©IDOSR PUBLICATIONS International Digital Organization for Scientific Research

IDOSR JOURNAL OF APPLIED SCIENCES 11(1):148-152, 2026 ISSN: 2550-7931

https://doi.org/10.59298/IDOSRJAS/2026/111148152 IDOSRJAS11106

Health Diplomacy in Post-Conflict Reconstruction

Nassimbwa Kabanda D.

Faculty of Medicine Kampala International University Uganda

ABSTRACT

Health diplomacy plays a pivotal role in shaping post-conflict health reconstruction by promoting universal access to health services, fostering governance reforms, and coordinating international engagement. This review examines the conceptual foundations of health diplomacy, the challenges faced by health systems in fragile and conflict-affected states, and the roles of international actors in post-conflict recovery. Drawing on case studies from Cambodia, Sierra Leone, and Northern Uganda, the analysis highlights strategies for service restoration, governance strengthening, and accountability enhancement while emphasizing equity and human rights for marginalized populations. Key challenges include infrastructural disruption, fragmented governance, limited democratic accountability, and dependence on international financing. The study underscores the importance of coordinated strategies, context-sensitive approaches, and robust monitoring and evaluation frameworks to ensure sustainable health system reconstruction. Policy recommendations include demand-driven international support, integration of equity considerations, capacity building, and long-term investment in governance structures to enhance resilience, effectiveness, and sustainability of health interventions in post-conflict settings.

Keywords: Health diplomacy**,** Post-conflict reconstruction**,** Health systems strengthening**,** Governance and accountability**,** and Equity and vulnerable populations.

INTRODUCTION

In post-conflict reconstruction, health diplomacy constitutes the promotion of universal access to health services across the policy sectors necessary for effective recovery. Post-conflict environments present an opportunity for reform of health systems to alleviate pre-existing inequities [1]. The government of Afghanistan invited actors in international health diplomacy to engage following the removal of the Taliban. Investments in health systems reconstruction and the introduction of large-scale reconstruction aid attracted attention to several countries after the cessation of hostilities, particularly Cambodia and Sierra Leone [1]. Although reconstruction varies across contexts, participation of international organisations such as the World Bank and UN agencies represents a key mechanism through which health diplomacy may be operationalised. Infrastructural disruption often results in lower health-system capacity than before conflict, with direct effects on health protection, particularly in poorer regions and among marginalised populations [2]. Such expected declines in health-sector access and equity frequently incentivise international engagement. Post-conflict recovery offers an infrequent opportunity to enhance overall health-system performance, yet extreme pressure to demonstrate a rapid return to pre-conflict conditions may nonetheless limit such prospects [2]. Reconstruction strategies are often shaped through high-level international coordination among bilateral and multilateral actors guided by the principle of harmonisation. In countries recovering from civil war, extensive coordination among multiple donor partners, including the UN and World Bank, usually occurs at either a national or regional level [3]. Although international involvement remains pervasive, democratic accountability is rarely improved. Systems novel to reconstruction scenarios might be pursued to bypass entrenched practices, yet scant evidence emerges to indicate that effective governance was favourably impacted during post-conflict health-system recovery [4].

Conceptual Foundations of Health Diplomacy

Health diplomacy, often described as "the negotiation of and drafting of agreements aimed at improving health conditions, and the provision of assistance to achieve an agreed state," encompasses a wide spectrum of endeavors these address the health of people in need, often in vulnerable settings and following conflicts, frequently entail a combination of health and development, and cut across humanitarian and development divides [3]. Actors include local governments, multilateral and other intergovernmental organizations, donors, non-governmental organizations, private voluntary organizations, faith–based organizations, international financial institutions, and other regional and multinational organizations [3]. Strategies and approaches include negotiation to agree on globally accepted health-related treaties and standards, participation in institution building, provision of health services, establishment of financing mechanisms, capacity building, establishment of information-sharing capabilities, regulatory control, and promotion of research and technology [4].

Health Systems in Post-Conflict Contexts

Health systems in conflict-affected and fragile states face unique challenges and disruptions before, during, and after crises and wars. The health sector is one of the most affected by armed conflict, and health systems are disrupted in a myriad of ways [6]. Understanding the main impacts of conflict on health systems and the wider health and well-being of the population is essential for policymakers. Health systems can take decades to fully reconstruct, especially in the worst-affected regions, underscoring the need to maximize any available resources during the early post-war period [3]. Over 40 countries have been classified as in "fragile" or "conflict-affected" situations by organizations such as the Organisation for Economic Co-operation and Development (OECD), the European Commission, and the World Bank. Many of these states have questionable legitimacy and territorial control, as well as limited accountability to citizens and vulnerable groups [5]. Health reconstruction in sensitive post-conflict environments, such as in South Sudan and Sierra Leone, therefore poses additional governance and political challenges. Humanitarian assistance and guidance must be integrated, and early policies must focus on rebuilding the capacity and legitimacy essential for longer-term recovery [1]. These crises are associated with severe hardship, humanitarian crises, rapid deterioration of health systems, surges in communicable and non-communicable diseases, and longer-term psychological and social scars when countries return to relative stability. Although targeted crises and their humanitarian impact do not lead to the same systemic collapse of wider health systems as experienced in Africa, they do interrupt already fragile services [3].

Roles of International Actors in Health Reconstruction

Post-conflict health reconstruction activities are often coordinated through efforts undertaken by international actors such as international governmental organisations, regional bodies, non-governmental organisations, and bilateral donors [4]. Such actors have an impact on governance mechanisms and funding; they engage fragmented or corrupt health authorities; they implement international policies and account to international audiences; they provide technical assistance or humanitarian aid; they frame the health issue as independent of other matters [2].

Governance, Accountability, and Sustainability

The governance arrangements put in place to oversee the reconstruction of health systems are intrinsically linked to issues of accountability and, consequently, sustainability. The political factors affecting reconstruction processes also limit the development of an effective accountability framework, both formally and informally [4]. Governance arrangements are usually contingent upon the decisions of national or local governments concerning the future role of external actors [4]. International actors often pursue health reconstruction initiatives in a climate of limited trust in the newly elected government, and without a clear political settlement, the accompanying accountability arrangements are seldom articulated [4]. In such contested circumstances, accountability may be concentrated in an informal domain. Reconstruction approaches that depend on the systematic pursuit of formalised governance and accountability frameworks may resonate little with the local realities of post-conflict reconstruction [5]. The conditions under which effective reconstruction may be facilitated or an impediment to the efforts of lead international actors to both remain involved and accountable, or the reconstruction benefit value of the approach, either vis-à-vis other sectors or at all, are often poorly delineated[5]. In such situations, providing accounting information or performance data both to those back-filling the absence of public finance, who may be assisting both directly inside and outside the state, and to groups aiming to expose corruption or engage in other domestic accountability efforts, and helping sustain, deal with, or in fact create conflicting agendas - remains intrinsically problematic and uncertain [5]. As a result, when the reconstruction and recovery effort is considered to comprise primarily restoration of services under conditions of absence of recovered authority or formal governance, supplementary or alternative reconstruction and counter-corruption information sets often gain traction [6]. Effective planning for the sustainability of health interventions post-reconstruction requires an in-depth understanding of both the substantive nature of those interventions and the accompanying political economy. The political analysis must encompass the manner in which dependence on additional funding is

expected to wither away and how government endorsement and financing are likely to be secured [4]. A detailed portrait of the intervention and the nature of health systems investment required to address, supplement, or complement such public systems reconstruction often tends to provide an anchor in comparing a broad range of policy options [6]. Planning for the in-built self-reinforcement of corruption practices as a by-product of previous reconstruction efforts, whether as part of officially sanctioned systems of leadership or much lower status and visibility or even informal scarcities, also remains of high immediate relevance [5].

Equity, Human Rights, and Vulnerable Populations

Health systems have a duty to promote equity and adhere to rights-based obligations, especially amid rebuilding efforts in post-conflict societies [5]. Marginalized populations, including impoverished individuals, displaced persons, women, children, and disabled people, commonly bear the brunt of conflict [1, 2]. Analysts have underscored the need for health reconstruction processes to resonate with principles of equity, human rights, and the protection of marginalized groups [5]. Consideration of age, gender, or disability within health plans also helps ensure attention to vulnerable segments of society. Democratization, decentralization, and the introduction of new aid modalities provide an opportunity to target these groups more effectively [5]. Streamlined coordination with international and local partners fosters the integration of marginalization criteria into eligibility assessments [4]. Policy dialogue among stakeholders can also promote transparent, open discussions about the political and economic dimensions of health service delivery, thereby enhancing decision-making effectiveness [4].

Case Studies in Health Diplomacy after Conflict

Health systems after conflict vary widely, yet common patterns emerge, and comparable experiences provide valuable lessons [6]. Three case studies illustrate the roles, approaches, and influence of international actors after conflict in Cambodia (1975–1979), Sierra Leone (1991–2002), and Northern Uganda (1986–2008). Together, these settings reflect diverse pre-conflict contexts and post-conflict pathways and highlight varying degrees of state authority, engagement, and support [4]. Cambodia suffered extensive health-system destruction, making it a priority for the World Health Organization and non-governmental organizations to restore services [4]. Health diplomacy focused on establishing functional systems under the Khmer Rouge (1975–1979) and early post-conflict coordination (1992). Following the 2008 to 2011 national election, international engagement decreased, the health sector witnessed considerable governance and accountability reforms, and health diplomacy shifted toward addressing inequity and rights [5]. Extensive health-system destruction in Sierra Leone raised hopes for health diplomacy to promote governance and state-building principles [3]. The country received substantial reconstruction aid after civil-war closure (2002), and reforms introduced during the transitional government (1996–1997) provided an opportunity for continued international engagement. A health-sector strategic-plan review (2007) indicated that while approaches to supporting governance had gained visibility, multilateral agencies largely delayed state-building health partnerships, despite the government's commitment to reforms [2]. In Northern Uganda, health diplomacy's initial emphasis on governance and accountability waned after the 2006 peace agreement [4]. Coordination was initially facilitated by the World Bank and Paris Declaration principles, and substantial aid targeted service delivery while avoiding routine management and financing systems. Basic services were restored despite underlying governance challenges [2]. Long-term development assistance commenced in the early 1990s, and an express effort was made to continue complementary activities [6, 7, 8].

Measurement and Evaluation in Post-Conflict Health Initiatives

Health initiatives in post-conflict settings often lack rigorous monitoring and evaluation to document their implementation and impact; such oversight is vital to ensure accountability and aid effective health system recovery [6]. For informative measurement and evaluation of post-conflict health initiatives, the following dimensions warrant consideration: establishment of relevant metrics on national inputs, service delivery processes, and health outcomes; appropriate identification of data sources; specification of a corresponding monitoring framework; recognition of inherent attribution complexities concerning the peace building process; and assurance of evaluator credibility and legitimacy while adhering to rigorous data protection protocols [6, 2].

Policy Implications and Strategic Frameworks

Based on the evidence and analysis presented, this section outlines the policy implications of health diplomacy as a strategic approach to reconstruction in post-conflict settings [5]. It formulates specific, actionable recommendations for international actors and identifies a set of scalable strategic frameworks aligned with the needs of diverse contexts [6]. Efforts to assist post-conflict health reconstruction can be oriented by three overarching goals: universal expansion of basic health services, progressive enhancement of health system functionality, and inclusion of recovery initiatives in broader state-building frameworks. Each goal can be pursued through policies and activities classified within four thematic domains: international financing of health initiatives, health governance reforms, health diplomacy coordination between various actors, and establishment of actors capable of directly supporting national health systems [4, 9, 10]. The relevant challenges and corresponding

policy issues are outlined in each case; moreover, for each domain and associated interventions, a set of illustrative indicators permits categorization of the potential health diplomacy contribution to reconstruction. A limited number of contexts sharing post-conflict characteristics can be prioritized for the maximum leverage of such an approach [5]. Rigid, supply-driven preconditions established by international actors commonly obstruct the establishment of effective international funding arrangements for state-led health reconstruction efforts [5]. Under such frameworks, local governments gain little to no ownership of the recovery process, reinstating the danger that the original conflict can be re-ignited later on. Conversely, a demand-oriented paradigm based on self-determined national requests for support complemented by the identification of governance-related challenges as much as is practicable enables national authorities to steer and lead the reconstruction effort [11, 12, 13].

CONCLUSION

Health diplomacy constitutes a critical mechanism for advancing health-system recovery in post-conflict environments, bridging gaps between humanitarian response, development assistance, and state-building efforts. Evidence from Cambodia, Sierra Leone, and Northern Uganda illustrates that international engagement can successfully restore essential services, support governance reforms, and promote equity, but its effectiveness is highly contingent upon local ownership, political legitimacy, and coordination among actors. Challenges persist, including infrastructural damage, fragmented health systems, limited accountability, and reliance on external financing, which may undermine long-term sustainability if not carefully managed. Sustainable post-conflict health reconstruction requires a holistic approach integrating service expansion, system functionality enhancement, and inclusion within broader state-building frameworks. Effective health diplomacy should prioritize context-specific strategies, reinforce governance structures, and target marginalized and vulnerable populations to ensure equitable outcomes. Coordinated monitoring and evaluation frameworks, capacity-building initiatives, and demand-driven international support are essential to maintain accountability, mitigate risks of recurring conflict, and foster resilient health systems. Ultimately, embedding health diplomacy within comprehensive reconstruction strategies can transform post-conflict health challenges into opportunities for sustainable development, social equity, and strengthened national health governance.

REFERENCES

1. Martineau T, McPake B, Theobald S, Raven J, Ensor T, Fustukian S, Ssengooba F, Chirwa Y, Vong S, Wurie H, Hooton N. Leaving no one behind: lessons on rebuilding health systems in conflict-and crisis-affected states. BMJ Global Health. 2017 Jul 1;2(2):e000327.
2. Paul-Chima UO, Ugwu CN, Alum EU. Integrated approaches in nutraceutical delivery systems: optimizing ADME dynamics for enhanced therapeutic potency and clinical impact. RPS Pharmacy and Pharmacology Reports. 2024 Oct;3(4):rqae024.
3. Witter S, Bertone MP, Chirwa Y, Namakula J, So S, Wurie HR. Evolution of policies on human resources for health: opportunities and constraints in four post-conflict and post-crisis settings. Conflict and Health. 2016 Dec;10(1):31.
4. Paul-Chima UO, Nnaemeka UM, Nneoma UC. Could dysbiosis of urban air microbiota be an overlooked contributor to pediatric asthma and neurodevelopmental disorders?. Medical Hypotheses. 2025 Sep 12:111758.
5. Ugwu OP, Ogenyi FC, Ugwu CN, Ugwu MN. Gut microbiota-derived metabolites as early biomarkers for childhood obesity: A policy commentary from urban African populations. Obesity Medicine. 2025 Sep 1;57:100641.
6. Lister G, Told M. Current and Future Issues in Global Health Diplomacy. InGlobal Health Diplomacy: Concepts, Issues, Actors, Instruments, Fora and Cases 2012 Nov 7 (pp. 27-36). New York, NY: Springer New York.
7. Ugwu CN, Ugwu OP, Alum EU, Eze VH, Basajja M, Ugwu JN, Ogenyi FC, Ejemot-Nwadiaro RI, Okon MB, Egba SI, Uti DE. Medical preparedness for bioterrorism and chemical warfare: A public health integration review. Medicine. 2025 May 2;104(18):e42289.
8. Ugwu OP, Ogenyi FC, Ugwu CN, Basajja M, Okon MB. Mitochondrial stress bridge: Could muscle-derived extracellular vesicles be the missing link between sarcopenia, insulin resistance, and chemotherapy-induced cardiotoxicity?. Biomedicine & Pharmacotherapy. 2025 Dec 1;193:118814.
9. Martineau T, McPake B, Theobald S, Raven J, Ensor T, Fustukian S, Ssengooba F, Chirwa Y, Vong S, Wurie H, Hooton N. Leaving no one behind: lessons on rebuilding health systems in conflict-and crisis-affected states. BMJ Global Health. 2017 Jul 1;2(2):e000327.
10. Paul-Chima UO, Nneoma UC, Bulhan S. Metabolic immunobridge: Could adipose-derived extracellular vesicles be the missing link between obesity, autoimmunity, and drug-induced hepatotoxicity?. Medical Hypotheses. 2025 Sep 28:111776.

11. Dowdeswell TL, Hania P. Regulating water and war in Iraq: A dangerous dark side of new governance. Indiana Journal of Global Legal Studies. 2014 Jul 1;21(2):453-82.
12. Ongesa TN, Ugwu OP, Ugwu CN, Alum EU, Eze VH, Basajja M, Ugwu JN, Ogenyi FC, Okon MB, Ejemot-Nwadiaro RI. Optimizing emergency response systems in urban health crises: A project management approach to public health preparedness and response. Medicine. 2025 Jan 17;104(3):e41279.
13. Balalian AA, Simonyan H, Hekimian K, Crape B. Adapting continuing medical education for post-conflict areas: assessment in Nagorno Karabagh-a qualitative study. Human Resources for Health. 2014 Aug 6;12(1):39.

CITE AS: Nassimbwa Kabanda D. (2026). Diabetes Complications in Low-Income Countries: A Narrative Review. IDOSR JOURNAL OF APPLIED SCIENCES 11(1):148-152.
https://doi.org/10.59298/IDOSRJAS/2026/111148152