Securing the health and well-being of crisis-affected communities is the primary goal of humanitarian action. It is a goal, however, that cannot be achieved by the health sector alone. In fact, every sector has a role to play in contributing to health. The success of collective, intersectoral, humanitarian action can therefore be best demonstrated through the measurement of health outcomes.

Local health staff and community health workers are among the heroes of humanitarian action, and they must be given access to the training, resources and support they require to carry out their work safely and effectively. This is increasingly important in light of the growing scale of humanitarian risks and needs. Governments and the international community have pressing responsibilities to build these capacities to manage risks and respond to emergencies at local and national levels.

But the health sector is increasingly under attack – especially in conflict zones where the greatest humanitarian and health needs are faced. Never before have health workers, patients, and health facilities been subject to such targeted violence and indiscriminate attacks. The very right to health and sanctity of health care are under serious threat, particularly in today’s war zones.

WHO’s Key Messages:

1. The health and well-being of affected populations is the ultimate goal of humanitarian action
2. The risks to health posed by humanitarian emergencies are at all-time highs – and worsening
3. Protracted conflict situations are among the greatest threats to health and health workers globally
4. Crises caused by disease outbreaks require the health and humanitarian communities to work together
5. Managing risk is essential: Preparedness pays, at all levels – country, regional, and global.

1. The health and well-being of affected populations is the ultimate goal of humanitarian action

   • Regardless of the type of event – acute onset natural disaster, conflict or disease outbreak – there are always risks to health.

   • United Nations surveys reveal that health is consistently among the top three priorities for crisis-affected communities. One of the most comprehensive needs assessments conducted in Syria, for example, found that “key informants across all governorates consistently ranked health needs as the first priority, followed by food security and WASH needs”, as can be seen in Figure 1. A similar assessment in the Central African Republic found that “overall, Health is clearly the top priority need, with 70% of key informants placing it amongst their top three priorities. Protection and Food follow”. This demonstrates that access to health care is a major priority in humanitarian settings. The UN global survey for the post-2015 agenda also rated healthcare among the top three priorities.

Securing health requires contributions from all sectors, not just health. By catering to basic needs (such as food, water, sanitation, housing, and health services), protecting vulnerable people from abuse and harm, reducing injury, preventing disability, minimising physical illness, alleviating mental health issues and providing the core services that enable the health sector to operate in a crisis (e.g. logistics, telecommunications), all sectors are interconnected and contribute to saving lives and improving the health and well-being of individuals and communities. Figure 2 shows the Inter Agency Standing Committee (IASC) Cluster Approach and the link between different sectors and health outcomes. The detailed roles of key humanitarian sectors in contributing to the health and well-being of communities are outlined in Annex 1.
Health outcomes and health indicators are central to measuring the effectiveness of collective humanitarian action. Given the role that all sectors have to play in securing the health and well-being of crisis-affected communities, health outcomes are an effective measure of intersectoral collaboration.

2. The risks to health posed by humanitarian emergencies are at all-time highs – and worsening

- Past decades have witnessed major events that pose huge risks to health, including large-scale outbreaks (e.g. SARS, Ebola in West Africa), sudden onset natural disasters (e.g. Haiti earthquake, Cyclone Nargis in Myanmar) and conflicts (e.g. Syria, Yemen).
- The number of people in need of humanitarian assistance has never been higher. In 2014, 58 million people were displaced, with an average duration of displacement of 17 years. There are currently 78.9 million people in need.
- The drivers of risk are worsening – more events will happen – and needs will continue to increase. Some of the drivers of humanitarian hazards include climate change, population movement, state fragility, conflict, urbanization and environmental degradation.
- Humanitarian work occurs more and more in protracted conflict situations, which have a disproportionate and long-term impact on the health sector.
- In addition, the Ebola Virus Disease outbreak in West Africa has shown that disease outbreaks can become humanitarian crises in their own right with devastating consequences beyond their impact on health. The response to health crises is therefore a shared responsibility among many actors.

3. Protracted conflict situations are among the greatest threats to health and health workers globally

- Vulnerable populations are at especially high risk in protracted conflict settings: 60% of preventable maternal deaths, 53% of under-five deaths, and 45% of neo-natal deaths take place in settings of conflict, displacement, and natural disasters. This is also where the humanitarian and development worlds collide: of the 10 countries in the world with the highest child mortality, WHO currently has emergency operations in seven (Sierra Leone, Somalia, DR Congo, CAR, Mali, Nigeria, Niger); and, of the 10 countries with the highest maternal mortality ratio, WHO has emergency operations in six (Somalia, Sierra Leone, CAR, Liberia, Cameroon, Nigeria).
- Attacks against patients, health workers and health facilities are among the most disturbing features of today's conflicts. They deny the right to health and run counter to the principle of the sanctity of health care. Protecting health in conflict requires interventions that go beyond the humanitarian sector. Ultimately, political, military and civic leaders have the responsibility for protecting health in these settings. They must be held accountable.
- The health sector suffers disproportionately in conflict situations compared to other areas of life-saving humanitarian action. Health status can deteriorate over protracted periods of conflict due to disruptions in health services and routine health programmes such as vaccination or vector control. Furthermore, damaged or destroyed health infrastructure can take a long time to rebuild, and it can take years to replace the skilled health workforce who have been injured, killed, or who have fled. This can have disastrous consequences for health status and the social fabric of communities. Long-term presence and combined adapted developmental and humanitarian approaches are therefore needed.
- Fragile states and conflict settings are fertile breeding grounds for disease outbreaks. Conflict enhances the risk factors for disease emergence and transmission (e.g. polio in Syria, cholera in Haiti, Ebola in West Africa). Strengthening disease surveillance systems, engaging with communities, and ensuring minimum primary health and hospital services in such settings are critical to preventing and controlling disease outbreaks.
- Health interventions can be used to increase access, support the opening of humanitarian corridors and negotiations for humanitarian pauses, or, in other words, to...
create a bridge allowing for the expansion of other services. For example, polio and measles vaccination campaigns have furthered humanitarian access in recent conflict settings including Afghanistan, Nigeria, Sudan, and Syria.

- **Functioning health services are essential to peace-building.** A synopsis study carried out by WHO, and confirmed by independent research, found the provision of health services to be a key peace-building factor for the conflicts in Central America in the 1980s and in Angola, Bosnia and Herzegovina, Croatia, and Haiti in the 1990s. In post-conflict settings, leaders often give priority to the restoration of social services as peace dividends. *Figure 3* shows that ensuring access to comprehensive health services in conflict situations helps with peace-building, while failure to do so can further lead to further deterioration.

- **The Millennium Development Goals and Sustainable Development Goals will not be met** unless we tackle the challenges of protecting health and delivering health assistance during protracted conflict.

*Figure 3: Positive or negative outcomes of healthcare delivery success/failure in conflict situation.*

4. **Crisis caused by disease outbreaks require the health and humanitarian communities to work together**

- The Ebola crisis has made clear to the world that neither individual countries nor the international community are prepared for a major epidemic or pandemic. The Ebola crisis in West Africa was a “defining moment for the health of the global community” and has shown how the health and humanitarian communities failed to support each other. It also showed that a strong WHO response capacity is required. WHO is undergoing substantial reforms to ensure the Organization’s emergency capacities are fit-for-purpose, but appropriate coordination and support mechanisms need to be established throughout the health and humanitarian systems. WHO cannot manage such crises alone.

- Such crises call on strong action by the wider humanitarian systems and communities, as consequences go far beyond the health sector. The response to health crises is a shared responsibility among many actors.

5. **Managing risk is essential: preparedness pays at all levels – country, regional, global**

- The Sendai Framework for Action for Disaster Risk Reduction (DRR) puts health at the centre of global policy and action to reduce disaster risks until 2030. Adopted by 187 Member States, the Sendai framework recognises that health is a key driver of sustainable community and national development. A holistic approach to health, which

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focuses on the management of risk factors as well as health effects, is required. By managing risks to health, people are able to sustain effective livelihoods and their contributions to community development. Countries and communities have shown that health can bring together sectors and agencies to focus on the common interest of ensuring people’s wellbeing. Multi-sectoral disaster risk management protects health, health infrastructure and services, including hard-earned gains for health development, MDGs 4, 5 and 6, and future development goals.

- To protect health, greater alignment is needed among various international treaties and agendas, such as health security (International Health Regulations or IHR(2005)), disaster risk reduction (Sendai), humanitarian reform (IASC Transformative Agenda), sustainable development (SDGs) and the animal-human interface (One Health – recalling that most new and emerging diseases are zoonoses (i.e. derive from animals)).

Annex 1 - Securing health and wellbeing requires contributions from all sectors

The role of key sectors in contributing to the health and well-being of communities are outlined below:

1. Health services: establishing standards and ensuring access to a minimum package of health interventions and coverage through partnerships. First and foremost, lives can be saved by providing health service delivery in the form of primary health care, referral and hospital care, to manage injury, communicable and non-communicable disease, improve children’s health, address sexual and reproductive health, and mental health. This is supported by additional critical health system building blocks, namely: qualified human resources; quality medicines and medical supplies; health financing; health information (especially for the detection of disease outbreaks); and leadership and coordination.

2. In large-scale emergencies, numerous actors participate in the health response, each with their comparative advantage. These range from communities, civil society, governments, NGOs (international and national), UN, international technical institutions, as well as the civilian and military assets of foreign governments. All health partners come together under the Health Cluster, set up to support national efforts. One major aspect of bolstering health service delivery when national capacities are overwhelmed is the deployment of WHO-coordinated FMTs. This allows the international community to augment the number of predictable, pre-cleared and self-sufficient teams that can be deployed to provide emergency medical services to affected populations. This coordinated support was first used at scale in the Philippines, and the system was successfully used for emergency responses to Ebola, and in Nepal and Vanuatu. All of these responses have relied heavily on FMTs. This has ensured quality and relevance of care while avoiding duplication and gaps. Such coordination mechanisms enforce strong regional cooperation and offer strong quality assurance to the overall humanitarian response.

3. Health, Water and Sanitation: Provision of safe and sufficient water, sanitation and hygiene (WASH) to households is fundamental for protecting public health and preventing disease outbreaks (including diarrhoeal diseases), and results in a number of other economic and social benefits. Safe water and sanitation is a universal human right recognized by the UN General Assembly and supported by legal tools and State obligations. WASH is an essential intervention in all emergencies and a critical component of preparedness, response and recovery efforts. In addition, WASH in health care facilities is essential for safe health care provision, infection prevention and control. According to a 2015 WHO/UNICEF review, 38% of facilities in low- and middle-income countries have no water at all. This was a critical factor in the amplification of Ebola Virus Disease in West Africa in 2014.

4. Health, Food Security and Nutrition: Food insecurity (and consequent undernutrition and malnutrition) severely impacts health status. Undernutrition and acute malnutrition increase the risk of disease, the severity of disease and, therefore, increase the chance of death; especially among children. Targeted health interventions are a top priority in saving lives when there are high levels of food insecurity and acute malnutrition in the community. This includes measles vaccination in

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children, and medical care for malnourished children, pregnant women, or those with chronic diseases; especially the elderly.

5. **Health and Education:** The implementation of virtually all interventions requires community education, uptake and behavioural change. The role of community education and mobilisation is one of the most important factors for disease containment, as was seen with the Ebola Virus Disease in West Africa. The education sector cooperated with the health sector in providing and delivering messages to care providers as well as raising awareness on the importance of continued education; not only for immediate access to treatment of Ebola, but also to alleviate the psychosocial effects of the disease among school children. In addition, the education system provides access to children for various interventions such as vaccination, food parcel distribution and health promotion for hygienic behaviours, early healthcare seeking, prevention of HIV/AIDS and other communicable diseases, as well as mine awareness.

6. **Health and Logistics:** In all crises, the procurement, import, safe storage, technical monitoring and distribution of medicines and healthcare materials to relevant facilities are critical for saving lives, and the logistical capacities of the whole humanitarian system contribute to the response (a recent World Bank study positions medicines as one of the five key items in humanitarian trade). This can be very complex as it can involve trade legislations and restrictions on imports. There may also be a need for specialised warehousing with a dedicated cold chain (to keep certain vaccines or medicines at a lower temperature). Specific procurements may be needed to cater for the differing health status of different populations. And, for outbreaks or releases of chemical or other hazards, special personal protective equipment (PPE) may be required, and medical evacuations assured.

7. **Health and Protection:** Health is a fundamental Human Right, with a protection obligation by Member States and, by extension, by mandated protection agencies. The interplay between health and protection is multi-facetted. International Humanitarian Law requires specific protection for health workers, facilities and transport, but recent conflicts show flagrant violations of the sanctity of healthcare, as documented by ICRC. If healthcare is not protected, society cannot function. Areas where the health and protection sectors intersect include efforts to ensure the safety, dignity and equity of access to health care; protect the unique needs of vulnerable and stigmatized patients and groups (like HIV/AIDS-affected populations); provide an appropriate health response to survivors of sexual and gender based violence and torture; ensure the confidentiality of health information; and address the needs of separated children seeking and receiving care in hospitals. Mental health and psychosocial interventions protect the dignity of survivors and enhance the overall response, including psychological and psychiatric interventions, and the social work done to support mental health and psychosocial well-being.

8. **Health and Recovery:** A focus on early recovery is a key factor in improving health outcomes. This takes the form of rehabilitating health facilities and information systems, de-mining and improving environmental health infrastructure, along with psychological, medical, and social recovery for the worst affected patients (e.g. SGBV patients, newly disabled patients). In addition, long-term progress in mental health care is possible when strategic efforts are made during crisis responses to convert short-term interest into momentum for mental health care reform.

**Annex 2 - References**

These are the reference documents referred to in the footnotes. They are all available to download at the following link: https://www.dropbox.com/sh/ej2whsm9ekd1kdo/AABykulluFeZ7_ADwzu2hTFVa?dl=0

We strongly encourage the WHS Secretariat to read them as they substantiate the positions and points highlighted in this paper and are all relevant contributions to the humanitarian debate in their own right.

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