases of protracted emergencies, and repeated and revised regularly in line with changes to the emergency.

42. Key actions of recovery readiness include:

- establishing a recovery coordination mechanism;
- designating and training focal points for recovery leadership;
- strengthening information systems to assess the economic impact and human costs of emergencies.

43. Readiness also involves preparing for formal assessments such as RPBAs, PDNAs or RDNAs. An evaluation of readiness can be conducted through standalone tools or integrated into after action reviews or intra-action reviews *(45)* to identify gaps and strengthen preparedness for future recovery efforts.

Recovery assessment

44. Recovery assessment aims to provide information needed for recovery planning and implementation. It covers *(46)*:

- evaluating the effect of the emergency on infrastructure and assets, service delivery, access to services, and governance and social processes;
- assessing underlying risks and vulnerabilities for building back better;
- estimating the damage and loss caused by the emergency;[5]
- estimating macro-economic consequences;
- identifying recovery needs based on the abovementioned evaluation and estimations.

45. The findings shape recovery priorities and inform investment decisions as well as resource mobilization. Where possible, assessments should be part of multisectoral efforts such as PDNAs, RPBAs, or health disaster recovery needs assessments (HDRNAs). In complex or overlapping crises, hybrid approaches may be necessary.

46. Although data quality may be limited, relevant information usually exists across multiple sources. Triangulating this data is essential for building a comprehensive picture of recovery needs. All assessments should be context-specific, politically sensitive and aligned with peacebuilding goals. They should be regularly updated to reflect changing conditions and, where necessary, complemented by ad hoc studies.

Recovery planning

47. Recovery planning translates assessment findings into a structured framework, strategy and plan. It articulates objectives for restoring essential services, rebuilding infrastructures, meeting increased health needs and strengthening health systems and public health functions.

48. In FCS, recovery plans must be flexible and responsive to changing circumstances, while maintaining a long-term focus on resilience and development. An area-based approach should be considered to effectively address the different needs and situations of the different affected areas.

49. Recovery plans may take the form of a standalone health recovery strategy and framework, a component of a broader multisectoral recovery or an integrated module within sectoral development plans.

50. Early recovery and resilience-building priorities should also be reflected in humanitarian needs overviews and humanitarian response plans (HRP). Ideally, the HRP will be multi-year and will include early recovery objectives aligned with the broader health recovery framework.

Resource mobilization

51. Effective health systems recovery requires predictable, flexible and well-aligned financing. A balanced approach combining domestic resources with international support ensures ownership and sustainability. Critical enablers in FCS include:

- bridging funds to facilitate the transition from response to recovery;
- multi-year funding to support recovery from complex or protracted emergencies;
- strong public financial management and transparency.

52. Aligning donor support with national health priorities maximizes impact. Where possible, pooled or trust fund mechanisms can streamline coordination and reduce fragmentation.

[5] “Damage” refers to total or partial destruction of physical assets, while “loss” refers to changes in economic flows as result of loss of revenue or unexpected expenditures to meet humanitarian needs.

Implementation

53. Implementing recovery strategies requires coordinated engagement among national authorities, United Nations agencies, donors and civil society organizations. Where government capacity is limited, implementation should be designed not only to deliver services but also to build local leadership, institutional systems and workforce capacity.

54. A dedicated recovery coordination mechanism should link strategic oversight with operational delivery, supported by ongoing risk analysis and contingency planning. Additionally, key elements of successful recovery implementation include:

- multisectoral collaboration and partnership;
- creating synergies between humanitarian and development coordination mechanisms and efforts;
- coordination between sectoral clusters (such as health and nutrition) and the early recovery cluster;
- engaging local communities and actors to ensure their participation and ownership;
- resource mapping and expenditure tracking to ensure accountability;
- adaptive management to address evolving risks.

Monitoring and evaluation

55. Monitoring and evaluation ensure the recovery is effective, accountable and adaptive to evolving conditions. Given the unpredictability of fragile contexts, regular risk assessments and contingency planning are critical to maintaining recovery momentum.

56. The monitoring and evaluation of a recovery process include the following:

- process evaluations to track implementation quality and identify operational barriers;
- outcome evaluations measuring progress using defined recovery objectives and corresponding indicators;
- operational and lessons-learned reviews, embedded in after action reviews or intra-action reviews and/or separate from them, to support institutional learning.

57. Box 1 on pages 12–13 provides examples from the initiatives that countries and international partners have taken towards health systems recovery.

Roles and responsibilities of national and international actors

58. Effective health systems recovery in FCS depends on the coordinated engagement of national authorities and international partners, including WHO and the broader health, humanitarian and development communities. Their roles are distinct but complementary across the different phases of health systems recovery, as well as during preparatory periods.

Before emergencies and at the beginning of any new recovery process

59. To prepare for effective post-crisis recovery, national health systems should establish a foundation of institutional readiness before any event whenever possible. However, in the context of FCS this should also be established before any recovery planning in the early and long-term phases of protracted emergencies or any overlapping acute emergencies and revised regularly in line with changes to the emergency situation. The key activities include:

- establishing a recovery coordination mechanism within the ministry of health to provide leadership and operational oversight;
- designating and training a recovery focal point team to manage intersectoral planning and response;
- integrating recovery planning into national emergency preparedness frameworks, ensuring it is embedded in health security and risk reduction strategies;
- conducting a health system risk assessment using all-hazard and vulnerability analysis to inform scenario-based planning.

60. To support these efforts, WHO and other health sector partners are expected to:

- strengthen intra-organization technical and operational capacities for supporting health systems recovery in FCS;
- leverage regional and national partnership platforms and mechanisms, in particular, the Regional Health Alliance *(47)*;
- provide institutional capacity-building to ensure countries have the leadership, tools and structures needed for the recovery process;
- support comprehensive health system assessments and the development of scenario-based recovery contingency plans to improve anticipatory action and prioritization.

Early recovery and transition

61. During the early phase of recovery, while an emergency response may still be ongoing, national health systems should:

- activate or establish coordination platforms that engage actors across health and non-health sectors;
- lead or co-lead recovery assessments to evaluate damage, loss and gaps in service delivery;
- develop a national recovery strategy and plan, grounded in assessment findings and national priorities;
- launch advocacy efforts to mobilize both domestic and international recovery funding;
- initiate implementation of priority recovery actions, including restoration of services and infrastructure.

62. In parallel, WHO and partners contribute by:

- providing technical support for recovery assessments and scenario modelling to inform strategic planning;
- assisting in the drafting of national recovery strategies and costed implementation plans, ensuring feasibility and alignment with broader health goals;
- advocating for and coordinating donor engagement to ensure adequate and sustained recovery financing;
- supporting coordination and convening across health sector actors to reduce duplication and promote synergy;
- ensuring the continuity of essential services during the transition period, particularly for vulnerable populations;
- building national capacity for implementation and leadership of recovery efforts through training and advisory support;
- facilitating access negotiations and policy dialogue in conflict-affected settings to maintain humanitarian space and enable service delivery.

Long-term (sustainable) recovery

63. As countries move beyond the immediate aftermath of crisis, national health systems take the lead in institutionalizing recovery and advancing long-term health system strengthening and development. Key responsibilities include:

- regularly reviewing and adapting the national recovery strategy to respond to evolving needs, evidence and feedback;
- scaling up and sustaining recovery implementation through national systems and platforms;
- transitioning health financing away from external dependency towards domestic public financing, anchored in fiscal policy and budget reform;
- shifting operational management of services from international actors to national ownership and oversight;
- developing and implementing a social health protection plan, aligned with UHC principles, to promote equitable access and financial protection.

64. WHO and partners continue to play a strategic role by:

- supporting domestic resource mobilization strategies and fiscal transition planning to ensure sustainability of recovery gains;
- integrating vertical or parallel service delivery platforms established during emergencies into national health systems;
- strengthening national data systems to ensure continuity, comprehensiveness and equity of health services, including those provided to refugees and migrants;
- co-leading monitoring and evaluation with government stakeholders to track progress and support adaptive implementation;
- documenting and disseminating lessons learned, good practices and innovations emerging from country recovery experiences to inform ongoing efforts and future preparedness.

Box 1. Applying the health systems recovery framework in FCS: Regional practices and examples

Countries in the Eastern Mediterranean Region are increasingly applying the WHO health systems recovery framework across the recovery phases and in preparation for recovery attempts. The following examples illustrate how countries have begun to operationalize specific priority actions, despite fragile contexts and ongoing challenges.

Example 1. Palestine: Preparing for health system recovery amid escalating conflict in the Gaza Strip

Over the past seven decades, Palestine has experienced numerous escalations of conflict, with the events following 7 October 2023 among the most devastating. In response to this unprecedented crisis, the United Nations Country Team and the Humanitarian Country Team prioritized immediate humanitarian relief, while simultaneously planning for early and medium-term recovery.

This dual-track approach was implemented in collaboration with the Palestinian Authority and supported by strategic partnerships with the World Bank and the European Union. Within this framework, WHO, as the health sector lead, along with health sector members, undertook several key actions to ensure its readiness for supporting a recovery process that is integrated into the humanitarian response and can commence even under constrained conditions *(48)*. These actions included establishing a three-level recovery working group at the onset of the crisis, recruiting a recovery technical officer at the WHO country office, strengthening health information systems, compiling baseline data essential for recovery assessments, actively participating in local, national and multipartner coordination mechanisms and developing a health system recovery principles paper.

These efforts enabled health sector partners to effectively contribute to an interim RDNA *(49)* as a key resource for critical initiatives such as the Health Sector Recovery Strategy, the Conflict Recovery Framework and national recovery plans, particularly the Palestinian Authority's Gaza Recovery and Reconstruction Plan. It is critical to have a clear recovery strategy and coordination mechanism in place before funding becomes available.

Example 2. Sudan: Adaptive strategies to continue the maternal death surveillance and response system

Since the escalation of armed conflict in April 2023, Sudan has been grappling with a prolonged humanitarian crisis that has severely disrupted its health system across all 18 states. Amid these formidable challenges, the Federal Ministry of Health has demonstrated notable resilience and adaptability in sustaining essential health surveillance functions, including the maternal death surveillance and response (MDSR) system.

Established in 2009, the MDSR system is designed to reduce maternal mortality through the systematic notification, review and response to maternal deaths. In the context of widespread disruption, the Federal Ministry of Health, with technical and logistic support from the United Nations Population Fund (UNFPA), implemented a series of adaptive strategies to ensure the continuity of this critical system.

By simplifying and modifying procedures outlined in national guidelines, the Federal Ministry of Health was able to maintain core functions such as case notification, review and supportive supervision. MDSR committee meetings continued in 11 states despite the ongoing conflict. Furthermore, with support from UNFPA, the MDSR system was successfully integrated into the District Health Information Software 2 (DHIS2) platform, enhancing data collection, management and analysis capabilities.

In 2024, a total of 1024 maternal deaths were reported through the MDSR system, of which 857 cases (84%) underwent comprehensive review. These reviews provided critical insights into the underlying causes and contributing factors of maternal mortality, informing targeted interventions in emergency obstetric care, infection prevention and control (IPC), and the training and supervision of frontline health workers.

This experience highlights the potential for early recovery and resilience in health surveillance during conflict by leveraging existing systems and adapting to the ongoing conflict and local contexts.

Example 3. Syrian Arab Republic: Post-earthquake recovery while responding to conflict

In the Syrian Arab Republic, the 7.8-magnitude earthquake on 6 February 2023, followed by a 6.4-magnitude (Mw) aftershock along the border with Türkiye two weeks later, significantly worsened the already dire conditions caused by 12 years of conflict. In response, the World Bank conducted a Global Rapid Post-Disaster Damage Estimation (GRADE) *(50)* focused on assessing direct physical damages in the country. Building on this, the World Bank launched the Syria Rapid Damage and Needs Assessment *(51)*, providing preliminary estimates for infrastructure reconstruction and service delivery restoration. The assessment also outlined guiding principles for recovery and building back better during both the early recovery phase (0–12 months) and the short-term recovery phase (1–3 years).

In parallel, the United Nations carried out the Syria Earthquake Recovery Needs Assessment, based on the PDNA methodology. With the participation of 11 United Nations agencies, funds and programmes, it proposed a three-year earthquake recovery and disaster risk reduction strategy to support affected communities and national recovery efforts.

In this context, the health recovery strategy had to address the compounded impacts of prolonged conflict, the COVID-19 pandemic, a cholera outbreak and the earthquake on the health system of the Syrian Arab Republic. Immediate priorities included restoring essential health services in operational facilities and continuing service delivery through mobile units in areas lacking functional health infrastructure. Medium- to long-term priorities focused on rebuilding human resources, rehabilitating damaged health care facilities, strengthening emergency care and pandemic preparedness and engaging the private health sector to ensure the provision of affordable services.

Example 4. Somalia: Adopting the nexus approach by aligning the Humanitarian Response Plan and the Health Sector Strategic Plan

Somalia's health system has been severely weakened by over three decades of civil war, political instability and recurring natural disasters. Despite these challenges, the government, alongside international partners, is working to seize opportunities for recovery and resilience-building, while continuing to address urgent humanitarian needs.

On one hand, the Humanitarian Response Plan focuses not only on life-saving interventions but also aims to deliver comprehensive health services through an integrated model that includes strengthened referral pathways *(52)*. On the other, the Health Sector Strategic Plan 2022–2026 (HSSP III) sets out medium-term goals to improve access to affordable, equitable and high-quality health services, guided by a primary health care approach *(53)*. This strategy builds on evidence from the 2020 essential package of health services, which promotes the expansion of integrated service delivery as a cornerstone of health system recovery and development.

Bridging these two efforts, WHO, UNICEF and other partners support both plans. Additionally, Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Financing Facility and the World Bank align their financing with national priorities to strengthen primary health care, essential health services and supply chain management systems *(54)*.

Example 5. Iraq: Post-conflict transition from humanitarian response to development

For over a decade, Iraq faced significant humanitarian challenges due to conflict, mass displacement and the collapse of health infrastructure. By 2022, however, the humanitarian landscape began to evolve, with many emergency programmes transitioning to national ownership *(55)*. This marked a pivotal shift in Iraq's health system from one driven by crisis response to a focus on recovery, resilience and sustainable development.

Building on the lessons learned from the humanitarian response, the Government of Iraq devised the National Development Plan (2018–2022), followed by an updated plan for 2024–2028 *(56),* that formulated strategic objectives for the health sector related to enhancement of health sector governance, health insurance, health infrastructures, health care services, disease control and prevention, health workforce and private sector engagement.

The years 2022–2023 were also a time of recovery from the public health impact of the COVID-19 pandemic, and Iraq leveraged progress made during the pandemic response to strengthen its health system.

In parallel, the Ministry of Health with support from WHO conducted a Universal Health and Preparedness Review *(57)*, becoming the first country in the Eastern Mediterranean Region to do so. The review reinforced Iraq's strategic direction for recovery by identifying critical operational priorities, including strengthening primary health care, enhancing surveillance and information systems, improving health financing and boosting emergency preparedness. Of course, strengthening primary health care was not a new direction, but rather a foundational element of Iraq's humanitarian health response that laid the groundwork for Iraq's recovery and for pursuing UHC, health security and other health-related SDGs *(58)*.

In support of these priorities, Iraq has made substantial progress in digital transformation of health information systems as a cornerstone of health systems recovery, through the institutionalization of the Health Resources and Services Availability Monitoring System (HeRAMS) and expanding the national District Health Information System 2 (DHIS2) platform *(59)*. This transformation has significantly improved data quality, outbreak detection, resource planning and accountability in service delivery.

Conclusion

65. Health systems recovery in the Eastern Mediterranean Region is not a luxury but a strategic necessity. As conflicts, disasters and overlapping emergencies continue to destabilize lives and institutions, recovery has emerged as the cornerstone of resilience. This is not merely about restoring what was lost, but about reimagining and rebuilding systems that are stronger, more equitable and more capable of withstanding future shocks.

66. This paper argues that recovery must begin early, be embedded in national leadership and bridge humanitarian, development and peacebuilding domains. It must be locally owned, politically informed and grounded in the realities of FCS. The Region cannot afford fragmented or reactive approaches – what is required is deliberate, coordinated and forward-looking action.

67. Recovery is not only about systems; it is about sovereignty, stability and dignity. For millions living in protracted crises, rebuilding health systems is a pathway to restoring hope and trust in institutions. It is also the most cost–effective investment in preparedness, equity and sustained peace.

68. The operational framework outlined in this paper provides a practical approach that is adaptable to country contexts, aligned with WHO's Strategic Operational Plan for the Eastern Mediterranean Region 2025–2028 and rooted in real-world lessons from across the Region and beyond. However, frameworks alone are not enough. What is needed now is political will, sustained financing and a bold commitment to act, especially in the most complex and neglected settings.The Eastern Mediterranean Region has already demonstrated that recovery is possible, even in the face of deep fragility. The challenge now is to ensure that recovery processes are institutionalized, and are planned and funded. The future of health in the Region depends on it.

69. This year's paper and the accompanying discussion aims to build momentum for health systems recovery in FCS. Member States are invited to endorse the corresponding resolution as a key milestone towards achieving UHC, health security and other health-related SDGs.

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Annex 1. Selected population and health system indicators in FCS countries in the Eastern Mediterranean Region and comparison with non-FCS countries

Indicator	Afghanistan	Iraq	Lebanon	Libya	Palestine	Somalia	Sudan	Syrian Arab Republic	Yemen	Non-FCS range	Non-FCS mean	Non-FCS median
Health impact												
Life expectancy at birth (years) (2021) *(1)*	59.13	71.47	74.34	72.18	73.49	53.95	67.59	72.44	65.76	64.87–78.95	73.41	74.38
Healthy life expectancy (HALE) at birth (years) (2021) *(1)*	50.4	61	63.2	62.1	62.9	47.4	58.5	62.3	56.5	56.99–67.78	63.86	63.98
Maternal mortality ratio (per 100 000 live births) – SDG 3.1.1 (2020) *(1)*	620	76	21	72	20	621	270	30	183	7.17–154.16	34.67	16.91
Neonatal mortality rate (per 1000 live births) – SDG 3.2.2 (2022) *(1)*	35.5	13.4	10.4	5.5	8.9	35.1	25.7	10.5	21.9	2.61–38.76	10.16	7.62
Under-5 mortality rate (per 1000 live births) – SDG 3.2.1 (2022) *(1)*	57.7	23.5	17.4	10.3	14.3	106.1	51.6	21.4	41.3	5.25–60.96	17.57	11.46
Probability of dying from any of cardiovascular disease, cancer, diabetes, chronic respiratory disease between the exact ages 30 and 70 (%) (premature death from noncommunicable diseases) – SDG 3.4.1 (2021) *(2)*	32.7	22.7	11.9	19.8	18.3	27.6	21.2	21.3	25.8	9.3–26	16.05	13.9
Tuberculosis incidence (per 100 000 population) – SDG 3.3.2 (2022) *(1)*	80	21	10	59	0.35	243	50	17	48	0.8–92	20.95	11
Health outcomes												
Universal health coverage (UHC)												
UHC: Service coverage index – SDG Indicator 3.8.1 (2021) *(1)*	41	59	73	62	NA	27	44	64	42	43.91–81.77	68.57	70.23
Population with household expenditures on health > 10% of total household expenditure or income (%) – SDG Indicator 3.8.2 (2014-2021) *(1)*	26.08	19.57	26.6	NA	9	0.13	12.46	6.88	15.83	0.37–31.14	7.76	5.14
Population with household expenditures on health > 25% of total household expenditure or income (%)) – SDG Indicator 3.8.3 (2014–2021) *(1)*	8.03	4.18	6.3	NA	1.5	0	1.75	1.41	4.16	0.04–6.10	1.48	0.96
Health security												
Prepare – SDG indicator 3.d.1. International Health Regulations (IHR) capacity and health emergency preparedness *(3)*	35	59	70	38	44	41	33	55	44	30–97	78	78

Indicator	Afghanistan	Iraq	Lebanon	Libya	Palestine	Somalia	Sudan	Syrian Arab Republic	Yemen	Non-FCS range	Non-FCS mean	Non-FCS median
Health outputs												
Physical accessibility												
Percentage of facilities offering services according to national defined service package	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Percentage of facilities meeting minimum standards to deliver tracer services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Percentage of facilities compliant with IPC measures	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Financial accessibility												
Out-of-pocket health expenditure as % of current health expenditure (2022) *(4)*	77.95	47.83	33.42	30.47	33.55	42.14	51.42	45.73	70.2	7.48–53.83	27.84	30.99
Inputs												
Health financing												
Current health expenditure as % gross domestic product (2022) *(5)*	23.09	4.29	5.74	4.65	9.73	2.62	4.62	4.15	6.19	2.18–9.73	4.50	4.62
Current health expenditure per capita in US$ (2022) *(6)*	80.65	254.62	392.38	278.38	350.64	15.35	31.58	34.36	38.12	38.77–2315	777.89	295.1
Domestic general government health expenditure as percentage of general government expenditure (%) (2022) *(7)*	1.13	5.84	15.5	5.06	13.48	2.5	6.72	7.78	2.51	5.15–19.03	9.33	8.31
Health workforce												
Density of medical doctors (per 10 000 population) – SDG 3.c.1 (2014–2023) *(8)*	3.17	10.22	26.8	20.42	21.68	0.48	2.5	15.21	0.98	1.94–84.89	34.21	28.76
Density of nursing and midwifery personnel (per 10 000 population) (2014–2023) *(9)*	5.49	26.48	19.18	63.77	19.53	2.61	10.83	17.57	5.41	1.94–84.89	34.49	28.76
Density of dentists (per 10 000 population) (2014–2023) *(10)*	0.06	5.02	12.5	5.8	7.215	0	2.5	10.22	0.19	0.06–8.85	4.94	3.68
Density of pharmacists (per 10 000 population) (2014–2023) *(11)*	0.32	6.19	16.3	4.1	11.30	0.02	0.24	16.31	0.53	1.65–20.30	7.49	6.14
Physical infrastructure												
Primary health care facilities per 10 000 population (2020) *(12)*	1.2	7.1	2.5	2.1	1.4	NA	1.5	0.9	1.4	0.2–7.0	1.85	0.7
Medicines and other health products												
Availability of selected essential medicines in public and private health facilities – SDG 3.b.3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Public (2020) *(12)*	NA	NA	NA	13	92	NA	48.7	NA	NA	96.7–100	99.3	100
Private (2020) *(12)*	NA	NA	NA	NA	100	NA	59	NA	NA	11.6–100	86.9	100

Indicator	Afghanistan	Iraq	Lebanon	Libya	Palestine	Somalia	Sudan	Syrian Arab Republic	Yemen	Non-FCS range	Non-FCS mean	Non-FCS median
Health facility functionality (HeRAMs)												
% Health facilities fully functional (HeRAMs)* (2024) *(13)*	91	70	NA	NA	0	94	51	93	61	NA	NA	NA
% Health facilities partially functional (HeRAMs)* (2024) *(13)*	8	30	NA	NA	46	2	11	6	35	NA	NA	NA
% Health facilities non-functional (HeRAMs)* (2024) *(13)*	1	0	NA	NA	54	4	38	1	4	NA	NA	NA
% Health facilities not damaged (HeRAMs)* (2024) *(13)*	76	79	NA	NA	11	84	83	89	89	NA	NA	NA
% Health facilities partially damaged (HeRAMs)* (2024) *(13)*	15	19	NA	NA	75	8	16	2	9	NA	NA	NA
% health facilities fully damaged (HeRAMs)* (2024) *(13)*	0	0	NA	NA	14	0	1	0	2	NA	NA	NA
Attacks on health care												
Attack on health care (2024) *(14)*	2	NA	149	NA	715	3	72	84	NA	NA	NA	NA

* This analysis is based on HeRAMs data from seven of the Region's countries classified by the World Bank as being FCS. The number of reporting health facilities includes facilities in Afghanistan (4503), Iraq (5092), Somalia (430), Sudan (2366), the Syrian Arab Republic (127) and Yemen (5371). For Palestine, data includes only 35 hospitals from the Gaza Strip.

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