



## Doctors in War Zones: International Policy and Healthcare during Armed Conflict

JUNE 2018

This discussion note was drafted by Alice Debarre, Policy Analyst on Humanitarian Affairs at the International Peace Institute. It is intended to lay out some of the key issues and to provoke thoughts and discussions in anticipation of and during IPI's thematic workshop, "Doctors in War Zones: International Policy and Healthcare during Armed Conflict," on June 8, 2018. It does not necessarily represent the views of the International Peace Institute. IPI welcomes consideration of a wide range of perspectives in the pursuit of a well-informed debate on critical policies and issues in international affairs.

Contemporary armed conflicts are often described as **protracted and complex**. Indeed, many have been ongoing for several years, and some experience occasional spikes in violence. In these contexts, armed actors often proliferate and hostilities are increasingly taking place in urban areas where their impact on vital infrastructure and communities is magnified. More and more people are on the move due to forced displacement, many of whom end up internally displaced, while others attempt to cross borders into neighboring countries and beyond. The impact this violence and instability has on the health of conflict-affected populations, both direct and indirect, is staggering, making the work of health actors all the more vital.

Conflict-affected settings present a **wide variety of challenges for health actors** who are working to ensure that affected populations receive adequate healthcare. These range from the constraints on the health system itself to challenges in the delivery of services. During times of armed conflict, the state is generally unable or unwilling to provide adequate health services to its population. As a result, the international community often steps in to fill the gap. Over the years, global health actors and humanitarian medical actors have developed numerous health policies, guidelines, frameworks, and structures, some of which were specifically designed to improve delivery in emergencies or humanitarian crises.

However, despite these advancements, **the international health response in conflict-affected settings still faces gaps and challenges**. Some policies and/or frameworks require rethinking or redesign, while others need to be better implemented. Health and humanitarian actors need to work together to ensure the international community better responds to the challenges of providing healthcare services to conflict-affected populations.

### Context-related challenges to the provision of healthcare services in conflict-affected settings

The specific challenges that health actors encounter will vary depending on the context, the type of conflict, the actors involved, and the health system already in place. Broadly, however, they can be categorized into health system constraints and healthcare delivery challenges.

Armed conflict has a profoundly **negative impact on health systems**. Health and health-supporting infrastructure (such as electricity, transportation, or water treatment) can be

intentionally or unintentionally damaged or destroyed and the capacity to provide all types of services is often dramatically reduced. The supply chains of health facilities can break down, creating shortages of medicine and medical supplies. Many health workers flee the conflict and violence, and in too many contexts, are specifically targeted by armed groups. Already weak data collection systems can collapse, making it difficult to know who needs to be reached and what services are required. Conflict often leads to a general decrease in government income, and resources tend to be directed away from health services toward other priorities such as security. In some contexts, private health providers step in, which can present opportunities but can also result in inadequate or unaffordable services, and can undermine the public health system. Finally, conflict increases the burden on the health system as people suffer from both its direct and indirect health consequences.

Armed conflict also **affects the delivery of services to those in need**, by increasing both the need for as well as the difficulties in accessing services. Most obviously, the general insecurity and instability, including widespread violations of international humanitarian law, create challenges for populations trying to access health services and for health actors trying to reach those populations. In many settings, armed conflict is accompanied by an increase in legal and administrative barriers to the delivery of healthcare services. Health facilities are also at risk of being taken over by military or security actors, undermining their impartial nature and increasing the risk of being targeted. Armed conflicts have also seen an increase in the politicization of health services, which creates particular risks for humanitarian health actors whose independence and impartiality are key to accessing populations in need.

Conflict-affected settings experience a deterioration in governance, specifically health governance, in addition to the often pre-existing governance challenges and dysfunctions. Non-state armed groups may control certain parts of the territory, and accessing populations under their control presents its own specific set of challenges. The movement of people displaced by violence makes them harder to reach, and internally displaced persons often live in conditions that further threaten their physical and mental health. Certain groups of people—women, children, persons with disabilities, or the elderly—are particularly vulnerable as armed conflict can exacerbate their health needs, vulnerabilities, and pre-existing health inequities. Finally, the urbanization of armed conflict also creates new challenges in reaching vulnerable people.

### Gaps and challenges in international health policy/governance

The international community has developed an extensive and complex health system with numerous policies, guidelines, frameworks, and structures that can assist conflict-affected states provide for the health needs of their populations. In the global health sphere, the **International Health Regulations** were adopted in 2005, and numerous policies and guidelines were developed on issues ranging from global health security, the health workforce, to more specific health interventions such as maternal and newborn health. The **WHO Health Emergencies Program** was created to support states and partners in dealing with health emergencies, including those that emerge in conflict environments.

On the humanitarian health side, a number of policies and guidelines have also been developed, often specifically for conflict-affected settings. The **Humanitarian Country Team (HCT)** was created in 2006 to coordinate humanitarian actors when a humanitarian crisis erupts or a situation of chronic vulnerability deteriorates. The HCT can manage a humanitarian response through sectoral clusters, one of which is the **Health Cluster**, intended to coordinate the activities of various health actors on the ground. In 2016, the IASC endorsed **the Level 3**

**Activation Procedures for Infectious Disease Events**, which can be triggered by armed conflict and result in the establishment of a HCT.

This system, however, still presents a number of gaps and challenges. Indeed, a certain number of gaps can be identified in international health policy in conflict-affected settings. The first is that **some types of health issues and needs have been under-prioritized**, with a tendency to focus on those issues that are most visible and therefore appear more urgent. For example, non-communicable diseases (NCDs) have typically not been considered a priority in humanitarian settings. Despite recent acknowledgement by the international community of the need to address these types of diseases, it has not yet translated into any significant action. Indeed, there remains a strong focus in international policy (and funding) on infectious diseases, and particularly those with epidemic or pandemic potential. Another identified gap is that **policies don't sufficiently provide or allow for context-specific responses** that take into account local burdens of disease and local capacities. For example, policies that assume some level of pre-existing health infrastructure or state governance may be challenging to implement in conflict-affected settings where these structures and systems are absent or lacking. A third gap in health policies developed for and implemented in conflict-affected contexts is their **lack of sustainability** and responsiveness to the longer-term. Given the aforementioned context-related challenges, putting in place health interventions that are sustainable requires thinking about creative ways to build resilience.

There are also systemic challenges to the implementation of adequate health interventions in conflict-affected settings. There is the obvious lack of **funding** for health interventions in conflict-affected settings, alongside challenges related to the nature of funding, which insufficiently allows for longer-term planning. There are also challenges surrounding the way that funding is allocated or earmarked, which may skew priorities and inadequately reflect a country's actual needs. Concerns have also been raised with regard to what has been termed the **"securitization of health,"** i.e. the framing in recent years of threats to health as security concerns. This focus on security has significantly influenced the global health agenda, resulting in a strong focus on infectious diseases of epidemic proportions. It has also led political considerations to come into play in action and cooperation on health issues. This may threaten the independence, neutrality, and impartiality of humanitarian health actors operating in conflict-affected settings.

Despite elaborate governance systems and structures put in place for and by public health and humanitarian actors in conflict settings, challenges remain in the implementation of international health policies and therefore in the provision of adequate health services. An important challenge is that of **coordination**, both between and among global health and humanitarian health actors.

Coordination helps avoid duplication and ensures that adequate, timely, and coherent services are provided to those in need. Recognition of the need for increased coordination and collaboration between the global health and humanitarian spheres was one of the outcomes of the IHR review following the 2014 Ebola outbreak. The creation of the WHO Health Emergencies program in 2016 helped link its work on outbreaks of contagious diseases and humanitarian emergencies, and, in its 13<sup>th</sup> Program of Work, the WHO identifies health emergencies as one of its priorities. The IASC Level 3 Activation Procedures for Infectious Disease Events (currently under revision) involves close collaboration between WHO and humanitarian actors to activate the cluster system. At the country-level, the epidemiological situation is discussed in Health Cluster meetings, and humanitarian actors often conduct epidemic surveillance, which feeds into

the structures states have put in place to implement the IHR. This, however, seems to be done on a somewhat ad hoc basis. There is a continued need to strengthen the interface between humanitarian and public health communities, both in terms of preventing and responding to outbreaks, as well as to ensure populations have access to adequate health services in the longer-term. Indeed, coordination also helps ensure continuity of care, and transitions to longer-term health endeavors.

Within the humanitarian health system, coordination mechanisms have been created and implemented, most notably the Humanitarian Country Team, working through the clusters. Unfortunately, the presence of clusters is increasingly being driven by the politics of states, and in countries where they are present, coordination and strategic prioritization of health interventions, although improved, is often still weak. There is a lack of incentives for organizations to participate in the clusters and implement the HCT's strategy set in the Humanitarian Response Plan. As a result, common planning remains challenging, and there continue to be issues of overlap and duplication. The cluster system is also often described as too slow and procedure-heavy, making it difficult to implement efficient and effective interventions. There are also challenges in health clusters' efforts to articulate humanitarian response with development strategies, ensuring that there is a predictable delivery of basic services once an acute emergency is resolved, or when it has transformed into a protracted situation.

Another important challenge is that of ensuring that international health actors are **effectively held accountable** for their health interventions in conflict-affected settings. Health actors today are accountable to their donors, to their own organizations, and to the populations they serve. There is, however, an imbalance: while there is a strong focus on accountability to donors, despite an apparent consensus on its importance and existing guidelines, there are insufficient mechanisms and processes being implemented to ensure that health actors are accountable to affected populations. As a result, there appears to be an overall lack of accountability. Indeed, accountability to donors has tended to focus on activities and outputs rather than on results and impact, though this may be slowly changing. It has also tended to be a process separate from that of ensuring accountability to affected populations, which may explain the apparent lack of implementation of such processes in conflict-affected settings. Finally, there is no system-wide accountability mechanism for international health actors. In the health clusters, efforts are made to monitor performance and provide guidance on accountability to affected populations, but it remains a coordination structure without broader powers to enforce recommendations or provide incentives to ensure better accountability.

The **INTERNATIONAL PEACE INSTITUTE** (IPI) is an independent, international not-for-profit think tank dedicated to managing risk and building resilience to promote peace, security, and sustainable development. To achieve its purpose, IPI employs a mix of policy research, strategic analysis, publishing, and convening. With staff from around the world and a broad range of academic fields, IPI has offices facing United Nations headquarters in New York and offices in Vienna and Manama.

## Guiding questions

### **Session 1: Challenges of providing healthcare in armed conflict**

- What are the challenges various actors face in providing healthcare in armed conflict?
- What are the constraints on the health system (e.g., breakdown of infrastructure, shortages of medicines, prioritization) and the challenges of delivering healthcare (e.g., violence & insecurity, movements of people, legal & administrative barriers) in armed conflict?
- What are the challenges and constraints linked to global health agendas (e.g., aid allocation, insufficient funding, securitization of health)?

### **Session 2: Health governance systems in conflict-affected settings**

- What are the governance systems and structures in place for public health actors and humanitarian actors (e.g., IHR, IASC Level 3 Activation Procedure, Global and Country Health Clusters, WHO Health Emergencies Programme)?
- How do they tackle the challenges discussed in Session 1, and what would be needed to ensure better implementation of health policies and hence more adequate health services for those in need?
- What are the commonalities between the health and humanitarian worlds, and how can we use these to ensure better health care services for conflict-affected people?
- How are current frameworks for collaboration between the health and humanitarian worlds working, and what could be done better?
- How can humanitarian health actors better ensure that gaps are filled and duplications avoided?
- How can global health frameworks better assist the provision of health care in humanitarian situations?

### **Session 3: Accountability in the international health system in conflict-affected contexts**

- What accountability mechanisms/process exist to ensure adequate delivery of healthcare in conflict-affected contexts (e.g., accountability to affected populations, accountability to donors)?
- How can international health and humanitarian actors be more effectively held accountable for their activities in these contexts?
- What incentives could be put in place to ensure health interventions are based on positive impact and results?
- What approaches have been shown to be successful to ensure accountability to affected populations?
- Is there a need for a system-wide accountability system?