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Hard to Reach: Providing Healthcare in Armed Conflict

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Cover Photo: Aishatou, a midwife, provides an antenatal consultation for Fatima, who is seven months pregnant. Maiduguri, Nigeria, May 18, 2017. Jean Christophe Nougaret/MSF.

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CONTENTS

Abbreviations

AAP	Accountability to affected populations
DRC	Democratic Republic of the Congo
HDN	Humanitarian-development nexus
ICRC	International Committee of the Red Cross
IDP	Internally displaced person
IHR	International Health Regulations
MSF	Médecins Sans Frontières
NCD	Noncommunicable disease
NWOW	New Way of Working
OCHA	UN Office for the Coordination of Humanitarian Affairs
UNDP	UN Development Programme
UNHCR	UN Refugee Agency
USAID	US Agency for International Development
WHO	World Health Organization

Executive Summary

Armed conflict is a global health issue. Long-lasting and protracted conflicts in particular have consequences not only for the war-wounded but also for the health of entire communities. Over the years, global health actors and humanitarian health actors have developed health policies, guidelines, frameworks, and structures to improve delivery of health services in emergencies or humanitarian crises. Despite these advancements, however, the international health response in conflict-affected settings still faces gaps and challenges. Some policies and frameworks need to be rethought or redesigned, while others need to be better implemented.

Health actors face numerous constraints to delivering healthcare in conflict-affected settings. First, they face constraints related to the health system. Conflict damages health and health-related infrastructure and leads to shortages in medicines, medical supplies, health personnel, and financial resources. It also increases the burden on already strained health systems. Second, armed conflict makes it more difficult for health workers to access populations in need and for these populations to access health services. This occurs due to increased insecurity, legal and administrative barriers, the militarization and politicization of healthcare, poor governance, displacement, and the exacerbation of existing vulnerabilities. Finally, some challenges result from the way donors and other states engage on humanitarian and health issues, particularly when they provide insufficient or short-term funding, allocate aid in a way that does not align with local needs, securitize healthcare, or include broad counterterrorism clauses in contracts.

The UN and its members states, as well as key international organizations, have developed a number of policies to respond to these challenges. Health actors on the ground have little control over most of the above challenges, but they can make a big difference by properly implementing these policies. However, gaps remain, both in international health policies themselves and in their implementation. Insufficient coordination among humanitarian actors results in gaps in or duplication of services, while insufficient coordination between humanitarian and global health actors undermines the complementarity of efforts and continuity of care. There is often a discrepancy between the priorities of health actors and the needs of the affected population, with key services for sexual and reproductive health or mental health being under-prioritized. Unsustainable, short-term humanitarian interventions do not transition smoothly to longer-term development work. Policies are not sufficiently tailored to specific conflict-affected contexts. Health actors are insufficiently accountable to affected populations for their performance. Finally, state-centric health frameworks can face challenges in conflict-affected states that are unable or unwilling to fulfill their role.

Tackling these challenges will have a direct impact on the lives of people in conflict-affected settings. However, doing so requires a radical shift in mindsets and the incentives that guide the actions of international health actors. Even so, more incremental changes can also be beneficial, including the following:

- **Improving coordination between and among humanitarian, development, and global health actors:** Humanitarian health actors could more regularly include global health actors in health cluster meetings, while the World Health Organization could strengthen internal and external links to humanitarian work. Humanitarian health actors could make the health clusters and other coordination mechanisms more transparent, inclusive, and participatory. Humanitarian and development actors could also cooperate more to ensure their work is complementary.
- **Responding to context-specific needs:** By engaging more with local actors, international health actors could better tailor their responses to local needs and priorities. Basing responses on comprehensive, impartial, and evolving needs assessments could also make sure responses address overlooked needs, such as reproductive health, mental health, and other noncommunicable diseases.
- **Holding health actors accountable to affected populations for their performance:** Donors could better incentivize performance accountability based on impact rather than outputs, while health actors could be more transparent about findings from monitoring and evaluation.

Involving local populations in assessing health services could also increase accountability to those affected by conflict. An independent monitoring and evaluation mechanism could particularly strengthen accountability.

- **Making responses sustainable:** International health actors could improve sustainability by better prioritizing the treatment of chronic needs, strengthening and working through existing health systems, and effectively handing over the response to local actors before they leave. They could also better implement the humanitarian-development nexus, something donors could facilitate by tackling funding silos and making funding more long-term.

Introduction

Armed conflict is a global health issue.[1] Long-lasting and protracted conflicts in particular have consequences beyond just the war-wounded—they have consequences for the health of entire communities. Conflict is the ultimate social determinant of health, and conflict-affected countries are lagging behind.[2] To live up to the commitment of the Sustainable Development Goals (SDGs) to "leave no one behind"—and in particular to achieve SDG 3 on health—priority needs to be given to reaching vulnerable people in conflict-affected countries. This is increasingly being recognized, including through an increased focus on universal health coverage in conflict-affected settings.[3]

Contemporary armed conflicts are often protracted and complex. Indeed, many have been ongoing for years and feature numerous armed actors. Hostilities are increasingly taking place in urban areas where they have greater impact on vital infrastructure and communities. More and more people are being forcibly displaced inside their own countries, while still others attempt to cross into neighboring countries and beyond. The impact of this violence and instability on the health of affected populations, both direct and indirect, is staggering, making the work of health actors all the more vital.[4]

Conflict-affected settings present a wide variety of challenges for health actors.[5] These range from constraints on the health system itself to challenges delivering and accessing health services. Such challenges make the work of health actors difficult and, at times, dangerous. They also have drastic and wide-ranging consequences for people in need of health services in those contexts.

During times of armed conflict, the state is generally unable or unwilling to provide adequate health services to its population. As a result, the international community often steps in to fill the gap. Over the years, global health actors and humanitarian health actors have developed numerous health policies, guidelines, frameworks, and structures, some specifically designed to improve delivery of health services in emergencies or humanitarian crises. Despite these advancements, however, the international health response in conflict-affected settings still faces gaps and challenges. Some policies and frameworks need to be rethought or redesigned, while others need to be better implemented to provide adequate health services to people in conflict-affected settings.

Though beyond the scope of this paper, it is also important to note that armed conflicts, especially protracted ones, have a significant impact on other

1 This policy paper focuses on situations of armed conflict. However, much of it could also apply to situations of violence that do not rise to the level of armed conflict but still create a need for humanitarian engagement.

2 Aniek Woodward, Kate Sheahan, and Tim Martineau, "Health Systems Research in Fragile and Conflict Affected States: A Qualitative Study of Associated Challenges," *Health Research Policy and Systems* 15, No. 44 (2017): 1-12.

3 See, for example, Switzerland's call for action on universal health coverage in emergencies. World Health Assembly, "Universal Health Coverage (UHC) in Emergencies: A Call to Action," Geneva, Switzerland, June 13, 2018, available at www.uhc2030.org/news-events/uhc2030-news/article/a-call-to-action-advancing-uhc-in-emergency-settings-481478/ ; and Jessica Turner, "Five Perspectives on a Call to Action for Universal Health Coverage in Emergencies," Safeguarding Health in Conflict, October 5, 2018, available at www.safeguardinghealth.org/five-perspectives-call-action-universal-health-coverage-emergencies .

4 The term "health actors" refers to all medical personnel working in government health structures, private health structures, and local and international organizations. This paper focuses on both humanitarian health actors and global health actors. Humanitarian health actors are organizations providing health services in conflict or disaster-affected areas in accordance with the humanitarian principles of humanity, neutrality, independence, and impartiality. Global health actors are more development-oriented actors working on transnational health issues, in particular infectious diseases, including GAVI, the Global Fund, the Bill and Melinda Gates Foundation, the World Health Organization (WHO), and the Global Polio Eradication Initiative.

5 Attacks against healthcare are not the focus of this project. These have been addressed in other IPI activities, notably in Els Debuf, "Evaluating Mechanisms to Investigate Attacks on Healthcare," International Peace Institute, December 2017; and Alice Debarre, "Safeguarding Medical Care and Humanitarian Action in the UN Counterterrorism Framework," International Peace Institute, September 2018. Such attacks have also been the focus of research and high-visibility campaigns by Médecins Sans Frontières (MSF, #NotATarget), the International Red Cross and Red Crescent (Health Care in Danger), and the Safeguarding Health in Conflict Coalition.

countries. Armed conflicts in one country can become a cause of regional instability, notably by driving people to flee and become refugees elsewhere. The health needs of displaced populations may differ from those of host populations, straining health systems and the ability of health actors to respond to needs. Communicable disease outbreaks resulting from armed conflict also do not respect borders. Policies therefore also need to consider the transnational effects of conflicts on health systems beyond the affected country.

This policy report aims to assist UN agencies, NGOs, member states, and donor agencies in providing and supporting the provision of adequate health services to conflict-affected populations. It maps and explains the challenges health actors face in those contexts, the understanding of which is key to ensuring that policies are adequate. It also looks at the governance structures being set up to operationalize those policies. The paper then seeks to identify and analyze key gaps in policy and implementation, as well as to provide recommendations for bridging those gaps. It focuses on questions related to the coordination of health actors, the prioritization of health services, the sustainability of health services and transitions to development, context-specificity and localization, accountability, and the state-centric nature of health policy.[6]

This work is based on a combination of desk research, interviews with more than seventy key informants, and an expert meeting bringing together key stakeholders and experts on global and humanitarian health.[7] Field research was conducted in Mali in May 2018 and in Nigeria in September 2018, with interviews conducted in New York and Geneva between September 2017 and February 2018.

Mapping the Challenges

Understanding the challenges of delivering healthcare in armed conflict helps guide and shape policies and frameworks implemented in such contexts. Of course, the challenges encountered vary depending on the context, the type of conflict and actors involved, the health system in place, and the humanitarian capacities on the ground. Broadly, however, these challenges can be categorized as constraints related to the health system, to the delivery of and access to health services, and to other states' engagement.

HEALTH SYSTEM CONSTRAINTS

Conflict affects all parts of a country's existing health system, from health and health-related infrastructure to research, policy and planning, and human and financial resources. In addition, many conflict-affected states already had weak health systems before conflict broke out, although armed conflict also affects some countries with sophisticated and functional health systems. As a result, conflict-affected states have among the worst health indicators and weakest health systems in the world.[8]

Breakdown of Infrastructure

Conflict adversely affects the health infrastructure, which may be either intentionally or unintentionally damaged, destroyed, or looted by warring parties. Those health facilities that are not entirely destroyed may end up shutting down or reducing their services. The damage to a conflict-affected country's health system is vast, particularly when armed conflict is being waged in urban areas (see Box 1).[9]

This has important health consequences.[10] It makes it difficult or impossible to treat conflict-related injuries, as well as health issues that are

6 Other organizations have taken an in-depth look at issues such as the gap in emergency responses. See, for example, Monica de Castellarnau and Velina Stoianova, "Bridging the Emergency Gap: Reflections and a Call for Action after a Two-Year Exploration of Emergency Response in Acute Conflict," Médecins Sans Frontières, April 2018.

7 IPI convened an expert workshop called "Doctors in War Zones: International Policy and Healthcare during Armed Conflict" in Geneva from June 7 to 8, 2018. See www.ipinst.org/2018/06/doctors-in-war-zones .

8 Tim Martineau et al., "Leaving No One Behind: Lessons on Rebuilding Health Systems in Conflict- and Crisis-Affected States," *BMJ Global Health* 2, No. 2 (2017): 1-6.

9 Hosanna Fox, Abby Stoddard, Adele Harmer, and J. Davidoff, "Emergency Trauma Response to the Mosul Offensive, 2016–2017: A Review of Issues and Challenges," *Humanitarian Outcomes*, March 2018, p. 17.

10 For an overview of these consequences, see UN General Assembly, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standards of Physical and Mental Health*, UN Doc. A/68/297, August 9, 2013.

Box 1. Destruction of health infrastructure in Nigeria

The conflict in northeastern Nigeria has led to the breakdown of health facilities and the complete collapse of public services—and this in a region that already faced neglect and underinvestment before the crisis. In Borno State, only around 30 percent of health facilities remain fully functional.[11] In most local government areas in the state, primary healthcare facilities have been partially or totally destroyed by Boko Haram. As people have been displaced to urban areas, health facilities in places like Maiduguri have become overstretched. The few remaining hospitals struggle with the bad electric supply in the region. Even in areas of Adamawa and Yobe States where there are health facilities still standing, those facilities and their available resources are often substandard.

indirect consequences of conflict.[12] In Yemen, for example, one of the main challenges to providing reproductive health and gender-based violence services is the fact that 50 percent of health structures are damaged or not operational.[13]

In the longer term, conflict also affects those who are unable to access regular treatment for noncommunicable diseases (NCDs).[14] Most people affected by NCDs require chronic care, which is difficult to provide and access in volatile and insecure settings with weakened health systems. In Yemen, for example, the conflict has rendered the health system unable to provide such care, and 25 percent of people in need of kidney dialysis have died each year since 2015.[15] Some patients suffering from physical injury require not only immediate care but also rehabilitation, which presents similar challenges as NCDs. Specialized services such as mental healthcare are particularly hard to find in conflict-affected settings.[16]

Conflict also damages crucial health-supporting infrastructure such as food and water safety and supply, sanitation, electric power, transportation, and communication. In the Central African Republic, the conflict has disrupted the country's already weak logistics and transport capacity, making it much more challenging to deliver medicine to rural areas.[17] Damaged agricultural infrastructure can lead to malnutrition and famine. The lack of essential services more generally increases a population's vulnerability to disease outbreaks. In Yemen, the ongoing fighting has crippled health, water, and sanitation facilities, creating the ideal conditions for diseases to spread.[18] Yemen also suffered from serious electricity shortages, which meant that lab services could not continue, the cold chain for vaccines was unable to function, and no air conditioners or fans were available for seriously ill patients in the scorching heat.[19] In urban contexts in particular, vital infrastructure is interconnected, causing

11 UN Organization for the Coordination of Humanitarian Affairs (OCHA), *Nigeria: 2018 Humanitarian Needs Overview*, February 2018; Maria Paola Bertone et al., "Performance-Based Financing in Three Humanitarian Settings: Principles and Pragmatism," *Conflict and Health* 12, No. 28 (2018); WHO and Government of Nigeria, *Nigeria: Northeast Response—Health Sector Bulletin No. 08*, September 2018.

12 For example, a study on child mortality in Africa showed the deadly but indirect toll that conflict has on children. Zachary Wagner et al., "Armed Conflict and Child Mortality in Africa: A Geospatial Analysis," *The Lancet* 392, No. 10150 (2018): 857-865.

13 CARE International, "Yemen: More Than 3 Million Women and Girls Suffering the Brunt of the Ongoing Conflict, Warns CARE," March 7, 2018, available at www.care-international.org/news/press-releases/yemen-more-than-3-million-women-and-girls-suffering-the-brunt-of-the-ongoing-conflict-warns-care . For a comprehensive overview of the collapse of the public health system in Yemen, see International Rescue Committee (IRC), "They Die of Bombs, We Die of Need: Impact of Collapsing Public Health Systems in Yemen," March 2018.

14 WHO, "Beyond the Bullets and Bombs: Saving the Lives of Chronic Disease Patients Living in Conflict Settings," November 23, 2017, available at www.emro.who.int/eha/news/beyond-the-bullets-and-bombs-saving-the-lives-of-chronic-disease-patients-living-in-conflict-settings.html .

15 Sharmila Devi, "Yemen Health under Relentless Pressure, *The Lancet* 391, No. 10121 (2018): 646.

16 In Syria, for example, there is only one operating mental health hospital for people with acute psychiatric conditions. Zaher Sahloul, "Why Ignoring Mental Health Needs in Young Syrian Refugees Could Harm Us All," *The Conversation*, January 30, 2018; WHO, *Health Emergencies: WHO Response in Severe, Large-Scale Emergencies—Report by the Director-General*, UN Doc. EB140/7, December 19, 2016.

17 Charles Ssonko et al., "Delivering HIV Care in Challenging Operating Environments: The MSF Experience towards Differentiated Models of Care for Settings with Multiple Basic Health Care Needs," *Journal of the International AIDS Society* 20, No. 4 (2017): 14-20.

18 WHO, "Statement by UNICEF Executive Director, Anthony Lake, WFP Executive Director, David Beasley and WHO Director-General, Dr Tedros Adhanom Ghebreyesus, Following Their Joint Visit to Yemen," July 26, 2017, available at www.who.int/mediacentre/news/statements/2017/joint-visit-yemen/en/ ; UNICEF, "Drinking Water Systems under Repeated Continuous Attack in Yemen," August 1, 2018, available at https://reliefweb.int/report/yemen/drinking-water-systems-under-repeated-continuous-attack-yemen-enar .

19 Human Rights Watch, "Yemen: Coalition's Blocking Aid, Fuel Endangers Civilians," September 27, 2017.

damage to one type of infrastructure to impact others.[20] In Gaza, electricity shortages brought health, water, and sanitation services to the brink of collapse, threatening the lives of patients relying on electric devices and leading to the temporary closure of several health facilities, further overstretching the facilities that remained.[21]

Shortages of Medicines and Medical Supplies

During conflict, health facilities' supply chains often break down, creating shortages of necessary medicines, medical commodities, and basic medical equipment, a lack of continuous supply, or even oversupply of certain types of medicines. Supply chain breakdowns can also lead to the use of lower-quality medicines. International sanctions, as in Syria, can also make the import of medicine a challenge.[22]

In organized camps for refugees or internally displaced persons (IDPs), humanitarian actors can mobilize resources to cover gaps in medicines, to an extent. Preexisting health facilities in urban and, especially, rural areas usually face more challenges. In 2016, the World Health Organization (WHO) reported that there was restricted access to surgical supplies, anesthetics, and safe blood products in Syria.[23] In Libya, health actors cannot procure essential medicines in part due to lack of funds but mostly due to an inefficient, unaccountable, and fragmented procurement system.[24] Similar reports of shortages of life-saving medicines have been coming out of Mosul in Iraq, Saada governorate in Yemen, and Donetsk in eastern Ukraine.[25]

Lack of medicines and medical supplies has consequences not only for patients but also for those treating them. Many health workers put their lives at risk because they do not have the right supplies or equipment. The death of a doctor from Lassa fever brought this issue to the fore in Nigeria, where health professional have cited a lack of supplies as a huge challenge to preventing and controlling infection.[26]

Shortage of Health (and Other) Personnel

There is no public health without health workers.[27] Attracting, distributing, retaining, and ensuring the performance of health workers is critical to a health system's functioning.[28] During conflict, however, health workers face both personal and professional challenges. They are often threatened, harassed, intimidated, or attacked by parties to the conflict, with health worker deaths being an all too common occurrence.[29] As mentioned above, they are also at risk of contracting infectious diseases due to inadequate medical supplies or equipment. Health workers often witness terrible events, potentially traumatizing them. Local staff in particular may worry that the next patient will be someone they know.

In addition, health workers are overburdened and overworked. The shortage of specialized health staff is a particular challenge, as many health workers lack training on or experience dealing with conflict-related cases or the specialized skills needed to treat the patient in front of them.[30] As a result, health workers may have to take on practices

20 International Committee of the Red Cross, "Urban Services during Protracted Armed Conflict: A Call for a Better Approach to Assisting Affected People," 2015, p. 28.

21 WHO, "Funding Urgently Needed to Prevent Collapse of Gaza Health System," February 22, 2018, available at https://reliefweb.int/report/occupied-palestinian-territory/funding-urgently-needed-prevent-collapse-gaza-health-system ; Teresa Welsh, "'Any Hospital in the World Would Have Been Collapsing': ICRC Gaza Spokesperson," *Devex*, May 18, 2018.

22 See, for example, Dahlia Nehme, "Syria Sanctions Indirectly Hit Children's Cancer Treatment," Reuters, March 15, 2017; and Jonathan Steele, "Sanctions Don't Stop Assad, but Hurt Us All, Say Syrian Medics and Businesspeople," *Middle East Eye*, October 26, 2017.

23 WHO, *Health Emergencies: WHO Response in Severe, Large-Scale Emergencies*.

24 John Zarocostas, "Libya: War and Migration Strain a Broken Health System," *The Lancet* 391, No. 10123, March 2018: 824-825.

25 UNICEF, "Violence Leaves 750,000 Children in Mosul Struggling to Access Basic Health Services," February 6, 2018, available at https://reliefweb.int/report/iraq/violence-leaves-750000-children-mosul-struggling-access-basic-health-services-enarku ; WHO, "Inside the Struggling Al-Jumhoori Hospital in Saada, Yemen," September 2017, available at www.who.int/emergencies/yemen/health-workers/en/ ; WHO, "'We Don't Have Enough Medicines to Treat Our Patients,'" August 2017, available at www.euro.who.int/en/health-topics/emergencies/health-response-to-the-humanitarian-crisis-in-ukraine/eastern-ukraine-health-professionals-share-their-daily-challenges-in-providing-care/we-dont-have-enough-medicines-to-treat-our-patients .

26 Clara Affun-Adegbulu, "Caring for the Carers: Occupational Hazards of Being a Healthcare Professional in Nigeria," International Health Policies, February 9, 2018, available at www.internationalhealthpolicies.org/caring-for-the-carers-the-occupational-hazard-of-being-a-healthcare-professional-in-nigeria/ .

27 WHO, *Global Strategy on Resources for Health: Workforce 2030*, 2016.

28 Martineau et al., "Leaving No One Behind."

29 See Safeguarding Health in Conflict, "Violence on the Front Line: Attacks on Health Care in 2017," May 2018; WHO, "Surveillance System for Attacks on Healthcare," available at https://publicspace.who.int/sites/ssa/SitePages/PublicDashboard.aspx ; and IRC, "They Die of Bombs, We Die of Need," p. 10.

30 For example, on sub-Saharan Africa's shortage of rehabilitation professionals, see Woody Rule, "Rehabilitation: A Growing Necessity in sub-Saharan Africa," *The Lancet Global Health Blog*, October 24, 2017; and on the shortage of trauma care specialists in Syria, see WHO, *Health Emergencies: WHO Response in Severe, Large-Scale Emergencies*.

beyond the scope of their training and knowledge, making it challenging to abide by WHO and other guidelines.[31]

Given these challenges, many health workers flee the conflict and violence or leave in search of better opportunities and a better life, leading to health worker shortages. Staff shortages extend to administrators and managers required to oversee and coordinate effective service delivery. In the Central African Republic, for example, most health professionals have fled, particularly from rural areas, and those based in the capital are difficult to relocate to those areas due to ongoing insecurity.[32] Health actors in northeastern Syria, Nigeria, and Mali have described their biggest challenge as the lack of qualified staff (see Box 2).[33] Insecurity also has a direct impact on the presence of international humanitarian health actors.[34]

Gaps in Health Data

Many conflict-affected countries already had weak systems for data collection and evidence generation before conflict broke out, but conflict generally leads to a complete collapse of those systems. Population surveillance breaks down as people flee the violence, and conducting sample surveys is difficult due to the general insecurity. Information coming out of health facilities may be lost or destroyed in attacks, or it may be less comprehensive as people have more difficulty accessing these facilities. This results in poor-quality data and lack of proper documentation.

Without the necessary evidence and data, it is difficult for policymakers to make decisions about where to target resources, which interventions to prioritize, and which policies to implement.[35] Gaps

Box 2. Shortage of health workers in Nigeria and Mali

In Nigeria, the shortage of health workers in the northeast is a major challenge. Even prior to the conflict, there were insufficient human resources for healthcare, and Nigeria more generally suffers from brain drain.[36] When the conflict broke out, some health workers were killed, and others fled. In September and October 2018, Boko Haram executed two health workers after holding them hostage for several months; one remains in captivity.[37] Most health workers are unwilling to work in areas where the security situation is volatile.

As a result, in Borno State in particular, there is a lack of trained and skilled health workers. Most health structures outside of the capital Maiduguri do not have Ministry of Health staff and are either empty, supported by NGO staff, or staffed by community health workers, who generally have less technical skills and expertise. Even where Ministry of Health staff are present, they are paid poorly and late, leading to high turnover that disrupts services.

In Mali, the lack of qualified health workers in conflict-affected areas is also a challenge. Even prior to 2012, there were insufficient health workers in the north, and things have only gotten worse. For example, the government's health personnel for the Kidal Region are not based in Kidal but in Gao. As a result, nongovernmental actors have had to step in. Additionally, there is high turnover of both national and international staff, and Mali has little recruitment capacity.

31 Namie Di Razza, "People before Process: Humanizing the HR System for UN Peace Operations," International Peace Institute, October 2017, available at www.ipinst.org/2017/10/humanizing-hr-system-for-un-peace-operations .

32 MSF, "Out of Focus: How Millions of People in West and Central Africa Are Being Left out of the Global HIV Response," April 2016, p. 47.

33 Phone interview, humanitarian worker, New York, October 2017.

34 For example, in South Sudan in 2016, the WHO decreased its surge deployments because of security concerns, and in March 2018, MSF announced the evacuation of both its national and its international staff following a violent attack in Nigeria's Borno State. See: WHO, *Health Emergencies: WHO Response in Severe, Large-Scale Emergencies*; MSF, "MSF Suspends Medical Activities in Rann." Press Release, March 2, 2018.

35 Richard G. A. Feachem, "Global Health Policy-Making in Transition," in *The Handbook of Global Health Policy*, Garrett W. Brown, Gavin Yamey, and Sarah Wamala, eds. (Chichester, UK: John Wiley & Sons, 2014), p. 12.

36 See, for example, NOI Polls, "New Survey Reveals 8 in 10 Nigerian Doctors Are Seeking Work Opportunities Abroad," August 3, 2017, available at http://noi-polls.com/root/index.php?pid=447&ptid=1&parentid=14 .

37 ICRC, "Nigeria: Health Worker Hauwa Mohammed Liman Executed in Captivity," October 16, 2018, available at www.icrc.org/en/document/nigeria-health-worker-hauwa-mohammed-liman-executed-captivity .

in data can also cause problems for vaccination campaigns, making it challenging to know who still needs to be reached.[38] Finally, these gaps undermine the ability to monitor the services provided and ensure health actors are accountable for those services.

Collecting data on displaced persons is particularly challenging, especially when people are displaced several times. Health actors need information on who they are, where they are, and what they need.[39] In the absence of reliable data, the vulnerabilities of displaced populations may remain hidden and unaddressed.

Insufficient Financial Resources

Many health systems already suffer from insufficient financial resources and inappropriate resource allocation before the outbreak of conflict. When conflict erupts, the need for financial resources for health only rises. However, conflict often leads to a drop in government spending on health as government incomes decreases or resources are directed away from health services or research and development toward other priorities such as military and security efforts.[40] The government may therefore be unable to pay the salaries of public health and other workers. In Yemen, public workers were not paid or received incomplete salaries for months on end, exacerbating the already drastic health crisis, including a cholera outbreak and famine.[41]

Inadequate government health budgets, as well as insufficient donor commitment (see below), often lead to additional barriers to accessing health services such as user fees for patients or increased out-of-pocket charges.[42] Many cannot afford these payments due to the impact of the conflict on their livelihoods and income.[43] In Iraq in 2015, the cost of health services was identified as the single biggest challenge to accessing healthcare.[44] Conflict may also cause financial transactions to be restricted or disrupted.

Unregulated Private Sector Involvement

Private providers of healthcare have become more influential in low- and middle-income countries, and—particularly in conflict-affected countries—they have sometimes stepped in to fill the void created by a weak or nonexistent public health system. The presence of private health actors can provide opportunities. In Mosul in 2017, for example, field hospitals were managed and administered by a private medical firm contracted by WHO. Using local staff, they served communities' emergency and primary healthcare needs.[45] The presence of private medical actors, however, can present a number of challenges. Private actors range from informal drug sellers to independent doctors to large corporate hospitals, depending on the setting.[46] The quality of services provided, therefore, can vary greatly. Where private health services are high quality, they are only available to those who have the means to pay for them. In Hassakeh in Syria, for example, there is a big private hospital with specialist staff providing high-quality health services, but its services are beyond the means of the vast majority of the people there, many of whom are IDPs with no income.[47]

In addition, the multiplication of private health actors may lead to a degradation of the public health system. For example, some public health systems have contracted or entered into informal

38 Global Polio Eradication Initiative, "Reaching the Hard to Reach: Ending Polio in Conflict Zones," June 21, 2017, available at http://polioeradication.org/news-post/ending-polio-in-conflict-zones/#.WUvGu8mIQXg.email .

39 UNICEF, "A Call to Action: Protecting Children on the Move Starts with Better Data," February 2018.

40 In South Sudan, for example, only 3 percent of the national budget goes to healthcare (one of the lowest percentages in the world), while over half goes to "security and administration;" see: Stefanie Glinski, "For Medical Workers in South Sudan's War, Just Reaching the Sick Is a Challenge," IRIN, April 24, 2018. In Yemen, the conflict has devastated the country's economy and severely eroded the capacity of the government to meet its financial obligations; see: IRC, "They Die of Bombs, We Die of Need," p. 8.

41 MSF, "Saving Lives without Salaries: Government Health Staff in Yemen," 2017; Elizabeth Dickinson, "Banking Conflict Exacerbates Yemen's Cholera and Famine," Devex, August 4, 2017; IRC, "They Die of Bombs, We Die of Need," p. 10.

42 Olga Bornemisza, Kent Ranson, Tim Poletti, and Egbert Sondorp, "Promoting Health Equity in Conflict-Affected Fragile States," London School of Hygiene and Tropical Medicine, February 2007, p. vi.

43 Martineau et al., "Leaving No One Behind," p. 3.

44 Health Policy Research Organization, Middle East Research Institute, and Liverpool School of Tropical Medicine, "Health System Challenges in the Face of the Humanitarian Crisis in Iraq," Health Systems Global, October 2015, p. 3.

45 John M. Quinn, Omar F. Amouri, and Pete Reed, "Notes from a Field Hospital South of Mosul," *Globalization and Health* 14, No. 27 (2018).

46 Maureen Mackintosh et al., "What Is the Private Sector? Understanding Private Provision in the Health Systems of Low-Income and Middle-Income Countries," *The Lancet* 388, No. 10044 (2016): 596-605.

47 Phone interview, humanitarian worker, New York, October 2017.

arrangements with private healthcare providers to increase coverage in conflict-affected settings. However, in such settings governments may have limited capability to manage and regulate these providers, which can lead to low-quality services and ultimately undermine state legitimacy. There is also a risk that private providers distort health system resources; for example, health workers often leave the public sector for better-paying jobs in the private sector.[48]

Increased Health Burden

Armed conflict often both increases the health needs of the population and undermines the health system's ability to cope with both new and preexisting needs. People suffer from the direct consequences of conflict, such as war wounds or explosive device accidents. In Syria in 2016, for example, around 25,000 people were injured each month because of the conflict.[49] This increases the need for emergency surgical care, which may require specialized skills that health workers lack.

Armed conflict also has extensive indirect consequences on the health needs of the population resulting from the breakdown of health and health-related systems. For example, conflict hampers the surveillance, prevention, and control of infectious disease outbreaks.[50] Unsanitary conditions, lack of access to clean water, and malnutrition resulting from conflict can increase the incidence of infectious diseases such as malaria, measles, cholera, or neglected tropical diseases, particularly in urban settings. Under-five and maternal mortality rates are higher in conflict zones, and conflict increases mental health problems.

CHALLENGES TO DELIVERING AND ACCESSING HEALTH SERVICES

Armed conflict not only constrains a country's health system, it also creates challenges both for health workers delivering health services and for affected populations seeking to access those services. Access to health services by the population and access by health workers to populations in need remain key challenges in most armed conflicts.

Insecurity and Instability

General insecurity and instability in conflict-affected contexts create challenges both for populations trying to access health services and for health actors trying to access populations in need. Traveling to and from health facilities can be difficult and dangerous. There are testimonies from the Central African Republic of young girls traveling for days with gunshot wounds to take a safer route to the hospital.[51] In addition, people may need to travel to several different facilities to receive the medical attention they need, entailing additional cost and risk. In contexts where there is active fighting, providing trauma care can be particularly challenging, as it requires health providers to be as close as possible to the frontlines.[52] In Syria, epidemic preparedness and response efforts are difficult to implement due to the general insecurity, with the result that vaccination campaigns do not reach a majority of people.[53]

Violations of international humanitarian law by parties to an armed conflict, and particularly the increasing number of attacks on medical facilities and personnel in recent years, are a significant obstacle to delivering and accessing health services. In conflicts today, medical workers are often directly targeted by attacks, incarcerated, detained, taken hostage, and tortured. In Afghanistan, the Central African Republic, Iraq, Syria, and other countries, hospitals have been attacked, destroyed, or forcibly closed.[54] These attacks contribute to the breakdown of health infrastructure and the shortage of health workers. They disrupt access to basic health services and sometimes cut off entire

48 Sophie Witter and Benjamin Hunter, "How to Move towards Universal Health Coverage in Crisis-Affected Settings: Lessons from Research," ReBUILD Consortium, June 2017, p. 3.

49 WHO, Health Emergencies: WHO Response in Severe, Large-Scale Emergencies.

50 For example, conflict increases vulnerability to polio outbreaks by disrupting routine immunization systems and mass displacement. See: Global Polio Eradication Initiative, "Reaching the Hard to Reach"; Michelle Gayer, Dominique Legros, Pierre Formenty, and Máire A. Connolly, "Conflict and Emerging Infectious Diseases," *Emerging Infectious Diseases* 13, No. 11 (2007).

51 MSF, "Central African Republic: 'The Only People Left in Zemio Are Those Who Couldn't Run Away,'" September 12, 2017.

52 Fox, Stoddard, Harmer, and Davidoff, "Emergency Trauma Response to the Mosul Offensive, 2016–2017," p. 12.

53 Phone interview, humanitarian worker, New York, October 2017.

54 Ashley Hamer, "Afghan Healthcare Under Siege as Escalating Conflict Cuts Off Access," IRIN, October 26, 2017; MSF, "Central African Republic: 'The Only People Left in Zemio Are Those Who Couldn't Run Away'"; UN OCHA, "Statement by Panos Moumtzis, Regional Humanitarian Coordinator for the Syria Crisis, on East Ghouta Hospital Attacks," February 20, 2018, available at https://reliefweb.int/report/syrian-arab-republic/statement-panos-moumtzis-regional-humanitarian-coordinator-syria-2 ; UNICEF, "Violence Leaves 750,000 Children in Mosul Struggling to Access Basic Health Services."

parts of the population from such services. As a result, many people lose trust in the safety of medical facilities or impartiality of healthcare providers, causing them not to seek care for fear of being targeted.

Legal, Administrative, and Other Barriers

In the past decade, there has been a trend toward counterterrorism laws and policies that can adversely impact the provision of medical care. Some laws that broadly criminalize support to designated terrorist groups may also be inappropriately applied to the provision of impartial medical care. This can lead to the harassment, arrest, or prosecution of medical workers. It can also place a heavy administrative burden on organizations, reducing the speed and increasing the cost of operations. Such laws and policies may also cause organizations to modify or terminate their operations to avoid violating them or to self-regulate beyond what is legally or contractually required. This creates challenges for humanitarian health actors in upholding humanitarian principles.[55]

Patients in conflict-affected contexts may face additional bureaucratic or administrative impediments to accessing healthcare. Documentation is often required to access any type of health service. However, people who have been forcibly displaced by conflict may not possess such documentation. In Gaza, Palestinians need to obtain medical permits from Israel to receive care outside of the territory, and these are regularly denied or delayed.[56] In Myanmar, people living in Rakhine State are required to apply for travel authorizations, hampering their access to health services, in particular if they live in IDP camps or remote areas.[57]

Health actors may also face bureaucratic impediments to accessing certain populations. In Luhansk and Donetsk, Ukraine, for instance, the government has put an "NGO accreditation service" in place—a process that hindered the ability of organizations to deliver effective healthcare.[58] In South Sudan in 2016, humanitarian worker visa fees were briefly hiked up to absurd levels, before an international outcry led to a reversal of the policy.[59] Administrative obstacles were also identified as one of the main challenges to delivering health services in Yemen.[60] In some areas, parallel authorities impose different requirements for humanitarian actors to operate. Airplanes delivering humanitarian supplies have only been allowed to land in the country if cleared by the proper authorities, an arduous process that requires providing detailed information. The few that have landed have only been allowed to stay for brief periods. Visas for medical workers and permits to operate are regularly and arbitrarily denied.[61]

Finally, political and military dynamics can result in governments restricting access to certain areas and parts of the population controlled by armed opposition groups. In Myanmar's Kachin and Northern Shan States, for example, the government prohibits international humanitarian actors from accessing areas controlled by ethnic armed groups.[62] In Nigeria, the government prohibits humanitarian actors from accessing parts of Borno State controlled by Boko Haram (see Box 3).

Militarization and Politicization of Healthcare

During armed conflict, hospitals and health facilities are at risk of being taken over or used by armed forces or law enforcement agencies for military purposes.[63] Both state armed forces and non-state armed groups have used health facilities to store arms and supplies, or even as bases from which to direct and launch their operations. This poses a serious threat to the life and health of both patients

55 Debarre, "Safeguarding Medical Care and Humanitarian Action in the UN Counterterrorism Framework," pp. 8–10.

56 Human Rights Watch, "Israel: Record-Low in Gaza Medical Permits," February 13, 2018, available at www.hrw.org/news/2018/02/13/israel-record-low-gaza-medical-permits .

57 Interviews in Myanmar, November 2018.

58 WHO, "Global Health Cluster Partner Meeting," December 9–10, 2015, Geneva, Switzerland, p. 3.

59 Amien Essif, "South Sudan's Visa Fee Hike a 'Threat' to Foreign Aid," Deutsche Welle, March 27, 2017.

60 IRC, "They Die of Bombs, We Die of Need."

61 Phone interview, humanitarian worker, New York, October 2017.

62 Interviews in Myanmar, November 2018.

63 UN General Assembly, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standards of Physical and Mental Health*, UN Doc. A/68/297, August 9, 2013.

Box 3. Restricted access to Borno State in Nigeria

Access to Nigeria's Borno State is a key challenge for humanitarian and health actors in Nigeria. Most of the territory remains under the control of non-state armed groups, and the government prohibits access to those areas, limiting humanitarian and health actors to working in military-controlled enclaves. There is little information as to the needs of the people living outside of these enclaves, although information collected from displaced populations suggests many are in dire need of aid.

Given the absence of Ministry of Health staff or humanitarian actors in those areas, there is very little if any access to health services. The only health intervention that has reportedly been undertaken in some of these inaccessible areas is a polio immunization campaign by a local organization, e-Health, funded by the Bill and Melinda Gates Foundation. This organization is reportedly escorted by the Civilian Joint Task Force (a militia formed to fight Boko Haram) or the Nigerian military to distribute polio vaccines in areas where they are engaged in military operations.[64] The WHO also supports "hard-to-reach" teams in a number of local government areas to provide basic health services to remote and displaced communities.[65]

Pressed by donor agencies and some NGOs, the UN humanitarian country team developed an access strategy for Borno State in 2018. However, not everyone is ready to pursue access more aggressively given sensitivities within the government. In particular, senior UN officials are perceived as being reluctant to push further on the question of access. Furthermore, some organizations feel that they need to improve the response in areas where they have access before expanding. Efforts to expand access are ongoing, including during the recent joint mission to the country by the UN Development Programme's (UNDP) administrator and the emergency relief coordinator in October 2018, but some worry that, with the upcoming elections in February 2019, the room for negotiation will only decrease.

and health workers, as it puts health facilities at risk of being targeted by the opposing party—potentially legally. Health facilities are protected from attack under international humanitarian law but may lose this protection if used to commit "acts harmful to the enemy."[66]

The militarization of health facilities also directly undermines their impartiality. The use of these facilities for military purposes, the use of armed guards to protect health facilities, or the use of healthcare delivery programs to further military goals can seriously compromise the perception of health workers as neutral and impartial actors.[67] This is detrimental to public health and can even lead to attacks on health workers.[68]

A related problem is the blurring of the lines between humanitarian and military activities. This can easily happen in integrated UN missions, which bring together peacekeeping operations and country teams in conflict-affected or post-conflict countries (see Box 4). The presence of military medical personnel can also blur the lines. Military medical personnel have increasingly been part of the response to health crises, in particular in conflict-affected settings. However, a review of the 2005 International Health Regulations recognized that in some situations, such as humanitarian emergencies, this can be highly sensitive, and precautions must be taken to ensure it does not undermine the civilian nature of the humanitarian

64 See WHO, *Joint External Evaluation of IHR Core Capacities of the Federal Republic of Nigeria, Mission Report: June 11–20, 2017*, 2017, p. 42.

65 WHO and Government of Nigeria, *Nigeria: Northeast Response—Health Sector Bulletin No. 08*, September 2018; WHO, "Who Teams Assist People in Hard-To-Reach Areas of Nigeria," February 24, 2017, available at www.who.int/news-room/feature-stories/detail/who-teams-assist-people-in-hard-to-reach-areas-of-nigeria .

66 Fourth Geneva Convention, 1949, Art. 19; Additional Protocol I to the Geneva Conventions, 1977, Art. 13; Additional Protocol II to the Geneva Conventions, 1977, Art. 11.

67 Margaret Bourdeaux, Vanessa Kerry, Christian Haggenmiller, and Karlheinz Nickel, "A Cross-Case Comparative Analysis of International Security Forces' Impacts on Health Systems in Conflict-Affected and Fragile States," *Conflict and Health* 9, No. 14 (2015), available at https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-015-0040-y .

68 UN General Assembly, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standards of Physical and Mental Health*, UN Doc. A/68/297, August 9, 2013, p. 11. See also, for example, Donald G. McNeil Jr., "CIA Vaccine Ruse May Have Harmed the War on Polio," *New York Times*, July 9, 2012.

Box 4. The blurring of humanitarian and military activities in Mali

In Mali, humanitarian actors on the ground all raised the politicization and militarization of health activities as a major challenge to principled humanitarian action.[69] This is mainly attributed to the presence of the UN mission in Mali (MINUSMA), widely considered a party to the armed conflict. In particular, the mission's implementation of quick impact projects—political projects designed to increase local populations' acceptance of peacekeepers—have been controversial. Despite policy dictating that such activities should not duplicate humanitarian activities, some projects have encroached on the humanitarian sphere and have included health-related activities.[70] This can cause confusion among the population, leading to the misperception or de-legitimization of humanitarian work, and even increasing the risk of humanitarian actors being targeted. It has also led to a loss of trust among the population, which may therefore refrain from seeking health services.

response.[71]

The politicization of health services is closely tied to militarization. In many conflict-affected contexts, governments, militaries, and armed groups may instrumentalize health services by denying access to or imposing conditions on healthcare providers as a political or military strategy. For humanitarian health actors in particular, this undermines their independence, neutrality, and impartiality, which are key to accessing populations in need and maintaining the trust necessary to continue their work. This has been a challenge in Syria, where the government requires that organizations register and provide information on staff and beneficiaries, and armed groups make demands about whom they can hire or provide services to.[72] In addition, many parties to the conflict have denied humanitarian access by besieging civilian populations in places like Daraa, Deir ez-Zor, and Eastern Ghouta to gain political leverage or as part of military maneuvers. Humanitarian actors must act carefully, as all sides of a conflict are likely to read their actions through a political lens.

Poor Governance

Armed conflict is often associated with less effective, less accountable, and less transparent governance.[73] Some governments are unwilling or unable to uphold their population's right to health during armed conflict (see Box 5).[74] Corruption, which is often exacerbated by conflict and can also fuel and prolong it, can divert already scarce resources from health services.[75] Moreover, many governments are already dysfunctional or lacked interest in improving the health of their citizens even before an outbreak of conflict.

Conflict can also lead to non-state armed groups controlling territories, populations, or resources.[76] Governments have little or no capacity to provide health services in such areas. The health services provided therefore depend on non-state groups' resources, culture or ideological posture, external

69 On the challenges for humanitarian actors linked to combining integration, stabilization, and counterterrorism agendas in Mali, see Alejandro Pozo Marín, "Case Study: Perilous Terrain Humanitarian Action at Risk in Mali," Medicins Sans Frontiers, March 2017.

70 Initially, the UN mission in Mali was not even sending out its list of quick impact projects to humanitarian actors. By May 2018, it was doing so, but it remained up to humanitarian actors to check that they were not operating in the same areas.

71 WHO, *Implementation of the International Health Regulations (2005): Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response—Report of the Director-General*, UN Doc. A69/21, May 13, 2016.

72 Funk et al., "Ethical Challenges among Humanitarian Organisations," p. 140.

73 Institute for Economics and Peace, *Global Peace Index 2016*, available at http://economicsandpeace.org/wp-content/uploads/2016/06/GPI-2016-Report_2.pdf .

74 See, for example, Fox, Stoddard, Harmer, and Davidoff, "Emergency Trauma Response to the Mosul Offensive, 2016–2017," p. 5: "Despite initial plans that correctly placed the responsibility for trauma care with the pro-government forces, both the Iraqi and international forces ultimately abdicated this responsibility, leaving humanitarian actors to fill the void."

75 Jens Christopher Andvig, "Corruption and Armed Conflicts: Some Stirring around in the Governance Soup," NUPI Working Papers, Norwegian Institute of International Affairs, 2007; US Institute of Peace, "Governance, Corruption and Conflict," Study Guide Series on Peace and Conflict, 2010, p. 67

76 In the Central African Republic, for example, armed groups control 70 percent of the country; see: Voices from the Field, "CAR: Four Things to Know about the Conflict in the Central African Republic," Medécins Sans Frontières, April 10, 2018. In the fight against polio in Afghanistan, access for vital immunization programs must be negotiated with the Taliban in some areas like Kandahar; see: Maija Liuhto, "Afghanistan Battles Polio: Rumours, Mistrust, and Negotiating with the Taliban," IRIN, May 10, 2018. In Nigeria, Boko Haram still controls some villages and pockets of countryside in Borno State. John Campbell and Asch Harwood, "Boko Haram's Deadly Impact," Council on Foreign Relations, August 20, 2018, available at www.cfr.org/article/boko-harams-deadly-impact .

Box 5. Governance challenges to health services in Mali

In Mali, governance issues create significant challenges for the delivery of health services. Actors on the ground cited insufficient human resources and expertise, slow and arduous procedures, and delays in implementation. They likewise stressed that weak leadership and governance at the central level led to insufficient control, supervision, and coordination of the implementation and application of health policies. The government tends systematically to accept any aid, whatever the priorities. Corruption and diversion of funds have led some donors to take projects out of the hands of the government, and some organizations have adopted "zero cash" policies when working with the government. Finally, government health structures appear not to significantly report to each other or supervise subordinate levels unless pushed to do so by partners, as is the case for vaccination campaigns

or internal support, priorities (e.g., whether they seek to govern), and grip on the population. In Angola, for example, the armed group UNITA managed to organize health services for the population under its control as it had financial resources and could rely on internal and international support.[77] Ethnic armed groups that control parts of Myanmar's Kachin and northern Shan states have developed health organizations that provide services to people in those areas.[78] Generally, however, most non-state groups do not seem to perceive it as in their interest to provide, or even allow the provision of, health services to populations under their control.

In addition, non-state groups are often difficult to engage with—particularly in the state-centric international system—which subsequently means that areas under their control do not receive the aid and support needed to ensure adequate health services. In particular, when non-state groups are considered criminal or terrorist groups, organizations may face some risk in engaging with them, even if they are only doing so to access populations in need of health services.

Movements of People

Conflict and violence trigger displacement, leading people to leave their homes to find safer living conditions, either elsewhere in their own country or in neighboring countries and beyond. The number of IDPs in the world today has reached a staggering 40 million. Most are displaced multiple times, and those who manage to leave their country sometimes return to face renewed internal displacement. It is often harder for displaced persons in transit, in camps, and in host communities to access the medicines or health services they need.[79] In 2017 in Nigeria, for example, over 40 percent of IDPs in camps had no access to basic health services.[80] In other places, such as Pakistan, access to government healthcare depends on registration in the place of residency, creating challenges for those displaced.

More and more IDPs are moving to urban settings rather than camps where they blend in with host populations. This can strain the health system and services in those areas. It is also challenging for healthcare providers to access and target those IDPs, who may have specific and acute needs. The protracted nature of most conflict-related displacement today brings the additional challenge of having to find more long-term, sustainable health solutions for those displaced.

Increased Vulnerabilities

In addition to those displaced, certain groups of people, such as women and girls, children and youth, persons with disabilities, and the elderly, are particularly vulnerable in times of armed conflict. These vulnerabilities are important to understand not only with respect to the conflict, but also in the context of the social, political, and economic

77 WHO, "Module 5: Understanding Health Policy Processes," in *Analyzing Disrupted Health Sectors: A Modular Manual*, 2009.

78 London School of Hygiene and Tropical Medicine, Health in Humanitarian Crises online course, available at www.lshtm.ac.uk/study/courses/short-courses/free-online-courses/health-in-humanitarian-crises .

79 Nonetheless, it must be noted that in some situations, refugees, and sometimes IDPs, have better access to health services than the actual host populations or those who have not been displaced. Bornemisza, Ranson, Poletti, and Sondorp, "Promoting Health Equity in Conflict-Affected Fragile States," pp. vii, 15.

80 WHO, "One Year after Nigeria Emergency Declaration," September 5, 2017, available at www.who.int/news-room/feature-stories/detail/one-year-after-nigeria-emergency-declaration- .

determinants of health and health inequity in their country.[81] Which groups of people will be most affected by armed conflict, and how, directly relates to their situation prior to its outbreak. Additionally, some people may have several types of vulnerabilities, with, for example, women with disabilities in a displaced setting facing a triple burden.[82] Conflict not only exacerbates these people's health needs, it also exacerbates their vulnerabilities, making it more difficult for them to access health services.

Displaced persons suffer from particular vulnerability, with increased mortality, disability, and psychological distress. For people on the move, the breakdown of public health infrastructure and services, close living quarters, poor access to water and sanitation, and food insecurity can increase the risk of outbreaks and the spread of infectious diseases.[83] Some of the highest mortality rates in humanitarian emergencies over the last decade have been recorded among IDPs.[84]

Conflict increases all forms of violence against women and girls.[85] Such violence is sometimes even used as a war tactic. In refugee camps in Bangladesh, UN Women reports that almost every woman and girl is either a survivor of or witness to multiple incidences of brutal sexual violence.[86] For health actors, providing care to survivors of sexual and gender-based violence in conflict-affected contexts can be challenging. Survivors are at risk of being stigmatized, requiring sensitive approaches that take into account local capacities and the cultural environment.[87] This issue affects not only women and girls but also men and boys, though the latter is both underreported and understudied.

Women are also the first to suffer from the general lack of access to medical care or facilities. Existing social norms limit the ability of women to access resources and opportunities, resulting in discrimination and inequalities that can have negative consequences for health.[88] Conflict exacerbates this, weakening or destroying existing systems to protect women or making them more difficult to access. In Yemen, for example, the destruction of the public water infrastructure has amplified the burden of water collection on women, with a devastating impact on health.[89]

Maternal mortality and morbidity are highest in crisis-affected countries, and over half of the world's maternal deaths occur in conflict-affected and fragile states.[90] When detained or in refugee or IDP camps, women often endure poor sanitary conditions and lack sexual, reproductive, and maternal health services.[91] Even outside of such settings, including in areas of Syria, women often face dangerous healthcare gaps, with poor antenatal care and high rates of risky home deliveries.[92] In fact, lack of access to sexual and reproductive healthcare is the leading cause of morbidity and mortality among displaced women and girls of reproductive age in humanitarian settings.[93]

81 Ayesha Ahmad and Lisa Eckenwiler, "Identities, Intersectionalities and Vulnerabilities in Humanitarian Operations: A Response to Slim," ICRC *Humanitarian Law & Policy*, March 1, 2018; Bornemisza, Ranson, Poletti, and Sondorp, "Promoting Health Equity in Conflict-Affected Fragile States," p. 9.

82 Ben Small, "Missing Millions: How Older People with Disabilities Are Excluded from Humanitarian Response," HelpAge International, April 30, 2018.

83 WHO, *Implementation of the International Health Regulations (2005): Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response—Report of the Director-General*, UN Doc. A69/21, May 13, 2016, p. 20; Monica Rull et al., "The New Who Decision-Making Framework on Vaccine Use in Acute Humanitarian Emergencies: MSF Experience in Minkaman, South Sudan," *Conflict and Health* 12, No. 11 (2018) ; Rebecca Y. Du, Jeffrey Stanaway, and Peter J. Hotez, "Could Violent Conflict Derail the London Declaration on NTDs?," *Neglected Tropical Diseases* 12, No. 4 (2018).

84 Bornemisza, Ranson, Poletti, and Sondorp, "Promoting Health Equity in Conflict-Affected Fragile States," pp. vii, 15.

85 Françoise Duroch and Catrin Schulte-Hillen, "Care for Victims of Sexual Violence, an Organization Pushed to Its Limits: The Case of Médecins Sans Frontières," *International Review of the Red Cross* 96, No. 894 (2014), p. 602.

86 UN Women, "Gender Brief on Rohingya Refugee Crisis Response in Bangladesh," October 2017; UN Population Fund, "Horrific Stories, Urgent Action: Addressing Gender-Based Violence Amid the Rohingya Refugee Crisis," September 28, 2017.

87 Duroch and Schulte-Hillen, "Care for Victims of Sexual Violence, an Organization Pushed to Its Limits," pp. 607–610.

88 See, for example, University College London Centre for Gender and Global Health, "The Global Health 50/50 Report," 2018, p. 17; UN Women, *A Global Study on the Implementation of United Nations Security Council Resolution 1325*, 2015, p. 76; Ayesha Ahmad, "Disclosure of Gender-Based Violence in Humanitarian Settings," in *Humanitarian Action and Ethics*, Ayesha Ahmad and James Smith, eds. (London: Zed Books, 2018), pp. 219–231; Rachel Vogelstein, "Pregnant in a War Zone: Why Respectful Maternity Care Matters in Humanitarian Settings," Council on Foreign Relations, August 22, 2018.

89 IRC, "They Die of Bombs, We Die of Need," p. 12.

90 UN Women, *A Global Study on the Implementation of United Nations Security Council Resolution 1325*, p. 77

91 Ibid., pp. 69, 74.

92 MSF, "MSF Reports Show More Assistance Is Needed to Meet Healthcare Needs," December 20, 2017.

93 Kristen Beek, Angela Dawson, and Anna Whelan, "A Review of Factors Affecting the Transfer of Sexual and Reproductive Health Training into Practice in Low and Lower-Middle Income Country Humanitarian Settings," *Conflict and Health* 11, No. 16 (2017).

Children and youth also face specific challenges in times of conflict. While youth are at risk of recruitment by armed groups, for the most part they suffer from the indirect consequences of conflict.[94] Children are often malnourished and at greater risk of suffering from various diseases. Young people in their developmental years are particularly vulnerable to high levels of stress and trauma, which, if not properly treated, can impair their mental, emotional, social, and physical development and sometimes lead to lifelong psychological needs.[95] In addition, availability of mental health interventions for children in conflict-affected settings is even lower than for adults.[96]

During conflict, people with physical or mental disabilities are also likely to experience greater vulnerability and dependency, as their usual family and community support structures are disrupted.[97] They do not enjoy equal access to food and healthcare.[98] For those with mental disorders in particular, humanitarian crises often exacerbate the reasons for their neglect, such as lack of resources, stigma, or different conceptions of what constitutes a medical problem.[99]

CHALLENGES LINKED TO OTHER STATES' ENGAGEMENT

Beyond the internal challenges within a country, some challenges result from the way donors and other states engage on humanitarian and health issues in conflict-affected settings. Given the contextual challenges described above, this engagement is often crucial and lifesaving. The approach to engagement, however, can complicate the provision of health services in conflict-affected settings.

Insufficient, Short-Term International Funding

International funding is crucial to providing health services in conflict-affected contexts, yet UN humanitarian response plans are rarely fully funded. At the end of 2017, for example, UN agencies launched the campaign #UkraineNotForgotten to plead for support for humanitarian assistance in Ukraine, where the health needs are dire.[100] As of October, the humanitarian response in the Democratic Republic of the Congo (DRC) in 2018 was only 28.2 percent funded.[101] Many global organizations that can provide essential health services, like the WHO, are notoriously underfunded.[102] Some types of health services or programs, such as that for survivors of gender-based violence, have also been seriously underfunded.[103]

Another funding-related constraint, in particular for humanitarian health services, is the short-term nature of international funding. More long-term sustainable funding is required to plan for and provide adequate and predictable health services, in particular chronic care and follow-up.[104] Through initiatives such as the 2016 Grand Bargain, major donors are pursuing new financing mechanisms to respond more effectively to protracted crises. In 2014, the UK Department for International Development introduced multi-year funding for protracted conflicts.[105] However, some have

94 Wagner et al., "Armed Conflict and Child Mortality in Africa."

95 World Vision, "Psychological Support for Refugee Children of Myanmar in Bangladesh," January 22, 2018, available at https://reliefweb.int/report/bangladesh/psychological-support-refugee-children-myanmar-bangladesh ; Sigiriya Aebischer Perone et al., "Non-Communicable Diseases in Humanitarian Settings: Ten Essential Questions," *Conflict and Health* 11, No. 17 (2017), p. 10; Catherine Lee et al., "Mental Health and Psychosocial Problems among Conflict-Affected Children in Kachin State, Myanmar: A Qualitative Study," *Conflict and Health* 12, No. 39 (2018).

96 Theresa S. Betancourt and Timothy Williams, "Building an Evidence Base on Mental Health Interventions for Children Affected by Armed Conflict," *Intervention (Amstelveen)* 6, No. 1 (2008): 39-56.

97 Lynne Jones et al., "Severe Mental Disorders in Complex Emergencies," *The Lancet* 374, No. 9690 (2009), p. 654.

98 Human Rights Watch, "People with Disabilities at Risk in Conflict, Disaster: Endorse Global Guidelines for Inclusive Humanitarian Response," March 19, 2016.

99 Jones et al., "Severe Mental Disorders in Complex Emergencies," p. 656.

100 WHO, "Portraits from Ukraine's Conflict Line, Where Humanitarian Assistance Is Most Needed," February 20, 2018, available at www.euro.who.int/en/health-topics/emergencies/health-response-to-the-humanitarian-crisis-in-ukraine/news/news/2018/2/portraits-from-ukraines-conflict-line,-where-humanitarian-assistance-is-most-needed .

101 For more details on financial requirements and funding pledges in humanitarian crises, see UN OCHA's *Global Humanitarian Overview 2018*, available at https://interactive.unocha.org/publication/globalhumanitarianoverview/ .

102 Chelsea Clinton and Devi Sridhar, *Governing Global Health: Who Runs the World and Why?* (Oxford: Oxford University Press, 2017), pp. 89–97.

103 UN Women, *A Global Study on the Implementation of United Nations Security Council Resolution 1325*, p. 72.

104 Paul B. Spiegel, "The Humanitarian System Is Not Just Broke, but Broken: Recommendations for Future Humanitarian Action," *The Lancet*, June 8, 2017, p. 1; Sophie Witter and Benjamin Hunter, "Sustainability of Health Systems in Crisis-Affected Settings: Lessons for Practice," ReBUILD Consortium, June 2017, pp. 2–3;

105 UK Department for International Development, "The Value for Money of Multi-Year Humanitarian Funding: Emerging Findings," May 1, 2017.

pointed out that multi-year funding is not sufficient in and of itself and will require changes in the system, culture, and mindsets to deliver on its promises.[106]

Aid Allocation

In armed conflict contexts, the prioritization of health issues is largely dependent on international funding and allocation of aid. Aid allocation shapes which countries receive assistance and what medicines and treatments people in those countries are able to access. However, questions have been raised as to how well allocation processes assess and address the needs and capacities of recipient countries.[107] Studies have shown that variations in development assistance for health are only partially explained by differences in disease burdens or income levels.[108] Many institutions still rely heavily on gross national income per capita as a criterion for allocation, which is a flawed approach.[109]

Furthermore, donors' agendas can lead to high levels of funding for priorities that may not correspond with the priority health needs in every context.[110] For example, countries consistently rank noncommunicable diseases as their primary health concern, but this is reportedly one of the areas in which WHO struggles the most to secure donor funding.[111] A large percentage of the budgets of international organizations such as UNICEF, UNDP, and WHO is earmarked for certain interventions or initiatives, often without consulting the countries concerned.[112] Health agendas therefore mainly respond to donors, rather than on-the-ground needs. In addition, most government donors channel funds for humanitarian health through international rather than local organizations, even though the latter are generally more attuned to the context and priority health needs of the populations they are serving and can have a more permanent and sustainable presence.[113]

Health actors also require fast and flexible funding that can be quickly unblocked in emergencies to allow for an immediate response. The Central Emergency Response Fund of the UN Office for the Coordination of Humanitarian Affairs (OCHA) is a good example, but it is often insufficiently funded and also has its challenges.[114] WHO's Contingency Fund for Emergencies, established in 2015, also provides funding for rapid response, and the World Bank has developed the Pandemic Emergency Financing Facility, a mechanism that can provide a surge of funds to enable a rapid and effective response to a large-scale disease outbreak.[115]

Securitization of Healthcare

The idea of linking health concerns and human security developed in the 1990s,[116] but it was in 2001 that a World Health Assembly resolution first tied the concept of health security to a global strategy for preventing the movement of communicable

106 Food and Agriculture Organization, OCHA, and Norwegian Refugee Council, "Living Up to the Promise of Multi-Year Humanitarian Financing," NRC, October 2017.

107 Jesse B. Bump, "Global Health Aid Allocation in the 21st Century," *Health and Policy Planning* 33, No. 1 (2018): 1-3; Y-Ling Chi and Jesse B. Bump, "Resource Allocation Processes at Multilateral Organizations Working in Global Health," *Health and Policy Planning* 333, No. 1 (2018): 4-13.

108 Michael Hanlon et al., "Regional Variation in the Allocation of Development Assistance for Health," *Globalization and Health* 10, No. 8 (2014).

109 For a more detailed discussion of these issues, see Mark Dybul, "Health Financing Seen from the Global Level: Beyond the Use of Gross National Income," *Policy and Law* 12, No. 2 (2017): 117-120; and Bump, "Global Health Aid in the 21st Century."

110 Rajaie Batniji and Francisco Songane, "Contemporary Global Health Governance: Origins, Functions and Challenges," in *The Handbook of Global Health Policy*, Garrett W. Brown, Gavin Yamey, and Sarah Wamala, eds. Chichester, UK: John Wiley & Sons, 2014, p. 72; Sophie Harman, "Critical Reflections on Global Health Policy Formation: From Renaissance to Crisis," in *The Handbook of Global Health Policy*, p. 49; Katerini T. Storeng, Jennifer Palmer, Judith Daire, and Maren O. Kloster, "Behind the Scenes: International NGOs' Influence on Reproductive Health Policy in Malawi and South Sudan," *Global Public Health* (2018).

111 Sara Van Belle, Remco van de Pas, and Bruno Marchal, "Queen Bee in a Beehive: WHO as Meta-Governor in Global Health Governance," *BMJ Global Health* 3, No. 1 (2017), p. 2.

112 Y-Ling Chi, Kalipso Chalkidou, and Jesse B. Bump, "The Need for New Approaches to Global Health Aid Allocation," Center for Global Development, February 20, 2018, available at www.cgdev.org/blog/need-new-approaches-global-health-aid-allocation ; Chi and Bump, "Resource Allocation Processes at Multilateral Organizations Working in Global Health"; Anders Nordström, "Is WHO Ready to Improve Its Country Work?" *The Lancet* 390, No. 10114 (2017): 2,749-2,757.

113 See, for example, Coastal Association for Social Transformation Trust, "Fast Responders Are Kept Far!: An Assessment on Localization Practice in the Humanitarian Response for FDMN," March 2018; and Storeng, Palmer, Daire, and Kloster, "Behind the Scenes: International NGOs' Influence on Reproductive Health Policy in Malawi and South Sudan."

114 The UN Central Emergency Response Fund's lifesaving criteria mean that the Secretariat is reluctant to fund the response to outbreaks until they have resulted in large-scale mortality; see: UN Central Emergency Response Fund (CERF), *2017 Annual Report*, OCHA, 2017; Jenny Lei Ravelo, "18 Months In, How Is Who's Health Emergencies Program Working?," Devex, January 31, 2018.

115 See WHO, "Contingency Fund for Emergencies (CFE)," March 2018, available at http://origin.who.int/about/who_reform/emergency-capacities/contingency-fund/en/ ; and World Bank, "Pandemic Emergency Financing Facility," July 27, 2017, available at www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-financing-facility .

116 UNDP, *Human Development Report 1994*. New York: Oxford University Press, 1994.

diseases across national borders.[117] In recent years, and with epidemics such as HIV and Ebola, there has been an increasing trend to frame threats to health as security concerns.[118]

This framing poses a number of challenges for healthcare in conflict-affected contexts. For some, the framing of global health security is concerning, as it politicizes health.[119] Indeed, the intervention of the UN Security Council or individual states in this arena often seems to be motivated more by political or security interests rather than strictly humanitarian or health concerns, which may threaten principled humanitarian action.[120]

The focus on security has also influenced the global health agenda, causing health actors to prioritize some diseases over others. Notably, the focus has been on epidemics and pandemics because of their potential impact on Western countries, at the expense of NCDs.[121] This focus has also led to health aid being directed according to national security rather than health needs. Instead of focusing on building health systems and ensuring appropriate health interventions based on levels of risk and disease burden in conflict-affected contexts, resources go toward disease surveillance and response systems. Nonetheless, there is increased awareness that these systems perform best and are more sustainable when part of a comprehensive public health system.[122]

Finally, the lack of consensus on the meaning of health security, and fear that there are hidden national security agendas behind it, can challenge mechanisms for global cooperation such as the International Health Regulations (IHR). Countries may become aware that unconditional open sharing of surveillance data may not be in their national interest.[123] In the past, World Health Assembly member states have expressed concerns about the use of the concept of health security to justify resolutions or other WHO initiatives perceived to benefit select countries.[124]

Counterterrorism Clauses in Donor Contracts

In addition to counterterrorism laws and regulations passed by conflict-affected states, counterterrorism clauses in donor contracts can create challenges for organizations providing health services in armed conflict settings where groups designated as terrorist also operate.[125] Among some leading donor states, such as the United States, counterterrorism laws criminalize acts preparatory to or in support of terrorism.[126] Some of those states also have their own list of individuals and groups designated as terrorist. Donor contracts may require organizations to ensure funds received do not support terrorism and may require the vetting of partners, vendors, suppliers, contractors, and sometimes even beneficiaries. This requires arduous internal procedures, which many larger organizations may have the resources for, but which present a challenge for smaller NGOs. It can also compromise the provision of impartial assistance and medical care.

Counterterrorism clauses in contracts from the US Agency for International Development (USAID) in particular have recently brought this issue to the fore. In Nigeria, UNICEF refused to sign a contract with one such clause, as it would have compromised its ability to provide impartial care. Recent reporting on tightened USAID

117 World Health Assembly Resolution 54.14, UN Doc. WHA54.41, May 21, 2001.

118 UN Security Council Resolutions 1308 (2000) and 1983 (2011) declared HIV/AIDS a security threat, and Resolution 2177 (2014) declared Ebola a threat to peace and security to be addressed by security, military, and intelligence authorities. That same year, the Global Health Security Agenda (GHSA) was launched. This agenda is a US-led partnership of states, international organizations, and NGOs that pursues a "multilateral and multi-sectoral approach to strengthen both the global capacity and nations' capacity to prevent, detect, and respond to human and animal infectious diseases threats whether naturally occurring or accidentally or deliberately spread."

119 "Health security" is a term used by many stakeholders who give it different meanings depending on their interests and agendas; see: Colin McInnes and Anne Roemer-Mahler, "From Security to Risk: Reframing Global Health Threats," *International Affairs* 93, No. 6 (2017), p. 1,329.

120 Colin McInnes and Alan Ingram "Health, Foreign Policy and Security: Towards a Conceptual Framework for Research and Policy," Nuffield Trust, 2004.

121 Feachem, "Global Health Policy-Making in Transition," p. 9; McInnes and Roemer-Mahler, "From Security to Risk," p. 1,314.

122 William Aldis, "Health Security as a Public Health Concept: A Critical Analysis," *Health Policy and Planning* 23, No. 6 (2008), p. 11.

123 Philippe Calain, "From the Field Side of the Binoculars: A Different View on Global Public Health Surveillance," *Health Policy and Planning* 22, No. 1 (2007).

124 Aldis, "Health Security as a Public Health Concept," p. 9.

125 Kate Mackintosh and Patrick Duplat, "Study of the Impact of Donor Counter-terrorism Measures on Principled Humanitarian Action," UN OCHA and Norwegian Refugee Council, July 2013; Jessica Burniske, Naz Modirzadeh, and Dustin Lewis, "Counter-terrorism Laws and Regulations: What Aid Agencies Need to Know," Humanitarian Practice Network, November 2014, available at https://odihpn.org/resources/counter-terrorism-laws-what-aid-agencies-need-to-know/ ; Counterterrorism and Humanitarian Engagement Project, "An Analysis of Contemporary Counterterrorism-Related Clauses in Humanitarian Grant and Partnership Agreement Contracts," May 2014, available at http://blogs.law.harvard.edu/cheproject/ .

126 US Code, Title 18, Part I, Chapter 113B, Sections 2339A and 2339B.

guidelines has also highlighted the challenge for NGOs operating in Syria, as new contractual terms require organizations to get special permission to provide aid in areas controlled by designated terrorist groups.[127]

Gaps in International Health Policy and Its Implementation in Armed Conflict

The UN and its members states, as well as key international health organizations, have developed a number of policies to enable affected populations to access adequate and appropriate health services. While the vast majority of these challenges are out of the hands of the health actors implementing them on the ground, the proper implementation of these policies can make a big difference. There are, however, gaps, both in international health policies themselves and in their implementation on the ground, that hinder the provision of adequate and appropriate health services to those who need them.

COORDINATION

Coordination among governmental, humanitarian, and global health actors in conflict-affected settings is key to ensuring that the health services provided are as efficient and effective as possible, filling gaps in provision, avoiding duplication of services, and maintaining continuity of care.[128] Despite significant progress, there remain gaps in coordination between humanitarian and global health actors and among actors providing humanitarian health services.

The UN humanitarian country team, chaired by the humanitarian coordinator, oversees humanitarian responses in a given country.[129] This team's role is to develop strategies and plans, mobilize and allocate resources, agree on common policies, promote adherence to principles and guidelines, and interface with other coordination mechanisms.[130] It is not a decision-making body, however, and its membership is voluntary. The humanitarian country team develops the humanitarian response plan for the country based on the humanitarian needs overview produced by OCHA in partnership with other humanitarian actors and, at least in theory, with local and national authorities, civil society, and affected populations.

In an effort to improve capacity, predictability, accountability, leadership, and partnership, the emergency relief coordinator launched a humanitarian reform initiative in 2005, leading to the creation of the cluster approach.[131] When warranted by the situation on the ground, coordination groups, or "clusters," are activated for sectors in which the needs are particularly high. The health cluster is therefore activated when there are clear health needs, where numerous health actors are operating, and when national authorities need help coordinating them.[132] It is responsible for ensuring that service delivery is driven by the humanitarian response plan. The Global Health Cluster led by the WHO supports clusters or cluster-like coordination mechanisms in twenty-seven countries, the majority of which are affected by armed conflict. Among other things, it identifies and addresses gaps in technical knowledge and available guidance to ensure health responses follow global best practices and standards.[133]

The cluster system is reportedly the most frequently used coordination mechanism at the country level, but in some contexts, cluster-like

127 Ben Parker, "US Tightens Counter-terror Clampdown on Syria Aid," IRIN, September 21, 2018; Ben Parker, "Shutdowns, Suspensions, and Legal Threats Put Relief in World's Troublespots at Risk," IRIN, September 26, 2018.

128 Note that there are also challenges linked to coordination with other sectors such as nutrition and water, sanitation, and hygiene, given that health requires a multidimensional response and more efforts are needed in humanitarian settings to ensure multi-sectoral coordination. Coordination among health and non-health actors is particularly important for certain types of health services, such as mental health services. This is emphasized in both Inter-Agency Standing Committee (IASC) and Sphere Project guidelines. See Karl Blanchet et al., "An Evidence Review of Research on Health Interventions in Humanitarian Crises," London School of Hygiene and Tropical Medicine, October 2015, p. 94; UN General Assembly, *Outcome of the World Humanitarian Summit—Report of the Secretary-General*, UN Doc. A/71/353, August 23, 2016, p. 18.

129 UN General Assembly Resolution 46/182 of 1991

130 See IASC, *Guidance for Humanitarian Country Teams*, 2009.

131 See IASC, *Guidance Note on Using the Cluster Approach to Strengthen Humanitarian Response*, 2006; IASC, *Reference Module for Cluster Coordination at the Country Level*, 2015; and IASC, *Operational Guidance on Designating Sector/Cluster Leads in Major New Emergencies*, 2007.

132 However, there has been a distinct reduction in officially activated clusters as governments increasingly want to lead their own response. This is the case in Nigeria, for example.

133 The Global Health Cluster Strategy for 2017–2019 is available at www.who.int/health-cluster/about/work/strategic-framework/GHC-strategy-2017-2019.pdf?ua=1 .

coordination groups are set up instead. This was the case in Nigeria, reportedly due to reluctance on the part of the government, which is concerned about international perceptions as well as a potential reduction in development funding (see Box 6).[134] The decision whether or not to activate the cluster system can reduce the speed and reactivity of the humanitarian response, as well as the ability for humanitarian actors to mobilize funds for the response.

Despite this elaborate coordination system and evident progress made, coordinating the provision of health services (and other humanitarian services more generally) is regularly mentioned as a challenge. Coordination remains too weak, and it is often described as time-consuming, excessively process-heavy, and inflexible.[135] It also tends to be under-representative of the national NGO community, which may not have the resources to engage with these mechanisms.

In addition to coordination among humanitarian health actors, there is a need for greater cooperation between humanitarian health and global health actors. In conflict-affected settings, global health and humanitarian actors increasingly share key objectives, such as epidemic preparedness and response, and their coordination is therefore central to ensuring effective and efficient health responses. In the past, there was little coordination and collaboration between the two worlds. For example, the IHR barely mention situations of armed conflict.[136] Given that the IHR is an international treaty, state parties are the main obligation bearers, but it does not address situations in which there is no functioning state, as can be the case in areas of armed conflict.

Coordination has improved since the 2014 Ebola outbreak in West Africa. This outbreak made the WHO's lack of operational responsiveness clear, and the WHO and other global health actors did not sufficiently leverage the expertise and capacities of humanitarian actors on the ground. For example, the health cluster was never officially activated in the affected countries, leading to challenges and delays in the response. The 2016 review of the IHR therefore recognized the need for increased coordination and collaboration between the global health and humanitarian worlds.[137] As a

Box 6. Coordination without a cluster in Nigeria

In Nigeria, global health and humanitarian health actors coordinate their epidemic responses in the northeast to a certain extent. The Nigeria Centre for Disease Control, supported by the WHO, coordinates surveillance and alerts for the country, and state primary health care development agencies coordinate all immunization matters at the state level. A number of humanitarian health actors work on case management and collect surveillance information. They transmit this information to the government, which then reports on the epidemiological situation in health sector coordination meetings. Organizations like Gavi, the Global Fund, and the Bill and Melinda Gates Foundation provide grants and vaccines to the Ministry of Health, through which all vaccine orders must go. However, most global health programs are national, and prevention plans developed by the Ministry of Health and WHO are reportedly not realistic for the conflict-affected states. Global health actors have also committed a large amount of funding to the polio response and have been able to reach zones that other actors have not in the northeast. However, so far, no other health activities have been linked to polio immunizations.

134 One interviewee also mentioned that the UN likely accommodated this pushback by the government given the high number of Level 3 activations in other contexts, the UN's already stretched capacities, and Nigeria being a middle-income country that did bit fit the usual criteria.

135 See, for example, Paul Knox Clarke and Leah Campbell, "Coordination in Theory, Coordination in Practice: The Case of the Clusters," *Disasters* 42, No. 4 (2018), p. 1; Olushayo Olu et al., "Lessons Learnt from Coordinating Emergency Health Response during Humanitarian Crises: A Case Study of Implementation of the Health Cluster in Northern Uganda, *Conflict and Health* 9, No. 1 (2015); Brian W. Simpson, "How to Fix the Broken Humanitarian System: A Q&A with Paul Spiegel," *Global Health Now*, June 9, 2017; and de Castellarnau and Stoianova, "Bridging the Emergency Gap."

136 Annex 2 of the IHR mentions armed conflict as a factor that would make an event more likely to be a public health emergency of international concern.

137 The WHO's Regional Committee for Africa proposed enhancing coordination and collaboration on health emergencies with other entities and agencies within and outside the UN. The IASC principals concurred on using the IASC and OCHA to coordinate the international response to large-scale infectious emergencies under the strategic and technical leadership of the WHO. WHO, Draft *Global Implementation Plan for the Recommendations of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response*, UN Doc. AFR/RC66/4, August 20, 2016; WHO, *Implementation of the International Health Regulations (2005): Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response—Report of the Director-General*, UN Doc. A69/21, May 13, 2016, pp. 26, 44.

result, the IASC developed System-Wide Level 3 Activation Procedures for Infectious Disease Events, which provides criteria for OCHA, in consultation with other stakeholders such as the WHO, to activate the humanitarian response system when there is a major infectious disease outbreak.[138]

Also in response to the Ebola crisis, the WHO added operational capabilities to its traditional technical and normative roles by creating the Health Emergencies Programme. This program combines working with states on preparedness; working on emergency response in collaboration with the global health cluster, the IASC, emergency medical teams, the Global Outbreak Alert and Response Network, and standby partners;[139] and working on recovery. It is meant to bridge the disparate worlds of infectious disease response and humanitarian relief.[140] It is also working to improve internal coordination and collaboration between its work strengthening health systems and responding to emergencies.

As health cluster lead, the WHO provides a link between the two communities, as well as with the government, on issues related to epidemic preparedness. In some countries, humanitarian organizations regularly provide technical and logistical support to governments in the conduct of activities such as vaccinations. UN humanitarian response plans regularly cite outbreaks and emergency preparedness and response as priorities.[141] At the country level, health cluster meetings provide updates on the epidemiological situation, with global health actors occasionally providing briefings.

Collaboration agreements have also emerged outside the UN, including between the International Committee of the Red Cross (ICRC) and the Global Fund to Fight AIDS, Tuberculosis and Malaria.[142] Responses to the recent Ebola outbreaks in DRC have shown the improved coordination and collaboration between global health, humanitarian, and governmental actors.[143]

Despite this progress, the two communities need to continue to strengthen their coordination and collaboration, particularly in conflict-affected settings. There is still insufficient expertise on epidemic preparedness and response in humanitarian organizations. In the IHR's joint external evaluation reports (the voluntary, collaborative, and multi-sectoral process to assess the state of implementation of the IHR in a particular country), there are few mentions of humanitarian health, even in contexts with humanitarian crises and responses. Assessment teams conducting such evaluations meet with the WHO but not with other humanitarian organization. Several joint external evaluation reports of countries facing humanitarian crises do not mention communication or coordination with humanitarian organizations for emergency response.[144] Indeed, coordination and collaboration remain limited, with little communication at the country level.

Increasing collaboration is challenging, however, as there may be tensions, or at the very least differences, in the way the humanitarian and global health communities operate. In particular, global health endeavors can be highly political, whereas humanitarian action must remain neutral, impartial, and independent. The key, therefore, is to ensure both can function and communicate effectively in carrying out their mandates.

Furthermore, some have pointed out that it unclear what coordination means in the context of the cluster system.[145] IASC guidance suggests that the humanitarian coordinator and humanitarian country team should work together to develop the humanitarian response plan and set priorities. The

138 For details, see IASC, "IASC Level 3 System Wide Activation Procedure for an Infectious Disease Event," November 22, 2017.

139 For information on standby partners, see WHO, "Standby Partners' Crucial Role in Emergency Response," February 2018.

140 WHO, "WHO's New Emergencies Programme Bridges Two Worlds," *Bulletin of the World Health Organization* 95, No. 1 (2017).

141 For example, the humanitarian response plans for Afghanistan (2018–2021) and Mali (2018).

142 ICRC, "Global Fund and ICRC Join Forces to Enhance Response to HIV, Tuberculosis and Malaria in Conflict-Affected Areas," July 17, 2018.

143 Esther Nakkazi, "DR Congo Ebola Virus Outbreak: Responding in a Conflict Zone," *The Lancet* 392, No. 10148 (2018), p. 623.

144 WHO, *Joint External Evaluation of IHR Core Capacities of the Islamic Republic of Afghanistan—Mission Report: 4–7 December 2016*, 2017; Évaluation externe conjointe des principales capacités RSI de la République du Mali—Rapport de mission: 27–30 juin 2017, 2017; *Joint External Evaluation of IHR Core Capacities of the Federal Republic of Nigeria—Mission Report: June 11–20*, 2017. In the Somalia report, however, where one of the mission team members was from a humanitarian organization (MSF), there are numerous mentions of the work of humanitarian actors and how they fit in to the context; see: *Joint External Evaluation of IHR Core Capacities of the Republic of Somalia—Mission Report: 17–21 October 2016*, 2017.

145 Clarke and Campbell, "Coordination in Theory, Coordination in Practice," p. 1.

clusters should then use this plan to develop their own response plans, which in turn should guide the activities of individual organizations.

In practice, however, this is rarely the case, as organizations have different funding streams and often come with preplanned activities. Reportedly, the cluster strategy is often developed based on its members' activities rather than the reverse.[146] One humanitarian actor on the ground in Nigeria described it as "coordination within the scope of each organization's interest." While the cluster system does not facilitate joint programming, it does allow for an understanding of the overall response and hence for the coordination of activities. There are diverging views within the sector as to whether such loose coordination is sufficient or whether stronger, more technical leadership from the health cluster is needed (see Box 7).

PRIORITIZATION OF HEALTH SERVICES

Strongly tied to funding, and beyond the prioritization of military or security considerations, the way certain health issues are prioritized over others can lead to gaps in the response. Resources are never sufficient to meet all health needs, and certain types of health services need to be prioritized in conflict-affected contexts. However, a variety of factors can create a discrepancy between the priorities set and the actual needs of the affected population.

Top-down approaches can lead to the international community not sufficiently focusing on the population's priority health needs. For example, as mentioned above, donor-influenced prioritization has led to a focus on communicable diseases that have epidemic potential and can cross borders (e.g., polio and Ebola).[147] This is not to say that there are not significant benefits to responding to such diseases, but they may not be the greatest health threat for the affected populations, who may suffer from other easily preventable or treatable diseases. In humanitarian crises and with the urgency that armed conflict brings, there is a risk of prioritizing easily defined interventions with readily measurable effects such as vaccinations rather than more complex issues such as mental health. There has also been a tendency to focus on health issues that are most visible and appear more urgent. As a result, chronic health issues such as diabetes or cancer tend to be sidelined.

The past several years, however, efforts have been made to address these gaps in health responses. In

Box 7. Coordination through the health cluster in Mali

In Mali, the WHO and International Medical Corps activated a co-led health cluster that is active at both the national and the regional level. The cluster was initially active mainly in the north of the country but increasingly focuses on the center as the conflict has shifted there. There are a number of other coordination structures active in the country, including the Cadre commun santé, for organizations funded by the European Civil Protection and Humanitarian Aid Operations (ECHO); the Partenaires techniques et financiers du secteur de la santé, for Ministry of Health partners; and the Groupe technique assistance humanitaire, which is composed of thirty-five international NGOs and operates within the framework of the Mali Forum of International NGOs (FONGIM).

Actors on the ground describe challenges coordinating health activities through the health cluster. They consider common planning difficult, given that organizations often come with their projects prepared and with little flexibility to modify them. Donors often have their own priorities, regardless of the indicators in the humanitarian response plan and humanitarian needs overview or suggestions provided by the health cluster. This leads to overlap and duplication of health activities. For some, better coordination among donors would strengthen the health cluster. There are also challenges dealing with numerous actors with different mandates, approaches, and management methods. The cluster system's slow and burdensome administrative procedures also make interventions less efficient. Finally, for many on the ground, the multiplication of coordination structures in Mali beyond the health cluster has not necessarily been helpful.

146 Ibid., pp. 9–10.

147 Rull et al., "The New Who Decision-Making Framework on Vaccine Use in Acute Humanitarian Emergencies."

the global health sphere, there is growing consensus on the need to strengthen healthcare systems as a whole instead of focusing on single-issue health interventions, particularly eradication campaigns.[148] Humanitarian actors have acknowledged that the huge burden of noncommunicable diseases (NCDs) on conflict-affected populations needs to be tackled.[149] While the WHO has started to prioritize NCDs at the global policy level, these initiatives do not grapple with how to prioritize NCDs in emergencies.[150] There have been some efforts to address this, such as the WHO's development of an NCD kit to treat chronic disease patients in emergencies, but NCDs still receive limited attention.[151] Notably, there are no existing standards or guidelines for treating NCDs in such settings.[152] NCD-related interventions remain challenging for a variety of reasons, including the need to plan for sustainable treatment and to have adequately trained health workers.[153] Efforts are still needed to address NCDs more systematically.

Mental health has increasingly come into the spotlight in conflict settings, and rightly so. Mental health problems affect six times more people than war wounds, leading to trauma that can be passed on through generations.[154] Health actors are now scaling up their activities on certain aspects of mental health, and international guidelines and standards have been developed.[155] In practice, however, mental health services need to be better embedded in humanitarian responses and national health policies.[156]

Likewise, emergency health responses have not sufficiently prioritized services related to gender-based violence and sexual and reproductive health, despite existing guidelines recommending the need to address these at the earliest stages of an emergency.[157] The focus on such issues is relatively recent, with most sexual violence programs starting in the early 2000s, but attention is increasing.[158] The health needs of men and boys, as well as of LGBTQ people, who are victims of sexual and gender-based violence, however, remain vastly under-addressed. One big challenge is that there is little documentation of best practices and a lack of agreement on how to define, prevent, and respond to gender-based violence.[159]

148 Robert Fortner and Alex Park, "The Enduring Appeal (and Folly) of Disease Eradication," UN Dark, April 3, 2018; "Global Health Gets a Checkup, A Conversation with Tedros Adhanom Ghebreyesus," *Foreign Affairs* 96, No. 5 (2017).

149 The Sphere Project's *Humanitarian Charter and Minimum Standards in Humanitarian Response* included NCD care as an essential health service. The ICRC, the Danish Red Cross, and Novo Nordisk have formed a partnership to tackle the growing issue of NCDs affecting millions of people living in humanitarian crises around the world; see www.novonordisk.com/sustainable-business/performance-on-tbl/access-to-care/humanitarianaction.html . The WHO is testing an emergency health kit for NCDs (in Syria and Iraq in 2017 and Libya and Yemen in 2018); see WHO, "Beyond the Bullets and Bombs." The WHO's revised Inter-Agency Emergency Health Kit contains new elements to treat acute conditions related to NCDs. The UN Refugee Agency (UNHCR) has developed an NCD toolkit with training-of-trainers manuals and clinical tools.

150 Perone et al., "Non-Communicable Diseases in Humanitarian Settings," p. 6.

151 WHO, "Non Communicable Diseases Kit 2016," available at www.who.int/emergencies/kits/ncdk/en/ .

152 A report of the WHO Independent High-Level Commission on NCDs includes a recommendation to "Integrate addressing NCDs and mental health conditions in humanitarian crisis settings, using WHO normative functions and platforms." WHO Independent High-Level Commission on NCDs, *Report of the Technical Consultation, 21–22 March 2018*; Paul B. Spiegel, Francesco Checchi, Sandro Colombo, and Eugene Paik, "Health-Care Needs of People Affected by Conflict: Future Trends and Changing Frameworks," *The Lancet* 375, No. 9711 (2010), p. 343; Perone et al., "Non-Communicable Diseases in Humanitarian Settings," p. 4. The health and nutrition cluster in Ukraine has made the difficult decision to limit the number of health interventions for chronic NCDs such as cancer and diabetes despite high needs; see the humanitarian response plan for Ukraine (2018).

153 See, for example, Nasser Yassin et al., "Evaluating a Mental Health Program for Palestinian Refugees in Lebanon," *Journal of Immigrant and Minority Health* 20, No. 2 (2018): 388-398; Sigiriya Aebischer Perone and David Beran, "Modifying the Interagency Emergency Health Kit to Include Treatment for Non-Communicable Diseases in Natural Disasters and Complex Emergencies: The Missing Clinical, Operational and Humanitarian Perspectives," *BMJ Global Health* 2, No. 1 (2017).

154 Perone et al., "Non-Communicable Diseases in Humanitarian Settings," p. 10.

155 See, for example, IASC, *Guidelines on Mental health and Psychosocial Support in Emergency Settings*, 2007; WHO and UNHCR, *mhGAP Humanitarian Intervention Guide: Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies*, 2015; and ICRC, *Guidelines on Mental Health and Psychosocial Support*, 2017. WHO's NCD medicine kit also includes drugs for the management of mental health issues, which are also integrated in MSF, UNHCR, and ICRC's essential lists of medicines Perone et al., "Non-Communicable Diseases in Humanitarian Settings," p. 10.

156 See, for example, Peter Hughes, "Ethical Encounters as a Humanitarian Psychiatrist," in *Humanitarian Action and Ethics*, Ayesha Ahmad and James Smith, eds. London: Zed Books, 2018; Mark van Ommeren, Fahmy Hanna, Inka Weissbecker, and Peter Ventevogel, "Mental Health and Psychosocial Support in Humanitarian Emergencies," *Eastern Mediterranean Health Journal* 21, No. 7 (2015), p. 499.

157 The IASC's 2010 *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* includes a Minimum Initial Service Package for reproductive health in crises.

158 See, for example, UN General Assembly and UN Economic and Social Council, *Strengthening of the Coordination of Emergency Humanitarian Assistance of the United Nations—Report of the Secretary-General*, UN Doc. A/72/76–E/2017/58, April 13, 2017, p. 20. The Security Council recognized the importance of medical services for women affected by armed conflict and specifically noted "the need for sexual and reproductive health services, including regarding pregnancies resulting from rape, without discrimination;" UN Security Council Resolution 2122 (October 18, 2013), UN Doc. S/RES/2122.

159 Dharini Bhuvanendra and Rebecca Holmes, "Tackling Gender-Based Violence in Emergencies: What Works?," *Humanitarian Exchange*, No. 60 (2014), p. 3; Blanchet et al., "An Evidence Review of Research on Health Interventions in Humanitarian Crises," p. 118. Some point to the insufficient use of the little evidence that does exist; see, for example, Sarah Chynoweth, Ribka Amsalu, Sara E. Casey, and Therese McGinn, "Implementing Sexual and Reproductive Health Care in Humanitarian Crises," *The Lancet* 391, No. 10132 (2018), pp. 1770–1771.

In conflict settings, the humanitarian health response is meant to be guided by the humanitarian response plan, which indicates strategic priorities based on the humanitarian needs overview. In many contexts, these increasingly point to NCDs, mental health, and sexual and reproductive health as priority health needs. IASC guidelines recommend that sub-working groups on mental health, gender-based violence, and sexual and reproductive health be set up to coordinate and guide such services during a humanitarian response.

However, this is not always the case, and even when such working groups exist, that does not necessarily translate into adequate prioritization and programming. For example, Nigeria's humanitarian response plan for 2018 mentions NCDs, mental health, and sexual and reproductive health as health priorities. On the ground, however, there is little talk of programming on NCDs, and very few organizations are delivering such services. Mental health and sexual and reproductive health sub-working groups were set up, but programs addressing these issues remain too few compared to the high level of need.

SUSTAINABILITY AND TRANSITIONS TO DEVELOPMENT

Given the protracted nature of many crises their impact on health systems, humanitarian responses have evolved from the traditional short-term emergency response to focus more on resilience. The question of sustainability has therefore increasingly factored into the planning and design of health interventions. Sustainable health services are more long-term and integrated into a country's health system. There is a clear recognition that the way health actors respond in conflict-affected settings can have a real and long-term impact on a country's health system, and that efforts to provide sustainable health services will help ensure this impact is not negative.

Making health services sustainable is challenging, as instability and uncertainty discourage longer-term initiatives. The breakdown of local health and health-supporting infrastructure, as well as the influx of external actors, has also often led to the development of parallel health systems that are unsustainable.[160] Furthermore, in many contexts, a sustainable health response calls for engagement with the host state, or at least local authorities in a particular area. This can cause humanitarian actors to be perceived as acting in support of one party to the conflict over another. It can also create a situation in which humanitarian actors are perceived to be enabling or supporting a government enacting problematic policies.

Health actors operating in conflict-affected settings can nonetheless do more to improve the sustainability of the services they provide, notably by supporting or working through national and local organizations or local health structures. In Mali, for example, humanitarian health actors have strongly prioritized working through community health structures that still function well in a number of areas. There are increasingly stronger calls in the international community to focus on strengthening health systems in conflict-affected settings.

One key way to do this is to ensure that humanitarian health services smoothly transition to early recovery and more development-oriented responses. This has been recognized and put forward in a number of UN (and other) policies, most recently in the New Way of Working (NWOW), launched at the 2016 World Humanitarian Summit, which emphasizes the importance of the humanitarian-development nexus (HDN). The idea behind the HDN is that humanitarian and development actors need to better coordinate and collaborate to ensure their efforts are complementary and provide continuous care for affected populations. OCHA developed the NWOW to implement this nexus by assisting humanitarian, development, and, where feasible, peace actors in better working together. The HDN and NWOW have become fixtures of many countries' humanitarian response plans (see Box 8),[161] and some protracted crises now have multi-year plans aimed at better addressing chronic needs.[162]

160 Martineau et al., "Leaving No One Behind."

161 See, for example, the humanitarian response plans for Ukraine (2018), Nigeria (2018), Mali (2018), Yemen (2018), and Afghanistan (2018–2021).

162 See, for example, the humanitarian response plans for Afghanistan (2018–2021) and the DRC (2017–2019).

Box 8. Implementing the humanitarian-development nexus in Nigeria

In Nigeria, the humanitarian-development nexus (HDN) is a central issue due to the protracted nature of the crisis. It is one of the priorities identified in the 2018 humanitarian response plan. Moreover, Nigeria is a pilot country for the UN's New Way of Working,[163] and the resident/humanitarian coordinator has published a strategic vision to support a platform to coordinate humanitarian and development assistance.[164] The UN has also recently set up an HDN taskforce in Abuja to develop collective outcomes for the next three to five years, and the WHO is creating an HDN working group for health in Maiduguri. The government has clearly been pushing for a transition to development through its Presidential Initiative for the North East and the so-called "Bama Initiative" to support the return of displaced persons.

Donors have also focused on the HDN. The EU is piloting the implementation of the HDN in the Lake Chad region and has developed a package aimed at restoring basic services in Borno State that covers both humanitarian and development activities and is currently developing one for Yobe State. The UK's Department for International Development (DFID) is about to launch a new eight-year health program in five northern states, including Yobe and Borno, through which it will work with both development and humanitarian actors. The World Bank has also started to engage,[165] notably through its Multi-Sectoral Crisis Recovery Project for North Eastern Nigeria,[166] as well as its national Saving One Million Lives and performance-based financing initiatives that include some money for the northeast. Events and workshops are being held for donors to get behind one approach for both addressing drivers of conflict and providing relief.

Despite international focus on the HDN in theory and policy, there has so far been little implementation. Organizations are making individual and sporadic attempts, but they are not guided by an overarching goal or framework. In the health sector, development activities remain limited in the northeast. There has been some work to strengthen health systems, mainly by humanitarian actors, and mainly with funding for early recovery through humanitarian channels.[167] However, concerns have been raised regarding such projects, including that they interrupt services with no interim solutions and have been undertaken in areas where no assessments were conducted.

Indeed, one key question is where it is appropriate and feasible to implement such projects. There seems to be consensus that such activities would be more appropriate in Adamawa and Yobe States, which are more stable and have a stronger government presence, than in Borno. Many actors question the relevance and feasibility of HDN activities in much of Borno, where communities have been entirely destroyed, attacks and displacement continue, and military escorts are required outside of the cities. Existing services are provided by humanitarian actors; no government or civilian structures are present. In many accessible areas, even the humanitarian response is of poor quality, in part due to insufficient presence on the ground, making it difficult to envision more risk-averse development actors working there.

Nonetheless, development actors have been more focused on Borno. Although there may be opportunities in some areas, and this focus may help push the government to expand its civilian presence, the security situation remains a concern. Some are also concerned about the impact focusing on development will have on the humanitarian needs and response. Development needs to complement, not replace, humanitarian action. A proper implementation of the HDN would also require better coordination between humanitarian and development actors, as well as among development actors.

163 Note that only one interviewee mentioned the need to engage with peacebuilding actors, stating that there has been very little talk about peacebuilding.

164 Edward M. Kallon, "Strategic Vision to Support a Coordinated Platform for the Delivery of Humanitarian and Development Assistance in Nigeria," UN Office of the Resident and Humanitarian Coordinator Nigeria, August 2017. Other UN documents relevant to the humanitarian-development nexus include UNDP and UNHCR, *Strategy on Protection, Return and Recovery for the North-East Nigeria*, February 2017; and UNDP and OCHA, *Resilience for Sustainable Development in the Lake Chad Basin*, August 2018. The UNDP administrator and the emergency relief coordinator recently went on a joint visit to Nigeria and "called on national and international partners to reinforce joint efforts to address dire humanitarian needs in the conflict-affected northeastern Nigerian states of Borno, Adamawa and Yobe, while at the same time speed up the recovery of livelihoods." UNDP and OCHA, "United Nations Humanitarian and Development Chiefs Join Forces to Support Crisis-Affected People in North-East Nigeria," October 2018.

165 The World Bank conducted a recovery and peace building assessment in northeastern Nigeria that looks at health issues and the need to reconstruct or repair health facilities and increase the availability of health services; see: *North-East Nigeria: Recovery and Peace Building Assessment—Synthesis Report*, June 2017, available at http://documents.worldbank.org/curated/en/542971497576633512/Synthesis-report .

166 World Bank, *Project Appraisal Document: Multi-Sectoral Crisis Recovery Project for Northeastern Nigeria*, March 2017.

167 This has included, for example, the rehabilitation of health structures and the implementation of the recovery and development parts of the Minimum Initial Service Package in more stable areas.

Transitioning from humanitarian to development activities, however, is a challenge in many conflict-affected settings. Different areas or populations within a country may be facing situations that require different types of responses. Indeed, the shift from humanitarian to development assistance is rarely linear. It is also important that the transition to development does not come at the expense of emergency response and does not compromise the humanitarian space.[168]

Beyond the emergency response, policies and structures developed for and implemented in conflict-affected contexts are often insufficiently responsive to the longer-term needs of the population. The UN cluster system, designed for emergency response and not for long-term coordination, remains in place in many protracted crises. Most health clusters do not have a clear process or criteria for deactivating themselves or transitioning to another arrangement when a crisis becomes protracted, which makes service delivery less predictable. The IASC's Level 3 procedures for activating a cluster or a cluster-like mechanism were also conceived for sudden events but have ended up being used for protracted and complex conflicts. The recognition of a need to have a separate system to identify severe emergencies that require a sustained response triggered a review of the these procedures, leading to the ongoing development of two separate systems, one for new crises and another for protracted ones.[169]

While humanitarian actors are working more closely than ever before with development actors,[170] they still do not reach out to coordinate with them enough. At the same time, development actors are insufficiently present in conflict-affected areas, as they are often more risk-adverse, and they face challenges coordinating among themselves, making it complicated for humanitarian actors to engage them. Nonetheless, many international health actors have acquired broader expertise and can now work on both relief and development activities, depending on the context and opportunities.

Humanitarian actors also tend to engage insufficiently with government ministries of health and other relevant ministries. However, ministries sometimes lack political will or face governance challenges, which can make engagement with them challenging, result in political interference, or make their contribution to the aid response ineffective. Where there is a functioning government, the efficiency and effectiveness of a health cluster or health working group often depends on the active engagement of the ministry of health.[171] Finally, planning for the long term is also challenging due to the short-term nature of the funding that humanitarian actors receive and the fact that humanitarian and development funding streams are often distinct.

CONTEXT-SPECIFICITY AND LOCALIZATION

There is widespread discussion and acknowledgement of the need for health policies and interventions to be more context-specific in two important ways. First, there is a need for policies and frameworks that enable the delivery of health services in conflict-affected settings and factor in the wide range of challenges explored in the first section of this paper. Global health policies often do not take into account or address conflict-affected contexts. As a result, they can be too complicated and unrealistic to implement in such contexts. In recent years, therefore, a wide range of health policies and frameworks specifically tailored to conflict and humanitarian settings have been developed.[172]

168 See de Castellarnau and Stoianova, "Bridging the Emergency Gap."

169 The SCALE-UP system will trigger prompt, coordinated, and substantial operational scale-up in response to large new crises. The SUSTAIN system will signal the need for continuing major responses and high levels of financing for the biggest protracted crises.

170 In Yemen, for example, the World Bank, UNICEF, the WHO, and others are working together to provide health services and strengthen the healthcare system. World Bank, "Making a Difference: Delivering Services for Yemeni People during Conflict," February 13, 2018, available at www.worldbank.org/en/news/feature/2018/02/13/making-a-difference-delivering-services-for-yemeni-people-during-conflict .

171 This is the case in Nigeria, where the Borno health commissioner takes an active part in the health sector working group, described as one of the better-functioning working groups.

172 See, for example, the IASC's 2010 *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* Minimum Initial Service Package; the IASC's 2007 *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*; the WHO and UNHCR's 2015 *mhGAP Humanitarian Intervention Guide*; *the WHO's 2013 Vaccination in Acute Humanitarian Emergencies: A Framework for Decision Making*; and the ICRC's 2016 *Field Guide for the Manage Limb Injuries in Disasters and Conflicts*. Nonetheless, some gaps remain. As mentioned above, for example, there is no policy for NCD interventions in emergencies or humanitarian crises.

Second, the policies and frameworks created specifically for humanitarian crises and conflict-affected settings should be tailored to the specific context in which they are being implemented. In the recent humanitarian response in Mosul, Iraq, for example, low contextual awareness reportedly led to activities that were out of sync with humanitarian needs.[173] Health actors need to understand preexisting disease burdens and health inequities in the context in which they are operating. Understanding the social and cultural context, as well as the gender dynamics, is also key to designing efficient and effective health responses, in particular with respect to gender-based violence, sexual and reproductive health, and mental health.[174] The WHO mental health guide for humanitarian emergencies therefore recommends briefing international staff on the local culture and context.[175] Insufficient contextualization can lead to inappropriately prioritized health services and have perverse effects on health systems and social dynamics.[176]

Health actors also need to understand existing structures and services. Research has shown that one of the issues with the Minimum Initial Service Package (MISP)—guidelines developed for responding to sexual and reproductive health needs as a priority in emergency interventions—is that it assumes some level of preexisting, functioning health infrastructure that international actors can support.[177] It is also important to continually evaluate health services against the changing context. In Afghanistan, for example, the government is designing, with the support of partners, a new basic package of health services to better align with the changing health needs of the population and the capacities of the country's health system.[178]

For many, however, the UN cluster system does not allow for sufficient context-specificity and flexibility. Its needs assessments tend to be one-off snapshots that do not take into account the local context.[179] One of the ways the international community has tried to grapple with the challenge of providing adequate, appropriate, and hence context-specific health services to conflict-affected populations is to push, at least in its discourse, for more localized efforts.[180] Localization has become somewhat of a buzzword, and it has many dimensions and interpretations.[181] Ultimately, it stems from the recognition that there are local capacities that can be tapped into and built on, that local actors are there before, during, and after an armed conflict, and that these actors understand the context and culture. Localized action therefore has the potential to better respond to the needs of affected populations, assist in the implementation of services, and increase the resilience of affected populations.

However, involving and using local capacities has been an express goal for a long time,[182] and despite the apparent consensus on it, efforts to meaningfully implement this goal remain ad hoc and insufficient.[183] Indeed, local populations are insufficiently represented in defining health priorities and designing programs. There are a number of factors at play in explaining this lack of implementation in practice.[184] One is the lack of direct financing for local and national NGOs. Such financing is almost

173 Fox, Stoddard, Harmer, and Davidoff, "Emergency Trauma Response to the Mosul Offensive, 2016–2017," p. 7.

174 Manuela Colombini, "Gender-Based and Sexual Violence against Women during Armed Conflict," Journal of Health Management 4, No. 2 (2002); Ahmad, "Disclosure of Gender-Based Violence in Humanitarian Settings"; Michael G. Wessels, "Do No Harm: Toward Contextually Appropriate Psychosocial Support in International Emergencies," American Psychologist 54, No. 8 (2009).

175 WHO and UNHCR, mhGAP Humanitarian Intervention Guide.

176 Sandro Colombo and Enrico Pavignani, "Recurrent Failings of Medical Humanitarianism: Intractable, Ignored, or Just Exaggerated?," The Lancet 390, No. 10109 (2017), p. 2,319; Aninia Nadig, "The Sphere Project: Taking Stock," Humanitarian Exchange, No. 53, February 2012: 30-32.

177 UN Women, A Global Study on the Implementation of United Nations Security Council Resolution 1325, p. 78

178 Karl Blanchet and Neha Singh, "Developing a New Basic Package of Health services for Afghanistan," London School of Hygiene and Tropical Medicine, November 7, 2017, available at www.lshtm.ac.uk/newsevents/expert-opinion/developing-new-basic-package-health-services-afghanistan-0 .

179 ICRC and Harvard Humanitarian Initiative, "Engaging with People Affected by Armed Conflicts and Other Situations of Violence," March 2018, p. 47.

180 See, for example, the localization work stream in the 2016 Grand Bargain, available at https://charter4change.org/ . Organizations like Local2Global, Charter4Change, the Global Mentoring Initiative, and the Start Network advocate for localization.

181 A 2016 study found that "localisation is used across the sector to refer to everything from the practice of increasing numbers of local staff in international organisations, to the outsourcing of aid delivery to local partners, to the development of locally specific response models;" see: Imogen Wall and Kerren Hedlund, "Localisation and Locally-Led Crisis Response: A Literature Review," Local2Global, May 2016.

182 See, for example, UN General Assembly Resolution 146/82 (1991) or the 2007 Global Principles of Partnership.

183 For a timeline of efforts and initiatives to improve localization, see CHS Alliance, "How Change Happens in the Humanitarian Sector: Humanitarian Accountability Report," 2018, pp. 46–47.

184 For a comprehensive description and analysis of these factors, see Coastal Association for Social Transformation Trust, "Fast Responders Are Kept Far!," pp. 55–57.

exclusively channeled through international NGOs, despite commitments made in the 2016 Grand Bargain to support and fund local and national responders.[185] In Syria, for example, where local partners deliver most of the assistance due to the limited presence of international actors, only a fraction of the funding goes directly to those local actors.[186]

Other reasons for the lack of engagement with local actors include the perception that it takes time and would delay or hamper the response. Concerns have also been expressed about the capacity of local actors and the quality and equity of services they would provide, and the consequent need for training them and ensuring the application of international standards.[187] In many contexts, supporting local workers could also put them at risk without necessarily ensuring that they have the tools to manage those risks.[188] Finally, humanitarian actors also express concerns that engagement with local actors may affect perceptions of their neutrality, as these actors may have ties in the areas in which humanitarian actors are working. In general, the international community remains risk-averse on this issue.

ACCOUNTABILITY

Accountability, understood as the systems and processes through which health actors justify and take responsibility for the services they provide, is a key element of and requirement for the international health response. Accountability in healthcare can be broken down into three different types: performance accountability, accountability to affected populations, and financial accountability. Performance accountability requires healthcare providers to demonstrate that their services are high quality and effective. This can be ensured through monitoring and supervision. Accountability to affected populations (AAP) is a term developed to describe taking account of, giving account to, and being held accountable by local populations.[189] It requires healthcare providers to be transparent with local populations and to consider their needs, priorities, perspectives, and capacities. This can ensure the services provided are adequate and appropriate for the local context. Financial accountability requires healthcare providers to track and report on how they allocate, disburse, and use the funds provided by donors. All three types are interlinked and can impact one another.

The humanitarian aid architecture does not exist within a legal and regulatory framework that can ensure accountability.[190] The cluster system, intended to increase accountability, does not have any hard tools to hold its members to account for the activities they engage in. Nonetheless, a number of mechanisms and processes to promote all three types of accountability have been put into place, but gaps remain.

In terms of performance accountability, the Cluster Coordination Performance Monitoring (CCPM) tool is a self-evaluation to determine whether a cluster is perceived as performing well by its coordinator and members.[191] The cluster or sector leads at the country level are responsible for ensuring adherence to standards and for the performance of the cluster or sector and are accountable to the humanitarian coordinator and emergency relief coordinator. Having the clusters co-led by UN agencies or NGOs also helps promote performance accountability. Where stakeholders consider that the lead agency is not adequately carrying out its responsibilities, the humanitarian coordinator is to consult with that agency and, where necessary, with the humanitarian country

185 CHS Alliance, "How Change Happens in the Humanitarian Sector: Humanitarian Accountability Report," 2018, pp. 21, 26; Coastal Association for Social Transformation Trust, "Fast Responders Are Kept Far!"

186 Eva Svoboda and Sara Pantuliano, "International and Local/Diaspora Actors in the Syria Response: A Diverging Set of Systems?," Humanitarian Policy Group, March 2015.

187 Sophie Witter and Benjamin Hunter, "How Do Different Types of Provider Affect Access to Effective and Affordable Healthcare during and after Crises?," ReBUILD Consortium, June 2017, p. 3.

188 Adelicia Fairbanks, "Going Local, Going Safely," ICRC *Humanitarian Law and Policy*, August 8, 2018 . ICRC and Harvard Humanitarian Initiative, "Engaging with People Affected by Armed Conflicts and Other Situations of Violence," p. 41

189 There are different understandings of what AAP means and what activities it describes in practice.

190 There have, however, been efforts to improve accountability in global health responses more generally, including an independent Oversight and Advisory Committee, created in 2016 to monitor the WHO's performance in implementing its new Health Emergencies Programme, and the Global Preparedness Monitoring Board, launched by the WHO and World Bank in 2018 to monitor progress, identify gaps, and advocate for sustained, effective work to ensure global preparedness for disease outbreaks and other health emergencies.

191 The Cluster Coordination Performance Monitoring tool is meant to produce periodic monitoring reports, every three to six months in an emergency and annually in a protracted crisis. In 2015, of the twenty-two active health clusters, fourteen completed this at the national level.

team and to propose alternative arrangements.[192]

However, this system remains weak. Monitoring is often insufficient, in particular of the implementation of annual humanitarian response plans , and the data is reportedly scarce and of poor quality.[193] The system has also been criticized for focusing too much on activities and outputs rather than results and impact.[194] In addition, given the absence of an independent and external monitoring mechanism, it can be self-validating, with agencies and organizations developing a strategy, defining funding priorities, executing programs, and then conducting evaluations. In many contexts, this whole process effectively rests in the hands of major UN agencies that lead the various clusters or sectors.[195] Because health actors primarily monitor their work for donor reporting, they can skew their interventions to conform to donor agencies' mandates.[196] This also means that the voices of affected populations do not necessarily have the space and influence they should in the design of programs.

To tackle some of these challenges, some organizations have used third-party monitoring by both for-profit and nonprofit agencies, though the quality of such monitoring varies.[197] There is a need for greater incentives to improve monitoring and evaluation. This could come, for example, from conditions imposed by donors, an external monitoring structure, or a voluntary charter of conduct. It could also come from a pre-certification or verification system, along the lines of the WHO's Emergency Medical Teams project, to ensure humanitarian health actors meet minimum standards of quality and efficiency. However, this would likely put local actors at a disadvantage, as they often have less capacity to meet such standards.

Since the 1980s, many initiatives, policies, and guides to ensure community involvement and feedback have been developed.[198] These feature prominently in many humanitarian policies and programs. In the 2012 Transformative Agenda, an initiative undertaken to make improvements to the 2005 humanitarian reform process, the IASC member agencies made a clear commitment to ensure accountability to affected populations (AAP).[199] The Global Health Cluster, for example,

Box 9. Monitoring performance accountability in Mali

In Mali, many humanitarian organizations appear to monitor program indicators (both qualitative and quantitative), and most can point to internal accountability mechanisms, codes of conduct, or accountability clauses in staff contracts. However, performance accountability remains a gap. Monitoring and evaluating performance is difficult given the challenges of the Malian context, notably the insecurity and the use of local NGOs as implementing partners. For example, in spite of huge investments, vaccination rates are reportedly going down, and there have been sporadic epidemics, raising questions around vaccines and the way health personnel handle them. A government representative acknowledged that project evaluations are often superficial and look at quantitative indicators rather than impact. The government nonetheless has reportedly successfully piloted results-based financing for health services, which included consultation with the population and allowed for daily monitoring of quality and engagement.

192 See IASC, *Operational Guidance on Designating Sector/Cluster Leads in Ongoing Emergencies*.

193 Clarke and Campbell, "Coordination in Theory, Coordination in Practice," p. 15; Alice Obrecht, "Dynamic Gridlock: Adaptive Humanitarian Action in the Democratic Republic of Congo," ALNAP, February 2018, p. 39.

194 Simpson, "How to Fix the Broken Humanitarian System: A Q&A with Paul Spiegel"; Obrecht, "Dynamic Gridlock," p. 41.

195 Jeremy Konyndyk, "Rethinking the Humanitarian Business Model," Center for Global Development, May 2018, p. 2.

196 Obrecht, "Dynamic Gridlock," p. 39; Konyndyk, "Rethinking the Humanitarian Business Model," p. 5.

197 Adele Harmer and François Grünewald, "Collective Resolution to Enhance Accountability and Transparency in Emergencies: Synthesis Report," Humanitarian Outcomes, August 2017, p. 15.

198 See, for example, Alma Ata Declaration 1979, Art. 4, Art. 7; IASC 2012, Accountability to Affected Populations, Tools to assist in implementing the IASC APP Commitments. IASC; Red Cross Red Crescent Guide to Community Engagement and Accountability, available at http://media.ifrc.org/ifrc/what-we-do/community-engagement/; the Humanitarian Accountability Partnership (HAP); the Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP); the Core Humanitarian Standard (CHS) on Quality and Accountability; the Grand Bargain. For a timeline of major initiatives, guidance, and reports, see CHS Alliance, "How Change Happens in the Humanitarian Sector," pp. 26–27.

199 See IASC, "IASC Principals Transformative Agenda 2012."

developed an AAP tool in 2017,[200] and AAP is often a key part of country humanitarian response plans, often specifically for the health response.[201] Indeed, the humanitarian country team is ultimately meant to be accountable to populations in need.

However, this has failed to produce any real accountability to aid recipients in conflict-affected settings.[202] AAP is difficult to achieve within the current humanitarian aid system.[203] The incentives to meaningfully implement AAP mechanisms are weak, including from donors that have insufficiently asked implementing partners to prioritize it. The system is resistant to change in general, and there has been a lack of leadership on this issue. The lack of a common definition of AAP and understanding of its goals and measurements has also been a challenge. The system makes it difficult for affected communities to engage in a meaningful way and prioritizes pushing information up to donors and governments rather than down to communities. As a result, communities often have limited information on how aid is targeted and what they are entitled to.

Implementation of AAP measures on the ground is largely driven by individual organizations, but even that is uncommon or does not necessarily alter the response. Health clusters do not provide strong guidance on AAP, and the health sector is behind in adopting the IASC framework for AAP.[204] In Nigeria, for example, the health sector has undertaken only ad hoc initiatives to promote AAP (see Box 10). Even though many organizations point to AAP mechanisms they already have in place, there is no real incentive to do it properly or to be transparent about the health information collected. It is often not considered a priority in major emergencies.

Community engagement, however, is not a panacea and has faced some criticism. For some humanitarian actors, such engagement goes beyond their mandate and may even be prejudicial to their neutrality and impartiality if confused for social change. Community engagement remains largely constrained by existing power dynamics,

Box 10. Promoting accountability to affected populations in Nigeria

In Nigeria, there are no systematic efforts to promote AAP. OCHA chairs an AAP/community engagement working group, and there are discussions to develop an AAP action plan, though many actors feel that not enough is being done. Nonetheless, some question the added value of such initiatives, pointing out that with so few health actors and services in many areas, people would not dare complain about the only actor operating in their area or would generally ask for more services rather than improved quality.

Some organizations have set up suggestion boxes, but given the language barrier and low literacy rates, these have not been very effective. Some have also set up free phone call systems, with varying reports as to their functionality. The UN is rolling out a new project in the northeast, U-Report, which will enable it to conduct monthly surveys that can be targeted geographically. However, this system works through text messaging, and many areas are cut off from the phone network. Additionally, the most excluded populations may not own mobile phones. One of the key ways humanitarian health actors have engaged with communities is by supporting community committees where they already exist and encouraging them to form where they do not. Many actors reportedly use these structures to inform and engage with communities, and some report specifically using such structures to receive qualitative feedback on their programs.

200 Health Cluster, Operational Guidance on Accountability to Affected Populations (AAP), August 2017, available at www.who.int/health-cluster/resources/publications/AAP-tool.pdf .

201 E.g. Humanitarian Response Plan Ukraine 2018, Afghanistan 2018-2021, Mali 2018, Nigeria 2018, Iraq 2018

202 Harmer and Grünewald, "Collective Resolution to Enhance Accountability and Transparency in Emergencies," p. 22; Tina Bouffet, "Everything You Always Wanted to Know about Engagement and Accountability… (But Were Afraid to Ask)," ICRC *Humanitarian Law and Policy*, April 17, 2018; ICRC and Harvard Humanitarian Initiative, "Engaging with People Affected by Armed Conflicts and Other Situations of Violence," p. 12; Susanna Krüger, András Derzsi-Horváth, and Julia Steets, "IASC Transformative Agenda: A Review of Reviews and Their Follow-Up," Global Public Policy Institute, February 2016; Ground Truth Solutions Humanitarian Voice Index (2018); Francesca Bonino, Isabella Jean, and Paul Knox Clarke, "Closing the Loop: Effective Feedback Mechanisms in Humanitarian Contexts, Practitioner Guide," ALNAP and CDA, 2014; and CHS Alliance, "How Change Happens in the Humanitarian Sector," p. 29.

203 For a comprehensive description and analysis of these challenges, see CHS Alliance, "How Change Happens in the Humanitarian Sector," pp. 34–35.

204 WHO, *Health Cluster Forum Meeting Report: 3–5 April 2017*, p. 20.

with humanitarian actors and donors remaining largely in charge of decision making and implementation. There is also a lack of evidence of the advantages of systematically ensuring engagement and participation or of what factors influence the feasibility and desirability of doing so. Indeed, different considerations may apply in highly constrained environments.[205]

A study from the UK's Department for International Development (DFID) nonetheless notes that "there is no doubt by all the organizations interviewed that community feedback helped them in their work," and some such initiatives hold potential.[206] For example, community scorecards have been use in some contexts.[207] In Nigeria, organizations are using community committees not only to provide information to the population regarding health services but also to receive qualitative feedback on their programs. However, meaningful engagement of affected populations needs more than ad hoc initiatives and requires a real shift in mindset within both humanitarian organizations and donor agencies.

Financial accountability can provide a strong incentive for health actors to provide efficient, high-quality services. Donors are increasingly implementing performance-based financing, through which health providers are at least partially funded based on their performance in meeting targets or undertaking specific activities.[208] However, donors often have limited ability to travel to monitor humanitarian projects in insecure contexts. Humanitarian organizations have also criticized their perceived focus on activities and outputs rather than results and impact. There is also concern about unrealistic donor demands, which can even lead to service gaps.[209]

It is clear that there is an imbalance between accountability to donors and accountability to affected populations, and aid agencies tend to emphasize the former. These two types of accountability should be linked, and most donors now emphasize the need to increase information about aid quality from affected people's perspectives. In practice, however, they are often separate processes, and AAP tends to be neglected.[210] There is a need, therefore, to incentivize a more people-centered approach. Indeed, if "[community] participation is "an afterthought in an essentially technocratic aid program, it will not be a success."[211] More generally, donors should work to ensure health actors have strong accountability mechanisms in place and should fund the costs these entail.

Finally, there is no global accountability mechanism for health or system-wide accountability mechanism for the humanitarian sector, although some initiatives provide independent monitoring on certain issues, such as the Global Preparedness Monitoring Board or the NCD Countdown 2030.[212] Some have therefore been calling for an independent accountability mechanism for both global health and humanitarian health.[213]

STATE-CENTRICITY

Conflict-affected states remain principally responsible for the health of their citizens, and ministries of health should oversee and, where possible, lead health responses. This is recognized in many policies and frameworks and, more generally, in how international responses are structured. The International Health Regulations are an international treaty and therefore set state parties as the obligation bearers. The WHO's mandate includes

205 ICRC and Harvard Humanitarian Initiative, "Engaging with People Affected by Armed Conflicts and Other Situations of Violence," pp. 50–51.

206 "Beneficiary Feedback Mechanisms: Lessons from a Multi-country Pilot," available at http://feedbackmechanisms.org/findings/ . Additionally, the participation of civil society and citizens in health policy and systems through embedded social accountability efforts has been noted as crucial for achieving meaningful gains. Lynn P. Freedman, "Implementation and Aspiration Gaps: Whose View Counts?," *The Lancet* 388, No. 10056 (2016): 2,068-2,069.

207 IRC, "16 Key Lessons on Collecting and Using Client Feedback: Highlights from the IRC Client Voice and Choice/Ground Truth Solutions Pilots," June 2017; Martina Björkman Nyqvist, Damien de Walque, and Jakob Svensson, "Experimental Evidence on the Long-Run Impact of Community-Based Monitoring," *American Economic Journal: Applied Economics* 9, No. 1 (2017).

208 Maria Paola Bertone, Sophie Witter, Jean-Benoit Falisse, and Giuliano Russo, "Context Matters (But How and Why?): A Review of Performance Based Financing in Fragile and Conflict-Affected Health Systems," *PloS One* 13, No. 4 (2018).

209 See, for example, Funk et al., "Ethical Challenges among Humanitarian Organisations," p. 142; and de Castellarnau and Stoianova, "Bridging the Emergency Gap," p. 35.

210 Julia Steets et al., "Drivers and Inhibitors of Change in the Humanitarian System," Global Public Policy Institute, May 2016.

211 Anthony Costello, "ALMA-ATA at 40: The Power of Sympathy Groups and Participation," *Health and Human Rights Journal*, September 21, 2018.

212 "NCD Countdown 2030: Strengthening Accountability," *The Lancet* 392, No. 10152 (2018): 986.

213 See, for example, Stefan Germann, ICM public consultation on global pandemics and global public health, 2016, available at www.icm2016.org/public-consultation-on-global-pandemics-and-global-public-health ; International Peace Institute, "Doctors in War Zones."

the need to respect the sovereignty of states, and its primary role is to support the government and ministry of health. Many of the UN policies and response mechanisms, described above and through which many other organizations work, are state-centric.

However, the state-centricity of health responses can lead to gaps, in particular in conflict-affected states that are unwilling or unable to fulfill their role. Some governments are the principal violators of international law, including the destruction of health facilities. More generally, governments may have political interests that lead them to block access to certain areas or choose certain priorities. The risk for a response that is solely state-centric is that it will be influenced by such political interests and will not be able to respond adequately to the needs of all people affected by conflict.

In contexts where this risk materializes, it is therefore important to leave or create space within existing policies and frameworks for independent action coordinated with, but not by, the UN or the government. The space for such action is shrinking, however, as the UN and its members states have sought to create a "one system" approach to responses. This approach has led to policies and frameworks for various parts of UN country teams—including the development and humanitarian components—and their partners to better work together and with the host government. Though this approach may have its advantages, including increased coherence and efficiency, in some contexts it risks politicizing the humanitarian response. Preserving neutral, independent, and impartial humanitarian action remains essential to ensure the most vulnerable are reached.

Conclusions and Ways Forward

Health actors face numerous challenges in conflict-affected contexts, which have a devastating impact for people living there. Most of these challenges are beyond health actors' control. As long as armed conflicts rage, and particularly where international humanitarian law is routinely violated, health infrastructure will be damaged or destroyed, the state's capacity to deliver health services will decrease, and health workers will flee. Nonetheless, global health and humanitarian health actors do have a degree of control over some challenges, particularly in relation to the gaps identified in this paper. Tackling these challenges will have a direct impact on the lives of people in conflict-affected settings. However, doing so is neither straightforward nor simple, in part due to external challenges, in particular those linked to funding and financing. Indeed, comprehensively addressing the gaps described above requires a radical shift in the incentives that guide the actions of international health actors. Even so, more incremental changes can also be beneficial, including in the four areas detailed below.

IMPROVING COORDINATION BETWEEN AND AMONG HUMANITARIAN, DEVELOPMENT, AND GLOBAL HEALTH ACTORS

Coordination is key to ensuring that services provided by all actors operating in a conflict-affected setting are complementary and that the overall response to health needs is effective. One aspect is coordination between global health and humanitarian health actors. In order to strengthen this coordination, global health actors could be more regularly included in health cluster meetings or become members of the health cluster or similar working groups at the country level. This could strengthen the knowledge and expertise of humanitarian health actors on epidemic surveillance, preparedness, and response. Close coordination between humanitarian actors and the WHO can act as a bridge with global health actors as well as with the host country's ministry of health. As such, the WHO should continue to strengthen internal operational links between its work strengthening health systems and the work of its Health Emergencies Programme. Finally, including humanitarian health actors in teams conducting joint external evaluations in countries experiencing conflict would help leverage their knowledge of health needs and responses in implementing the IHR.

Among themselves, humanitarian health actors still face challenges coordinating to ensure they are filling gaps and not duplicating health services. Many see the health clusters or other cluster-like coordination mechanisms as key for such coordination. This requires all members of these coordination mechanisms to share information on their

projects and activities systematically and comprehensively. It also requires these mechanisms to be representative of all health actors operating in the area they cover. These include not only UN agencies and international NGOs but also local actors, which are often under-represented. Those organizations responsible for coordination should make a conscious effort to engage with local actors systematically, and, where possible, to co-lead coordination mechanisms with local actors that have the capacity to do so. Processes for participation and engagement should facilitate access for local actors, in particular by not being too onerous. In contexts where the ministry of health is a helpful actor, giving it a strong role and presence in coordination mechanisms could strengthen coordination. Donors can also contribute to strengthening coordination by allowing for flexibility in programming when coordination meetings identify gaps or duplications.

It is also important for humanitarian and development actors to coordinate with each other to ensure their work is complementary and that care is continuous. This will help improve implementation of the humanitarian-development nexus. Key development actors should participate in health cluster or sector meetings and coordinate among themselves to facilitate the exchange of comprehensive information with humanitarian health actors.

RESPONDING TO CONTEXT-SPECIFIC NEEDS

It is important for health services to be context-specific to ensure they address priority needs in an adequate and appropriate manner. This requires international health policies, structures, and frameworks developed for conflict-affected settings to be sufficiently flexible. Processes should also be developed or, where they exist, strengthened to ensure the meaningful participation of local actors in the development and implementation of these policies. Over 50 percent of the Global Health Cluster's 700 partners worldwide are reportedly national and local organizations.[214] Even in terms of participation in coordination meetings, however, local actors are often vastly under-represented. Beyond participation, they have little influence on strategic decision making and planning for health clusters or similar working groups. They should have an opportunity to impact and shape the health response, for example by participating in the setting of priorities. To support increased participation of local actors, donors should also endeavor to pursue the commitments made in the Grand Bargain to increase direct funding of local NGOs.

The UN, NGOs, donors, and affected states also need to ensure that health responses are strictly guided by comprehensive, impartial, and evolving needs assessment. It is important to avoid prioritizing interventions just because they are easily defined and measurable, and to focus programs and resources on the main health problems of each particular context. Sexual and reproductive health needs and mental health needs need to be better assessed, understood, and addressed in emergencies. Given the high burden of noncommunicable diseases (NCDs) in many conflict-affected settings, there is also a need to think about how existing guidelines and procedures can be adapted to these settings. Where relevant, essential packages of medicines should also include medicine to manage common and high-burden NCDs. The use of kits such as the NCD kit developed by the WHO is a good practice to ensure NCDs are being addressed in emergency settings.

HOLDING HEALTH ACTORS ACCOUNTABLE TO AFFECTED POPULATIONS FOR THEIR PERFORMANCE

Being accountable for health services provided should be a key priority for all health actors. As discussed above, there are three types of accountability that are all interlinked. There is currently a strong imbalance in favor of financial accountability—accountability upward to donors—with the result that what donors ask for strongly influences practices to ensure performance accountability and accountability to affected populations. In terms of performance accountability, health actors tend to focus on outputs rather than on results and impact. There is therefore a need to develop different monitoring methods that could track and measure impact. Because of the influence donors have, they could do more to incentivize this type of

214 WHO Global Health Cluster, "From the Ground Up: Local Partners Improve Health Care," November 2017.

monitoring, for example by requesting reporting focused on impact. Health actors should also increase the transparency of the findings from their monitoring and evaluation. This would considerably strengthen accountability, particularly with respect to the people they serve.

More efforts are also needed to ensure accountability to affected populations. Such efforts will also help improve the context-specificity of responses. Populations need to play a key part in assessing the health services provided. There are innovative ways populations can be engaged to ensure health service providers are held accountable. Focus group discussions, complaint response mechanisms, and key informant interviews with community leaders are all ways health actors can receive qualitative feedback on their programs. For this to be effective, health actors also need to build the capacity of communities to engage with these types of activities and mechanisms. However, integrating such feedback into planning and implementation of programs is a challenge, as it requires a change in mindset and power dynamics within the humanitarian sector and donor agencies—from seeing affected populations as the receivers of health services to enabling them to be agents of change. Donors could help incentivize accountability to affected populations by requesting that partners develop and implement programs on the basis of information received through processes set up to give voice to the population's concerns and suggestions.

The establishment of an independent monitoring and evaluation mechanism could also help strengthen accountability. One way to achieve this could be to create an external, independent body that sends teams of experts to take a close look at the activities of various health actors in a transparent manner and on the behalf of affected populations.

MAKING RESPONSES SUSTAINABLE

Given the protracted nature of many conflicts—and, by extension, of the related humanitarian crises—humanitarian health actors should ensure that the services they provide are sustainable in the medium to longer term, where feasible. This requires better tailoring humanitarian health policies to longer-term needs. For example, they could better prioritize the treatment of more chronic health needs, lay out ways actors can strengthen existing capacity, and make clear that the creation of parallel health systems should be a measure of last resort. In programming, efforts to work through existing health structures, train and support local health workers, and effectively hand over the response to local authorities or organizations or development actors when humanitarian actors leave are key to ensure predictable delivery of services and continuity of care. Donors should encourage such efforts by providing longer-term funding.

Better implementation of the humanitarian-development nexus will also help ensure the sustainability of health services. Humanitarian and development actors need to work together to identify those areas where humanitarian services are still needed, those where efforts can start transitioning to early recovery, and those where more work to strengthen health systems is realistic and feasible. Where possible, and where it would not compromise the work of principled humanitarian actors, development and humanitarian actors should better collaborate to ensure smooth transitions to longer-term solutions. Donors have a role to play in supporting such collaboration on activities that address health needs in a more sustainable manner. Tackling internal silos between humanitarian and development funding streams will also be important for donor organizations to support activities that implement the humanitarian-development nexus.

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