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December 01, 2023

Law 394 Post-Conflict Justice & Law

Healing the Wounds:

Addressing Health Needs with a Gender-Responsive Focus During Post-Conflict Reconstruction

I. Introduction

The aftermath of armed conflict, no matter the cause or forces involved, culminates in the destruction of institutions, devastation of civilian life, and persistence of humanitarian and human rights violations.[1] War and violence break down local systems and infrastructure.[2] As a result, accessible adequate assistance is unavailable for individuals who need it the most.[3] Specifically, armed conflicts have a profound impact on population health through violence, displacement, damage to infrastructure, and the disruption of public health services; ultimately, this prevents conflict-affected countries from providing adequate health care to address the increased health needs of their populace.[4] However, the repercussions of armed conflict go beyond population harm as it also transforms health systems and influences the wider social determinants of health like socioeconomic status and gender barriers.[5] Consequently, vulnerable populations "affected by conflict and violence are at risk of death, displacement, loss of loved ones and injury - among others - and need medical care for both physical and psychological conditions."[6]

Thus, in *Part II: Addressing Health Needs in Post-Conflict Reconstruction*, this paper explores the implications of conflict on health concerns for a specific vulnerable population—women and girls—in

[1] *Armed Conflict*, AMNESTY INT'L, https://www.amnesty.org/en/what-we-do/armed-conflict/ (last visited Nov. 26, 2023).
[2] *Kuwait: ICRC Discusses Impact of Armed Conflict on Mental Health, Urges to Address Unmet Needs*, INT'L COMM. OF THE RED CROSS (Mar. 14, 2019), https://www.icrc.org/en/document/kuwait-icrc-discusses-impact-armed-conflict-mental-health-urges-address-unmet-needs [hereinafter *Impact of Armed Conflict*].
[3] *Id.*
[4] *See* Sylvia Garry & Francesco Checchi, *Armed Conflict and Public Health: Into the 21st Century*, 42 J. PUB. HEALTH e287, e287 (2019).
[5] *Id.* at e289.
[6] *Impact of Armed Conflict*, *supra* note 2 (quoting the speech of International Committee of the Red Cross's lead clinical psychologist, Milena Osorio, at the Middle East Psychological Association's conference in Kuwait).

fragile and conflict-affected countries. Within Part II, *Subsection A: The Impact of Conflict on Health Care* outlines the need to balance both the immediate and long-term health impacts of armed conflict during post-conflict reconstruction. Specifically, this subsection breaks down how the ideal health recovery process progresses from providing emergency services during the initial transitional phase of reconstruction to laying the groundwork for achieving a resilient and sustainable health system as an end goal. *Subsection B: Ensuring Gender-Responsive Health Care* identifies how the reconstruction phase presents a unique opportunity to develop a gender-responsive health system that provides nondiscriminatory health care by ensuring women and girls are incorporated in the research and redevelopment process for addressing health needs. Before discussing the actions necessary for bolstering gender equity in health care, this subsection highlights how the status quo upholds prejudicial structures that are detrimental to women's health needs. *Subsection C: A Right to Health and Legal Protections for Healthcare Needs* discusses how the need for gender-responsive health care is not only critical for a country's long-term well-being but is also legally protected by a right to health for all individuals and other legal mandates that play a role during and after armed conflict.

To explore this topic in a specific country, *Part III: Case Study: Afghanistan* discusses the decades of conflict Afghanistan has endured and its impact on the health needs of the country, particularly for women and girls. Within Part III, *Subsection A: History of the Conflict and the Impact on Women and Girls* summarizes the power struggle in Afghanistan, involving internal and external actors, that lasted over four decades and culminated in the resurgence of the Taliban regime. This subsection further discusses the armed conflict and the Taliban's impact on women and girls more broadly. *Subsection B: Health Needs in Afghanistan* dives further into the impact of conflict on the health needs in Afghanistan by outlining the immediate and long-term health concerns that have been unsustainably addressed by international actors. *Subsection C: Gender-Equity in Afghanistan's Health Systems* ties discussions from the previous two subsections together by focusing on the need and opportunity to ensure a gender-equitable health system develops in Afghanistan. The final part, *Part IV: Conclusion* highlights how gender equity in developing resilient and sustainable health systems is critical for a country's well-being

and is legally mandated during post-conflict reconstruction, as demonstrated by the need to rebuild a gender-responsive health system in Afghanistan.

II. Addressing Health Needs in Post-Conflict Reconstruction

A. The Impact of Conflict on Health Care

Armed conflict extensively devastates population health outcomes of the affected countries, negatively impacting nearly all metrics of health in some capacity.[7] The direct effects of conflict on population health include an increase in mortality and morbidity resulting from war-related injuries, forced labor, unlawful detention, and sexual violence in the conflict-affected region.[8] In conjunction with the direct effects of war-related atrocities are the longstanding impacts of conflict that lead to an indirect deterioration of public health through increased population displacement and psychological disorders.[9] Population displacement, in turn, promotes the transmission of communicable diseases,[10] increases the risk of violence, and exacerbates malnutrition rates; an increase in psychological disorders makes post-traumatic stress disorder, depression, and anxiety more prevalent.[11] Mental health services, beyond addressing psychological disorders, are often neglected in emergencies.[12] In post-conflict societies, immediate health concerns often include support for these disease outbreaks, food insecurity, emergency medical care services, and mental health support.[13] While providing immediate assistance for pressing

[7] Spencer Rutherford & Shadi Saleh, *Rebuilding Health Post-Conflict: Case Studies, Reflections, and a Revised Framework*, 34 HEALTH POL'Y AND PLAN. 230, 231 (2019).
[8] *Id.*
[9] *Id.*; Anushka Ataullahjan et al., *Investigating the Delivery of Health and Nutrition Interventions for Women and Children in Conflict Settings: A Collection of Case Studies from the BRANCH Consortium*, 14 CONFLICT AND HEALTH 1, 1-2 (2020).
[10] The spread of diseases can also cause greater harm than the disease itself as it leads to a significant proportion of mortality in conflict-affected settings. For example, in the Democratic Republic of Congo, the Ebola virus was a burden beyond the epidemic itself since it diminished broader disease mitigation efforts. *See* M.C. Van Hout & J.S.G. Wells, *The Right to Health, Public Health, and COVID-19: A Discourse on the Importance of the Enforcement of Humanitarian and Human Rights Law in Conflict Settings for the Future Management of Zoonotic Pandemic Diseases*, 192 PUB. HEALTH 3, 4 (2021).
[11] Rutherford & Saleh, *supra* note 7; Ataullahjan et al., *supra* note 9, at 1.
[12] *See* Muhammad Ali Pate & Franck Bousquet, *Ensuring Healthcare on the Frontlines of Conflict and Crisis*, WORLD BANK: DEV. FOR PEACE (Mar. 11, 2020), https://blogs.worldbank.org/dev4peace/ensuring-healthcare-frontlines-conflict-and-crisis.
[13] *See* Rutherford & Saleh, *supra* note 7; *see also* Ataullahjan et al., *supra* note 9, at 1.

health concerns in the aftermath of armed conflict is critical, it is important to consider the long-term well-being of the population through its healthcare system as well.

Armed conflict has an equally destructive effect on health systems. The World Health Organization (WHO) breaks down the essential components of health systems into the following six building blocks: (1) health service delivery, (2) human resources/the health workforce, (3) health information systems, (4) health system financing, (5) essential medical products and technologies, and (6) leadership and governance.[14] Unfortunately, there is a severe lack of research regarding health systems strengthening in fragile and conflict-affected settings, making it challenging to accurately gauge the state of public health using conventional health indicators.[15] Despite the difficulty in evaluating the direct and indirect consequences of violence on health systems and their components in conflict-affected settings, it is critical to do so in order to measure public health outcomes.[16] The quality of preventative and curative services in health systems deteriorates during armed conflict, and the actions of armed actors disregarding humanitarian principles exacerbate the resulting negative impacts.[17] The frequent attacks on health infrastructure—including health professionals such as doctors and pharmacists, and health facilities such as hospitals and clinics—result in a depletion of the health workforce, disruption to health service delivery, and limitations to essential medical products accessibility.[18] The health workforce faces added complications with coercive pressures to provide partisan care and work with limited supplies.[19] Additionally, a depleted health infrastructure also weakens monitoring systems and reduces available health information, two critical components of creating targeted initiatives improving health outcomes in

[14] World Health Organization [WHO], *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies*, i, vi (2010), https://iris.who.int/bitstream/handle/10665/258734/9789241564052-eng.pdf; Valerie Percival et al., *Health Systems and Gender in Post-Conflict Contexts: Building Back Better?*, 8 CONFLICT AND HEALTH 1, 5 (2014).
[15] *See* Tim Martineau et al., *Leaving No One Behind: Lessons on Rebuilding Health Systems in Conflict- and Crisis-Affected States*, 2 BMJ GLOB. HEALTH 1, 1 (2017).
[16] Manar Marzouk et al., *Health System Evaluation in Conflict-Affected Countries: A Scoping Review of Approaches and Methods*, 17 CONFLICT AND HEALTH 1, 2 (2023).
[17] Ataullahjan et al., *supra* note 9, at 1. Examples of how actors in armed conflict abandon principles of humanity and neutrality include the free reign of aerial bombardments and artillery fires that threaten health facilities. *Id.*
[18] *Id.*; Rutherford & Saleh, *supra* note 7; Martineau et al., *supra* note 15, at 2, 4.
[19] Van Hout & Wells, *supra* note 10.

conflict-affected regions.[20] Finally, armed conflict typically results in or occurs in conjunction with the collapse of leadership and governance, making health policies and financing mechanisms obsolete.[21]

Rebuilding healthcare systems involves coordination between international organizations, governments, and non-government organizations (NGOs) to invest in foundational health infrastructure, a robust healthcare workforce, and specific health programs.[22] Development actors primarily focus on preserving primary healthcare systems in the wake of conflict in order to ensure that all individuals can access essential health services.[23] In post-conflict health reconstruction, these actors focus on providing services for vulnerable populations—women, children, ethnic minorities, people with disabilities, and LGBTQ populations—where conflict disrupted the continuity of healthcare services through displacement, alongside strengthening health systems to mitigate the debilitating impacts of future conflicts.[24] The government's ability to deliver basic health services to the entire population is unfortunately compromised.[25] Development and humanitarian actors step in to fill the gap, but they often face numerous obstacles when assisting with critical health service delivery.[26] Specifically, aid workers face violent attacks, new emerging infectious disease outbreaks divert attention and resources[27] at the expense of continuing foundational health services, and variability in local sociopolitical contexts complicate the development of a baseline standard to meet for the quality of health services.[28]

Nevertheless, at the end of conflict and in the post-conflict period, international agencies take on the role of providing urgent health services.[29] It is crucial, however, for both international and local actors to balance sustainable health outcomes with immediate health needs by introducing health reform

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[20] Rutherford & Saleh, *supra* note 7.
[21] *Id.*
[22] *See* Pate & Bousquet, *supra* note 12.
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] Ataullahjan et al., *supra* note 9, at 1.
[27] For example, the cholera outbreak in Yemen or the Ebola epidemic in the Democratic Republic of the Congo diverted resources and funding. *Id.* at 2.
[28] *Id.*; Rutherford & Saleh, *supra* note 7.
[29] Martineau et al., *supra* note 15, at 2.

measures that also increase local health capacities and structures.[30] Given that post-conflict reconstruction requires coordination between multiple stakeholders, the complexities and current research generally focus on the immediate needs following conflict rather than the health system as a whole. [31] Ideally, the first year of post-conflict reconstruction should be transitional and involve the continuation of emergency services, and then the next few years should focus on rehabilitation and reconstruction of the health system. [32] The end goal in post-conflict countries should be "sustainable development" where the health sector is indistinguishable from other developing countries, irrespective of the damage caused by armed conflict. [33]

In any case, the rebuilding process is slow and prolonged.[34] International actors have to coordinate to focus on the six components of a health system as defined by the WHO. [35] There is also debate on the level of reform because too many reforms can overwhelm an already weakened health system and may make it difficult to transfer ownership of the health system to local institutions, risking unsustainable dependency on foreign aid. [36] The impact of prolonged international aid is a fragmented health system that lacks a strong foundation and is unsustainable.[37] External actors are often limited in the resources and support they provide to lay the groundwork for indigenous health operation capacities during the immediate emergency aftermath or the long-term rehabilitative period following a conflict, increasing the risk of a turbulent transition upon the international agencies' withdrawal from the conflict-affected region. [38]

However, post-conflict reconstruction presents an opportunity for new initiatives to take shape in the country, and decisions made at an early stage of health system development have a significant

[30] Rutherford & Saleh, *supra* note 7, at 230.
[31] *Id.* at 231.
[32] *Id.*
[33] *Id.*
[34] *See id.*
[35] *See id.*
[36] *Id.* at 232.
[37] Martineau et al., *supra* note 15, at 2.
[38] *Id.*

influence on the country's health system evolution.[39] As a result, the immediate post-conflict period is critical for both the immediate health outcomes and the long-term trajectory of resilient and sustainable health system development.[40] Thus, countries in a post-conflict period have the unique opportunity of prioritizing gender-responsive health recovery to ensure the basis for gender equity in health systems is present in the immediate aftermath of conflict and beyond.

B. Ensuring Gender-Responsive Health Care

Gender inequity poses a significant ongoing challenge within the health sector. Health systems broadly are not gender-neutral, but rather reflect the structures of oppression and discrimination that exist in society.[41] Societal perceptions of women have a direct impact on their health outcomes.[42] According to the Women and Gender Equity Knowledge Network, structural inequities in society based on discriminatory values can predispose women to disease, disability, and injuries that are inadequately addressed and researched.[43] Gender bias in health services can also lead to a shorter lifespan, birth practices that endanger women's health, and miscommunication with health care providers that results in inadequate care.[44] Additionally, women have a harder time accessing health services, and when they do receive services, providers are often unequipped to adequately assess the health needs of women.[45] For example, providers overlook cardiac symptoms in women.[46] Although some distinctions in vulnerability to particular diseases are determined by biology, social conditions affect a woman's diagnosis and ability to recover from exposure to diseases.[47]

An underlying explanation for inadequate services is the influence of biases in health research that undermine the interaction between gender, social factors, and health outcomes.[48] For example, when

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[39] *Id.*
[40] *Id.*
[41] *Ensuring Gender-Responsive Health Systems*, WHO, https://www.who.int/activities/ensuring-gender-responsive-health-systems (last visited Nov. 26, 2023) [hereinafter *Gender-Responsive Health*].
[42] Percival et al., *supra* note 14, at 3.
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] *Id.*

measuring health outcomes, sex-disaggregated data is not systematically collected and research is not focused on gender-specific solutions.[49] A landscape study of health system evaluations in conflict-affected countries notably failed to include the voices of women.[50] Of the compiled studies and sources, 64% (37 of 58) did not include data disaggregated by sex and gender, and 32% of those sources (12 of 37) included primarily male participants.[51] For example, one study only interviewed male participants to explore improving security measures in Syria for accessing healthcare services.[52] Another study on noncommunicable disease care in Palestine only incorporated the perspective of male participants, except for including the perspectives of two female doctors.[53] One study analyzing the health outcomes of a diabetes clinic in the Democratic Republic of Congo only interviewed male health workers and attempted to justify the absence of a female perspective as a result of the limited number of women in the field, but other studies have noted no difficulties in recruiting and interviewing women health workers.[54] Without the representation of women in health research, it is difficult to tackle both disease-specific concerns and primary healthcare issues that plague women's healthcare service delivery.

Structurally, although women are the backbone of a robust health workforce, they are granted few opportunities for leadership positions, encounter payment disparities, remain underrepresented in decision-making capacities, and frequently face gender-based discrimination and harassment in comparison to their male counterparts.[55] Women also hold a disproportionate amount of unpaid informal roles that lack adequate social protections.[56] Although the informal health workforce plays a crucial role in supporting the health system of a country, the providers in these informal health systems are

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[49] *Id.*
[50] *See* Marzouk et al., *supra* note 16, at 7.
[51] *Id.*
[52] *Id.* (citing Nasser Fardousi et al., *Healthcare Under Siege: A Qualitative Study of Health-Worker Responses to Targeting and Besiegement in Syria*, 9 BMJ OPEN 1, 1-12 (2019)).
[53] *Id.* (citing Jane Collier & Hanna Kienzler, *Barriers to Cardiovascular Disease Secondary Prevention Care in the West Bank, Palestine – A Health Professional Perspective*, 12 CONFLICT AND HEALTH 1, 1-13 (2018)). I use "female" when discussing this study, as opposed to "women," to accurately represent the study and its parameters. The rest of this paper uses "women" when advancing my argument on the need for gender equity in healthcare.
[54] *Id.* (citing Yazan Douedari & Natasha Howard, *Perspectives on Rebuilding Health System Governance in Opposition-Controlled Syria: A Qualitative Study*, 8 INT'L J. HEALTH POL'Y AND MGMT. 233, 233-44 (2019)).
[55] Percival et al., *supra* note 14, at 10.
[56] *Gender-Responsive Health*, *supra* note 41.

undervalued and lack sufficient social and financial safeguards to continue providing aid.[57] Health system reforms have the power to either exacerbate or alleviate gender inequities.[58] To create an equitable health system that prioritizes gender pay parity and equity in the workplace, gender-responsive policies that promote women in leadership and protect working conditions are critical at all levels of health governance.[59]

Armed conflict has health impacts on the population writ large, as previously discussed, but women and girls are disproportionately affected by the violence and are often neglected during post-conflict reconstruction.[60] In times of conflict, the absence of law and order increases the risk of sex and gender-based violence, unsafe abortions, and maternal mortality.[61] Essential sexual, reproductive, and maternal health services are often the first to lose necessary attention, funding, and resources, especially when there are new outbreaks of infectious diseases.[62] The broad disruption to sexual and reproductive health services hinders the delivery of contraceptives, which results in the rise of teenage pregnancies, sexually transmitted infections, and child marriages. [63] There are also specific health concerns that arise from disrupted care. For example, the interruption of prenatal care services due to conflict leads to complications in detecting conditions such as preeclampsia and eclampsia.[64] When comparing countries of similar socioeconomic and demographic characteristics that are and are not experiencing armed conflict, there are higher rates of maternal and infant mortality in conflict-affected countries.[65] Other increased detriments to maternal health conditions include low birth weights for babies, unsafe abortions, fetal deaths, and premature births. [66] The capacity of health systems is compromised and depleted during conflict due to displaced personnel, insufficient funding, supply chain interruptions, and health facility

[57] *Id.*
[58] Percival et al., *supra* note 14, at 1.
[59] *Gender-Responsive Health*, *supra* note 41.
[60] *See* Ataullahjan et al., *supra* note 9, at 1-4.
[61] Percival et al., *supra* note 14, at 4.
[62] Pate & Bousquet, *supra* note 12.
[63] Sara Milena Ramos Jaraba et al., *Health in Conflict and Post-Conflict Settings: Reproductive, Maternal, and Child Health in Colombia*, 14 CONFLICT AND HEALTH 1, 2 (2020).
[64] *Id.*
[65] *Id.* at 3.
[66] *Id.*

damages, making it difficult to respond to the increased need for gender-based health services.[67] Even when health facilities are functioning and providing gender-specific health services—such as reproductive health services—women are faced with access issues such as financial, transportation, or familial barriers.[68] An additional challenge is the narrow focus on sexual and reproductive violence itself because it funnels resources away from other health concerns that also negatively impact women, especially when policymakers are under the false impression that incorporating health services that focus on sexual and reproductive health is sufficient and the sole need to ensure a gender-responsive health system.[69] In order to develop a resilient and sustainable health system after addressing the immediate health needs of a conflicted affected region, an equitable, gender-responsive focus is necessary during reconstruction.[70] Even though gender equity in health system reform is a crucial political and social goal for the international community engaged in post-conflict reconstruction, it is vastly under-researched and isolated from broader health system reforms.[71]

Ensuring a gender-responsive health system in a post-conflict society—a crucial component of post-conflict reconstruction—includes bolstering health research with studies including a gender-focused perspective, addressing structural inequities in health systems by promoting women in healthcare leadership positions, and responding to gender-based health needs that increase during times of armed conflict. A gender-responsive health system not only aligns with the principles of human rights and social justice but also upholds the legal protections guaranteed to all individuals.

C. A Right to Health and Legal Protections for Healthcare Needs

Individuals are guaranteed a right to health, a legal protection that must be upheld both during and after conflict. International mandates advocating for non-discriminatory health care during armed conflicts are in the interest of parties in conflict—for example, to ensure the preservation of their own

[67] Percival et al., *supra* note 14, at 4.
[68] *Id.* at 5-7.
[69] *See id.* at 4.
[70] *See id.* at 11-12.
[71] *Id.* at 4-5.

military capabilities by preventing the spread of diseases—and the interest of non-participating actors, particularly those in regions bordering conflict zones where the transmission of diseases threatens social, economic, and political stability. [72] Despite the clear alignment with self-interest, most actors often fail to adhere to the mandates. Among the various factors that contribute to the implementation failures are infrastructure breakdowns and the weaponization of diseases as biological warfare. [73] The lack of consequences for actors who neglect their responsibilities in upholding the right to health also seems to be a contributing factor to this issue. [74] Essentially, there are several internationally mandated requirements protecting healthcare needs and the right to health at all times, but there is a lack of enforcement to ensure countries and specific actors in conflict uphold these rights.

In 1864, the Convention for the Amelioration of the Condition of the Wounded in Armies in the Field established the first of what is now known as the Geneva Conventions, marking the inception of International Humanitarian Law (IHL).[75] IHL regulates the conduct of actors in armed conflict and protects individuals not partaking in the hostilities of conflict.[76] The International Court at the Hague, individual nation-states, and the United Nations (UN) have the authority to enforce the Geneva Conventions, and the International Committee of the Red Cross (ICRC) often monitors and sometimes enforces the provisions of IHL as well.[77] International Human Rights Law (IHRL), similarly, imposes a range of enforceable obligations on countries regarding how they should treat their citizens.[78] The international adoption of the Universal Declaration of Human Rights (UDHR) through the UN in 1948 is generally acknowledged as the foundation of IHRL, and signatories to the UDHR bear the responsibility for enforcing IHRL.[79] When countries fail to enforce IHRL, regional bodies such as the Council of

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[72] Van Hout & Wells, *supra* note 10.
[73] *Id.*
[74] *Id.*
[75] *Id.*
[76] *The Geneva Conventions and their Commentaries*, INT'L COMM. OF THE RED CROSS, https://www.icrc.org/en/war-and-law/treaties-customary-law/geneva-conventions, (last visited Nov. 26, 2023).
[77] Van Hout & Wells*, supra* note 10.
[78] *Id.*
[79] *Id.*

Europe or international actors like the UN assume the role of enforcement.[80] IHL and IHRL frameworks complement one another and are used to leverage health needs during times of conflict.[81] Specifically, IHL and IHRL overlap in terms of advocating for a right to health. [82] The distinction, however, is that IHRL applies to all situations, and IHL specifically governs the conduct of actors in international or internal armed conflict. [83]

Upon further inspection, IHL provides guidance for the protection of healthcare facilities, medical personnel, medical vehicles, and the wounded and sick in both international and internal armed conflicts.[84] IHL aims to achieve these protections by distinguishing between combatants and civilians at all times and ensuring there are precautions in place to protect non-combatant populations.[85] One particular instrument to afford these protections is the Geneva Conventions. The Geneva Conventions apply in all cases of armed conflict between and within nations, including declared wars and civil wars, and in cases of occupation where soldiers of one nation partially or totally occupy another nation, even if there is no armed resistance to the occupation.[86] The Geneva Conventions of 1949 are comprised of 429 articles of law in four different conventions, the product of an international conference revising earlier treaties safeguarding war victims.[87] The Additional Protocols of 1977 and 2005 serve as supplements to the Geneva Conventions.[88] Nations that ratify the Geneva Conventions are responsible for adhering to the humanitarian articles of law and holding other nations accountable by enforcing legal sanctions against those who violate the outlined principles. [89]

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[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.*
[85] *Id.*
[86] *Summary of the Geneva Conventions of 1949 and Their Additional Protocols*, AMERICAN RED CROSS (Apr. 2011), https://www.redcross.org/content/dam/redcross/atg/PDF_s/International_Services/International_Humanitarian_Law/IHL_SummaryGenevaConv.pdf [hereinafter *Geneva Conventions Summary*].
[87] *Id.*
[88] *Id.*
[89] *Id.*

Each of the four Conventions includes provisions that protect a subset of the population and certain related medical needs of that population. Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field protects wounded soldiers and civilian support personnel alongside medical personnel, facilities, and equipment in armed conflict. [90] Specifically, Article 12 stipulates that the wounded and sick should be provided nondiscriminatory, humane treatment, and should be free from inadequate medical assistance, violent attacks, or torture;[91] Article 19 protects fixed and mobile medical units;[92] Article 24 provides medical personnel with protection in all circumstances;[93] and Article 35 extends those protections to the transportation of medical equipment during conflict. [94]

Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea adapts the protections of Convention (I) to reflect conditions at sea and protect armed forces members, civilians, and medical personnel who are at sea.[95] Specifically, Article 12 outlines protections and care for the wounded, sick, and shipwrecked;[96] Article 23 protects medical establishments ashore;[97] Article 24 focuses on protections for hospital ships utilized by relief societies and private individuals;[98] Articles 36 and 37 focus on protections for personnel of ships, including medical and religious personnel;[99] and Articles 38, 39, and 40 protect medical transport, including transportation of medical equipment.[100]

Convention (III) Relative to the Treatment of Prisoners of War outlines provisions that guarantee humane treatment, adequate housing, and sufficient food, clothing, and medical care for prisoners of

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[90] *See* Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field arts. 12, 19, 24, 35, Aug. 12, 1949, 6 U.S.T. 3114, 75 U.N.T.S. 31 [hereinafter Geneva I].
[91] *Id.* at art. 12.
[92] *Id.* at art. 19.
[93] *Id.* at art. 24.
[94] *Id.* at art. 35.
[95] *See* Geneva Convention (II) for the Amelioration of the Condition of the Wounded, Sick and Shipwrecked Members of Armed Forces at Sea arts. 12, 23, 24, 36-40, Aug. 12, 1949, 6 U.S.T. 3217, 75 U.N.T.S. 85 [hereinafter Geneva II].
[96] *Id.* at art. 12.
[97] *Id.* at art. 23.
[98] *Id.* at art. 24.
[99] *Id.* at arts. 36-37.
[100] *Id.* at arts. 38-40.

war.[101] Specifically, Articles 13 through 16 outline provisions for the humane treatment of prisoners;[102] and Articles 29 through 33 provide health protections to prisoners of war camps with provisions regarding the general hygiene and medical services provided at the camps[103].

Convention (IV) relative to the Protection of Civilian Persons in Times of War protects civilians in areas of armed conflict and occupied territories, and it also includes several health-related provisions.[104] Specifically, Article 14 establishes protections for hospitals and safe zones;[105] Article 16 grants general protections and respect for vulnerable populations like expectant mothers and the wounded;[106] Article 17 stipulates that any local agreements regarding the evacuation of vulnerable populations and medical personnel must be honored;[107] Article 18 focuses specifically on the protection of hospitals and specifies that civilian hospitals "may in no circumstances be the object of attack, but shall at all times be respected and protected by the Parties to the conflict;"[108] Article 20 extends those protections to support staff at civilian hospitals[109]; Article 23 focuses on the protection of medical supplies, food, and clothing by granting "the free passage of all consignments . . . intended for children under fifteen, expectant mothers and maternity cases;"[110] and Article 27 guarantees general humane treatment against all acts of discrimination and violence, specifying that "[w]omen shall be especially protected against any attack on their honour, in particular against rape, enforced prostitution, or any form of indecent assault."[111] In regard to occupied territories, Articles 55 and 56 require Occupying Powers to cooperate with local authorities to ensure that the public health of the territory is preserved and contagious

[101] *See* Geneva Convention (III) Relative to the Treatment of Prisoners of War arts. 13-16, 29-33, Aug. 12, 1949, 6 U.S.T. 3316, 75 U.N.T.S. 135 [hereinafter Geneva III].
[102] *Id.* at arts. 13-16.
[103] *Id.* at art. 29-33.
[104] *See* Geneva Convention (IV) Relative to the Protection of Civilian Persons in Times of War, Aug. 12, 1949, 6 U.S.T. 3516, 75 U.N.T.S. 287 [hereinafter Geneva IV].
[105] *Id.* at art. 14.
[106] *Id.* at art. 16.
[107] *Id.* at art. 17.
[108] *Id.* at art. 18.
[109] *Id.* at art. 20.
[110] *Id.* at art. 23.
[111] *Id.* at art. 27.

infectious diseases are curbed by allowing medical personnel to carry out their duties.[112] Articles 91 and 92 extend those requirements to places of internment.[113] All four Conventions work together cohesively to ensure protection for different subsets of populations in times of conflict.

In 1977, the international community adopted two Additional Protocols supplementary to the Geneva Conventions to provide additional protections for victims of international and internal armed conflicts.[114] Focusing on international armed conflicts, Protocol I expands protection for certain subpopulations with Articles 15, 76, 77, and 79 providing special protections for civilian medical personnel, women, children, and journalists respectively.[115] For women specifically, Article 76 provides that,

> 1. Women shall be the object of special respect and shall be protected in particular against rape, forced prostitution and any other form of indecent assault.
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> 2. Pregnant women and mothers having dependent infants who are arrested, detained or interned for reasons related to the armed conflict, shall have their cases considered with the utmost priority.
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> 3. To the maximum extent feasible, the Parties to the conflict shall endeavour to avoid the pronouncement of the death penalty on pregnant women or mothers having dependent infants, for an offence related to the armed conflict. The death penalty for such offences shall not be executed on such women.[116]

Additionally, Protocol II elaborates on protections for victims of internal conflicts like civil wars.[117]

As seen by the Geneva Conventions, IHL governs the means and methods of warfare that in turn indirectly affect the right to health, but also has specific provisions regarding health and health services.[118] The provisions of IHL can lay the foundation for future international action. For example, in 2016, the United Nations Security Council (UNSC) adopted Resolution 2286 on "healthcare in armed conflict,"

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[112] *Id.* at arts 55-56.
[113] *Id.* at arts. 91-92.
[114] *Geneva Conventions Summary*, *supra* note 86.
[115] *See* Protocol Additions to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts arts. 15, 76, 77, 79, Aug. 12, 1949, 1125 U.N.T.S. 609 [hereinafter Protocol I].
[116] *Id.* at art. 76.
[117] *Geneva Conventions Summary*, *supra* note 86. However, Protocol II does not apply to internal disturbances such as riots or isolated acts of violence. *Id.*
[118] Van Hout & Wells*, supra* note 10, at 5.

which mandates greater protection for health infrastructure by labeling attacks against hospitals and medical personnel as war crimes, requiring reports to the UNSC in instances of hostilities against hospitals and medical personnel, and placing a responsibility on nations to protect their populations and hold violators of IHL accountable.[119]

Despite the robust provisions of IHL that work towards upholding a right to health, there are serious drawbacks that prevent complete effectiveness. First, there is a lack of enforcement of IHL both during and after conflict. [120] For example, Israel imposed severe limitations on the movement of medical supplies to Gaza in 2023 and 2006, causing a public health crisis.[121] Although the International Criminal Court at the Hague began investigations into potential war crimes committed by Israel in Occupied Palestinian territories in the past, it has not held Israel accountable to date.[122] Israel largely escapes criticism for its health rights violations due to the unwavering support it receives from the United States within the UNSC. [123] Given that the five permanent members of the UNSC—China, France, Russia, the United Kingdom, and the United States—have veto powers, they can frustrate the enforcement of IHL.[124] For example, in 2017, Russia and China vetoed a UNSC resolution imposing sanctions on parties that used chemical weapons in the Syrian conflict. [125] A second drawback is the lack of international criteria providing an outline for the acceptable quality of healthcare coverage, service delivery, and infrastructure during times of armed conflict.[126] Even the Geneva Conventions, despite all the protections for medical care, facilities, personnel, and equipment, do not mandate available, accessible, acceptable, and quality health services to civilians in times of armed conflict. [127]

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[119] S.C. Res. 2286, ¶ ¶ 1-4, (May 3, 2016).
[120] Van Hout & Wells*,* *supra* note 10.
[121] *Id.* at 5; Areesha Lodhi, *Is Israel Violating the Laws of War Meant to Protect Children?*, AL JAZEERA (Oct. 14, 2023), https://www.aljazeera.com/news/2023/10/14/is-israel-violating-the-laws-of-war-meant-to-protect-children;
[122] Lodhi, *supra* note 121.
[123] Van Hout & Wells, *supra* note 10, at 5.
[124] *Id.*
[125] *Id.*
[126] *Id.*
[127] *Id.*

Different instruments of IHRL attempt to fill the gaps in the international standard, or lack thereof, for healthcare. The WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[128] The IHRL instruments oblige states to take measures to ensure the highest attainable standard of physical, mental, and social health and well-being for all individuals, including those in post-conflict societies. As a baseline, Article 25 of the UDHR stipulates that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services . . . ."[129] Additionally, Article 6 of the International Covenant on Civil and Political Rights (ICCPR) establishes the right to life, a right being threatened by armed conflict.[130] General Comment No. 6 on the ICCPR clarifies that an inherent right to life requires countries to adopt "positive measures," including those that protect health, like reducing infant mortality, increasing life expectancy, and eliminating malnutrition and epidemics.[131] The right to health is specifically established by Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[132] Article 12 outlines four areas where action is needed to fully realize this right: infant mortality, environmental and industrial hygiene, the prevention and control of epidemics, and medical services in the event of sickness.[133] Interpretative guidance, specifically General Comment No. 14, outlines four elements of the right to health: availability, accessibility, acceptability, and quality.[134] Availability includes satisfaction of the underlying determinants of health by ensuring health facilities and services are available in

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[128] *Constitution*, WHO, https://www.who.int/about/accountability/governance/constitution (last visited Nov. 26, 2023).
[129] G.A. Res. 217 (III) A, at 25, Universal Declaration of Human Rights (Dec. 10, 1948).
[130] International Covenant on Civil and Political Rights art. 6, Dec. 19, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR].
[131] U.N. Hum. Rts. Comm., General Comment No. 6 on Article 6: Right to Life, ¶ 21, U.N. Doc. CCPR/C/GC/36 (Sept. 3, 2019).
[132] International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 19, 1966, 999 U.N.T.S. 171 [hereinafter ICESCR].
[133] *Id.*
[134] U.N. Comm. on Econ., Soc. and Cultural Rts., General Comment No. 14 on The Right to the Highest Attainable Standard of Health, ¶ 12, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

sufficient quantity, both during and after conflict; accessibility focuses on non-discrimination and the free flow of information, which are both critical to ensuring that vulnerable populations like women and girls can access health facilities and services; acceptability ensures protection for cultural practices and local communities in a gender-sensitive manner, an important aspect of continuing health services when considering the gender-based violence that occurs during times of conflict; and quality recognizes the need for the most updated scientific and medically appropriate goods and services, which should include treatment for vulnerable populations in conflict. [135] By virtue of the right to health and the guidelines for maintaining essential health services, providing primary care, and supplying basic medicines, IHRL attempts to fill the identified gaps in creating an international standard of healthcare access for fragile and conflict-affected settings.[136]

The UDHR, ICCPR, and ICESCR do not refer to armed conflict specifically but can be applied to ensure that health rights are honored across all conflicts. [137] A human rights framework in post-conflict societies, paired with humanitarian law during times of conflict, can improve healthcare and uphold the right to health for everyone, including women. This IHL and IHRL framework ensures that states fulfill procedural, substantive, and special obligations to vulnerable populations. Not only would countries have to control their own actions, but an IHL and IHRL framework would also require countries to be responsible for holding other actors accountable for any violations of international mandates, including violations of the right to health.

III. Case Study: Afghanistan

A. History of the Conflict and the Impact on Women and Girls

Afghanistan has been in the throes of complex conflict for several decades involving various internal and external actors. The conflict in Afghanistan gained global attention when the Soviet Union

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[135] *Id.* (including my own application of the four elements of a right to health for women's healthcare during and after armed conflict).
[136] *Van Hout & Wells, supra* note 10, at 5.
[137] *Id.* The exception is a reference to IHL in General Comment No. 14 of ICESCR and the need for humanitarian assistance in armed conflict and adopting a wider definition of health in armed conflict. *Id.*

invaded in 1979 to support the communist government of the country.[138] The Soviet presence incited rebellion amongst the indigenous rebellion groups known as the mujahideen.[139] The United States supported the mujahideen, which contributed to the Soviet Union's eventual withdrawal in 1989.[140] Following the Soviet withdrawal, Afghanistan was politically fragmented and descended into a civil war among various mujahideen factions.[141] The Taliban, founded in 1994 during the civil war, eventually gained control of Kabul in 1996, imposing a strict interpretation of Islamic law and affecting the quality of life in Afghanistan.[142] The Taliban regime controlled most of Afghanistan, welcoming international terrorist organizations like al-Qaeda, until 2001.[143]

On September 11, 2001, the conflict in Afghanistan changed forever due to the global reaction to al-Qaeda's attacks in the United States.[144] In response to the terrorist attack, the United States and North Atlantic Treaty Organization (NATO) allies invaded Afghanistan in 2001 to oust the Taliban and eliminate al-Qaeda.[145] Although the United States spent twenty years in Afghanistan with extensive military operations to stabilize the country with a functional government, the Taliban continued to attack and eventually regained control.[146] In 2020, the United States and the Taliban signed an agreement in Doha, Qatar, outlining a plan for the withdrawal of the United States and NATO troops in exchange for the Taliban's commitment to prevent terrorism and prohibit al-Qaeda from operating within areas under Taliban control.[147] Notably, the agreement excluded specific provisions protecting women's rights, an

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[138] *Afghanistan War*, ENCYC. BRITANNICA, https://www.britannica.com/event/Afghanistan-War/U-S-troop-surge-and-end-of-U-S-combat-mission (last visited Nov. 26, 2023).
[139] *Id.*
[140] *Id.*
[141] *Id.*
[142] *See* Gilles Dorronsoro, *Who are the Taliban?*, CARNEGIE ENDOWMENT FOR INT'L PEACE (Oct. 22, 2009), https://carnegieendowment.org/2009/10/22/who-are-taliban-pub-24029.
[143] *Afghanistan War*, *supra* note 138. The Taliban also harbored al-Qaeda's leader, Osama bin Laden. *Id.*
[144] *See The U.S. War in Afghanistan*, COUNCIL ON FOREIGN RELATIONS, https://www.cfr.org/timeline/us-war-afghanistan (last visited Nov. 26, 2023).
[145] *See id.*
[146] *See id.*
[147] Mujib Mashal, *Taliban and U.S. Strike Deal to Withdraw American Troops from Afghanistan*, N.Y. TIMES (Aug. 23, 2021), https://www.nytimes.com/2020/02/29/world/asia/us-taliban-deal.html.

area where constant human rights violations were occurring.[148] In 2021, following the withdrawal of the United States' forces, the Taliban rapidly gained control of significant parts of Afghanistan, culminating in the fall of Kabul in August.[149] The Taliban had regained power.[150]

During the Taliban's five-year rule from 1996 to 2001, women were the target of egregious acts of violence and curtailment of rights.[151] For example, the Taliban restricted women from working, obtaining an education, and appearing in public without a male chaperone. [152] When women broke the Taliban's strict rules, they were subject to severe public punishments. [153] After the Taliban's removal from power, women's rights improved and women advanced in employment, education, and health. [154] When the Taliban regained power in Afghanistan, gender-based discrimination increased and the quality of women's lives in the country deteriorated yet again. [155] The Taliban regime implemented draconian restrictions targeting women and girls, including the following: a restriction of a women's freedom of movement by prohibiting flying or driving more than 45 miles without a male relative; a mandate that women be fully covered in public; a ban on women in public parks, gyms, and bathhouses; a closure of secondary schools for girls and a suspension of women attending university; and a dismissal of women employees in local and international NGOs.[156] In general, the economic and humanitarian crisis in Afghanistan disproportionately affects women and girls with this vulnerable population facing added barriers to health care, experiencing higher levels of unemployment, and suffering from increased gender-

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[148] Lynne O'Donnell, *Women Cut out of the Afghan Peace Process*, FOREIGN POLICY (Mar. 30, 2021, 3:41 PM), https://foreignpolicy.com/2021/03/30/afghanistan-women-taliban-peace-talks-biden/.
[149] Amnesty Int'l, *Afghanistan: Death in Slow Motion: Women and Girls under Taliban Rule*, AI Index ASA 11/5685/2022 (July 27, 2022).
[150] *See id.*
[151] CLAYTON THOMAS, CONG. RSCH. SERV., IF11646, AFGHAN WOMEN AND GIRLS: STATUS AND CONGRESSIONAL ACTION (2023).
[152] *Id.*
[153] *Id.* If the women weren't punished, their male chaperones were punished, and this entrenched the misogynistic ideology that men had power over women to keep them in check in society. *Id.*
[154] *Id.*
[155] *Id.*
[156] *Id.*; *Women's Rights in Afghanistan One Year After the Taliban Takeover*, UN WOMEN (Aug. 15, 2022), https://www.unwomen.org/sites/default/files/2022-08/Gender-alert-2-Womens-rights-in-Afghanistan-one-year-after-the-Taliban-take-over-en_0.pdf.

based violence.[157] An increase in gender-based violence and added barriers to access health care reflect a few of the burdens overwhelming the Afghanistan health system and its treatment of women in particular.

B. Health Needs in Afghanistan

Afghanistan is facing a health emergency due to decades of conflict and instability. Despite initial healthcare responses and humanitarian aid international actors provided, a lack of sufficient funding could result in eight million Afghans losing access to essential health assistance.[158] Currently, about 450,000 patients have no access to life-saving trauma care support, including blood transfusions and referrals.[159] Additionally, 1.6 million people need mental health and psychosocial support but have no access to these services.[160] Even though more than 2.2 million people received mental health services in all thirty-four provinces across the country in 2018, there is still a dire need for mental health services.[161] Additionally, in 2022, Afghanistan experienced the following infectious disease outbreaks: (1) a nationwide measles outbreak that affected 77,120 people, (2) an acute watery diarrhea outbreak affecting 242,562 people, and (3) a dengue fever outbreak in Nangarhar, Laghman, and Kabul with 993 people affected.[162] In the wake of multiple disease outbreaks, Afghans have died due to a lack of medicine.[163] Gul Ahmad from the Ghor province was told by her doctor that their hospital did not have the medicine needed for her five-year-old son, but she did not have the money to take her son to another larger clinic.[164] Her five-year-old son died from diarrhea.[165] WHO Director-General, Dr. Tedros Adhanom Ghebreyesus, noted, "The situation in

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[157] THOMAS, *supra* note 151.
[158] *Afghanistan's Health System Suffers Critical Underfunding, Calls for Donor Support*, WHO (Aug. 18, 2023), https://www.who.int/news/item/18-08-2023-afghanistan-s-health-system-suffers-critical-underfunding--calls-for-donor-support.
[159] *Id.*
[160] *Id.*
[161] Pate & Bousquet, *supra* note 12.
[162] *Afghanistan Emergency Situation Report*, WHO (Dec. 2022), https://www.emro.who.int/images/stories/afghanistan/emergency-situation-report-december.pdf?ua=1.
[163] Fereshta Abbasi, *Afghans Dying from Lack of Medicine*, HUM. RTS. WATCH (May 9, 2022, 12:45 PM), https://www.hrw.org/news/2022/05/09/afghans-dying-lack-medicine.
[164] *Id.*
[165] *Id.*

Afghanistan is grave, and the lack of resources and funding to support health workers and facilities is putting countless lives at risk."[166]

Even though more recently the general public pinpointed cost as the largest barrier to accessing healthcare, conflict and violence are still ongoing concerns.[167] For most Afghans, the decades of violent conflict will remain a barrier to accessing healthcare in their perception.[168] During the 1979 Soviet invasion of Afghanistan, efforts to depopulate rural areas to reduce support for the indigenous mujaheddin also involved the destruction of healthcare facilities.[169] The withdrawal of Soviet troops in 1988 devastated over sixty percent of rural health facilities.[170] The power struggle between different groups in the country, and eventually the Taliban's seizure of power, limited the government's capacity to provide adequate health services and required the country to rely on NGOs.[171] In addition to prior decades of conflict, ongoing violence has resulted in healthcare facilities being attacked by armed groups in Afghanistan.[172] In the first four months of 2019 alone, WHO reported thirty-four attacks that killed nine workers and patients and closed down eighty-seven medical facilities.[173] A healthcare provider, Najmusama Shefajo, broke down the effects of war and poverty through everyday experiences and anecdotes.[174] As an obstetrician-gynecologist in public hospitals and private clinics for the past eight years, Dr. Shefajo noted only a handful of patients had access to adequate healthcare and shared that, "[i]f a mother doesn't have the money to eat properly or for proper medicines, then she can't bring a healthy baby into the world and if her baby is unhealthy, it affects the entire community."[175] In the wake of armed conflict, it would be reasonable to assume that the provisions of the Geneva Conventions should apply to ensure that hospitals and medical personnel are protected. However, that does not appear to be the case in

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[166] *Afghanistan's Health System Suffers Critical Underfunding, Calls for Donor Support*, *supra* note 158.
[167] MÉDECINS SANS FRONTIÈRES, PERSISTENT BARRIERS TO ACCESS HEALTHCARE 6-7 (2022).
[168] *Id.* at 3.
[169] Rutherford & Saleh, *supra* note 7, at 234.
[170] *Id.*
[171] *Id.*
[172] Ali M. Latifi, *Years of War and Poverty Take Toll on Afghanistan's Healthcare*, AL JAZEERA (May 25, 2019), https://www.aljazeera.com/news/2019/5/25/years-of-war-and-poverty-take-toll-on-afghanistans-healthcare.
[173] *Id.*
[174] *Id.*
[175] *Id.*

Afghanistan given the direct attacks on healthcare facilities and personnel and the indirect impacts the conflict has had on the Afghan people. Unfortunately, as a result, armed conflict has weakened an already struggling health system.

The health system in Afghanistan, more broadly, lacks funding, resources, qualified personnel, and sufficient medical supplies.[176] "Afghanistan's health system is on the brink of collapse," the WHO Director-General warned after visiting Kabul and witnessing the suffering of Afghans across the country in 2021.[177] The imminent humanitarian and health catastrophe in the country is due to the lack of financial support for Sehatmandi, the country's largest health project, which has left healthcare facilities short-staffed and without medical supplies. [178] The Director-General's report also stated that a breakdown in health services would trigger a ripple effect that undermines the availability of essential basic healthcare services. [179] If the healthcare delivery system in Afghanistan fell apart, primary healthcare services across the country would cease and emergency health needs would remain unresolved.[180] Unfortunately, more than two-thirds of the population needed humanitarian aid in 2022, and yet, the Afghan health system did not have sufficient medical supplies and could not pay healthcare workers.[181] A healthcare worker in Bamiyan shared that three or four kids die every week of malnutrition, a preventable disease but one that the healthcare facility does not supply enough medicine to provide treatment. [182] Afghanistan remains one of the world's most perilous environments for infants, children, and mothers, with limited access to hospitals or health facilities for a majority of that subpopulation.[183] As a reflection of the dangerous conditions, the nation grapples with one of the highest infant mortality rates globally, and each year,

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[176] *See* MÉDECINS SANS FRONTIÈRES, *supra* note 167, at 3.
[177] *Acute Health Needs in Afghanistan Must be Urgently Addressed and Health Gains Protected*, WHO (Sept. 22, 2021), https://www.who.int/news/item/22-09-2021-acute-health-needs-in-afghanistan-must-be-urgently-addressed-and-health-gains-protected.
[178] *Afghanistan's Healthcare System on Brink of Collapse, as Hunger Hits 95 Percent of Families,* UN NEWS (Sept. 22, 2021), https://news.un.org/en/story/2021/09/1100652.
[179] *Acute Health Needs in Afghanistan Must be Urgently Addressed and Health Gains Protected*, *supra* note 177.
[180] *Afghanistan's Healthcare System on Brink of Collapse, as Hunger Hits 95 Percent of Families*, *supra* note 178.
[181] Abbasi, *supra* note 163.
[182] *Id.*
[183] *Afghanistan* Health, UNITED NATIONS CHILDREN'S FUND [UNICEF], https://www.unicef.org/afghanistan/health, (last visited Nov. 26, 2023).

thousands of Afghan women die from easily preventable pregnancy-related concerns. [184] In addition to a lack of access to medicines for disease treatment, most doctors are inadequately compensated and forced to supplement their income by working after hours. [185] As a monthly average, doctors are making somewhere between $151 to $189 while treating an increasing number of patients as hospitals are overloading their capacity of patients. [186] For example, hospitals built in the 1960s that were meant to serve three hundred to four hundred patients are now admitting over one thousand patients, forcing doctors to treat three times as many patients as they normally would. [187] Additionally, healthcare providers are forced to use substandard equipment—performing complex surgeries with basic tools or handing out expired medicine—that prevents providing sustainable treatment to the 1.9 million people who find themselves in need of medical attention. [188] The development and stability of the Afghan health system, including support for the health workforce, will remain a critical aspect of the country's recovery and long-term well-being.

International actors play a key role in supporting health systems in Afghanistan. Historically, before the United States' occupation in 2001, there were twenty international NGOs and two hundred local NGOs providing a significant portion of the country's available healthcare. [189] In recent times, the WHO has supported life-saving health interventions to ensure the long-term resiliency and sustainability of services.[190] As a part of its efforts in 2022, WHO updated the National Disease Surveillance and Response System by training one thousand surveillance officers to conduct outbreak investigations and responding to more than nine hundred outbreaks with support from 121 surveillance teams; introduced and expanded laboratories at central and regional levels; reduced mortality and morbidity resulting from vaccine-preventable diseases by administering the measles vaccine to around 8.16 million children, the

[184] *Id.*
[185] Latifi, *supra* note 172.
[186] *Id.*
[187] *Id.*
[188] *Id.*
[189] Rutherford & Saleh, *supra* note 7, at 234.
[190] https://www.emro.who.int/images/stories/afghanistan/emergency-situation-report-december.pdf?ua=1

polio vaccine to more than nine million children, and the COVID-19 vaccine to 10.8 million individuals; expanded health infrastructure by establishing ninety-six public hospitals under the Sehatmandi Project and 189 primary healthcare facilities in underserved remote areas,[191] while also delivering medical and non-medical supplies to 1,228 health facilities; trained healthcare workers in emergency and trauma care[192] services; bolstered mental health support services[193] leading to more than 900,000 counseling sessions; and focused on gender-focused services by introducing the National Advanced Referral Center for Survivors of Violence that provided health services to 423 survivors of violence. [194] Focusing on logistical improvements for health systems in Afghanistan, WHO is bolstering its health information management with the Health Resources and Services Availability Monitoring System (HeRAMS), which provides information on the availability of resources in the 4,225 health facilities in the country, and WHO is conducting monitoring and field visits to ensure health facilities provide quality healthcare services.[195] The WHO has cemented itself as one of the most important stakeholders in rebuilding and bolstering the health system in Afghanistan.

The United States Agency for International Development (USAID) also provides health assistance to a network of health clinics that serve over seventy percent of the population with fundamental health services like care for maternal and child health, tuberculosis, COVID-19 prevention, and broader primary healthcare needs.[196] USAID's health priorities in Afghanistan include preserving the health advancements made in the past twenty years, stabilizing the healthcare systems, and improving

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[191] *Afghanistan Emergency Situation Report*, *supra* note 162. The support for 189 primary healthcare facilities included 70 basic health centers, 85 sub-health centers, and 34 mobile health teams, which ultimately led to 152,253 individuals receiving healthcare services. *Id.*

[192] In December 2020, WHO trained 20 physicians on intensive care unit management, basic emergency care, and safe blood transfusions, and ultimately the training supported 1,748 patients who were transported through ambulatory services for trauma cases. *Id.*

[193] WHO is also working on translating the Mental Health Gap Action Program Intervention Guide to assist healthcare workers with clinical decisions regarding mental health conditions in non-health settings. *Id.*

[194] *Id.*

[195] *Id.*

[196] *Afghanistan Health Sector Fact Sheet*, U.S. Agency for International Development [USAID], https://www.usaid.gov/sites/default/files/2023-03/USAID%20Afghanistan%20Health%20Sector%20Fact%20Sheet%20-%20March%202023.pdf (last visited Nov. 26, 2023).

overall health outcomes.[197] Working through the Afghanistan Reconstruction Trust Fund (ARTF), a multilateral donor platform that focuses on delivering life-saving care to women and children, USAID has contributed over $220 million for health infrastructure since 2014 and supports healthcare service delivery to over 2,300 health facilities across all thirty-four provinces in the country through Health Emergency Response (HER) initiative.[198] Specifically, the work of USAID through ARTF supports routine immunization, nutrition counseling, malnutrition treatment, tuberculosis care, and reproductive health services for women and children.[199] Additionally, USAID's bilateral partnerships provide mentorship and training for the healthcare workforce to improve the quality of health services.[200] USAID's private partnerships focus on distributing essential health products.[201] For example, the agency works with local marketing organizations on projects that support maternal and child health, including "the sale of 45,515 tubes of chlorhexidine gel for umbilical cord care, and 1,096,200 tabs of iron folate to support healthy pregnancies."[202] USAID's work aligns with the assistance WHO and United Nations Children's Fund (UNICEF) provides in areas of basic health service delivery, infectious disease eradication, water, sanitation, and hygiene (WASH) health, and national disease surveillance.[203] In fact, USAID supports the National Polio Surveillance System and the National Disease Surveillance System to identify and address potential disease outbreaks and prevent epidemic outbreaks, especially in areas that need the most support.[204] Finally, USAID is also focusing on long-term strategizing and investments in the health sector, in its capacity as co-chair of the Health Sector Thematic Working Group, to build resilient and sustainable health systems for Afghanistan.[205]

USAID efforts have led to the following: a decrease in the number of under-five deaths by almost 50% from 2010 to 2018, an increase in the number of women receiving antenatal care by 45% from 2003

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[197] *Id.*
[198] *Id.*
[199] *Health*, USAID, https://www.usaid.gov/afghanistan/our-work/health (last visited Nov. 26, 2023).
[200] *Id.*
[201] *Id.*
[202] *Id.*
[203] *Afghanistan Health Sector Fact Sheet*, *supra* note 196.
[204] *Health*, *supra* note 199.
[205] *Afghanistan Health Sector Fact Sheet*, *supra* note 196.

to 2018, a rise in full immunization coverage by 20% from 2010 to 2018, and a decrease in child mortality by 50% from what it was two decades ago. [206] International support is beneficial for Afghanistan's health system recovery, but it is also important to be mindful of developing a long-term dependency on international organizations that inhibits a smooth transition to indigenous institutions and structures. The ultimate goal of post-conflict health reconstruction is the development of resilient and sustainable health systems where local actors are capable of achieving the same advancements.

International support has been critical to rebuilding Afghanistan's health system, but there is still much left to be desired in terms of creating a gender-responsive health system in the country. The WHO Director-General's report on the health needs in Afghanistan emphasized the need for women to access health education, health care, and the health workforce. Specifically, he stated, "With fewer health facilities operational and fewer female health workers reporting to work, female patients are hesitant to seek care. We are committed to working with partners to invest in the health education of girls and women, as well as continue training female health workers." [207]

C. Gender Equity in Afghanistan's Health Systems

Gender equity in the Afghan health system is a critical concern, given the unique challenges and vulnerabilities that Afghan women and girls face. On December 24, 2022, the Taliban issued a decree banning women from working in national and international NGOs, further endangering women's rights in the country and worsening the public health crisis.[208] Although the ban exempts the healthcare sector and the WHO is continuing operations that utilize health workers who are women, the ban hasn't precluded constraints on access to health services for women and children.[209] For example, health partners of the WHO in 228 healthcare facilities suspended delivery of healthcare services leaving 1.5 million people

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[206] *Health*, *supra* note 199.
[207] *Acute Health Needs in Afghanistan Must be Urgently Addressed and Health Gains Protected*, *supra* note 177.
[208] Leslie Roberts, *Taliban Ban on Female NGO Staff is Deepening Afghanistan's Public Health Crisis*, SCIENCE (Jan. 16, 2023, 7:45 AM), https://www.science.org/content/article/taliban-s-ban-female-staff-ngos-deepening-afghanistan-s-public-health-crisis.
[209] *Afghanistan Emergency Situation Report*, *supra* note 162.

without access to adequate healthcare.[210] Some NGOs that rely on a staff of women have suspended operations, which curtails access to medicines and jeopardizes the campaign to eradicate polio.[211] Additionally, organizations are worried about the safety of the women on their staff so they temporarily suspended operations.[212] The ban coupled with cultural factors, such as women not being able to interact with male healthcare providers and aid workers, has suspended aid for half the population in Afghanistan and has left 11.6 million women with limited or no access to health services.[213] Other restrictions include women not being able to enter health centers without a "mahram," or male chaperone.[214] Some NGOs are trying to work around the ban by adhering to the Taliban's strict chaperone rules and incorporating new terminology—"health centers" —to facilitate safe spaces for women and children.[215]

Even before the Taliban regained control of Afghanistan and issued gender-based restrictions, women were facing the brunt of the health issues in the country.[216] In the early 2000s, Afghanistan had the second highest maternal mortality rate in the world as a result of decades of conflict, poverty, and insufficient reproductive health services like a lack of midwives or doctor assistance during birth.[217] Barriers to access health services for women include security, economic, and education concerns, alongside cultural restrictions like prohibiting examinations by male doctors.[218] Improving healthcare for women in Afghanistan requires a comprehensive approach to resolving each of these barriers.[219]

After the defeat of the Taliban regime in 2001, international actors and Afghanistan's government worked to rebuild an effective healthcare system by expanding access to health services.[220] As a result of their services, from 2000 to 2018, maternal mortality decreased from 1450 to 638 deaths with rates of

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[210] *Id.*
[211] Roberts, *supra* note 208.
[212] *Id.*
[213] *Id.*
[214] Zahra Nader & Nargis Amini, *The Taliban are Harming Afghan Women's Health*, FOREIGN POLICY (Mar. 2, 2022, 9:01 AM), https://foreignpolicy.com/2022/03/02/the-taliban-are-harming-afghan-womens-health/.
[215] Roberts, *supra* note 208.
[216] Zainab Ezadi et al., Comment, *Afghan Women and Access to Health Care in the Past 25 Years*, 43 THE LANCET 1, 1 (2022).
[217] *Id.*
[218] *Id.*
[219] *Id.*
[220] *Id.*

death falling by at least 64%, births supervised by specialists increased by 46.4%, and modern family planning services increased by 12%.[221] Despite these advances, Afghanistan is still ranked 167th in terms of gender inequality as per the Human Development's Gender Inequality Index analyzing reproductive health, women's leadership in government, education outcomes, and economic activity.[222] After the Taliban regained control in August 2021, healthcare for women has further deteriorated.[223] The country's healthcare system is almost entirely dependent on foreign aid, and the United States' abrupt withdrawal created an economic crisis putting 90% of Afghans below the poverty line and compounding the health crisis.[224] Reports have highlighted that women and girls do not have access to basic health services, like family planning services and access to contraception, professional provider support during birth, prenatal and postnatal care, specialty treatments like fertility treatments, and preventative care like a pap smear or mammograms.[225] Human rights experts have issued a warning that the Taliban is institutionalizing gender-based discrimination and violence, and this includes limiting access to life-saving health care.[226] The goal in Afghanistan, whether in an emergency or the post-conflict reconstruction phase, has always been to save and improve lives.[227] This goal can never be accomplished until women are prioritized in terms of health needs.

Under international law, women are to be protected from gender-based violence and discrimination.[228] This protection extends to Afghan women subjugated to the violence of the Taliban.[229] During the armed conflict, the Geneva Conventions protect civilians and medical personnel broadly, and

[221] *Id.*
[222] *Gender Inequality Index*, U.N. DEVELOPMENT PROGRAMME [UNDP], https://hdr.undp.org/data-center/documentation-and-downloads (last visited Nov. 26, 2023).
[223] Zainab Ezadi et al., *supra* note 216.
[224] Zahra Nader & Nargis Amini, *supra* note 214.
[225] *Id.*
[226] *Id.*
[227] *Success of Afghanistan Reconstruction will be Measured in Lives Saved and Improved*, WHO (Nov. 26, 2001), https://www.who.int/news/item/26-11-2001-success-of-afghanistan-reconstruction-will-be-measured-in-lives-saved-and-improved.
[228] HUMAN RIGHTS WATCH, AFGHANISTAN HUMANITY DENIED: SYSTEMATIC VIOLATIONS OF WOMEN'S RIGHTS IN AFGHANISTAN 10 (2001).
[229] *Id.*

women are awarded special protections against gender-based violence and inadequate health services.[230] Bridging the gaps in the quality of care guaranteed to women and girls both during and after conflict, the ICCPR protects women from gender-based violence in its guarantee of the right to life, and the ICESCR provides women the right to the "highest attainable standard of physical and mental health," which includes nondiscriminatory health services.[231] Afghanistan ratified ICCPR and ICESCR on January 24, 1983, meaning that it is bound to its provisions, and as a result, must provide adequate healthcare to the women in the country.[232] Additionally, Afghanistan signed the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) on August 14, 1980, which guarantees an added layer of protection for all Afghan women.[233] These humanitarian and human rights treaties provide the basis for a gender-responsive health system that protects the women of Afghanistan, and they must be upheld to ensure adequate healthcare for women in the country is available. Key components of gender equity in Afghanistan's health systems include access to healthcare, maternal and child health improvements, gender-based violence services for survivors, support for family planning and reproductive health, and increased participation of women in healthcare leadership. To attain gender equity in healthcare systems will require working with government agencies and NGOs while upholding mandates of international law. Achieving gender equity in healthcare is not only a matter of human rights but also essential for improving overall health outcomes and promoting broader stability in a post-conflict society.

IV. Conclusion

In the challenging aftermath of armed conflicts, addressing health needs becomes paramount for effective post-conflict reconstruction. Armed conflicts not only have a direct consequence on the health outcomes of a conflict-affected country, but they also devastate health systems more broadly. Thus,

[230] *See* Convention I, *supra* note 90; Convention II, *supra* note 95; Convention III, *supra* note 101; Convention IV, *supra* note 104; Protocol I, *supra* note 115.
[231] ICCPR, *supra* note 130; ICESCR, *supra* note 132.
[232] HUMAN RIGHTS WATCH, *supra* note 228, at 11.
[233] *Id.*

striking a delicate balance between urgent and long-term health concerns is imperative to ensure the well-being of affected populations immediately after armed conflict and beyond. Addressing health needs involves coordination between local governments, international actors, and humanitarian organizations in a sustainable manner that allows for a seamless transition to indigenous institutions. The coordination amongst these actors includes providing immediate medical assistance and access to essential services in the short term to address urgent health crises that may arise in the wake of conflict, while simultaneously rebuilding robust healthcare systems through a focus on health infrastructure development.

Post-conflict reconstruction also presents a unique opportunity to establish a gender focus in the health recovery process. Gender inequity currently persists in the health sector, reflecting the discriminatory structures of society. More specifically, the biases in health research, structural barriers excluding women from leadership positions, and the disproportionate impact of armed conflict all result in poor health outcomes and services for women and girls. The unique challenges and vulnerabilities women and girls face necessitate gender-sensitive health policies and interventions. Not only does a gender-responsive health system ensure the long-term well-being of a conflict-affected country, but it also is legally mandated by international humanitarian and human rights mandates.

For Afghanistan, a country that has experienced prolonged conflict, prioritizing health needs in post-conflict reconstruction is of utmost importance, with a particular emphasis on addressing the distinct requirements of women. Immediate efforts in the country should be directed toward providing accessible healthcare services, trauma care, and psychosocial support to the population. In the long term, investments in healthcare infrastructure, training healthcare professionals, and implementing preventive health measures are critical for sustained population well-being. Importantly, initiatives must be designed to include and empower Afghan women in the reconstruction process. This involves ensuring their representation in decision-making bodies related to healthcare, addressing gender-specific health concerns, and promoting women's access to healthcare services. A comprehensive and inclusive approach to health reconstruction in Afghanistan will contribute not only to the overall well-being of the population

but also to the nation's broader stability and development while upholding principles of international humanitarian and human rights law.