Introduction

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Two hundred seventy-four million people – one in thirty people on the planet – are in humanitarian need as of September 2022.[1] More than one hundred million of these individuals are displaced, usually as a result of crisis: conflict, political upheaval, economic meltdown, or climate shocks.[2] In a humanitarian crisis, health is the most urgent and paramount need. But today the system for preventing and addressing humanitarian crisis is failing, and with it, the health needs of millions of vulnerable people are under threat. From treating childhood acute malnutrition to delivering COVID-19 vaccines to ensuring access to sexual, reproductive, maternal, and newborn health, health care in humanitarian contexts requires a dramatic rethink amid growing challenges to access and service delivery.

Health care in conflict, crisis, and humanitarian settings remains an uphill battle. The essays in this issue of *Dædalus* highlight how modern conflicts and, in particular, civil wars impact humanitarian health, analyzing the unique challenges humanitarian health responders face working in conflict zones and with nonstate actors. Taken together, these essays show that health care for civilians in conflict settings around the world is suffering not just from operational or technical challenges, but from a broader "system failure" globally. With more than fifty active conflicts in the world and a record one hundred million people forced to flee their homes because of conflict and disaster, the system for preventing and addressing humanitarian crisis, built on the twin pillars of, first, state sovereignty and responsibility, and second, international law and rights, is failing. The reasons for that failure speak to the very structure of the international system, and that means things will get worse unless action is taken.

First, states are increasingly failing to fulfill their basic responsibilities toward their citizens. In civil wars, which have come to represent the face of modern conflict, states are attacking their own populations and refusing to allow aid to communities they view as the enemy. As discussed by Anastasia Shesterinina in her essay, the majority of major conflicts today are intrastate conflicts, with Ukraine being the notable exception.[3] This means the provision of health care, operated in most countries by public health systems, is withdrawn for political purposes by the very governments tasked with the responsibility of providing it in the first place. As Ann-Kristin Sjöberg and Mehmet Balci explain in their essay, this of-

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ten means nonstate actors are responsible for the provision of health care in large swaths of conflict-affected countries.[4]

Second, diplomacy has been in retreat for the past ten years, resulting in more armed conflicts that last longer and are never fully resolved. This in turn puts more civilians at risk, increases their health needs, and reduces the capacity of the health systems in these countries to respond to those needs.

Third, respect for international law has been abandoned, putting health workers and civilian infrastructure in the crosshairs of armed actors. Despite well-codified laws protecting civilian infrastructure like hospitals and health clinics from attack, health care has increasingly become a target in conflict, often part of a deliberate military strategy and not simply as collateral damage, as highlighted in the essay by Simon Bagshaw and Emily K . M. Scott.[5] The rules and institutions meant to hold violators accountable have not been successful at stopping this onslaught of impunity.

Finally, the humanitarian system is failing to fill the yawning gap between needs and services. Though aid budgets have doubled since the global financial crisis of 2008, the needs have tripled. UN appeals are less than half-funded and humanitarian responses to many of the worst crises around the world are less than 20 percent funded.[6] This shortfall has particularly urgent effects for health needs in conflict settings, not just acute needs like life-saving surgeries, but also noncommunicable diseases, mental health services, maternal health, and community health and hygiene awareness programs, which depend on reliable, robust funding to ensure both the reach and scale required for impact.

The system failure playing out in conflict zones around the world highlights the challenge of delivering health services to people in crisis. Four key areas of need stand out.

Childhood Acute Malnutrition

Each year, more than fifty million children suffer from acute malnutrition, otherwise known as wasting, a scale larger than any single humanitarian crisis on the planet. Malnutrition is an underlying cause in 50 percent of under-five mortality, and in conflict zones where food systems are disrupted, access to potable water is reduced and famines are common, it can kill more children than bombs and guns.[7] The number of children experiencing acute malnutrition is expected to grow by millions more in the immediate term. We know that treatment for wasting is highly effective, however 80 percent of malnourished children currently lack access, and the concern is that rising global food prices will not only increase the prevalence of acute malnutrition, but will also increase the cost of treatment with ready-to-use therapeutic food.[8]

The war in Ukraine has caused additional strains on global food security and, in turn, acute malnutrition among children. Nowhere is the effect being felt more

urgently than in the East African countries of Somalia, Kenya, and Ethiopia, which rely on Russia and Ukraine for nearly 90 percent of their wheat imports.[9] In Somalia, an International Rescue Committee (IRC) clinic has experienced an 818-percent increase in children with wasting from February to June 2022.[10] We need to address the wasting crisis through a public health approach similar to the one that has brought the HIV epidemic to heel. Such an approach would explicitly prioritize scale and coverage by simplifying and decentralizing core interventions. While it would value prevention, it would not shy away from delivering highly effective treatment to those who need it. And while it would continue to require solid evidence and adhere to the principle of "do no harm," it would also adopt a bias to action that reflects the absolute urgency of delivering a simple, proven cure to children who may die without it.

At present, treatment is delivered through a bifurcated system that treats severe and moderate forms with different products, through different supply chains, at different delivery points. In addition, children are admitted and dosed according to complex weight-based calculations, primarily through formal health facilities. This approach is difficult to coordinate and impossible to scale.

A growing body of evidence led by IRC's research shows that simplified approaches – a combined protocol for diagnosing and treating both moderate and severe acute malnutrition, and family diagnosis using a simple, color-coded armband and treatment delivery by community health workers – are equally effective, more cost-effective, and easier to scale than the current, more complex model.[11] To scale this feasible, lifesaving intervention, we need to: 1) adopt these simplified approaches as best practices for broad delivery; 2) support nationally led efforts to treat wasting; 3) hold ourselves accountable for progress; and 4) increase the funding needed to make it happen. UNICEF, the lead UN agency on wasting, has a vital role to play in leading these practice changes.

Last Mile Delivery of Vaccines

The COVID-19 pandemic has highlighted the importance of timely, efficient, and widespread distribution of vaccines, not only to protect individuals but entire communities from viruses. But in the fragile and conflict-affected settings where IRC works, the World Health Organization (WHO) goal of 70 percent vaccine coverage remains far out of reach, with deadly consequences. A recent study in *The Lancet* estimates that 45 percent of COVID-19 related deaths could have been averted in low-income countries had the 20 percent vaccination coverage target originally set by the global vaccine alliance COVAX been met in each country.[12] Despite a supply of doses that has begun to outpace government delivery capacity, frontline responders, including both local civil society and international operational NGOs, remain largely sidelined by distribution channels.

There is significant potential to extend governments' funding and resources, addressing access barriers in the service of universal health care goals. At the White House's Second Global COVID-19 Summit in May 2022, the IRC committed to expanding the capacity of governments around the world to deliver vaccines in humanitarian settings and estimated that with $160 million and sufficient doses, we could reach nearly all eligible people in thirty fragile and conflict-affected countries where the IRC works.[13] But this effort is only possible if donors direct resources to frontline NGOs and civil society, not just to governments and international organizations.

Since the start of the pandemic, we have seen a decline in routine immunization among children who have not received any vaccines: "Global vaccination continues to decline in 2021 with 25 million children missing out on lifesaving vaccines, 2 million more than in 2020, and 6 million more than in 2019."[14] These so-called zero-dose children are more vulnerable to deadly and debilitating infectious diseases, and account for nearly half of all vaccine-preventable deaths. To reverse this backslide and improve immunization coverage, Gavi, the Vaccine Alliance recently launched the Zero-Dose Immunization Program, a $100-million project to vaccinate zero-dose children living in displaced communities and fragile and conflict-affected settings across eleven countries.[15] The IRC is leading a consortium with Gavi in the Horn of Africa and working with partners to extend the reach of health systems into cross-border and hard-to-reach communities, as well as areas controlled by nonstate actors. This innovative, NGO- and community-led approach, a first for Gavi, is designed to complement government services and overcome the barriers of the traditional state-led system, which too often lets children in fragile and conflict-affected communities fall through the cracks.

Sexual, Reproductive, Maternal, and Newborn Health

In nearly every crisis, the most vulnerable suffer the worst consequences. In humanitarian settings, that population often includes women and young children, whose health needs are no exception to the rule.

Ensuring access to adequate maternal and newborn health care is one critical yet often overlooked area of need. In many of the Sub-Saharan African countries the IRC operates in, one in ten children do not live to see their fifth birthday. At the same time, in many of the contexts where the IRC works, women and newborns are dying at increasingly high rates. According to the most recent UN estimates, 55 percent of global maternal mortality, 38 percent of neonatal mortality, and 38 percent of stillbirths occur in the thirty countries with a 2022 UN Humanitarian response plan.[16] Looking more closely at just four crisis-affected countries – Democratic Republic of the Congo, Nigeria, Somalia, and South Sudan – there are 850,000 maternal, neonatal, and fetal deaths occurring each year, the vast majority of which are preventable.

According to the WHO, scaling up known interventions, including pregnancy care, care during labor, and care for small and sick newborns, has the potential to save three million lives every year.[17] IRC is identifying and testing approaches to bring maternal and newborn health care closer to women and babies in conflict-affected communities who are unable to safely reach a health facility.

Closely linked to maternal and newborn health is the urgent need to support the sexual and reproductive health needs of women and girls in humanitarian settings, who often lack access to life-saving care, especially contraception and abortion. Approximately one-third of maternal deaths annually could be prevented by meeting the need for contraception, and nearly all deaths related to unsafe abortion can be prevented by providing access to safe abortion care.[18] Globally, unsafe abortions cause roughly 10 percent of maternal deaths and 596 severe complications per one hundred thousand live births, and fatal complications are likely to be even greater in humanitarian settings and fragile states.[19] The cycle of unintended pregnancy and unsafe abortion is both a cause and result of gender inequality and becomes more severe during crises, leading to excess morbidity and mortality.

The IRC's flagship contraception and abortion care program remains one of the largest privately funded programs the IRC has ever operated, delivering contraception to nearly three hundred thousand women and girls, post-abortion care to over twenty thousand women and girls, and safe abortion care to over four hundred women and girls since its implementation in 2011.[20] In the next five years, the IRC will build on this momentum by designing and implementing innovative approaches, such as self-care, for increasing access to contraception and abortion care in acute and protracted emergencies and fragile settings.

Protecting Health in Conflict Settings

In all three of these areas, more work needs to be done, more services need to be provided, more action must be taken. But the failure of the humanitarian system to make up for the broader failures of the international system on health is not just about a lack of resources. Humanitarians themselves are increasingly being prevented from delivering lifesaving aid to communities in need.

According to ACAPS (Assessment Capabilities Project), nearly two hundred million people in humanitarian need, 70 percent of all people in need, are living in countries with very high or extreme humanitarian access constraints.[21] These access constraints – which range from bureaucratic red tape to armed checkpoints to direct attacks on aid workers – prevent people from being treated by doctors, receiving enough food to protect against malnutrition, and accessing the medicines and insulin required for their health needs.

This is not the collateral damage of conflict. It is not the result of a stray bullet or a military mistake. It is often a deliberate part of the war strategy – one that

directly violates the laws of war. And those who complain, expose, or campaign, whether they be UN officials or NGOs or political opposition, are often targeted for retribution. This is part of the broader "age of impunity" in which we now live.[22] Crimes without punishment. Actions without consequences.

These dangers are most pronounced in the health sector. The Safeguarding Health in Conflict Coalition's most recent annual report documented attacks on over fourteen hundred health workers and four hundred fifty health facilities in 2021.[23] The WHO itself has acknowledged over one hundred attacks on health care workers and facilities in Ukraine alone in the first one hundred days of the war.[24] This is a violation of standards rooted in the Geneva Conventions and international human rights law that severely compromises the safety and effectiveness of humanitarian actors. Moreover, if these attacks are not met with swift accountability, they reinforce a culture of impunity that can only sow chaos and further empower bad actors. At IRC, we aim to work with others to bring to bear all the international system's measures of accountability and censure to better protect health services in conflict settings.

Revitalizing health care for the quarter of a billion people in humanitarian need requires rethinking our approach to how we deliver these services amid conflict and humanitarian access restrictions, vaccine inequity, and unique challenges facing the most vulnerable populations: women and children.

These challenges are obviously interrelated, and they are not exclusive, but they have a common element: the notions of "system strengthening" that have led to such progress in stable settings over the last twenty or thirty years need to be adapted, radically, for places where states, populations, and rebel groups are engaged in conflict. The whole notion of what constitutes "the system" is different: more informal, more contested, more dangerous, less singular, less stable, less planned.

In conflict settings, the system depends on norms and understandings more than rules and laws. It requires countervailing power to the tendencies toward impunity. Above all, it needs to be bottom-up and community-led, rather than top-down, prizing flexibility to deliver sustainability. With respect to these four challenges and many others, the experience of IRC as a solutions-focused NGO shows that community leadership is the key and can be meaningful when it marries local expertise with external support.

While operational and technical solutions by health experts and frontline humanitarian responders will be critical to addressing these gaps, these fixes can only staunch the bleeding. They cannot stop the killing. Addressing the drivers of health needs among displaced and vulnerable communities requires grappling with the political and structural elements of system failure. From raising the cost of the veto in order to break the gridlock in the UN Security Council to taking the

realpolitik out of humanitarian access by establishing an independent monitor that can call out the strangulation and weaponization of aid, the international system requires a system reboot to function properly.[25]

These fixes are the realm of diplomats and political leaders, not doctors and humanitarians. But without action, the demand for health provision in humanitarian settings will continue to outgrow the ability of humanitarians to supply it.

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