If We Fail in Health We Fail Overall

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MUKESH KAPILA, AUG 9 2016

The much hyped, first-ever World Humanitarian Summit has come and gone. Convened by UN Secretary General Ban Ki-moon, 9000 participants from 173 countries assembled in Istanbul on 23-24 May 2016. They included 55 heads of state and government, and hundreds of civil society, NGO, academic, and private sector organizations.

Issuing a call to 'stand-up for humanity', the Summit's conclusions range from commitments to provide leadership to prevent and end conflict, uphold norms that safeguard humanity, leave no one behind, move from delivering aid to ending need, and expand 'investment in humanity'.

A special session on global health, moderated by the former Tanzanian President Jakaya Kikwete, addressed crisis-related health challenges. These include the emerging and re-emerging infectious diseases that cause public health emergencies, the desperate health needs of people forcibly displaced by conflicts such as in Syria or trying to cope with disasters, and the increasing violence against health workers, facilities, and patients.

The full webcast of the session can be seen here. The high-level panel from around the world emphasised that health is a basic and fundamental human right that is always a top concern expressed by crisis-affected people. But it is also often the most unmet need. The consequences are devastating, and particularly evident in protracted crises: unhealthy communities cannot cope nor recover effectively or become resilient to further crises. A shifting global landscape is escalating the risks to global health security. The risk drivers include demographic and climatic/environmental factors, as well as urbanization and forced population movements.

Respect for health workers, facilities, and patients are central to the ongoing provision of life-saving health services to crisis-affected populations. The distinctive nature of health action during emergencies must be upheld in accord with established humanitarian principles and medical ethics. Meanwhile, it is of grave concern that attacks on healthcare and denial of access have become such a frequent feature of today' armed conflicts.

The determinants of health are broadly multisectoral and so must be the response to crisis-related health needs. Additionally, the health sector, with its underpinning sciences and its evidence based practices can be pivotal in bridging the relief-development nexus. The universally-acknowledged moral dimension to health can help build the confidence and trust that may help with peace-building.

Meanwhile, current modalities are not always meeting the health needs of people during both acute and protracted crises in a consistent and predictable manner. Recognising also that threats to health are at an all-time high, do not respect national boundaries, and can create serious and wider humanitarian consequences, as shown by the experiences with avian influenza, Ebola, and Zika, the session urged that health should be put at the centre of collective humanitarian action through concrete individual and joint actions. Accordingly, five key areas are identified for a global undertaking on health in crisis settings.

First, we must use all our extensive knowledge and capacities to enable all crisis-affected people to gain access to an essential health package. This must be based on already well-known norms, standards, and guidelines, and be adaptable to local needs and circumstances. The gaps in provision for children and in the reproductive and sexual health needs of women must be corrected; psychosocial support as well as services for the elderly, chronically ill and those with non-communicable diseases and disabilities should not be overlooked.

Second, we must ensure better health outcomes and accountability in emergencies. This requires strong

emergency health response capabilities at community and national levels, supported by predictable co-operation arrangements at regional and global levels to deploy surge assistance when local capacities are overwhelmed. Building–up strong national health systems are an imperative, and emergency responses should not undermine them. The multisectoral response to health crises must include improved collaboration among health, humanitarian, and development partners, as well as greater inclusion of local actors. Human resource gaps need to be plugged through scaled-up quality training and leadership development. Accountability for health outcomes needs standardized indicators and context-specific targets, applied with consistency, and the greater use of independent needs assessments and evaluations.

Third, we must better prepare for, and respond more effectively to infectious hazards and outbreaks. This calls for long-term investment in the core capacities required under the International Health Regulations, and their underpinning national public health systems. Engaging with communities to promote healthy behaviours and boosting their resilience, as well as correcting misinformation and misconceptions is vital. Our global health security depends on the timely, transparent and efficient coordination with which we tackle public health emergencies of national and international importance.

Fourth, we must do much more to prevent attacks and protect healthcare delivery. Attacks on healthcare and denial of access is a violation of international humanitarian law. They must be better documented and impunity ended by developing and implementing robust national legislation and policies, as well as recourse to international mechanisms when necessary. Continuous advocacy is warranted with all parties engaged in armed conflict. Communities and their leaders could also help with designing best practices that prevent and halt violence against or denial of healthcare.

Fifth, flexible and equitable multi-year resourcing is essential to secure health in crises. This includes enhanced national budgetary and donor contributions alongside mechanisms such as health insurance schemes, pandemic insurance, and expanded social safety nets. A greater proportion of funding should flow directly to local actors where feasible. There must be equity in service provision between refugees/internally displaced and affected host/national populations. A multi-hazard approach, longer term investments in basic public health and service delivery functions, and private sector collaborations can all help to plug critical gaps on a sustainable basis.

The Summit recognised the special role of emergency health work: if we fail in health, we fail in the overall humanitarian endeavor. And without addressing the health needs of crisis-affected people, the health targets of the Sustainable Development Goals cannot be fully realised.

Some 55 entities – representing a wider group of approx 350 stakeholders – governments, international bodies, NGOs, civil society, and private sector – have indicated their alignment to the global undertaking on health in crisis settings, through some 72 commitments. Will they be delivered, and will that transform health by reducing the burden of avoidable and preventable death, disease, and disability that adds to the burdens on the tens of millions of people caught up in new, recurrent, or unending crises?

The road from Istanbul will be long and difficult, requiring optimism and perseverance in equal measure. The bandwagon is already moving on to New York for the forthcoming UN Summit on Refugees and Migrants. In between, we must learn from experiences such as the atrocity in Nice and the prolonged pain of Aleppo that how we journey is going to be as important as getting to the destination.

About the author:

Mukesh Kapila is professor of Global Health and Humanitarian Affairs at the University of Manchester, chair of Nonviolent Peace Force, and chair of the Manchester Global Foundation. He is also Special Representative of the Aegis Trust for the prevention of crimes against humanity. Associate Fellow at the Geneva Centre for Security

Policy and adjunct professor at the International Centre for Humanitarian Affairs, Nairobi. Formerly, he was Special Adviser to the World Humanitarian Summit, Undersecretary General at the International Federation of Red Cross and Red Crescent Societies, United Nations Resident and Humanitarian Coordinator for the Sudan, Special Adviser to the UN High Commissioner for Human Rights, and Head of Conflict & Humanitarian Affairs at the UK Government Department for International Development. He can be followed on twitter at http://www.twitter.com/mukeshkapila. He is the curator of the Flesh and Blood blog on E-IR.