https://ijhpm.com
Int J Health Policy Manag 2026;15:10008

OPEN ACCESS

doi 10.34172/ijhpm.10008

IJHPM
International Journal of Health Policy and Management

Commentary

Changing Wars, Changing Lenses: Understanding Human Resources for Health in Conflict-Affected Settings

Comment on "Human Resources for Health in Conflict Affected Settings: A Scoping Review of Primary Peer Reviewed Publications 2016–2022"

Jean-Benoît Falisse*

Abstract

Onvlee and colleagues' review of human resources for health (HRH) in conflict-affected settings (CAS), together with the commentaries engaging it, invites closer attention to how the dynamics of conflict shape HRH. This commentary asks how that attention can be operationalised. First, I argue that conflict studies, political science, and political economy offer complementary tools: conflict typologies show who fights whom and across which borders, and therefore who employs, regulates, and protects health workers; theories of wartime violence show where health workers can work and whom they can reach; political settlements analysis shows who decides on pay, deployment, and recognition; and attention to the stage of conflict shows whether windows for reform open at all. Second, drawing on the limited-statehood and "liminal health system" literatures, I argue that cross-border arrangements for training, recognising, and deploying health workers are structural features of HRH: what the health labour market (HLM) framework records as "outflow" is often a reorganisation of the workforce.

Keywords: Health Workforce, Conflict-Affected Settings, Political Economy, Cross-Border Health Systems, Limited Statehood

Copyright: © 2026 The Author(s); Published by Kerman University of Medical Sciences. This is an open-access article distributed under the terms of the Creative Commons Attribution License (https://creativecommons.org/licenses/by/4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Citation: Falisse JB. Changing wars, changing lenses: understanding human resources for health in conflict-affected settings: Comment on "Human resources for health in conflict affected settings: a scoping review of primary peer reviewed publications 2016–2022." *Int J Health Policy Manag.* 2026;15:10008. doi:10.34172/ijhpm.10008

Article History:
Received: 14 May 2026
Accepted: 9 October 2026
ePublished: 17 October 2026

***Correspondence to:**
Jean-Benoît Falisse
Email: jb.falisse@ed.ac.uk

Introduction

Onvlee and colleagues' 2023 scoping review of human resources for health (HRH) in conflict-affected settings (CAS)[1] is a welcome synthesis of an evidence base that is uneven, geographically clustered, and dominated by short-horizon operational research. It identifies numerous challenges—constraints in health education, parallel management, high stress, to name but a few—most of which are also present in non-conflict-affected low- and middle-income settings; and rightly concludes that conflict multiplies rather than simply replicates them. Three commentaries have already engaged the review. Lim and colleagues[2] highlight escalating attacks on health workers and the erosion of international humanitarian law. Aziz[3] argues that the health labour market (HLM) framework is ill-suited to settings where assumptions of institutional functionality are violated. Pavignani[4] foregrounds two persistent silences: the political agency of health workers, and the informal practices through which they keep services running.

Building on these commentaries and drawing on the social sciences I come from, I add two further arguments. The first is that neighbouring disciplines offer productive tools for understanding "the stage, severity and other dynamics of conflict" with which, Onvlee and colleagues argue, HRH policies must be aligned, a call Aziz echoes. The second is that the cross-border and "liminal" dimension of contemporary HRH in CAS deserves to be treated structurally rather than as a residual feature of national systems. Both arguments, in different ways, push back against treating the nation-state as the natural unit of HRH analysis.

Opening the "Conflict-Affected" Umbrella

The 36 studies Onvlee and colleagues include reflect the conflict landscape that had been prevalent since the end of the Cold War: long-running civil wars and insurgencies in Syria (11 studies), DR Congo (6), Afghanistan, Yemen, Iraq, South Sudan, Central African Republic, Mali, Burkina Faso, Nigeria, Libya, and Myanmar (settings whose pre-war health and education systems also differed widely). In the widely used Uppsala Conflict Data Program (UCDP) typology, these are predominantly "intrastate" or "internationalised intrastate" conflicts where "fragile" states, or at least states with limited capacities, confront insurgent groups. International actors are involved indirectly through aid, sanctions, or proxy support. The HRH dynamics characteristic of these settings—workforce attrition, parallel governance by non-state actors, donor-driven retention strategies—have been the focus of numerous HRH frameworks and indeed of a broader

Centre of African Studies, School of Social and Political Science, The University of Edinburgh, Edinburgh, UK.

literature on "state-building" in CAS.[5]

Several of the deadliest and most internationally prominent conflicts since 2022 sit less comfortably within these categories; in 2024, the UCDP recorded four interstate conflicts, the highest number since 1987. Russia's war on Ukraine is a state-on-state war in a country that has a dense and well-trained health workforce. The wars in Gaza, Lebanon, and the broader Middle East involve direct belligerent states, including some of the most powerful and technologically equipped countries on earth. Sudan's war, and the long-running conflicts in DR Congo and Yemen, have seen foreign states involved not only through proxies but also much more openly (direct peace talks, such as those between Rwanda and DR Congo, acknowledge the interstate nature of these conflicts). These wars differ as much from one another as they do from the cases in the review; they are named together not to compare them, but because none fits the intrastate typology that dominates the review's evidence base.

Different conflict types shape distinct lines of enquiry about HRH. Whether the state remains the main employer and regulator on the territory it controls, whether health workers are drawn into military service, and which legal regime protects them (international humanitarian law protects medical personnel differently in international and non-international armed conflicts) are among the core questions for understanding HRH dynamics. Of course, these questions may change over time: for instance, as Lim and colleagues[2] highlight, the return of state-on-state wars has not meant greater respect for international humanitarian law from signatory belligerents—quite the contrary: the Safeguarding Health in Conflict Coalition has reported a sharp escalation in incidents of violence against healthcare since 2022.[6] Yet war typologies have merit as a starting point for examining how the specificities of conflict affect HRH.

The CAS label has done useful work, carving out a research space distinct from generic low- and middle-income country analysis and supporting cross-case learning; the question is less whether to open the umbrella than how (in a sense, Onvlee and colleagues do not say anything different when they call for interrogating the political economy of conflict in their conclusion). HRH researchers do not need to invent yet another typology; peace and conflict studies offer many tools already. Kaldor famously differentiated between "old" state-on-state wars and "new" wars, which she defined as marked by the retreat of inter-state violence in favour of mixed state/non-state networks fighting over identity, predation, and territory.[7] Kalyvas's typology of civil war—distinguishing irregular, conventional, and symmetric non-conventional patterns, and theorising the logic of violence within each—opens questions about which forms of violence health workers are most exposed to, and how the geography of territorial control shapes who reaches care.[8] The political settlements literature reframes governance dynamics in terms of the underlying bargains between elites about how power and resources are shared, with direct implications for who pays health workers, which cadres are favoured by ruling coalitions, and how qualifications are recognised.[9]

These frameworks are complementary, and their combination allows a better understanding of the context of HRH in CAS. Typologies such as the UCDP's, or Kaldor's distinction, describe who fights whom and across which borders, and therefore who is likely to employ, regulate, and protect health workers; Kalyvas's work bears on where, within a territory, health workers can work and whom they can reach; and political settlements analysis asks who decides on pay, deployment, and recognition. Aziz's[3] call for conflicts to be "defined and staged," and her attention to the "non-linear recovery trajectories" of protracted fragility, add a temporal layer, which is very useful for understanding windows of opportunity (or the lack thereof) for HRH reform.

Borders and Liminal Health Systems

The changing character of war also reminds us of the need to understand HRH beyond state borders. Onvlee et al note out-migration as "outflows" within the HLM framework, and the diaspora as a possible resource. This is understandable given the HLM framework's design around national labour markets, yet recent scholarship complicates the picture and offers new vocabulary. Working on northwest Syria in 2012–2024, Fouad and Bou-Orm[10] propose to import into health systems research the political science concept of "limited statehood": areas where central state authority cannot implement or enforce its rules. The concept names a deficit of state authority rather than who fills it, which is a question of governance in its own right (non-state governance actors typically include armed groups, NGOs, faith-based organisations, or diaspora networks). New research has explored contexts where such limited statehood interacts with borders. Drawing on their research on the Thailand–Myanmar border, DiStefano and colleagues[11] describe a "liminal health system" (liminal meaning "betwixt and between") that emerges in border areas of limited statehood. In this system, formal and informal actors organise training, payment, supply chains, and patient pathways across, not along, borders. Fouad and colleagues[12] extend the comparative argument across Syria and Myanmar, asking what cross-border health systems look like when they become structural rather than residual. Liminal health systems echo the broader cosmopolitan critique developed by authors such as van de Pas,[13] which questions framing HRH as a solely or overwhelmingly national project. In the specific context of many contemporary CAS, at least three dynamics warrant more sustained attention.

First, training infrastructure is often relocated rather than simply lost. In settings of limited statehood, where authority over education is limited (and even more so in liminal health systems), training can move: Bdaiwi and colleagues[14] documented how Syrian medical education in opposition-held areas operated partly across the Turkish border, with curricula, examinations, and de facto accreditation negotiated transnationally. Fehmi and colleagues[15] have also highlighted transnational partnerships in the case of Ukraine, in which a medical university opened a campus across the border, and in Gaza, in which around 760 international volunteer faculty have taught medical students online. These are not "outflows" in the standard HLM sense; they are reconstituted training

and labour markets that operate in new geographies.

Second, the regulatory recognition of qualifications, an even more contested HRH variable, is also being reconfigured rather than necessarily lost. Substantial discrepancies exist across cases: whilst Poland introduced conditional licences for Ukrainian doctors, dentists, nurses, and midwives after February 2022,[16] the equivalent recognition for Syrian, Sudanese, or Afghan health workers has been sparser, slower, and politically contingent. One hypothesis worth exploring is that the capacity of conflict-displaced health workers to practise in host settings is shaped less by clinical competence than by where they come from, the willingness of host regulators, and the political reception of the displacement, whatever the nature of the conflict they fled.

Third, diaspora and support groups are being mobilised in new ways in areas of limited statehood. Tele-intensive care provided from the United States to Syrian hospitals through a diaspora medical society[17] and trauma care supported through a global telemedicine initiative during the 2023–2024 military assault on the Gaza Strip[18] are two examples of health work performed from outside the territory where care is delivered. Such arrangements raise questions about regulatory accountability, quality assurance, who controls these channels, and the consequences for in-country institutional capacity when diaspora and foreign-based practitioners become the de facto workforce.

These dynamics exemplify the conceptual issue at stake: treating movement (be it of infrastructure, people, skills, ideas, or otherwise) across state-controlled areas as loss, as the HLM framework does, misses the reconfiguration under way. The limited-statehood and liminal-health-system lenses reframe movement as a necessary reorganisation of the workforce that operates across formal/informal divides and puts health workers' agency at the centre (echoing Pavignani's[4] commentary).

Conclusion

A new review of the fast-growing literature on HRH in CAS is already overdue. The four commentaries now published on Onvlee and colleagues' 2023 scoping review provide tools to analyse and draw lessons from contexts with very different educational and healthcare systems and patterns of destruction and violence. This commentary has emphasised two points. First, operationalising the call to disaggregate "conflict-affected" means engaging with analytical frames developed in conflict studies, political science, and political economy. Second, it is essential to recognise that cross-border and liminal arrangements are structural features of contemporary HRH. In practice, those who study, fund, and plan the health workforce in CAS should: (1) map the conflict before the workforce (eg, who fights whom and where, where health workers are and who employs them, who decides on pay and recognition); (2) follow health workers, training, and qualifications across frontlines and international borders, so that movement is no longer necessarily counted as loss; and (3) treat diaspora networks, foreign-based practitioners, and host-state regulators as part of the HRH system (and ask who controls remote and cross-border care and to whom it is accountable). All three point toward the same agenda: re-engaging the political economy dimensions that operational frameworks have tended to bracket.

Disclosure of artificial intelligence (AI) use

Section(s) of manuscript affected: All.

Type of AI tool(s) used: Claude (Anthropic).

Purpose of use: Language editing and manuscript check (grammar, consistency). The author takes full responsibility for the content.

Ethical issues

Not applicable.

Conflicts of interest

Author declares that he has no conflicts of interest.

References

1. Onvlee O, Kok M, Buchan J, Dieleman M, Hamza M, Herbst C. Human resources for health in conflict affected settings: a scoping review of primary peer reviewed publications 2016–2022. *Int J Health Policy Manag*. 2023;12:7306. doi:10.34172/ijhpm.2023.7306
2. Lim AM, Hung KK, Wong CS, et al. Supporting Healthcare Workers on the Frontline of Conflicts: Comment on "Human resources for health in conflict affected settings: a scoping review of primary peer reviewed publications 2016–2022." *Int J Health Policy Manag*. 2025;14:9457. doi:10.34172/ijhpm.9457
3. Aziz R. Rethinking Human Resources for Health Planning in Labour Markets Disrupted by Conflict-Affected and Fragile Settings: Comment on "Human resources for health in conflict affected settings: a scoping review of primary peer reviewed publications 2016–2022." *Int J Health Policy Manag*. 2026;15:9534. doi:10.34172/ijhpm.9534
4. Pavignani E. Paying Attention–and respect–to the agency of conflict-affected health workers: Comment on "Human resources for health in conflict affected settings: a scoping review of primary peer reviewed publications 2016–2022." *Int J Health Policy Manag*. 2026;15:9580. doi:10.34172/ijhpm.9580
5. Witter S, Falisse JB, Bertone MP, et al. State-building and human resources for health in fragile and conflict-affected states: exploring the linkages. *Hum Resour Health*. 2015;13:33. doi:10.1186/s12960-015-0023-5
6. Safeguarding Health in Conflict Coalition (SHCC). Epidemic of Violence -- Violence against Health Care in Conflict 2024. SHCC; 2025.
7. Kaldor M. *New and Old Wars: Organized Violence in a Global Era*. 3rd ed. Stanford, CA: Stanford University Press; 2012.
8. Kalyvas SN. *The Logic of Violence in Civil War*. Cambridge University Press; 2006.
9. Behuria P, Buur L, Gray H. Studying political settlements in Africa. *Afr Aff (Lond)*. 2017;116(464):508-525. doi:10.1093/afraf/adx019
10. Fouad FM, Bou-Orm IR. Health systems in limited statehood: a new analytical lens for research and practice. *Lancet*. 2025;406(10508):1071-1072. doi:10.1016/S0140-6736(25)01403-5
11. DiStefano L, Than KK, Traill T, et al. A liminal health system: exploring the resilience strategies of healthcare providers and communities along the Thailand-Myanmar border. *SSM-Health Systems*. 2026;6:100209. doi:10.1016/j.ssmhs.2026.100209
12. Fouad F, Than KK, Bertone MP, Witter S, Kyaw NN, Bou-Orm IR. Rethinking cross-border health systems for contexts of mobility and forced displacement. *SSM-Health Systems*. 2026;6:100172. doi:10.1016/j.ssmhs.2026.100172
13. van de Pas RAM. *A Cosmopolitan Outlook on Health Workforce Development*. Global Academic Press; 2020. doi:10.26481/dis.20200914rp
14. Bdaiwi Y, Rayes D, Sabouni A, et al. Challenges of providing healthcare worker education and training in protracted conflict: a focus on non-government controlled areas in north west Syria. *Confl Health*. 2020;14(1):42. doi:10.1186/s13031-020-00287-9
15. Fehmi Z, Nakkash N, Jaroudi R, et al. Preserving Medical Education in Conflict Zones through Transnational Partnerships: Field Lessons from Gaza and Ukraine. *Disaster Med Public Health Prep*. 2026;20:e101. doi:10.1017/dmp.2026.10359
16. Andriiashenko L, Zabdyr-Jamróz M, Lipowski P, Domagała A.

Immigration of medical personnel from Ukraine to Poland – Context, regulations, and trends. *Health Policy*. 2025;152:105241. doi:10.1016/j.healthpol.2024.105241

17. Moughrabieh A, Weinert C. Rapid deployment of international tele–intensive care unit services in war-torn Syria. *Ann Am Thorac Soc*. 2016; 13(2):165-172. doi:10.1513/AnnalsATS.201509-589OT
18. Alser K, Mallah SI, El-Oun YRA, et al. Trauma care supported through a global telemedicine initiative during the 2023–24 military assault on the Gaza Strip, occupied Palestinian territory: a case series. *Lancet*. 2024; 404(10455):874-886. doi:10.1016/S0140-6736(24)01170-X