Health in humanitarian crises 3

Recurrent failings of medical humanitarianism: intractable, ignored, or just exaggerated?

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Humanitarian health workers operate in dangerous and uncertain contexts, in which mistakes and failures are common, often have severe consequences, and are regularly repeated, despite being documented by many reviews. This Series paper aims to discuss the failures of medical humanitarianism. We describe why some of these recurrent failings, which are often not identified until much later, seem intractable: they are so entrenched in humanitarian action that they cannot be addressed by simple technical fixes. We argue that relief health-care interventions should be contextualised. Perhaps medical humanitarianism deserves a better reputation than the one at times tarnished by unfair criticism, resulting from inapplicable guiding principles and unrealistic expectations. The present situation is not conducive to radical reforms of humanitarian medicine; complex crises multiply and no political, diplomatic, or military solutions are in sight. Relief agencies have to compete for financial resources that do not increase at the same pace as health needs. Avoiding the repetition of failures requires recognising previous mistakes and addressing them through different policies by donors, stronger documentation and analysis of humanitarian programmes and interventions, increased professionalisation, improved, opportunistic relationships with the media, and better ways of working together with local health stakeholders and through indigenous institutions.

Published **Online** June 8, 2017 http://dx.doi.org/10.1016/S0140-6736(17)31277-1

This is the third in a **Series** of four papers about health in humanitarian crises

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Introduction

Failures, ranging from the waste of resources to actual harm, must be interpreted in relation to health needs, available resources, and operational constraints, which are often overwhelming. Some failures, because of their political and financial causes, are refractory to correction, embedded as they are in the humanitarian enterprise, with its "extraordinary capacity to absorb criticism, not reform itself, and yet emerge strengthened".[1] The same lessons are repeatedly learned but fail to inform practice and are quickly forgotten. Many factors, which are not all intrinsic to the field, such as the growing demands on the humanitarian system, the increasing complexity of crises, and the mismatch between needs and resources, contribute to this effect. The Ebola epidemic in west Africa has publicly exposed shortcomings that are familiar to experienced humanitarians, such as an unacceptably

Key messages

- Not all failings can be blamed on medical humanitarianism, given the high-risk environments in which it is needed. A balanced assessment of medical humanitarianism should recognise its intrinsic limitations.
- Some failings of medical humanitarianism recur, and they cannot be remedied solely by technical fixes. Regardless, investing in documentation and analysis is crucial to expose and correct shortcomings of humanitarian interventions.
- Medical humanitarianism is questioned to a lesser degree than humanitarianism in general. But its unique features deserve further enquiry and open debates.
- Sound intelligence should guide the realistic appraisal of the opportunities at hand in a given crisis, and of the implications of the choices made.
- The professionalisation of medical humanitarianism should be further promoted.

Search strategy and selection criteria

We did a purposeful non-systematic literature review to identify peer-reviewed articles and grey literature reports relevant to the main categories of failings in humanitarian health action (extrinsic or distant; contextual; cultural, value laden; and technical, programmatic, or operational). We shortlisted articles and reports on the basis of title relevance, and, if that was not sufficient to exclude a report, by reading the abstract.

We searched the PubMed database for peer-reviewed reports published in 2007–17 in English, Spanish, Portuguese, and French, using combinations of key terms for humanitarian crisis ("complex emergency", "war", "humanitarian", "humanitarian emergency", "natural disaster", "refugee", "internally displaced", "displaced", "crisis-affected", "crisis affected", "armed conflict", "forced displacement", and "forced migration") and health status, system, or response effectiveness (MeSH key terms for "health status", "health status indicators", "delivery of health care", "health services accessibility", and "relief work"). These two concepts were combined into a search with the general outline of [humanitarian crisis key term] AND [health status, system, or response effectiveness term], with truncated terms when necessary.

Additionally, we searched for relevant grey literature published 2007–16 by consulting archives of Médecins Sans Frontières, the Overseas Development Institute's Humanitarian Policy Group, and the Internal Displacement Monitoring Centre.

In addition to the above searches, we also referred to our knowledge of published work, including older literature, and consulted various colleagues to gather additional reports. For each report shortlisted, we checked the bibliography section for further reports of interest.

We read shortlisted reports and noted the main recurrent shortcomings in health humanitarian action and their effects on health status and health systems under each category of failing (panel 1). We have cited only a subset of the most relevant articles and reports, selected from a much vaster body of literature.

For **publications by Médecins Sans Frontières** see http://www.msf.org/en/content-type/publications

For **publications by the Humanitarian Policy Group** see https://www.odi.org/publications

For **publications by the Internal Displacement Monitoring Centre** see http://internal-displacement.org/publications?Theme=Humanitarian

For more on the **Sphere Project** see http://www.sphereproject.org

delayed response,[2] politically induced overreactions (eg, flight bans), poor understanding of the sociocultural (eg, local practices of burying the dead or fears of Ebola protective suits) and political (eg, the use of the army for controlling quarantined people) contexts, and ineffective worldwide health governance.[3] In this Series paper we review the failures of medical humanitarianism by discussing their main causes, patterns, and effects, and we provide suggestions for improving future practice.

Criticism of humanitarian response has always spurred initiatives and reforms, such as the development of the Sphere Project in response to the humanitarian shortcomings in the aftermath of the Rwandan genocide in 1994. The outcome of the reform of the WHO Emergencies Programme after the initially ineffective response to the Ebola outbreak cannot be appraised yet because improvements will not be immediate.[4] The contexts of crises have evolved, with blurred boundaries between politics, military, and relief operations. Preserving humanitarian principles has proven difficult, with relief agencies vulnerable to geopolitical agendas;[5] relief workers are increasingly targeted by combatants.[6] The effectiveness of the humanitarian enterprise is improving.[7,8] Because of expanded resources, new technologies, and improved technical proficiency—which occurred only partly as a result of learning from past mistakes—and more attention to assessment and accountability, the high levels of mortality that were previously recorded are not seen now.

The harmful effects of humanitarian assistance can be seen in the Biafra war in 1967, which might have been unwillingly prolonged by it.[9] In the Ethiopia famine of 1984, food aid for civilians was redirected to Mengistu's army, supporting his military efforts against rebels in Tigray and neighbouring Eritrea. Aid has supported and legitimised various abusive regimes, such as in Cambodia, Zimbabwe, Sudan, and North Korea; it has been used to normalise an intractable political situation in Palestine[10,11] and as a vector of western ideology in Afghanistan, Somalia, and Iraq.[8] These harmful consequences are usually only identified much later; and sometimes they are never noticed because agencies leave before the effects of their actions become clear. Furthermore, relief agencies have previously kept silent to human rights abuses to maintain access to populations in need;[12] and international agencies working with one party in a conflict risk legitimising that party and becoming instruments in the country's political struggle.[13] By affecting the determinants of the conflict, humanitarian assistance can either exacerbate the violence or reduce tensions.[14] However, withdrawing aid out of legitimate concerns about its misuse can have negative consequences.[15]

Failing in humanitarian goals has sometimes been deliberate, when withholding or delaying relief fitted donors' geopolitical agendas,[16] for example in the famines affecting Ethiopia in the mid 1980s and South Sudan in 1998.[17] The inadequate response to the famine that struck south-central Somalia in 2011–12, despite early warnings, was partially due to the US antiterrorism legislation.[18]

When unable to achieve ambitious goals against the powerful forces at play in a given crisis, humanitarians face difficult moral choices.[14] Contextual factors, of which humanitarian workers have little or no control, can determine side-effects of relief interventions. Failed interventions are not the sole responsibility of relief workers and should be considered in the wider humanitarian context, where "*injections of external finance and expertise can only complement local resources*";[19] in this context, the impact of official aid is often exaggerated by media and donors.

Characterising humanitarian medicine

Compared with the extensive literature on the failings of the overall humanitarian enterprise, insightful and self-critical analyses of medical humanitarian interventions are rarely published, with the exception of Médecins Sans Frontières (MSF).[20] In fact, since the early 1980s, MSF has promoted reflection and debate on humanitarian and development aid and human rights, often through an independent think tank, the Centre de Refléxion sur l'Action et les Savoirs Humanitaires (CRASH).

We suggest several tentative explanations for the scarce attention to failings of medical humanitarianism. The nature of health-care provision might make it less vulnerable to humanitarian pitfalls. For example, the regulation of health-care practice might be more stringent than in other sectors. Additionally, the technical focus of health care gives it an aura of neutrality, while protecting it from the criticism of non-health experts.

In regions as turbulent as Afghanistan, South Sudan, and Somalia, health-care provision has been increasingly framed as contributing to statebuilding, despite the weak evidence supporting such a view.[21] This view of health-care provision, encouraged by some donors, has endangered the neutrality of relief interventions, delayed and blunted responses, and blurred their respective goals.[22] In light of the dreary record of past statebuilding efforts, a focus on health benefits over other goals such as statebuilding is legitimate indeed.

In violent contexts in which no resolution is in sight, humanitarian engagement in health-care provision might become protracted. In these circumstances, a pure humanitarian approach is not sufficient, and needs adaptations to the particular context.[23] Many international health-care providers have acquired mixed expertise: they can shift from relief to development and back in response to field conditions and opportunities. By working in a long-term crisis, such organisations acquire a better understanding of the overall political, social, military, and cultural context that they are working in. The organisation might keep their knowledge and decisions unpublished to avoid reactions from host governments, which might lead to their expulsion from the field.

Regardless, major developments that are underway[24] force humanitarian agencies to adapt their policies and interventions. Medical humanitarianism is being reconfigured in this process, and its repercussions must be thoroughly studied. First, the severe, long-term conflicts in middle-income countries, such as Iraq and Syria, affect populations with a different epidemiological profile, marked by chronic non-communicable diseases (NCDs). Patients who are used to relatively sophisticated health services expect effective responses of higher technical complexity and delivery cost than might be expected by individuals from poorer settings. Second, large population movements (internally displaced people and refugees abroad) combine with conflict-induced changes in health-service delivery to produce "the geographic reorganisation of health care within and across borders under conditions of war".[25] Third, the urbanisation of refugees, returnees, and internally displaced people rules out the use of the standard packages developed by relief agencies.[26] Cash-based programming has been increasingly recognised as a suitable alternative to direct health-care provision.[27] Fourth, violent and impoverished urban settings call for humanitarian engagements, even in the absence of open conflict,[28] as dramatically shown in 2014–15 by the Ebola epidemic, which caused huge social and economic disruptions that were disproportionate to the number of cases and deaths.[29] Fifth, new entrants to the humanitarian field, such as Turkey and the Organisation of Islamic Cooperation, bring alternative methods of operation that offer a competitive advantage in some cases.[30] For example, they can be more flexible in their responses than larger organisations, and they might have easier access to some areas thanks to their islamic identity.

The Syrian conflict has increased the obstacles facing medical humanitarianism to an unprecedented extent. Health workers have not been spared; since the start of the conflict, more than 800 have been killed.[31] Preventing access to care by violent means has been used as a weapon of war.[32] Aid has been mostly delivered by informal networks of Syrian groups crisscrossing the borders, with whom relief agencies have had to learn to collaborate.[33] Cross-border operations and delivering health services on an intermittent basis with mobile health units are often the only strategies that can be used in such dangerous environments.

We propose a matrix of categories of failings in health humanitarian action, together with their main causes and their effects on the health status of affected populations and health systems (table 1).

Causes of failings

Extrinsic or distant causes

Decisions about humanitarian health-care provision in crises are usually made from a distance. Geopolitical considerations, the media, operational convenience, donor agendas, and competing crises all affect humanitarian health interventions. With declining financial resources and increased competition, institutional preservation becomes a concern of relief agencies, which too often end up being dependent on donor priorities at the expense of the needs identified in the field.[34]

The mutually dependent relationships of donors, media, and health-care providers give visibility to some crises and not others. Humanitarians might alert the media about the deterioration of a crisis, frequently dramatising it to grab attention and funds,[35] and then journalists might publish sensational stories to capture the public and reader's attention. Or they might not. Many severe crises fail to reach the headlines, like the fighting in the Democratic Republic of Congo[36] and in northern Uganda.[37] The resulting relief response is frequently fragmented, and some responses might in the aggregate be in excess of needs and absorption capacity, like in Goma (1994–95), the Indian Ocean tsunami (2004–05), Darfur (2005–09), and Haiti (2010–11).

The media might highlight disasters[38] that would have otherwise remained invisible, like the Chinese famine of the 1950s, which was probably the worst man-made famine in history. Humanitarians need to learn how to engage better with the media, providing them with relevant information and interpretations, and using a language that can be understood and used in a non-ambiguous way.

Highly publicised, so-called noisy crises do not last long. After years of funding, donor fatigue sets in and disillusion and competition with other emergencies leads to cuts in aid. These cuts often happen when the host's needs are still high, and Darfur is a striking example of disconnection between distant funding decisions and unmet health needs.

The customary split of the western aid industry between its development and humanitarian aspects is inappropriate in entrenched political crises such as those in Somalia or Palestine. The same would apply to the Democratic Republic of Congo, where "neither humanitarian nor development approaches as normally understood are well adapted to this kind of context".[39] With its alternation between turbulence and calm, South Sudan exemplifies the inadequacy of segmented donor approaches. Far from sticking to one aid mode or another, health-care providers must be able to respond to frequent, sudden crises while working with a long-term perspective, which is negated by short funding cycles, funding gaps, discontinuity of interventions, unrealistic linkages to political progress, and demands for quick demonstrable results. Furthermore, the disinterest of humanitarian health organisations for developments after their departure impedes their learning about the outcomes of their intevention.[40] Worldwide, emergency aid is overstretched; it cannot address all needs, particularly in chronic crises. The recent World

	Causes	Effect on health status	Effect on health systems	Example regions
Extrinsic or distant				
Noisy crises: crowded humanitarian arenas with coordination challenges, tendency to chronicise with donor fatigue and to become forgotten; forgotten crises: inability to meet health-care needs of affected populations	Donor agendas; concurrent crises; media coverage; reluctance to engage in hopeless situations	Excess morbidity and mortality	Fragmentation of interventions with inefficiencies; artificial split between relief and development approaches, because different funding streams exist; service delivery gaps; imposition of international priorities and approaches, regardless of their relevance to each specific context; adoption of unrealistic goals and expectations	Darfur and Haiti (noisy); Democratic Republic of Congo, northern Uganda, and Yemen (forgotten)
Contextual				
Constraints to service delivery due to political or security obstacles; diversion of aid; legitimisation of governments or political and military groups	Political relationships with national health authorities and stakeholders outside the officially recognised state framework	Excess morbidity and mortality in communities without access to health care	Inequality in service provision across areas with segregation of services; humanitarian workers become target of attacks; inadequate policies or guidelines that can be adopted by service providers; aid diverted	Afghanistan, Darfur, South Sudan, Syria
Cultural, value-laden				
Effectiveness and uptake of delivered services negatively affected by users' perceptions; political factors and poor communication between humanitarian workers and beneficiaries	Cultural distance and inadequate communication between relief workers and crisis-affected populations or between distant managers and frontline workers; fragmentation of relief agencies; rigid adoption of criteria not duly contextualised	Excess morbidity and mortality; population groups not given the assistance they require; waste of available resources	Segregation of international humanitarian workers from beneficiaries, resulting in an inability to understand the health needs and contextual developments, leading to mistrust of health workers	Afghanistan, Ebola in west Africa, Pakistan, Somalia
Technical, programmatic, or operational				
Relief agencies and workers without the adequate competence and experience to design and carry out effective and duly contextualised humanitarian programmes; inability to learn and improve results; misguided donations of medicines and equipment; multiplication of ill-adapted and ineffective in-service training initiatives	Poor situation analysis; disregard of needs because of donor priorities and restrictions and inappropriate techniques applied to systemic issues; familiar approaches used regardless of their contextual appropriateness; labour market scarcity of suitable staff; insufficient supervision and support of staff	Health needs inadequately met for many reasons, including unskilled health workers, shortages of medicines, and insufficient public health education	Weaknesses and distortions exacerbated; inefficiencies; inequities; disregard for the available knowledge	Democratic Republic of Congo, Haiti, Somalia

These categories are not mutually exclusive. Different shortcomings can occur concomitantly and their causes might overlap and interact in complex ways.

Table 1: **Key failings in humanitarian health action with their main causes and effects**

Humanitarian Summit reaffirmed the need for bringing humanitarian and development efforts closer to each other. In reality, these needs often overlap and should be addressed together.[41]

Unrealistic and opportunistic calculations can lead donors to exaggerate sustainability concerns, thus justifying early withdrawal of their aid.[42] For example, health-care user fees have often been implemented (to decrease dependency on donors) without proper consideration, leading unsurprisingly to reductions in clinic attendance, continued low revenues, and the ensuing side-effects.[43,44]

Distressed environments are marked by fragmented responses—eg, multiple funding sources, redundant service delivery points, mixed supply channels, assorted data-collection arrangements, competing agendas, and intermittent provision. The recognition that fragmentation persists despite countless initiatives points to it as a structural characteristic of humanitarianism (panel 1).[47]

Priorities (which are often conflicting) set by agencies can multiply until implementation of a coherent plan of action becomes impossible. Instead, the size of their financial backing determines which priorities triumph over the others. Generously funded services expand, absorbing available capacity regardless of the actual burden of disease. In Somalia, an inventory of external resources identified an evident misalignment between health needs and funding.[50] In northern Uganda, HIV/AIDS programming dominated the health-care landscape, despite the scant evidence supporting its privileged funding.[12] In Sierra Leone, conflicting donor agendas in human resources for health and high turnover of technical assistance resulted in duplications and incoherence in policy making in the preparation of the Free Health Care Initiative.[51]

A maze of constraints exists that field workers must work within, including restrictions to medicines, donors requiring use of equipment from their country, access restrictions by the host government, and prohibition against funding of host state activities. Far from being guided by needs, principles, or technical considerations, choices about implementation of humanitarian interventions are made within the narrow spaces left by these often conflicting and changing restrictions. As a result, the comprehensiveness and coherence of health care suffer, and operational efficiency is also undermined.

Contextual determinants

For humanitarians, collaborating with the health authorities of a state engaged in conflict is an awkward necessity. The controversy ignited by the 2013–14 polio outbreak in Syria, with WHO being accused of subservience to a government engaged in civil war,[52] exemplifies a quandary often faced by international organisations, who are impeded by their obligations to member states to act decisively on global health problems.[53]

In Sudan, with a history of restrictions to relief, humanitarian health agencies were allowed to operate only in Darfur, under strict control and without access to rebel-held areas. In Syria, Government barriers have severely curtailed access to besieged areas. This strong-state emergency,[54] as previously witnessed in Sri Lanka and Myanmar, imposes uncomfortable trade-offs to relief organisations, which if adopting too adversarial (although ethically legitimate) a stance might face expulsions, or tightened operational constraints.

Agencies might be perceived by insurgents as aligned with the government, and consequently attacked. Mistrustful communities might abstain from using health services, or being forced to stay away by one faction of the conflict. Health services might become segregated across the front line. In Afghanistan during the Soviet occupation, in Mozambique during the civil war, and in South Sudan until 2005, government and rebel-held areas were served by separated health-care systems. The effectiveness and efficiency of the delivered services suffered as a consequence.

Collaborating with host governments (whatever their record of human rights abuses) becomes mandatory when delivering health care to internally displaced people[12,54] who might be hostile to state authorities that are perceived as responsible for their predicament. Humanitarian health-care providers have to act carefully between the two sides of the war, both prone to read their actions through a political lens.

Aid resources could be diverted to benefit governments or rebels, or to strengthen their respective health services, which is a controversial result if the abusive power holders gain political rewards from it. The argument often voiced that external assistance supporting health care frees state resources for war purposes is plausible, but perhaps unlikely. Many oppressive governments are not concerned with the welfare of their people, who would most likely be denied access to health care in the absence of humanitarian provision.

Another decision confronting humanitarian health-care providers relates to technical aspects. By ignoring guidelines issued by weak health authorities (sometimes appropriate to local conditions), humanitarians further undermine their adhesion and set unattainable or inappropriate standards for host health systems. Conversely, humanitarian providers might have to abide to outdated national health-care guidelines, or those with no clear evidence to support them, and thus ineffective policies and entrenched malpractices cannot be exposed and corrected.[55]

Panel 1: **Haiti—lessons from the past have not been learned[45]**

Haiti, which had been nicknamed the republic of non-governmental organisations,[46] saw a rapid influx of countless organisations and volunteers after the 2010 earthquake. As for the Indian Ocean tsunami in 2004 and the Pakistan earthquake in 2005, the responses of governments, institutions, and private citizens were exceptionally generous, and contributed to attracting many humanitarian agencies.[47] Some organisations came with a track record of relief work, but many more came with inexperienced staff and weak logistical capacity that overburdened the already scarce transport, communication, and lodging resources.[48] Within a few weeks of the earthquake in Haiti, more than 400 medical NGOs registered with the health cluster[45] and an unknown number of charities were working outside any coordination mechanism. Language was a barrier to effective coordination, and because many international staff were unable to speak French or Creole, initial coordination meetings were held in English. National authorities and partners had restricted access to the UN compound where the coordination meetings took place. The few competent and experienced health cluster officials were overwhelmed by the constant influx of disparate agencies asking for guidance and logistical support. A more strategic focus on the agencies that had a stronger capacity and longer-term commitment to Haiti would have been more effective than an attempt to consult all agencies to reach a consensus.[45] Like in other large disasters, the transfer of coordination leadership from the UN to national counterparts occurred too late in Haiti. The Haiti response needed a stronger and higher profile investment by the UN in the coordination mechanism.[49]

Cultural value-related factors

The perceptions of relief health actions are shaped by culture and the interests of the different participants.[56] For people in need, the provision of the health care is not enough, because they might still need to negotiate access to it. Needing to collect information about the available options, sifting facts from rumours, weighing costs and risks incurred, and appraising received benefits are everyday experiences of refugees.[57] To many refugees, knowledge of these factors is as important as the provision of health care itself.

The differences in culture and lifestyle[58] and the social boundaries between relief health workers and beneficiaries have been magnified by security responses and procedures that have led to workers often living in fortified compounds.[59] The ensuing segregation leads to a low-trust environment and the spread of rumours; "a mutually reinforcing relationship between perceptions and rumours can exist in order to make sense of life in times of upheaval".[56] This mistrust could be seen during the Ebola crisis in west Africa as a result of the initial misunderstanding by humanitarian workers (and, to a lesser extent, national authorities) of the cultural procedures for burial and other complex social interactions that could have increased the risk of Ebola virus transmission.[30]

The tension between voluntarism (ie, organisations with ideological, altruistic orientations) and professionalism (ie, organisations focusing on the technical quality of their interventions) permeates the history of

medical humanitarianism.[60] Recently, the professionalisation of humanitarians has been more common, but this can have unintended effects, such as the creation of additional barriers between them and local people because of the focus on technical solutions and the use of specialised language that might be unfamiliar to beneficiaries and their counterparts.[61] The Ebola outbreak that ravaged west Africa in 2014–15 has shown the social and economic disruption produced by poor communication,[62] and the mistrust it created between aid workers and locals.

Concerns about the potential harmful effects of using mental health and psychosocial support interventions that are based on western theory and practice in emergencies have sparked off an intense debate in the humanitarian community.[63,64] By medicalising distress and trying to give mental health support to entire conflict-affected populations, some interventions might have caused harm.[65,66] For example, these supply-driven context-insensitive approaches entail risks of stigma and further abuses.[67]

Humanitarian health interventions entail risk of failure, but agencies have a culture of avoiding admitting this.[68] Such behaviour was reported during the crisis striking Maban County in South Sudan in 2011–12, where "..even internally within NGOs there was little reporting of problems up the line to Juba, and there was little incentive to be open about gaps and failings or to address them in a collaborative manner".[69] Documented failures are dangerous, influencing donor funding decisions and in turn, the survival of the agencies. Reputational risk aversion (ie, ways to avoid compromising the organisation's reputation) is understandable, but detrimental to learning: mistakes might be more instructive than successes.[70]

Technical and programmatic factors

Despite the advances in many humanitarian health areas (eg, immunisation and management of malnutrition), the evidence base for many interventions remains weak.[71] Further, the implementation of health interventions frequently suffers from common technical drawbacks, some of which are to some degree impossible to eliminate in the complex context of a crisis. Technical drawbacks include poor situation analysis, weak coordination, inadequate coverage of effective programmes, inappropriate techniques applied to systemic issues, funding-induced prioritisation, insufficient resources, and weak accountability systems.

Despite the existence of a standard methodology for nutritional assessment, inconsistencies and errors have been documented.[72,73] Admission to programmes commonly requires meeting rigid criteria that is ill-adapted to multifaceted situations. For example, the common policy and practice of providing nutritional programmes only to children younger than 5 years denies support to adults and older children who might also need it.[74] Because of rigid criteria, specific groups that are targeted by special programmes might get health care that is inaccessible to ordinary people; and displaced people might benefit from better services than the host population, which can be as poor and deprived.[75]

Arguably, too many health-care interventions and health agencies still use improvisation and show incompetence (panel 1). The focus of evidence-based interventions and the need for demonstrating impact is often at odds with and seldom recognisable in actual humanitarian practice.

Research shows that evidence per se has little relevance for decision makers, who need to take other factors into account.[76] Indeed, "…evidence informs aid policy and practice only when the political context, the networks, and the knowledge are all in alignment".[77] Decisions about health-care interventions in crises are influenced mostly by previous decisions in that country (path dependency), convenience, the trust and behaviour between organisations, and implicit values and assumptions of decision makers. Evidence-free management might be justifiable when the information is incomplete or difficult to interpret.[78] Less acceptable is the frequent sidelining of solid data and knowledge because of political or organisational expediency, as witnessed in Darfur.[79]

Effects or manifestations of the failings

Medical humanitarianism has improved in many aspects over past decades in terms of quality of provisions and organisation of aid, mortality rates, and immunisation and malnutrition programmes. However, worldwide crises are increasing in scale and complexity and the humanitarian system cannot deal with these challenges in a coherent and effective way.[80] The effects of failings of medical humanitarianism on the health of populations are numerous, including increasing unmet health needs, exposure to diseases, and risk of epidemics, which all result in increased morbidity and mortality. The severe epidemics of diarrhoea that struck Rwandan refugees in Goma, Democratic Republic of Congo (then Zaire) were initially handled poorly by inexperienced health workers with inadequate skills in oral rehydration therapy.[81] Similarly, the poor management of severely malnourished children was recognised as one of the causes of the high case fatality risk in South Sudan in 1998. During this famine and that in Ethiopia in 2000, outbreaks of communicable diseases occurred at food distribution points where transmission was increased because of high concentrations of aid beneficiaries.[82] Another example is in Darfur, where the inadequate sanitation of crowded camps for displaced people, caused by aid cuts, was linked to increased diarrhoea-related deaths.[83]

When shaped by fashionable policies, goals, tools, and standardised service delivery models imposed by external aid agencies without the necessary contextualisation, humanitarian interventions can have pervasive effects on health systems. Ill-adapted and rigid programming, standard packages of essential services, and monitoring

tools premised on predictability and control are adopted.[84] The experience and knowledge of the context that has been gained by qualified indigenous professionals is lost because they are forced to leave, then replaced by new organisations. The espousal of blueprints for humanitarian strategies and plans is facilitated by the poor understanding of events by decision makers (eg, national authorities and donor officials). For example, performance-based payment of health-care providers is promoted in distressed contexts, despite a thin evidence base on its benefits and unintended effects.[85,86]

Fundraising and reporting pressures force projects to collect an enormous array of data, and distorted pictures of the health-care arena ensue as it is assessed with inconsistent methods and standards (panel 2). Some reports, when unfounded or biased, might cause unintended consequences;[88] for example, because of low-quality data with little analytical value, conflict was long postulated to accelerate HIV transmission, until solid evidence proved otherwise.[89] This misinterpretation caused a waste of resources in the form of attention, funding, and guidelines that were directed towards a health issue that should not have been a priority.

Costs of health-care provision rise because of unaffordable service delivery models, fragmented production, generous funding, security and logistical constraints, and humanitarian imperatives (ie, the obligation to provide assistance wherever it is needed regardless of costs). Investments are decided by the availability of resources, rather than on appropriateness and sustainability grounds.[35] Sophisticated facilities are built in the least favourable contexts, like in Nyala (Darfur), where a high-tech hospital donated by a bilateral agency remained closed for years because of resource and capacity shortages.

Relief interventions are not the only contributors to fragmentation of services. External forces add to domestic ones to multiply the providers. Privatisation and commoditisation of health care might further diversify the field, a fact that is often neglected by aid agencies and health-system analysts. Paradoxically, poor families might incur large health expenses, even where humanitarian health providers offer them for free, as seen in Afghanistan or Darfur.[90] For example, some displaced people might prefer to use private health care to avoid detection by the police.[91]

The reliance of humanitarian health interventions on training activities for local health workers, particularly of the in-service and community-based varieties, diversifies and segments the health workforce by informally providing expertise that is not recognised at a national level. Training is hurried, under-resourced, and uncoordinated with no common curricula or standards, so human resources of disparate categories and dubious skills abound in protracted crises. Once deserted by the projects that trained and employed them, many workers transfer to private practices.[92]

***Panel 2:* Assessment of needs in Iraq**

In Iraq in 2003, needs assessments were the main, and often the only, activity of many agencies, and about 1600 health facilities (about 75% of the entire network) were assessed over 3 months.[87] Given the insecurity, governance void, and complex negotiations for access to some areas and populations, attempts at coordinating needs assessments were only partially successful. Despite the initial effort by WHO and some non-governmental organisations to define a common template for health assessments, health agencies did not follow the guidance. In accessible areas, different health facilities were assessed by different agencies using varying methods, and many less accessible units could not be studied, giving a biased picture. External agencies ended up substituting a new geography of accessibility for the administrative division of the country (eg, by governorates and districts). Time and security constraints, and the scarcity of records (destroyed in looting) forced many assessors to collect only qualitative and superficial information, which in the fast-changing environment became quickly outdated. Some systemic issues received little attention, such as the interruption of financial flows (salaries for health-care workers and other recurrent expenditure) and its repercussions in terms of informal user fees implemented by health workers to cover the financial losses. Needs assessments became specialised and fragmented, often showing an obsession for technical details related to infrastructure and equipment of health facilities, totally delinked from their wider health infrastructure network. Engineers looked only at generators and water supply systems and military doctors at operating theatres and laboratory equipment. Their benchmarks for defining gaps and needs were often borrowed from foreign health systems, detached from the context at hand and in some cases unrealistic even for pre-war Iraq. As a result, the collected data failed to translate into true understanding and informed prioritisation.

The excess of unrequested, expired, unsorted, or inappropriate medicines and medical equipment that have been donated to help in emergencies is a recurrent problem. Often, their transportation and subsequent disposal costs more than the actual value of the donated goods. Disposing of the useless pharmaceuticals places an additional burden on local, already overstretched health workers.[93] In very constrained situations, like that in Gaza, where returning the donations might be impossible, environmental hazards can also be an issue. The Guidelines for Pharmaceutical Donations are frequently ignored, as in the response to the 2004 tsunami in Sri Lanka, where more than 80% of the medicines received were unsolicited, unexpected, and unsorted.[94]

Qualifying the criticism

Only a contextualisation of relief interventions enables the determination of whether they are truly harmful or whether other factors associated with the overcrowded health-care arena, which are outside of the humanitarians' control, can be blamed. The performance of relief agencies should be appraised while taking into account the risky decision-making environment, the frequent mismatch between needs and available resources, and the few options available. Further, impartiality might be at odds with sustainability, which calls for an engagement with host states.

The ills affecting distressed health systems should not be blamed only on medical humanitarianism, and

assuming that the situation would improve once humanitarian health agencies have left is unrealistic. The crises in the Central African Republic, forgotten until recently, and Guinea Bissau, a dysfunctional state without substantial external assistance, have long shown these features. Even within countries with so-called noisy crises, peaceful regions could have great health needs that are left unaddressed by humanitarian health agencies, such as is the situation in Democratic Republic of Congo.[95]

Relief health actions are frequently blamed for the disruptive effect they might exert over fragile indigenous health services, including private providers. According to this view, the free health care provided by humanitarians suffocates local private businesses. The same might happen with pharmaceutical supply schemes. However, in Leogane, Haiti, local private providers did not suffer as feared.[96] The evolution of some health-care arenas under protracted stress, such as Somalia and eastern Democratic Republic of Congo, where private health providers have multiplied despite a strong humanitarian presence, challenges the validity of this legitimate concern.

In fact, during crises, private health-care provision might be sustained by the resources flowing (both officially and informally) from the humanitarian industry to private operators. Given that the public and private segments of a pluralistic health-care arena are inextricably linked, humanitarian provision might have beneficial effects for the whole health-care market. Access to services expands, while the subsidised competition restricts prices and qualified health professionals are kept in positions where none would otherwise be present.[97] Furthermore, the injection of resources benefits the impoverished local economy.[98]

Key conclusions and future considerations

Several components of medical humanitarianism should be improved to boost its efficiency and effectiveness. Some changes, such as the professionalisation of relief health workers, have begun; other recommendations that we put forward are mainly long-term and aspirational.

First, humanitarian donors would become more effective by adopting a reactive and opportunistic approach. Feasible, rather than desirable, interventions should be chosen. Goals should be set according to available resources, capacity, and operational space, and sometimes not be set at all, such as when baseline conditions are unknown or conditions are very unpredictable. Providers should be encouraged to contextualise guidelines, standards, and criteria. The pursuit of best practices should give way to empirically determined best-fit interventions.[77] Expectations about the effect of medical humanitarianism should be moderated and tightly confined to health gains. Donor decision makers should realise the limitations of remotely overseeing implementers through formalised tools, and increase their familiarity with health-care provision on the ground.

Second, investment in documentation and analysis and the sharing of information transparently are needed to identify and improve bad performance of interventions. Key neglected areas that we have described concerning provision of health care to urban refugees or internally displaced people, including the management of NCDs and the delivery of health-care in unsafe areas, should be thoroughly studied during and after humanitarian health interventions. Taking advantage of the available information is more productive than commissioning new studies during times of crisis. Furthermore, evaluation methods for humanitarianism should be restructured,[84] focusing on constraints, realistic options, and actual results in pluralistic health-care settings, all of which should be comprehensively appraised[99] by independent institutions. Notably, any appraisal of outcomes should look at the long-term effects of medical humanitarian interventions.[100]

Third, the analysis should encompass the whole health-care arena, which includes not only the humanitarian enterprise, but also state bodies, spontaneous associations, individuals, faith-based organisations, and diasporas. In many settings, the combined responses from non-humanitarian sources exceed the aid response. In these examples, formal or informal bodies might suggest other opportunities for foreign donors who are interested in boosting the effectiveness and sustainability of the health services they support. In Syria, health care relies on local implementers because of restricted access, offering an opportunity to learn more about this type of intervention.[101]

Fourth, the professionalisation of humanitarian medicine should be promoted, and public awareness should be raised about the inadequacy of well intentioned but incompetent actions. Organisational and personal incentives should ensure long-term appointments and discourage medical tourism. Senior staff, capable of setting strategic directions of emergency health interventions and negotiating them with the other stakeholders, should be hired. Such investment seems justified, taking into account the costly consequences of inappropriate strategies and flawed programme designs.

Fifth, the strong influence exerted by the media on humanitarian actions should be taken into account. Journalists will always assess humanitarian crises from a different point of view to that of health-care providers, but media awareness of the failings of humanitarian medicine should be exploited and cultivated. Independent information centres might be useful to provide the media with accurate data and interpretations that are relevant to them.

The unravelling of the state system under the combined effects of the global recession, climate change,[102] and growing inequality is leading to the proliferation of severe crises in growing and increasingly vulnerable populations. Furthermore, the difference between actual needs and response capacity is increasing: forced displacement

reached a record high of more than 65 million people in 2015, and the funding gap between requirements and contributions to UN appeals increased, with a shortfall of 45% in 2015.[103] A more effective, contextualised medical humanitarianism based on lessons learnt, new developments, and better coordination of efforts is needed, using local institutions when possible. Humanitarian health players should not be condemned to repeat past mistakes. Health action in crisis could become more effective if it were based on lessons learnt, new developments, and better ways of working together, wherever possible with and through local institutions.[104,105]

Contributors
Both authors participated equally in the conception, writing, and review of the manuscript, and approval of its final version.

Declaration of interests
We declare no competing interests.

Acknowledgments
We would like to thank Francesco Checchi, Bayard Roberts, and Dorothy van Schooneveld.

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Ten humanitarian crises and trends to watch in 2020. Hereâ€™s our take on key concerns that will shape the aid industryâ€™s work in 2020, from Yemen â€” where this boy received food aid â€” to dealing with urban displacement.Â Humanitarian guidelines built for rural camps were found to be â€œunworkableâ€ in an urban environment, home to a complex array of actors and unfamiliar forces. And yet, almost a decade later, urban response experts say an attitude shift is still needed if aid organisations are going to adapt.Â Conflict, displacement, and weakened health and sanitation systems were already making it difficult to meet the medical needs of many communities. The rising threat of low immunisation rates and a reluctance to vaccinate against preventable diseases is exacerbating those needs. 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.