



HEALTHCARE IN CONFLICT SETTINGS

LEAVING NO ONE BEHIND

Report of the WISH Healthcare in Conflict
Settings Forum 2018

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FOREWORD

Recent conflicts have brought into focus the worst that humanity can do to itself, testing the limits of international law and norms. For civilians caught up in conflict – ‘left behind’ from global prosperity and progress – the rhetoric around rule of law, human rights and humanitarianism may well seem meaningless.

This report begins by outlining the multifaceted and interlinked impacts of conflict on health for such populations. It also describes the key global frameworks that should minimize harm and help protect health during conflict, including Agenda 2030, adopted by all member states in 2015.

Agenda 2030 is a global vision “to strengthen universal peace in larger freedom”. The means to achieve this vision are found in the United Nations (UN) Sustainable Development Goals (SDGs). This report asks the bold question: how can we achieve universal health coverage (UHC) among conflict-affected populations?

This report includes a framework of principles to guide health action in conflict settings. Innovative solutions are needed to tackle key constraints. These may be new technologies, new forms of information gathering and analysis, or the application of existing technologies and approaches in new ways. Yet innovations alone will not solve the challenges for healthcare provision during conflicts. Tackling issues such as violence against health workers, or the 70 percent global gap in funding, will require a different mindset and new global ways of working.



A black and white signature of Professor the Lord Darzi of Denham, written in a cursive style.

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EXECUTIVE SUMMARY

Conflicts today are increasingly complex and protracted. The impact of conflict on an individual's health ranges from trauma injuries and infectious disease to mental illness and loss of continuity of care for chronic conditions. Conflict also affects the determinants of health, for example, food security and nutrition status. Lack of healthcare personnel, destruction of infrastructure and disruption to supply chains all adversely affect the availability and quality of healthcare.

Yet the imperative to protect medical care in conflict situations is enshrined in international humanitarian law, enacted through humanitarian principles such as impartiality. Health can be a bridge to peace. Human rights and medical ethics apply in conflict, just as they do in peacetime. So do global goals such as UHC and the pledge to 'leave no one behind'. Although human suffering during conflicts is inevitable, this report considers what more can be done to protect, promote and preserve health and healthcare.

The central question of this report is: how can UHC be achieved in conflict-affected populations by 2030? We present the challenges for this endeavor as well as innovative ideas to enable progress despite the obstacles.

Key challenges discussed include:

- Attacks on healthcare providers in conflict settings
- Access to populations affected by conflict
- Healthcare for refugees and displaced people
- Resourcing healthcare
- The new burdens: non-communicable diseases (NCDs) and mental illness
- Data-related challenges
- Lack of standardized packages of services
- The politics of healthcare in conflict, and loss of trust in the system.

There is no single way to solve these challenges. Therefore, this report sets out a framework of interconnected principles, core strategies and priority actions that together can help to make progress and a meaningful difference (see [Figure 1](#)). Our recommendations constitute a new **global compact for health-care in conflict settings** to advance UHC for conflict-affected populations.

Figure 1. Actions to advance UHC in conflict settings



SECTION 1. CONFLICT AND ITS IMPACTS

Conflict today

Contemporary conflicts are complex and typically involve a wide range of state, non-state and international actors. Fragmentation is not unusual – for example, up to 6,000 militias are thought to operate in Syria.¹ States may work together in strategically aligned coalitions, such as in the Saudi-led coalition in Yemen. Conflict today is also an increasingly urban phenomenon.² The average conflict lasts 17 years, and leads to protracted crises. At the same time, war is apparently becoming increasingly lawless: hospitals are targeted and chemical weapons are sometimes used, despite being banned.³

As [Figure 2](#) shows, most conflicts today are non-international or non-state (commonly referred to as 'civil wars') and involve a plethora of non-state armed groups.

This report considers all types of conflict (see [Appendix](#) for definitions), as well as ethnic violence and all types of armed conflict-affected populations. This includes people living in active armed conflicts, people newly and forcibly displaced by conflicts (refugees, internally displaced persons and other forced migrants), as well as people living in early post-conflict situations.

The human impacts of conflict

- Up to 90 percent of current war casualties are civilians⁴
- 20 people a minute are forcibly displaced as a result of conflict or persecution,⁵ totaling 65.6 million people, including 22.5 million refugees⁶
- 10 million stateless people are denied a nationality and access to basic rights⁷
- The average refugee displacement is now 26 years; 23 of the 32 protracted refugee situations at the end of 2015 had lasted for more than 20 years⁸
- 60 percent of all chronically food-insecure and malnourished people globally, including 75 percent of all stunted children, live in conflict-affected countries.⁹

What are the impacts of armed conflict on health?

Conflict causes death and injury. Its principal victims are civilians. The impacts of weapons are amplified by high population density in urban areas. Treating resultant trauma injuries requires a referral system, including functioning tertiary-level facilities. In turn, this requires drugs and other medical supplies, as well as water, soap, electricity and food. None of these basic amenities are guaranteed in war zones. It also requires trained health workers who, caught up in the conflict themselves, may become internally displaced or forced to flee the country in fear of targeted attacks. The impact of conflict on the Syrian health workforce has been catastrophic, with estimates suggesting that up to 27,000, or over half of all Syrian doctors, have fled the country since 2011.¹⁰

The lack of healthcare personnel and destruction of health infrastructure combined with the impact of mass displacement (usually defined by overcrowded, inadequate and unsanitary living conditions) increases the risk of infectious disease outbreaks. Examples include re-emergence of diphtheria in Bangladesh and Yemen.¹¹ The world's largest cholera outbreak (also in Yemen) occurred in the middle of war.¹² It is not a coincidence that recent Ebola virus outbreaks have all occurred in fragile countries, where health systems have been weakened by conflicts.

A new and worrying impact is evidence of antimicrobial resistance. Infections in war wounds in the Middle East have been attributed to multidrug-resistant pathogens. Yet few facilities have the capacity to diagnose these cases, and there are reports of delays in treatment and clinical mismanagement of wounds.¹³

Conflict creates new burdens of disease but ongoing healthcare needs remain. For example, women in conflict still need access to family planning and emergency obstetric care. Yet evidence shows that more than one-third of maternal deaths and half of all child deaths occur in areas where health systems have been disrupted due to violence¹⁴ (see [Figure 3](#)). The spread of endemic diseases such as malaria are also likely to be intensified during conflicts.¹⁵ In South Sudan, the top four causes of death between 2005 and 2016 remained lower respiratory infections, diarrheal disease, HIV/AIDS and sexually transmitted diseases.¹⁶

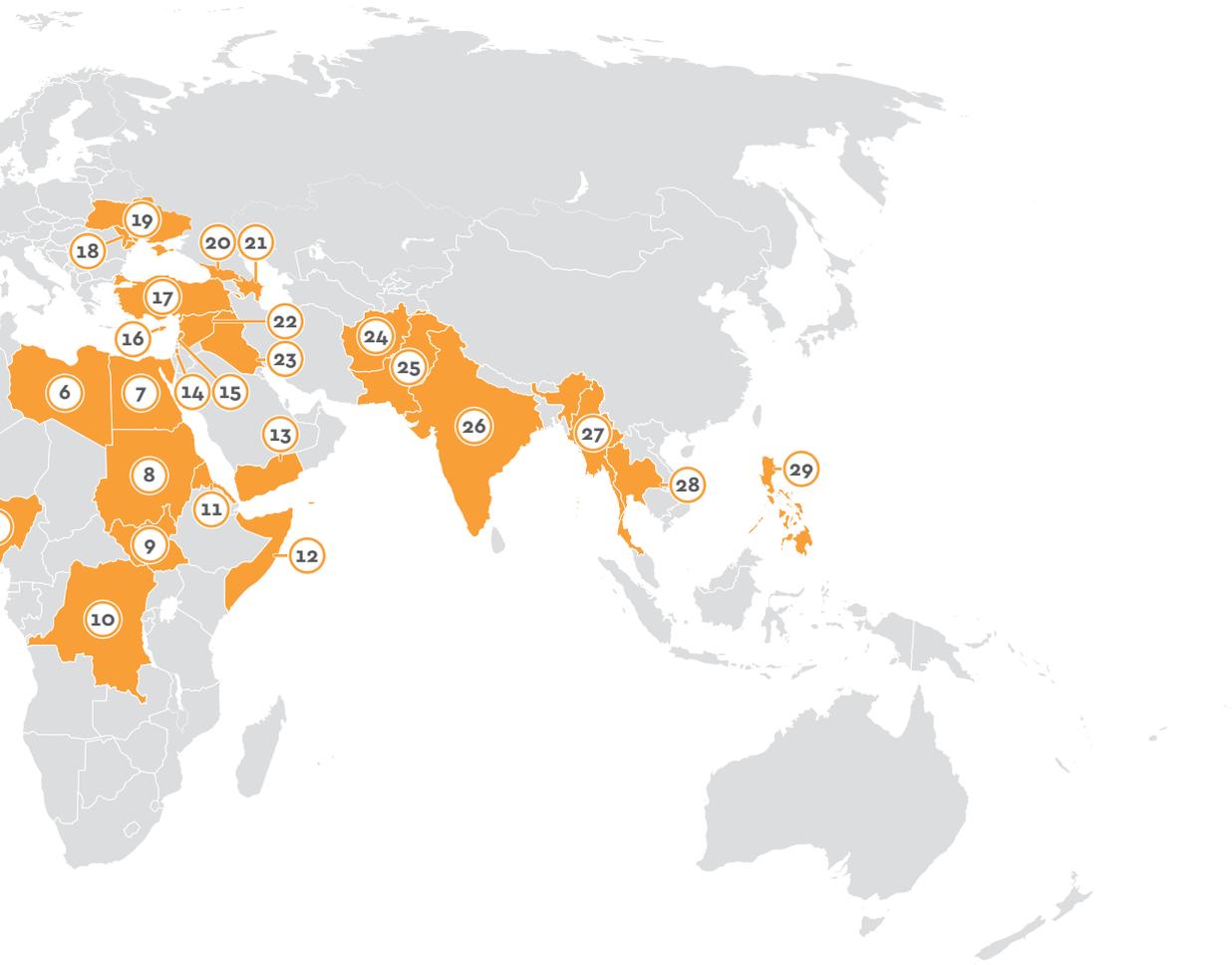
Figure 2. Locations, types of conflict and populations in need



-  Active conflicts in 2017
-  Belligerent occupations
-  Non-international armed conflicts
-  Millions of people in need of humanitarian assistance

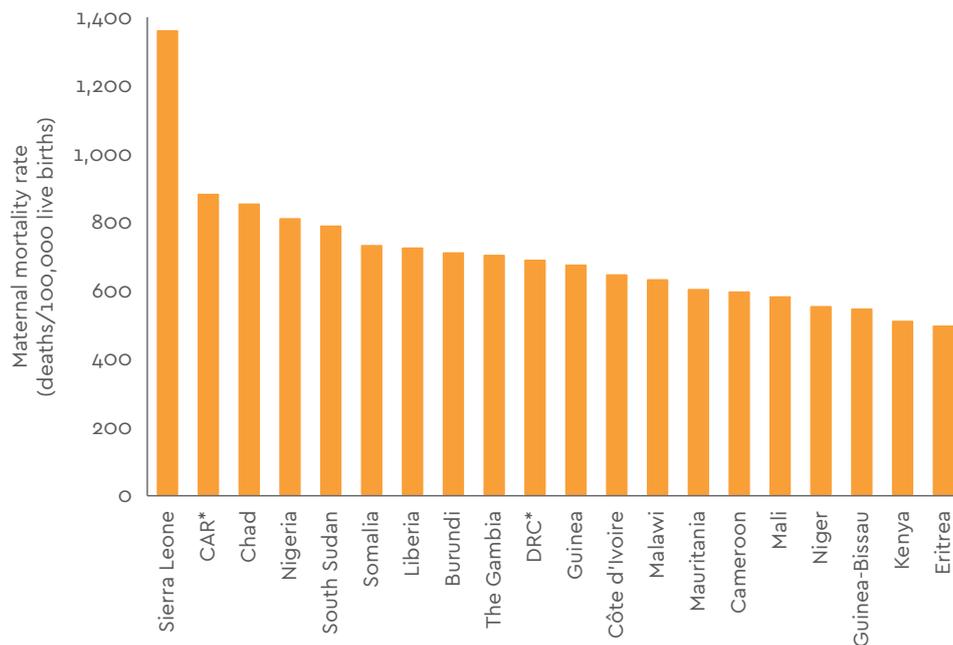
<p>1. Mexico</p>  <p>Number unknown</p> 	<p>2. Colombia</p>  <p>Number unknown</p> 	<p>3. Western Sahara</p>  <p>Number unknown</p> 	<p>4. Mali</p>  <p>5.5</p> 	<p>5. Nigeria</p>  <p>7.7</p> 
<p>11. Eritrea</p>  <p>Number unknown</p> 	<p>12. Somalia</p>  <p>5.4</p> 	<p>13. Yemen</p>  <p>22.2</p> 	<p>14. OPT*</p>  <p>2.5</p> 	<p>15. Lebanon</p>  <p>Number unknown</p> 
<p>21. Azerbaijan</p>  <p>Number unknown</p> 	<p>22. Syria</p>  <p>13.1</p>   	<p>23. Iraq</p>  <p>8.7</p>  	<p>24. Afghanistan</p>  <p>5.5</p> 	<p>25. Pakistan</p>  <p>Number unknown</p>  

* DRC: Democratic Republic of the Congo; OPT: occupied Palestinian territory
 Source: Geneva Academy (2017)¹⁷



<p>6. Libya</p>  <p>1.1</p>  	<p>7. Egypt</p>  <p>Number unknown</p> 	<p>8. Sudan</p>  <p>7.1</p> 	<p>9. South Sudan</p>  <p>7.1</p> 	<p>10. DRC*</p>  <p>13.1</p> 
<p>16. Cyprus</p>  <p>Number unknown</p> 	<p>17. Turkey</p>  <p>Number unknown</p> 	<p>18. Moldova</p>  <p>Number unknown</p> 	<p>19. Ukraine</p>  <p>3.4</p>   	<p>20. Georgia</p>  <p>Number unknown</p> 
<p>26. India</p>  <p>Number unknown</p>  	<p>27. Myanmar</p>  <p>0.9</p> 	<p>28. Thailand</p>  <p>Number unknown</p> 	<p>29. Philippines</p>  <p>Number unknown</p> 	

Figure 3. Maternal mortality rates in conflict-affected countries



* CAR: Central African Republic; DRC: Democratic Republic of the Congo
Source: Index Mundi, Maternal mortality rate, 2018¹⁸

Figure 4 summarizes the widespread health system impacts of conflict in North-East Nigeria.

As well as damaging health systems, conflict has an impact on other sectors. This in turn affects the determinants of health and, ultimately, health outcomes. This interconnection is clearly seen in Yemen where air strikes have destroyed infrastructure and displaced people into crowded and unsanitary conditions. At the same time, restricted humanitarian aid access and enforced blockade of imports has caused shortages of food, medical supplies, fuel and chlorine. Less than half of all health facilities are fully functional.¹⁹

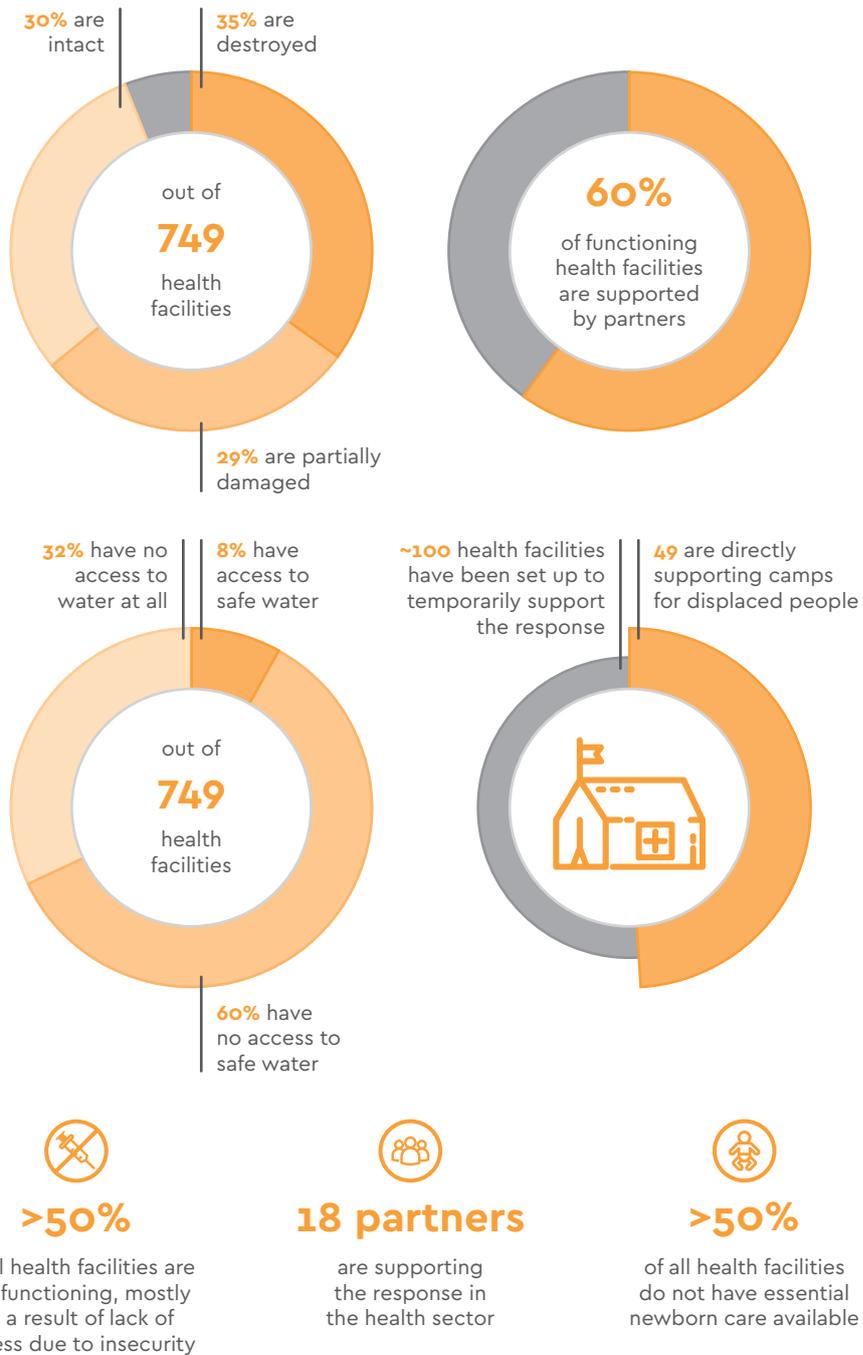
Health system failure, such as in North-East Nigeria and Yemen, also disrupts the continuity of care for NCDs. In pre-conflict Yemen, NCDs represented a significant burden of disease in the country, accounting for 55 percent of all-age mortality in 2015.²⁰ Without access to medicines, this figure is likely to increase. It is estimated that 25 percent of dialysis patients have died every year since the start of the conflict.²¹

Figure 4. Impact of conflict on health systems in North-East Nigeria in 2017



6 million people

in Borno, Yobe and Adamawa states are in need of healthcare assistance



Source: Adapted from World Health Organization Health Resources and Services Availability Monitoring System (HeRAMS), 2017²²

The Global Burden of Disease Study 2015 found a correlation between conflict and depression and anxiety disorders.²³ Studies also show a link between trauma exposure and views supporting violence as a means of conflict resolution.²⁴ Conflict-related stress can lead to increased substance abuse, with consequential health complications. In post-conflict Somaliland, the vast majority of men chew *khat*, a narcotic plant. This amphetamine-like drug has negative impacts on individual users, their families and communities, including loss of economic productivity and a potential increase in gender-based violence.²⁵

Over the course of the Rwandan genocide in 1994, an estimated 250,000 women were raped, and many contracted HIV. Decades later, these women are living with the physical and psychological consequences.²⁶

Case study 1. Psychosocial capacity-building in Gaza

Decades of conflict, socioeconomic decline and service closures have left the Gaza Strip lacking in basic services.²⁷ Research has found changes in children's behavior associated with the psychological distress caused by conflict, including increased levels and occasions of violence such as bullying. Resources for mental healthcare are very limited.

Al Fakhoora,²⁸ a program of the Education Above All foundation, has established a psychosocial capacity-building project in Gaza, in partnership with the United Nations Development Programme, the Qatar Red Crescent Society and the United Nations Children's Fund (UNICEF). Psychosocial rehabilitation is aimed at supporting trauma survivors and their families, for example, using art therapy. The Ministry of Education and Higher Education trains counselors and teachers in schools. Al Fakhoora also helps integrate child protection and psychosocial support modules into the higher education curriculum while building capacities and networks among counselors and social workers of the Ministry of Health and the Ministry of Social Affairs.

To date, some 145 schools have benefited and 420 counselors and more than 11,000 teachers have been supported – enabling more than 45,000 students to be reached in Gaza. Counselors have proved instrumental in training teachers in stress management, teaching them how to incorporate positive discipline in everyday activities. They have also helped to refer children in need of protection and have taught a culture of resilience.

SECTION 2. HEALTHCARE PROVISION IN CONFLICT SETTINGS

How does health have a special place in conflict settings?

All parties to armed conflicts are responsible for ensuring that civilian populations are protected. This principle is codified under **international humanitarian law** (also known as the law of war) as well as in **human rights law**²⁹ (see [Appendix](#)). Together, these legal frameworks should ensure universal healthcare for the sick and wounded in conflict, which is provided impartially, on the basis of need, and without discrimination.

Also included in international humanitarian law is the protection of those providing medical assistance from being harmed, prosecuted or punished for doing so. Such protection only ceases if medical facilities are being used for military purposes, such as sheltering unwounded soldiers, or military intelligence activities. International humanitarian law also protects medical transport, whether military or civilian, provided it is not carrying arms.

International humanitarian law is an important framework for UHC in conflict settings. But such laws are only as strong as the accountability mechanisms behind them. Although attacks against civilians may be considered war crimes by the International Criminal Court,^{*} there is no effective mechanism to enforce this, as illustrated by the current failure to achieve accountability in Syria.

The 1948 Universal Declaration of Human Rights sets out fundamental human rights (see [Appendix](#)), including the right to healthcare, without discrimination, during times of war and in peace. However, the international accountability mechanisms for human rights law are even less developed than those for international humanitarian law.

The 1951 Convention on the Status of Refugees states that refugees are entitled to health services equivalent to that of the host population, and that everyone has the right to the highest standards of physical and mental health.³⁰ In countries where health services may be inadequate for the host population, fulfilling the right to health for refugees is less straightforward, and is also politically challenging.

* The Rome Statute of the International Criminal Court is the treaty that established the International Criminal Court; 123 states are party to the statute, which establishes four core international crimes: genocide, crimes against humanity, war crimes and the crime of aggression.

Accompanying the legal frameworks outlined above are the humanitarian principles that serve as a guide for all personnel delivering aid in conflict and crises (see Table 1). The humanitarian principles are derived from the core principles of the International Red Cross and Red Crescent Movement. They are central to the work of humanitarian organizations and are formally enshrined in two UN General Assembly resolutions.

Table 1. Humanitarian principles

Humanity	Neutrality	Impartiality	Independence
Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings.	Humanitarian actors must not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature.	Humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religious belief, class or political opinions.	Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented.

Source: UN Office for the Coordination of Humanitarian Affairs (2012)³¹

Medical providers in conflict settings are professionally bound by medical ethical principles, which do not change in times of armed conflict. These ethical principles are:

- Respect for autonomy – the patient has the right to refuse or choose his or her treatment
- Beneficence – a practitioner should act in the best interest of the patient
- Non-maleficence – to not be the cause of harm
- Utility – to promote more good than harm
- Justice – concerns the distribution of scarce health resources and the decision of who gets what treatment.

Health as a bridge for peace

The concept of health as a bridge for peace is based on the principle that shared health concerns can transcend political, economic, social and ethnic divisions.³² The concept has seen success, with warring parties agreeing to grant access and not interfere with the work of medical personnel during

designated 'days of tranquility'.³³ Examples come from El Salvador, the former Yugoslavia, Lebanon, Uganda and Sierra Leone. In Sudan, a three-day polio campaign in 2005 was successful in vaccinating more than 5 million children.³⁴

Other activities may include joint projects among health professionals, which can reduce negative stereotypes and open up channels for communication and co-operation. Israeli and Palestinian health professionals have participated in joint training programs, shared health information, and facilitated the treatment of Palestinian patients within Israel.³⁵

Advocates argue that negotiations around healthcare delivery cultivate informal channels of communication that can contribute indirectly and directly to the peaceful settlement of the conflict.³⁶ Such activities can change the dynamics of the conflict and contribute to peacemaking. However, critics argue that to use healthcare in this way risks its politicization and erodes the fundamental humanitarian principle of neutrality.

World Innovation Summit for Health (WISH) research on health in conflict settings

For this report, WISH commissioned a YouGov online survey of 4,465 people across four countries (Australia, Qatar, UK and US) to examine attitudes around healthcare in conflict settings.

We asked three questions:

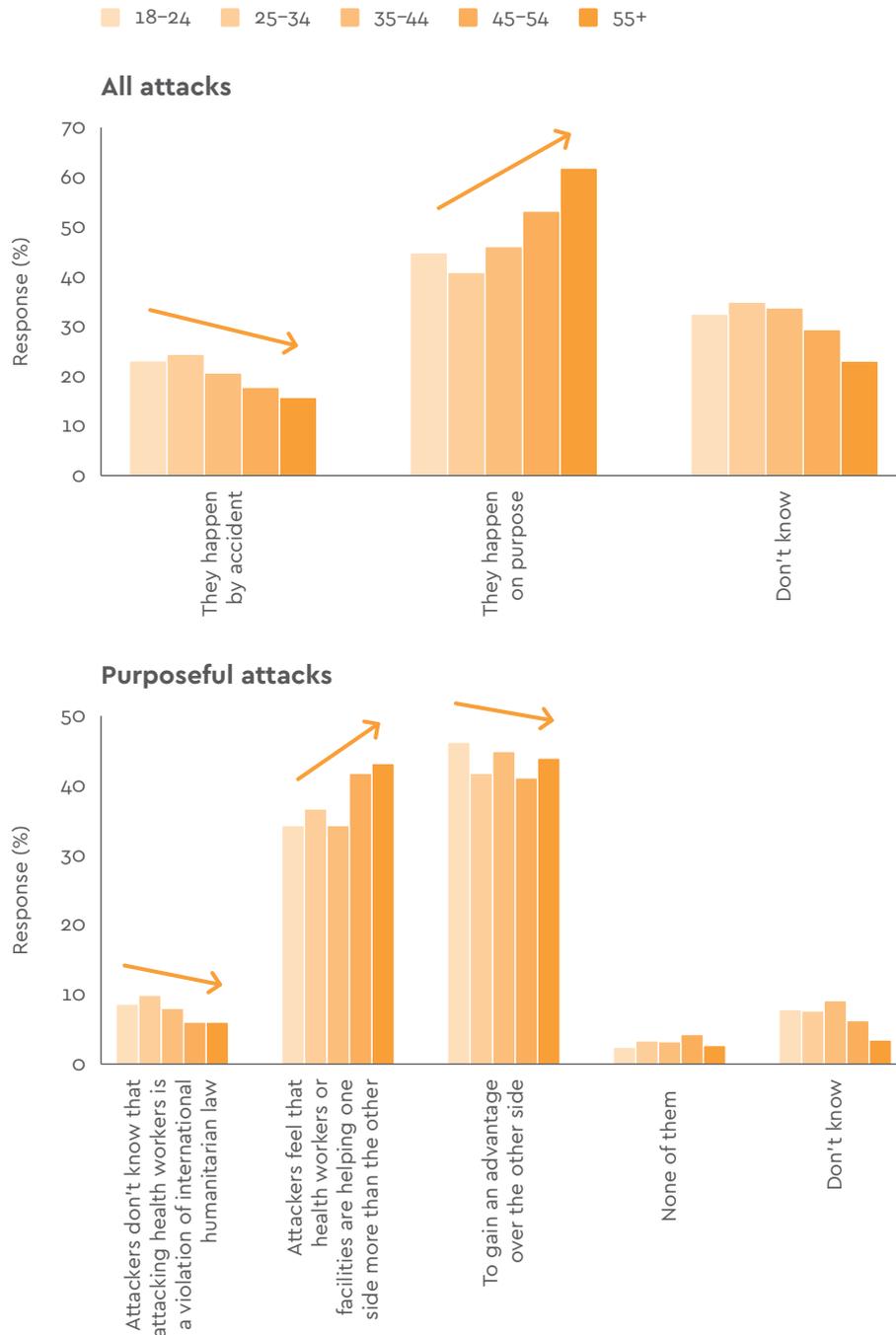
1. Do you think that attacks on health workers in armed conflicts happen most often on purpose or by accident?
2. What do you consider is the most important need of people living in areas affected by conflict?
3. In general, who, if anyone, do you think should be mostly responsible for looking after the health of people living in areas affected by conflict?

Figures 5A–C present highlights of the findings and identify potential trends.

Across the four countries sampled, the older people get, the less likely they are to think attacks happen 'by accident'. For those that answered attacks happen 'on purpose', the main reasons given were: to gain advantage over the other side; and that attackers feel that health workers or facilities are helping one side more than the other. Again, these data show an age-related trend (see Figure 5A). Across all countries, safety and security were considered the most important need for people in conflict. In Qatar, healthcare was considered more important than food or water (see Figure 5B). Across all age groups, most people think that the national government should be mostly responsible for

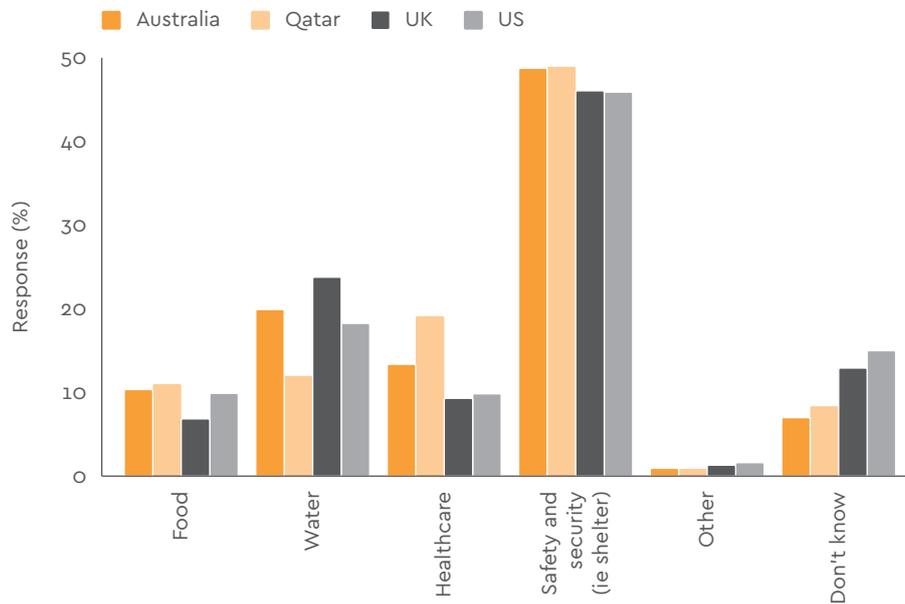
looking after the health of people living in areas affected by conflict. However, young people (18–24) consider the military and United Nations more responsible than their older counterparts (55+) (see Figure 5C).

Figure 5A. WISH research findings on healthcare in conflict settings: "Do you think that attacks on health workers in armed conflicts happen most often on purpose or by accident?"



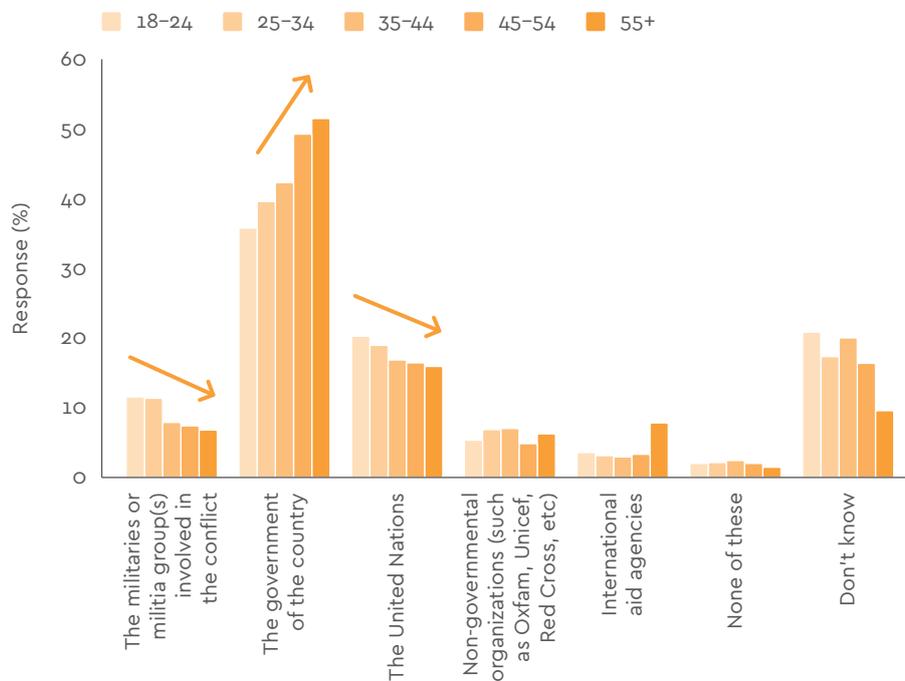
Source: YouGov survey for WISH³⁷

Figure 5B. WISH research findings on healthcare in conflict settings: "What do you consider is the MOST important need of people living in areas affected by conflict?"



Source: YouGov survey for WISH³⁸

Figure 5C. WISH research findings on healthcare in conflict settings: "In general, who, if anyone, do you think should be mostly responsible for looking after the health of people living in areas affected by conflict?"



Source: YouGov survey for WISH³⁹

Providers of healthcare in conflict settings

Many actors work to meet the health needs of conflict-affected populations. Besides institutional actors such as UN agencies, the International Red Cross and Red Crescent Movement, and non-governmental organizations (NGOs), they include a range of civil society groups, private clinics and traditional medicine practitioners.

Typology of local humanitarian responders

Local personnel (not including internationally affiliated organizations and southern international NGOs) include:

- National and sub-national state actors
- National authorities in aid recipient countries
- National and sub-national civil society actors
- National societies of the International Red Cross and Red Crescent Movement
- National NGOs or civil society organizations (CSOs)
- Local and national private sector organizations
- Sub-national/local NGOs or CSOs.

See [Appendix](#) for more information.

The lack of access to services provided by the international community and its partners does not prevent people from seeking other care. Conflict settings are often dominated by largely unregulated local health providers that may not have any interaction with the formal public or private healthcare sectors. As in the majority of low-income countries, care-seeking among conflict-affected populations usually begins at 'pharmacies': drug shops where there is unlikely to be a trained pharmacist but many prescription drugs are available over the counter.⁴⁰ Inappropriate treatment and counterfeit and substandard drugs are major problems.⁴¹

Traditional healers are also an important and trusted provider for conflict-affected populations. While public health systems are disrupted or destroyed by conflict, traditional healers may show more resilience. Research from five conflict settings reveals how folk healing practices work with and complement biomedical healthcare. These practices are particularly widespread in mental health.⁴²

Non-state armed groups often play a role in health service provision in conflicts. Better understanding of health service provision by these groups – and how it interacts with provision from other sources – is important for thinking about UHC in conflict-affected areas. Groups as diverse as the Revolutionary Armed Forces of Colombia, the Liberation Tigers of Tamil Eelam in Sri Lanka, the Communist Party of Nepal (Maoist), the South Sudan People Liberation Movement in Opposition and the Karen National Liberation Army in Myanmar have provided or facilitated health assistance.

Figure 6. Providers of healthcare during conflict



*: Refugees only

Source: Adapted from Checchi F (2017)⁴³

Note: This figure is not an exhaustive representation of all providers, nor is it meant to represent any specific context, it is meant for illustrative purposes only.

Current financing for healthcare in conflict settings

To analyze global humanitarian funding trends, the UN's Financial Tracking Service (FTS) is the most comprehensive and useful dataset available. However, it does not record all humanitarian resources. At least \$5 billion of annual donations from private individuals to NGOs are not listed in the database. For example, Médecins Sans Frontières (MSF) alone reported spending of €1.4 billion in 2016, funded almost entirely by individuals. Turkey donated aid to Syrian refugees within their own borders but this is not accounted for in monetary terms on the UN Office for the Coordination of Humanitarian Affairs FTS database.

Data from the FTS present a discouraging picture. In 2018 (across all sectors), only \$7 billion of the total \$25.3 billion requested for selected settings had been funded by mid-year. This leaves a gap of \$18.3 billion or 72 percent of required funding to meet essential needs.⁴⁴ The situation in 2016 is outlined in [Figure 7](#).

Figure 7. Funding for conflict-affected areas in 2016

	Funds requested for healthcare (\$ million)	Funds met (%)	People in need (million)	Total incoming funds (\$ million)
 Afghanistan	42	 13.1	 1.6	120.2
 Central African Republic	40.3	 25.3	 2.2	58.1
 Chad	30.8	 28.2	 1.9	69.3
 Democratic Republic of the Congo	189	 18.3	 13.1	N/A
 Iraq	109.6	 124.4	 9.7	282.3
 Mali	11.9	 32.8	 2.0	51.2
 Myanmar	16.5	 15.8	 0.5	79.9
 Somalia	106.8	 51.7	 5.5	71.2
 South Sudan	123	 51.7	 5.4	191.4
 Sudan	64.2	 34.9	 4.3	54.9
 Syria	464.9	 34.8	 12.8	675.2
 Yemen	430.4	 35.6	 14.8	873.6

Source: FTS (2018)⁴⁵

The international community's donors are significant funders of healthcare in conflict settings. However, the figures do not include another important source of funding – remittances. Remittances are classified as current private transfers from migrant workers resident in a host country for more than a year (irrespective of their immigration status) to recipients in their country of origin.⁴⁶

Humanitarian funding in the form of remittances is already thought to have outstripped official assistance in many emergencies. It has also been associated with increased empowerment and decreased vulnerability.⁴⁷ Many health services are sustained financially by the diaspora through their direct investment, recurrent support to facilities, donated equipment and good and voluntary short-term work. Remittances may be directed through faith-based organizations, which are an important, and often preferred, provider of health-care in some conflict areas.⁴⁸

SECTION 3. UNIVERSAL HEALTH COVERAGE (UHC) IN CONFLICT SETTINGS

Agenda 2030 and UHC

In 2015, the UN General Assembly adopted the 2030 Agenda for Sustainable Development (Agenda 2030) with 17 SDGs and 169 targets.⁴⁹ Health is recognized as integral to achieving the SDGs⁵⁰ and also has its own Goal 3 that calls for *ensuring healthy lives and promoting well-being for all at all ages*. This report is primarily focused on target 3.8: to achieve UHC.⁵¹

Building on the WHO definition,⁵² the 2015 WISH forum report *Delivering universal health coverage: A guide for policymakers* describes UHC as meaning that all people and communities can access the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

Figure 8. Health in conflict in the SDG era – relevant goals



Source: Adapted from WHO⁵³

UHC embodies three related principles:

1. **Equity** in access to health services – everyone who needs services should get them, not only those who can pay for them.
2. The **quality** of health services should be good enough to improve the health of those receiving services.
3. **Protection** against financial risk, and ensuring that the cost of using services does not put people at risk of financial harm.⁵⁴

Central to Agenda 2030 is the promise to 'leave no one behind', to ensure that progress benefits everyone, everywhere. This means that services for the most inaccessible groups should be a priority.⁵⁵ Many health outcomes are significantly worse in conflict-affected settings and UHC will only be achieved with a strong focus on fragile and conflict-affected states.⁵⁶

Table 2 highlights that there is still progress to be made.

Table 2. UHC scores for conflict-affected countries

Country	WHO/World Bank UHC indicator score* (/100)	Country	WHO/World Bank UHC indicator score* (/100)
Afghanistan	34	Myanmar	60
Central African Republic	33	Somalia	22
Chad	29	South Sudan	30
Democratic Republic of the Congo	40	Sudan	43
Iraq	63	Syria	60
Mali	32	Yemen	39

* Value of 100 denotes full coverage.
Source: WHO/World Bank Group⁵⁷

The Agenda for Humanity

Complementing Agenda 2030, the Agenda for Humanity⁵⁸ sets out the major actions and changes needed to reduce humanitarian need, risk and vulnerability (see Figure 9). The Agenda for Humanity was introduced at the 2016 World Humanitarian Summit (WHS), a key outcome of which was the Grand Bargain. This is an agreement between the biggest donors and aid agencies on working practices to deliver an extra billion dollars over five years for people needing humanitarian aid, including greater funding for national and local responders and reduced bureaucracy through consistent reporting requirements. Specifically, the Grand Bargain commits to providing 25 percent of global humanitarian funding to local and national responders by 2020, along with more unallocated funds, and increased multiyear funding to ensure greater predictability and continuity in humanitarian response.⁵⁹

Figure 9. Agenda for humanity commitments



Source: Agenda for Humanity⁶⁰

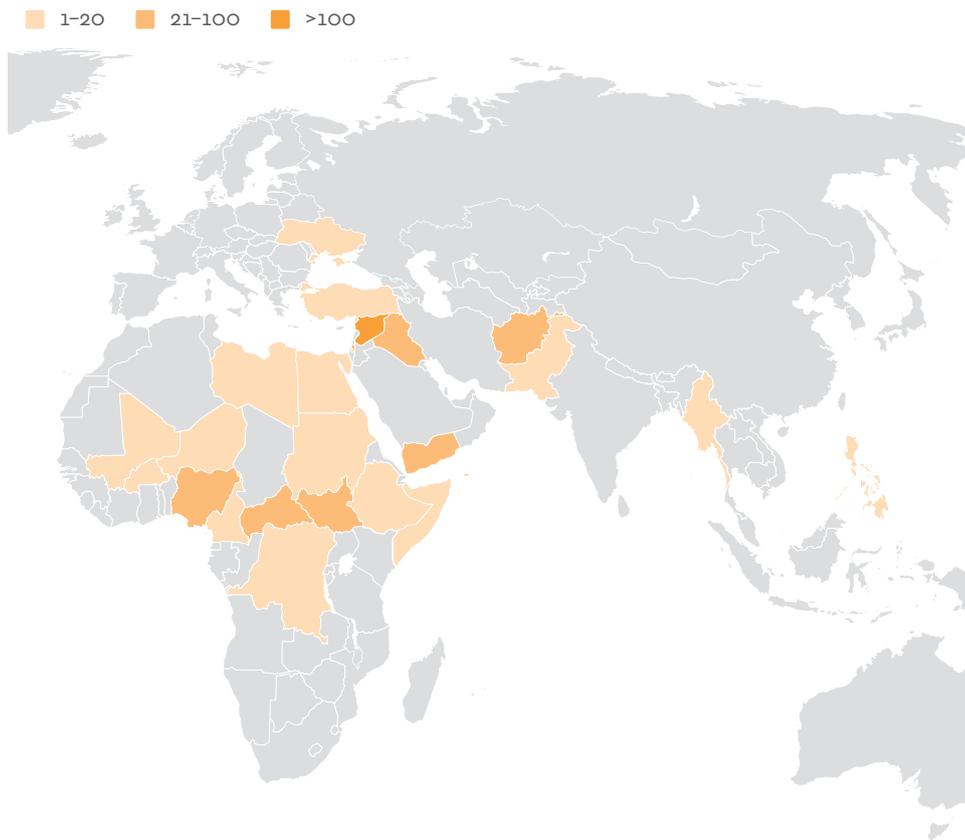
What are the critical challenges for the achievement of UHC among conflict-affected populations?

Many obstacles currently impede the journey to UHC for conflict-affected populations. Before proposing a way forward, an understanding of the scale and scope of critical challenges is needed. Below is a summary of the situation, based on research and interviews with Forum members.

Attacks on healthcare providers

One of the most significant challenges for the delivery of healthcare (and realization of UHC) in conflict situations is the apparent increased number and scale of attacks on healthcare providers.⁶¹ Attacks include: direct armed attacks; destruction or looting of medical facilities; use of medical facilities for military purposes; obstruction of access to medical care; firing on ambulances; and threats, intimidation and violence against health workers.⁶² These attacks violate the Geneva Conventions, customary international law and various provisions of international human rights treaties.⁶³ Aside from Syria,

Figure 10. Attacks on healthcare in conflict settings in 2017



Country	# reported conflict-related attacks on health	Country	# reported conflict-related attacks on health
Afghanistan	66	Nigeria	23
Burkina Faso	3	OPT*	93
Cameroon	2	Pakistan	18
CAR*	52	Philippines	5
DRC*	20	Somalia	3
Egypt	8	South Sudan	37
Ethiopia	2	Sudan	13
Iraq	35	Syria	252
Libya	15	Turkey	5
Mali	14	Ukraine	3
Myanmar	4	Yemen	24
Niger	4	Total	701

* CAR: Central African Republic; DRC: Democratic Republic of the Congo; OPT: occupied Palestinian territory
 Source: Safeguarding Health in Conflict Coalition (2017)⁶⁴

incidents have occurred in Afghanistan, Yemen, Sri Lanka, South Sudan, Kosovo, occupied Palestinian territory and Central African Republic among others.⁶⁵ The impact of attacks extends beyond the immediate and devastating direct effects. For example, attacks make health facilities – supposedly places of healing and sanctuary in war – places of danger and fear. While there have been concerted efforts to better document and raise awareness of attacks on healthcare services, this has not resulted in improvements in the field.

Accessing populations affected by conflict

Access to healthcare in conflict settings is routinely limited by violence, a lack of security and politically created barriers such as blockades. In a review of responses in South Sudan, Democratic Republic of the Congo and Jordan, MSF found that, when assistance is most needed, international humanitarian workers are rapidly evacuated or confined to compounds and programs are suspended or downgraded to skeleton staff.⁶⁶ Where access is controlled by armed forces, difficult negotiations are the norm and tough choices have to be made, for example, around paying bribes. New ways are urgently needed to better remotely support local, community-based health personnel.

Healthcare for refugees and displaced people

More people are fleeing conflict than ever before. Refugees in formal camps may have access to basic services, but this is not consistent everywhere. Internally displaced persons in informal settlements often have very limited access to affordable, appropriate healthcare. Most of those people who are displaced are in Africa, where health systems are weak and under-resourced. Coverage for additional populations is thus a significant challenge. In 2017–2018 some 688,000 Rohingya crossed over from Myanmar into Bangladesh, and there are now over 900,000 refugees in Bangladesh.⁶⁷ The scale of the influx and the scarcity of resources have resulted in a critical humanitarian emergency; the crowded living conditions and poor infrastructure in camps and settlements expose the refugees to further health risks.

Resourcing

Most humanitarian agencies rely on funding from government donors who are often influenced by their own political agendas.⁶⁸ Such institutional aid is heavily bureaucratized. For example, it usually takes funds three months to arrive in the field.⁶⁹ One of the biggest sources of inefficiency is the short-term nature of grants. This interrupts programming, despite the fact that most crises are protracted and can benefit from long-term planning. Short-term grants for humanitarian health cannot bring about UHC.

Figure 11. Inequities in humanitarian health expenditure between countries and regions

	Funds requested (\$ million)	Funds met (%)	People targeted (million)	Funding per person (\$)
 Afghanistan	339	 85	 3.5	 82
 Central African Republic	531	 39	 1.9	 108
 Democratic Republic of the Congo	690	 60	 6.0	 69
 Myanmar	189	 59	 0.6	 199
 Sahel region	5	 24	 7.7	 0.16
 Somalia	885	 56	 3.5	 141
 South Sudan	1,291	 93	 5.0	 239
 Syria	-	-	-	 128
 Syria Regional Refugee and Resilience Plan	4,539	 61	 13.9	 200
 Yemen	1,633	 62	 13.2	 78

Source: OCHA (2017)⁷⁰

Relief funding can also fluctuate from year to year. For example, in the context of a 19 percent increase in needs, confirmed 2017 funding reported to the UN's FTS was \$21.3 billion, down from \$22.9 billion in 2016.⁷¹

Very few agencies receive unearmarked funding. The ones that do, principally MSF and the International Committee of the Red Cross (ICRC), respond speedily in crises but may not stay on for longer-term recovery, as it is not in their mandate. It is estimated that 40 percent of post-conflict countries

revert to a state of conflict. Although rapid short-term support is essential to save lives and reduce suffering, new ways of working are required to achieve UHC and ensure health security in the long term.⁷²

Despite the fact that most humanitarian action is delivered by local personnel, two-thirds of funding in 2017 went to just 13 international groups.⁷³ The risk of corruption and the requirements of accountability are often used to justify donor behavior despite efforts such as the Good Humanitarian Donorship initiative.⁷⁴

International funding is highly inequitable (see [Figure 11](#)). There is no prioritization at the global level, rather individual organizations compete for funds linked to their own geographic and interests. The global system does not respond to health needs in a fair and transparent manner, and this has implications for trust and accountability.

Inherent in the concept of UHC is the principle that “people should be protected against financial risk, ensuring that the cost of using services does not put people at risk of financial harm”.⁷⁵ The easiest way to avoid this is to ensure that services are available free of charge. This is a key strategy employed by most providers of health in conflict settings.⁷⁶ However, it raises issues for sustainability.

Also inherent in UHC is the expectation of domestic resource mobilization: increasing the flow of taxes and other income into government treasuries.⁷⁷ This can be a sustainable financing solution for UHC. Yet in places where the context does not permit the generation of adequate tax revenues, the question of how to finance UHC remains unresolved.

The new burdens: NCDs and mental illness

NCDs are a major and increasing cause of morbidity and mortality in areas of protracted and recurrent crises.⁷⁸ For refugees, the costly burden of NCD care falls on host countries; for example, the Jordanian Ministry of Health spent \$53 million on care for refugees over just three months in 2013.⁷⁹ Only modest help has been provided through international aid to expand host country health capacities, with even less available for NCD care.⁸⁰ Data indicating which interventions have the best outcomes, or how to deliver them, are limited.⁸¹ In Syria, research has found that challenges to NCD care implementation included a lack of knowledge on unmet needs in the population, lack of consensus on healthcare provision objectives, and no clear methodology for prioritizing resources.⁸²

Unfortunately, mental health in conflict settings remains largely neglected or misdiagnosed. The multisector nature of effective mental health interventions is a challenge. Protective factors, such as the available resources and political stability of a country, may lessen the impact on mental health in crisis settings, but these factors are beyond the health sector's sphere of influence.⁸³

Data-related challenges

Armed conflicts weaken health information systems. Combatants may perceive health data as politically sensitive or threatening. Population figures, as well as mortality data, are especially controversial.⁸⁴

A study in *The Lancet* analyzed the availability of public health information during the first six months of 20 recent armed conflicts and natural disasters. The analysis suggests that recent practice falls considerably short of even minimum requirements. The authors found even the most basic information such as the '4W matrix' (who does what, where and when) was only collected in 2 out of 13 armed conflicts. In no crisis was the full set of minimum information available; for example, vaccination coverage and nutrition status data. Even when information exists, it is poorly accessible and scattered across various platforms.⁸⁵

Needs assessments are fundamental to planning healthcare. However, assessments are usually not well coordinated.⁸⁶ More than 25 percent of humanitarian responders consider the lack of knowledge around true needs to be a major constraint to mounting effective responses.⁸⁷ Questions have also been raised around the independence and objectivity of assessments conducted by humanitarian agencies that 'need needs' to secure funding.⁸⁸

Data disaggregation is key to ensuring that 'no one is left behind'. For example, the displaced, the disabled, the mentally ill, the elderly and minority groups are often neglected from data systems. These challenges are not unique to conflict settings; an inadequacy of disaggregated data for vulnerable groups has been documented in Kenya, Nepal, Ghana and elsewhere.⁸⁹

Lack of standardized packages of services

There is no universally agreed package for health services in conflict settings. What services a person receives amounts to little more than luck, compounded by the inequities in funding allocation. Available standards (such as in the Sphere Project – see [Case study 2](#)) are not universally implemented. Where and when an organization may decide to respond is often driven by fundraising or political objectives.

Case study 2. The Sphere Project⁹⁰

The Sphere Project was launched in 1997 to improve the quality of assistance and protection in disaster or conflict responses. The underlying principle is that affected populations have a right to live in dignity, and that all steps should be taken to alleviate their suffering. The handbook published by the project contains a humanitarian charter, as well as core standards. Technical chapters cover minimum standards for: water supply, sanitation and hygiene promotion; food security, nutrition and shelter; settlement and non-food items; and health action. Sphere recommendations include the following key actions and indicators:

- Supporting local health workers and integrating them fully into health services.
- Standardizing training programs and prioritizing them according to key health needs and competence gaps.
- Ensuring fair and reliable remuneration for all health workers, agreed among all agencies and in collaboration with the national health authorities.
- Minimum staffing levels that include at least: one medical doctor per 50,000 population; one nurse per 10,000 population; one midwife per 10,000 population; and one community health worker per 1,000 population.

An attempt to standardize reproductive health services in crises is found in the United Nations Population Fund's (UNFPA's) Minimum Initial Service Package (MISP).⁹¹ This is a set of actions initiated at the onset of every crisis. The five objectives of the MISP are to:

1. Ensure an organization is identified to lead the implementation
2. Prevent and manage the consequences of sexual violence
3. Reduce HIV transmission
4. Prevent maternal and newborn death and illness
5. Plan for comprehensive sexual and reproductive healthcare, integrated into primary healthcare, as the situation permits

However, in reality, the MISP is either neglected or not implemented, and funding is often inadequate.⁹² Although the MISP should be implemented in the initial phase of a crisis before a transition can be made to more stable health-care provision, protracted crises such as that in Syria create gaps in care⁹³ and uncertainties for women.

A longer-term model to standardize services in conflict-affected areas is the Basic Package of Health Services (BPHS) approach. This aims to increase capacity and provide resources to cover basic health needs in conflict-affected

countries in a structured and standardized way. In a context where the health ministry no longer has the capability to provide healthcare, the BPHS can step in and allow the pooling of internal funds, local knowledge and logistics, international funds and NGO labor forces.

The arguments in support of the BPHS contracting approach are based on the intent to foster coordinated nationwide service delivery to increase effectiveness, efficiency and equity.⁹⁴ These clearly align with UHC ambitions. However, in Afghanistan, there is evidence that the BPHS has created inequalities in access to facilities and inconsistent costs of care, and left behind those from poorer households.⁹⁵ Crucially, the BPHS does not adequately reflect local health needs. Although NCDs represent more than half of all outpatient visits, and more than half of all mortality in Afghanistan, NCDs are not included in the current package. The BPHS in Afghanistan is currently under revision to address these issues but it is unclear how an expanded BPHS will be funded.

The politics of healthcare in conflict settings

Health systems can provide security and stability to communities.⁹⁶ However, during conflict, "neither health system nor state are impartial bystanders".⁹⁷ Healthcare in conflict settings may be used explicitly by state or non-state groups to 'win hearts and minds'. Especially in ethnic conflicts, services may be withheld from certain groups in violation of humanitarian principles and medical ethics.

In Afghanistan, health and provision of other basic services and infrastructure have been used as a key strategy in the war against the Taliban. Although these efforts have increased access to healthcare for many Afghans,⁹⁸ there is evidence that aid has been diverted and misused, and potentially destabilized further an already fragile situation.⁹⁹ There is also doubt about the quality of health services provided in such circumstances, and a lack of documented proof that the claimed strategic benefits materialize in practice.¹⁰⁰

The pursuit of UHC in humanitarian crises has also been critiqued more generally. If UHC is a project for the state, what happens when the state is absent, unwilling, or complicit in human rights abuses?¹⁰¹ Indeed, "a country's advance towards universal health coverage can never excuse indefensible breaches of fundamental human rights".¹⁰²

Case study 3. Contracted health services and counterterrorism in Mosul

To operate in Mosul, WHO has contracted services, including 'trauma stabilization units', to private sector companies that are embedded in the military. Although these units have saved many lives, the contractors have not always complied with the principle of impartiality, and there are reports that patients have been turned away.¹⁰³ It is alleged that decisions to fund these units may not only be about access to civilians at the frontlines, but linked to donor priorities in the battle against the Islamic State (ISIS).

If, as required by humanitarian principles, medics treat suspected ISIS members, their facilities' protected status may be jeopardized by anti-ISIS counterterrorism activities and demands that doctors hand over suspected ISIS patients after treatment.¹⁰⁴ In such cases, counterterrorism policies appear to override humanitarian imperatives.¹⁰⁵

Loss of trust

'Beneficiaries' of aid are rarely consulted in decision-making processes. Their ideas and feedback on programs are seldom incorporated. Combined with ineffectual needs assessments, this means that humanitarian aid can be ineffective and disempowering to affected populations. This lack of representation, compounded by the politicized nature of aid, has resulted in a loss of trust in the system. This is illustrated below by figures from *The State of the Humanitarian System 2015* report:

- 44 percent of aid recipients were *not* consulted on their needs by agencies prior to the start of programs.
- Only 53 percent of affected people were satisfied with the speed at which aid arrived.
- Only 33 percent said they had been consulted on their needs.
- Only 20 percent of those consulted said that agencies had acted on this feedback and made changes.¹⁰⁶

SECTION 4. MAKING UHC A REALITY FOR CONFLICT-AFFECTED POPULATIONS

Although the world as a whole has the knowledge, capacities and resources necessary to make UHC a reality for conflict-affected populations, there is no quick fix or single solution. To deal with the constraints highlighted by this report, we will need strong political will, systematic organizational effort, reoriented and additional financing, our best science and innovation and ingenuity that challenges the status quo.

Case study 4. Deliver Accelerated Results Effectively and Sustainably (DARES)¹⁰⁷

The DARES collaboration among WHO, World Food Programme (WFP), UNICEF, UNFPA and World Bank aims to preserve and improve health systems in conflict settings. Building on positive results in Yemen, Djibouti and Libya, the initiative is now being piloted in Central African Republic and Democratic Republic of the Congo. The collaboration is guided by the following principles:

- 1. Support national systems.** Working with national and subnational authorities, recognizing the political context, DARES will collaborate with national and international partners to strengthen national systems, and be proactive to prevent, prepare for and respond to deteriorating health situations.
- 2. Implement multiyear, flexible programming.** DARES will take a proactive, longer-term perspective on country engagement and avoid short-term planning and budget cycles.
- 3. Ensure evidence-based programming.** Programs and interventions will be prioritized based on data, evidence and joint analysis, with a focus on the most vulnerable.
- 4. Maximize partnership.** DARES partners will work collaboratively to conduct joint needs assessments, iterative planning and performance monitoring, ensuring there is collective decision-making and risk management.

Principles

There are a number of agreed global frameworks and commitments to provide UHC. We draw on these for our **eight foundational principles** to advance UHC for conflict-affected populations by 2030:

- 1. Healthcare in conflict is a human right.** For all civilians and for refugees, healthcare is a legal entitlement. This is embedded in human rights law (for civilians), international humanitarian law (for civilians and combatants) and refugee law (for refugees and asylum seekers).¹⁰⁸
- 2. States have a responsibility to deliver healthcare to conflict-affected populations.** This is a legal duty. Agenda 2030 reinforces this responsibility in health-related goals, and it is also embodied by the 'leave no one behind' cross-cutting objective.¹⁰⁹
- 3. Non-state local actors are crucial to achieve UHC for conflict-affected populations.** This echoes the partnership aims of Agenda 2030 and is essential when access is limited for international actors. UHC strategies must be rooted in local contexts. UHC will not be possible without the contribution of local personnel; however, many are currently operating beyond the UN and other regulated systems.
- 4. Both state and non-state providers have a duty to provide healthcare impartially and equitably.** This is stated in medical ethics and international law.¹¹⁰ Equity is also embodied in the humanitarian principles and Agenda 2030 commitments. UHC efforts must start with the most 'left behind' groups, covering those who are the hardest to reach first.
- 5. Health transcends the biomedical model.** Health also covers mental and societal health, which are especially important for conflict-affected populations.
- 6. Healthcare is not a target during conflict.** This is enshrined in international humanitarian law, and also humanitarian principles. Health is a global public good that we all have a responsibility to protect and promote.
- 7. Healthcare in conflict is provided for health's sake alone.** It is not used for political or other causes.
- 8. UHC provision in conflict settings is a shared endeavor that bridges humanitarian, development and global health goals.** This requires defining collective outcomes, joint analysis, planning and programming. It also means recognizing that, as functioning health systems are at the heart of UHC, all actors need to work to protect and preserve health systems and not undermine them during the stresses of a conflict.

Strategy

Combining these principles with those of UHC in general (equity, quality and financial protection), we set out a **five-point strategy** toward UHC for conflict-affected populations.

- 1. Shared financing of healthcare for conflict-affected populations.** This should be the collective responsibility of all UN member states, as well as all global health actors committed to UHC. The cost of meeting UHC needs in conflict settings is estimated at \$7.65 billion per year (\$57 per capita).*

Following the financing model for UN peace-keeping operations, states could pay assessed contributions: the more economically developed a country is, the larger their contribution.¹¹¹ In addition, global health donors pledge an agreed proportion of their annual budget to a healthcare in conflict pool.

UHC and global health security (GHS) are interconnected. Ensuring GHS must involve strengthening local systems for prevention and care. This report calls for those donors investing billions in GHS to urgently consider the importance of allocating funding to healthcare in settings where, without everyone's health, security is at risk.

By the time it reaches personnel in the field, funding should be flexible, unearmarked and able to be spent across multiple years. In line with WHS commitments, at least 25 percent of funds (current and future) should go directly to local health providers.

- 2. Independent needs assessments.** Health needs for conflict-affected populations should be assessed by an independent body of commissioners who are not connected to agencies appealing for or expending funds. Standardized templates should be used to cover a full range of health and health-related indicators. A key part of the assessment process should involve listening to affected people, using anthropological methods to better understand their needs. Separating the assessment process from institutional fundraising and politics would enable fairness and help rebuild trust.

* While this estimate has been calculated using official data published by the UN's FTS, there are a number of caveats: the unit costs of medicines, equipment and healthcare workers vary widely across different contexts; delivering aid to those with easy access to healthcare facilities differs from reaching those suffering conflict in hard-to-reach settings; and it does not account for informal health services provided in certain settings.

3. **Equitable allocation of resources.** If assessments use standardized methods, comparison between contexts becomes possible. This would enable a more equitable allocation of resources, with independent commissioners prioritizing allocations in a transparent way using public health and humanitarian principles.
4. **A standardized minimum package for UHC in conflict settings.** While no two contexts are the same, the package of health services must be standardized. A basic package based on an independent needs assessment and adapted to local needs should aim for universal implementation to enable all populations to meet their essential health needs (see [box](#) below.)

Sphere standards (see [Case study 2](#)) could be used as the benchmark, recognizing that exact specifications will be adjusted by context-driven needs, and adapted in line with local sociocultural beliefs and practices. To build trust, health interventions should be co-produced with local providers and people.

Reflecting the current burden of disease, 70 percent of today's conflict-affected populations are suffering from one or more NCDs such as diabetes, cardiovascular and chronic lung diseases, cancer and disabilities. There is also a large mental health burden. Therefore, any minimum package must include NCDs as a central part of achieving UHC. Humanitarian health practitioners need to redefine treating NCDs as lifesaving activities; for example, on a par with immunizations.

Key components of the basic package¹¹²

These are the core components of the minimum package that should be available and accessible to all conflict-affected populations. The interventions implemented under each service will be tailored to the setting, to ensure that they are appropriate and affordable, and using Sphere standards as the guide.*

Increased access to more services must not come at the expense of quality, which is a crucial cross-cutting issue that cannot be neglected.

No individual components in the below list are new. What is new is the proposition that (dependent on assessed local needs) **the full range of services – the basic package – is accessible to all conflict-affected populations.**

As already noted, what services a person may or may not currently receive amounts to little more than luck. Using this package as the minimum starting point for all UHC efforts in conflict settings should help improve this situation.

* The prescription of specific interventions under these broad areas is beyond the scope of this report.

Area	Service
Child health	Community case management
	Outpatient curative care
	Routine vaccination (Expanded Programme on Immunization)
	Pediatric inpatient care
Sexual, reproductive, maternal and neonatal health	Antenatal and postnatal care
	Skilled birth attendance
	Basic and comprehensive emergency obstetric and neonatal care
	Family planning
	Management of sexual and gender-based violence
Nutrition	Infant and young child feeding promotion
	Targeted supplementary feeding for moderate acute malnutrition
	Outpatient management of severe acute malnutrition
	Stabilization center for severe acute malnutrition with complications
HIV and tuberculosis (TB)	Prevention of mother-to-child HIV transmission
	HIV tracing, testing and treatment
	TB tracing, testing and treatment
Mental health	Mental health and psychosocial support
Adult health	Management of NCDs
	General adult inpatient care
Injuries	Trauma surgery

The implementation of the package must follow the principles of UHC: equity in access, quality and financial protection for all.

- 5. Shared information systems and independent assessments of results and impact.** In the field, data should be collected using new digital technologies (see [Case study 5](#)) and analyzed in real time to avoid delays in programmatic decision-making. Simultaneously, field data could be fed into aggregated public databases, where artificial intelligence tools may be used to aid the commissioners to monitor service quality and key indicators toward UHC. The results claimed by operational aid agencies should be independently verified by the commissioners.

Case study 5. Dharma data revolution

Overcoming data-related challenges will require innovative use of technologies. The Dharma platform's software enables bespoke data architecture and can be used on any operating system or mobile device.¹¹³ The platform accommodates complex surveys, making mobile data collection for epidemiology simple and user-friendly. With minimal training, local personnel can run powerful analytics for health surveillance. In doing so, they become program analysts, not just implementers. The platform can operate as an electronic health records system. Offering real time analytics in multiple languages enables immediate access to insights derived from data. The platform can track longitudinal studies on a large scale in low-resource environments.¹¹⁴ Dharma has been used by MSF and others in conflict zones, including in Syria and in the Rohingya crisis.¹¹⁵

Enabling actions

The success of the strategy requires further enabling actions in two priority areas:

1. To prevent and deter attacks on healthcare providers
2. To reach the most left behind, conflict-affected populations.

To prevent and deter attacks on healthcare providers

Neither legal nor voluntary mechanisms are adequately preventing or deterring illegal attacks. Even Security Council resolution 2286 of 2016 has yet to make a tangible difference on the ground. Progress toward achievement of all the SDGs is jeopardized while healthcare provision is threatened. All governments, including warring parties, non-state actors and international bodies need to work together to stop attacks on healthcare. Key actions include:

- **Documenting attacks and their impacts systematically.** Building on the work and experience of organizations like the ICRC, MSF and the International Rescue Committee, the WHO Attacks on Healthcare project aims to roll out a global surveillance system for monitoring attacks. A pilot in Syria has shown good results.¹¹⁶

- **All organizations need to agree on classification that can be applied globally.** It is also necessary to document the wider and longer-term impacts of attacks on populations. Methodological innovation and more systematic analysis are needed, but documentation alone will not solve the issue. Action is needed – from states and from citizens.
- **Expanding public awareness and education.** A global culture shift is required to establish a universal social norm of zero tolerance for illegal attacks on healthcare. This could be compared to anti-tobacco or climate change awareness campaigns, which have shown impressive progress. It would require every country to incorporate education on humanitarian values and norms, as well as awareness of international humanitarian law in schools and through public education. Model curriculums and techniques already exist with the ICRC and should be rolled out more widely.
- **Developing an independent accountability mechanism.** Current mechanisms within national and international courts' prosecution mechanisms are inadequate and new accountability models are needed. We suggest adapting the Monitoring and Reporting Mechanism on grave violations of children's rights in situations of armed conflict.¹¹⁷ In this mechanism, parties to armed conflict determined by the UN Secretary-General to have recruited or used children in armed conflict are listed in an annex to the Secretary-General's annual report on children and armed conflict. This mechanism combines three key elements of a compliance system: monitoring; 'naming and shaming' violators; and constructive engagement to end violations by assisting parties to develop timebound action plans for releasing children from their ranks.¹¹⁸ As recommended by Ban Ki-moon,¹¹⁹ the same process should be initiated for attacks on healthcare in conflict settings. Constructive engagement would involve scaling up the work of the ICRC to help train and educate perpetrators in international humanitarian law, as well as sharing the lessons from their Health Care in Danger project, including tools and guidance on how to implement the law in practice.¹²⁰

To reach the most left behind, conflict-affected populations

- **Local personnel need to be empowered and invested in.** The current model to provide healthcare for hard-to-reach or inaccessible populations is centered on external actors. This is impossible when access is denied, and is expensive and inefficient even when possible. Much more could be done through remote support, using new technologies. In addition, international actors need to 'let go'¹²¹ of power and control. Communication technology can help train and support health workers in real time.¹²² Harnessing other new technologies – for example, scaling up the use of drones to deliver supplies – could also help to empower local personnel to work more effectively in areas cut off from the international community.¹²³

- Following through on the WHS commitment to **directly send 25 percent of funding to local health workers** is a necessity. For example, in Somalia, this means directly supporting decentralized administrations; in Syria, it means working with new health governates.¹²⁴ In both Somalia and Syria, it means looking more critically at the impact of counterterrorist legislation on Islamic organizations, such as charities, that have a role to play in UHC efforts for populations inaccessible to outsiders.
- Rather than seeing only the negative impacts of 'health worker flight' (losing personnel and expertise), **those who stay should be empowered to take on new responsibilities**. Community health workers have a key role to play in UHC and can also help with the burden of mental health by carrying out psychological first aid.
- **For displaced populations, 'individualized healthcare provision' is needed**. Each journey of forced displacement is unique, as are the health needs of displaced individuals. Individuals could be issued with an electronic 'health passport' that they can use to gain access to services wherever they are, with service providers compensated through a centralized payment mechanism, similar to cash transfers already in use. This would allow continuity of care for refugees and internally displaced persons, regardless of where they are forced to go. Moving toward UHC for refugee populations would be facilitated by **integrating refugee and host community health services**. Parallel systems are unsustainable and create tensions. To increase access to healthcare, issuing **work permits for refugee health workers**, as Turkey does, would be mutually beneficial. Integration of patients and health workers into host health systems is a pragmatic solution to meet needs and act as a bridge for wider integration.

SECTION 5. CONCLUSION: A GLOBAL COMPACT ON HEALTHCARE IN CONFLICT SETTINGS

Healthcare provision in conflict settings is characterized by disruption, fragmentation and complexity. The daunting list of challenges described in this report highlights how the achievement of UHC in conflict settings must be conceived in a new and different way. This requires a boldness of vision and an agreement that the promotion of health, like peace, is a global public good. We do have the knowledge, capacities and resources to reduce the harmful impacts of conflict on health. Protecting, preserving and promoting health in conflict settings is essential for building and sustaining societal peace.

The recommendations outlined in this report – eight foundational principles, five core strategies and two priority actions – are interconnected, with progress required in all areas to make a meaningful difference. They constitute a new **global compact for healthcare in conflict settings**, with the aim of advancing UHC among conflict-affected populations worldwide.

Such a global compact requires the leadership of political leaders and global policymakers, unified by a shared purpose, and the construction of partnerships to deliver on specific results in specific contexts. In turn, it needs structures and systems to be redesigned. The targets and indicators already established under the SDGs provide the metrics for monitoring progress over the period to 2030.

However, to truly 'leave no one behind' and achieve UHC for conflict-affected populations, global health and humanitarian actors, as well as their donors, must transform current ways of understanding and responding to healthcare needs in conflict. A new way of seeing is also required, one where people – not money and politics – are at the forefront of vision. The needs, capabilities and preferences of communities caught up in conflict, including a whole range of unrecognized health providers, must be the starting point for any endeavors to improve their health.

APPENDIX

Definitions of key terms*

Armed conflict: a contested incompatibility that concerns government and/or territory where there is use of armed force between two parties, of which at least one is the government of a state (eg Ukraine and Russia).

Non-state conflict: the use of armed force between two organised armed groups, neither of which is the government of a state (eg in parts of Syria).

One-sided violence: the use of armed force by the government of a state or by a formally organized group against civilians (eg Myanmar and the Rohingya).

Non-state armed groups (NSAGs): groups that are wholly or partly independent of state governments and which threaten or use violence to achieve their goals.

Protracted crises: environments in which a significant proportion of the population is acutely vulnerable to death, disease and disruption of livelihoods over a prolonged period of time (eg Somalia).

International humanitarian law**

- International humanitarian law is the law that regulates the conduct of war (*jus in bello*)
- It is that branch of international law which seeks to limit the effects of armed conflict by protecting persons who are not participating in hostilities, and by restricting and regulating the means and methods of warfare available to combatants
- It includes the Geneva Conventions and the Hague Conventions, as well as subsequent treaties, case law and customary international law
- It is designed to balance humanitarian concerns and military necessity, and subjects warfare to the rule of law by limiting its destructive effect and mitigating human suffering

* Uppsala University, Sweden (2018). Definitions – Department of Peace and Conflict Research. [online] Available at: www.pcr.uu.se/research/ucdp/definitions [Accessed 9 Jun. 2018].

** International Committee of the Red Cross (ICRC). International law on the conduct of hostilities: overview. ICRC; 2010. Available at: www.icrc.org/eng/war-and-law/conduchostilities/overview-conduct-of-hostilities.htm [Accessed 12 September 2018].

- Key treaties include the 1907 Hague Regulations, four Geneva Conventions and their Additional Protocols
- Key principles include distinguishing between civilian and military targets, proportionality in the use of force
- Non-state armed groups are also bound by these laws of war.

Typology of local humanitarian responders*

	Typology	Definition
Local humanitarian responders	1 National and sub-national state actors	State authorities of the affected aid recipient country engaged in relief, whether at local or national level.
	National authorities in aid recipient countries	National government agencies, authorities, line ministries and state-owned institutions in recipient countries, eg National Disaster Management agencies. This category can also include federal or regional government authorities in countries where they exist.
		Sub-national government entities in aid recipient countries exercising some degree of devolved authority over a specifically defined geographic constituency, eg local/municipal authorities.
	National and sub-national civil society actors	CSO engaged in relief headquartered and operating in their own aid recipient country and with autonomous governance, financial and operational decision-making.
	2 National Societies of the International Red Cross and Red Crescent Movement	National Societies that are based in and operating within their own aid recipient countries. National Societies are independent auxiliaries of national governments in the humanitarian field.
3 National NGOs/CSOs	National NGOs/CSOs operating in the aid recipient country in which they are headquartered, working in multiple subnational regions, and not affiliated to an international NGO. This category can also include national faith-based organizations.	
4 Sub-national/local NGOs/CSOs	National NGOs/CSOs operating in a specific, geographically defined, subnational area of an aid recipient country, without affiliation to an international NGO/CSO. This category can also include community-based organizations and faith-based organizations.	
5 Local and national private sector organizations	Organizations run by private individuals or groups as a means of enterprise for profit, that are based in and operating within their own aid recipient countries and not affiliated to an international private sector organization.	

* Organisation for Economic Co-operation and Development (OECD). Localising the response. OECD; 2017. Available at: www.oecd.org/development/humanitarian-donors/docs/Localisingtheresponse.pdf [Accessed 12 September 2018].

Human rights law*

- The modern incarnation of human rights was born in the aftermath of World War II. In 1945, the Charter of the United Nations set out a vision “to save succeeding generations from the scourge of war ... and to reaffirm faith in fundamental human rights”.
- This Charter was followed closely by the Universal Declaration of Human Rights in 1948, which is the foundation of international human rights law.
- International human rights law lays down obligations which states are bound to respect.
- By becoming parties to international treaties, states assume obligations and duties under international law to respect, protect and fulfill human rights.
- The obligation to respect means that states must refrain from interfering with or curtailing the enjoyment of human rights.
- The obligation to protect requires states to protect individuals and groups against human rights abuses.
- The obligation to fulfill means that states must take positive action to facilitate the enjoyment of basic human rights.

Human rights law places emphasis on the principle of non-discrimination.**

Of particular relevance for this paper is the **right to health**, defined in Article 25 of the Universal Declaration of Human Rights:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.***

This right has been further developed in Article 12 of the International Covenant on Economic, Social and Cultural Rights, which has been in force since 1976 (see box below).

* Footer K and Rubenstein L. A human rights approach to health care in conflict. International Review of the Red Cross, 31 March 2013. Available at: www.icrc.org/en/international-review/article/human-rights-approach-health-careconflict [Accessed 30 July 2018].

** See General Comment No. 18 of the Human Rights Committee in UN document. HRI/GEN/1/Rev.5, Compilation of General Comments and General Recommendations adopted by Human Rights Treaty Bodies, pp. 134-137.

*** United Nations (UN). Universal Declaration of Human Rights. UN; 2018. Available at: www.un.org/en/universal-declaration-human-rights [Accessed 12 September 2018].

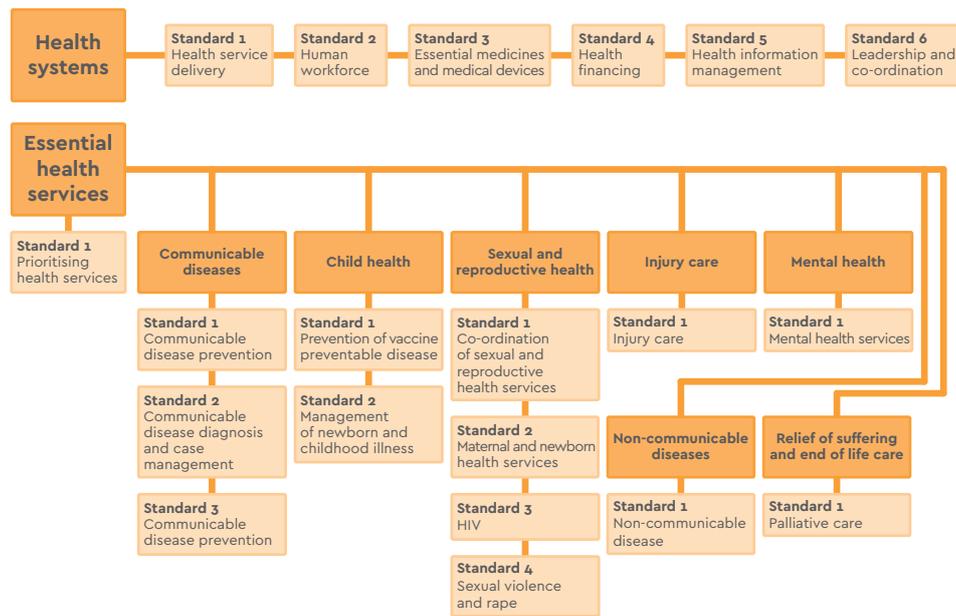
Article 12, International Covenant on Economic, Social and Cultural Rights

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - i. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - ii. The improvement of all aspects of environmental and industrial hygiene;
 - iii. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - iv. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The right to health contains both freedoms and entitlements, and like all human rights, imposes three layers of obligations on states: the responsibility to respect – to refrain from directly interfering with a right; to protect – to prevent third-party interference with the enjoyment of a right; and to fulfil – to take steps to ensure the fullest possible realisation of a right.*

* Office of the United Nations High Commissioner for Human Rights (OHCHR). International Covenant on Economic, Social and Cultural Rights. OHCHR; 2018. Available at: www.ohchr.org/en/professionalinterest/pages/cescr.aspx [Accessed 12 September 2018].

Sphere standards for health action*



Source: Draft chapter on health from www.sphereproject.org/sphere/en/handbook/revision-sphere-handbook/draft-ready-for-feedback/health-action

* The Sphere Project. Draft 2 of the Sphere Handbook now ready for review and feedback. The Sphere Project, 2018. Available at: www.sphereproject.org/handbook/revision-sphere-handbook/draft-ready-for-feedback [Accessed 12 September 2018].

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Any errors or omissions remain the responsibility of the authors.

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