Johns Hopkins Center for Humanitarian Health–*Lancet* Commission on health, conflict, and forced displacement: health in a world of crises and impunity

Paul Spiegel†, Esperanza Martinez†‡, Orit Abrahim§, Chi-Chi Undie†‡, Chiara Altare, Benjamin Schmid, Aula Abbara†, Awsan Bahattab§, Ietza Bojorquez†, David Cantor†, Rosemary Jouhaud§, Kemish Kenneth Alier†, Daniel Maxwell†, Andres Moya†, Eray Ontas§, Sabina Faiz Rashid†, Malavika Rao§, Hugo Slim†, Arwa Abdelhay†, Huda Basaleem†, Ghislain Bisimwa†, Fouad M Fouad†, Joanne Liu†, Nicolas Meda†, Sara Pantuliano†, Muhammad Zaman†, Munzer Alkhalil§, Kathryn Falb§, Kerrie Holloway§, Ishrat Jahan§, Thaenpaavai Kannan§, Helen Lindsay§, Pacifique Mwene-Batu§, Farzana Misha§, Iwona Anna Bielska§, Koiti Emmily Nasunbga Modi§, Stella Muthuri§, Moumini Niaoné§, Ibrahim R Bou-Orm§, César Rodriguez§, Alina Sadaf§, Altaf Saadi§, Camila Polinori, Caroline Perrin Franck, Vinay Kampalath, Jonathan Polonsky, Mirana Michelle Randriambelonoro, Karl Blanchet†‡¶*

Executive summary

A humanitarian system in failure, and the cost in lives

> "They always call for dialogue and meetings, but you, the community member, have no say."
>
> *Refugee woman, Uganda*

Both health and human rights are being dismantled globally in plain sight and with escalating impunity, driven by geopolitical fragmentation, erosion of the rule of law, and transactional approaches to aid and security that undermine protection and accountability. Conflict-related deaths nearly doubled between 2021 and 2024, and an estimated 239 million people require humanitarian assistance in 2026. The health systems and humanitarian ecosystem meant to protect health and life are buckling under the scale, duration, and political complexity of contemporary crises.

International law and humanitarian principles are increasingly violated with impunity, and civilians are bearing the cost. In 2024, violence against or obstruction of health care reached its highest level on record, with 3663 documented incidents. Protections for civilians, forcibly displaced people, and humanitarian workers are routinely breached. Humanitarian assistance is instrumentalised for political and military ends, access is manipulated as leverage, and health professionals are imprisoned or killed for providing impartial care.

Humanitarian needs have outpaced a politicised, fragile, and structurally inadequate funding model. In 2025, the Global Humanitarian Overview was cut mid-year from US$44 billion to $29 billion, with only 55% funded by year's end. For 2026, a downsized and hyperprioritised Overview seeks $33 billion, of which $23 billion is required to meet the most life-threatening needs. For scale, this is equivalent to roughly 1% of annual global military expenditure. The result is rationing by design: assistance reduced from 239 million people in need to 87 million selected for lifesaving assistance. This narrow prioritisation has become a mechanism to legitimise abandonment rather than mitigate harm, reflecting a system deliberately organised around donor control, geopolitical priorities, and the transfer of risk onto civilians.

The governance and financing landscape is overtly politicised, with humanitarian and global health funding increasingly shaped by national security and foreign policy priorities rather than humanitarian need. Donor withdrawals, budget cuts, and tightly conditioned funding have further recast humanitarian and public health financing as statecraft. A system governed in this way will not self-correct: exclusion becomes normalised, accountability is reduced to compliance, and humanitarian health becomes increasingly selective and unreliable, with large-scale need left outside response plans.

The consequences for population health are immediate and cumulative. In conflict and displacement settings, excess mortality is driven less by direct violence than by the breakdown of essential health services, public health functions, and the social determinants of health. Disruptions to vaccination, primary care, maternal and newborn services, and to the continuity of care for chronic conditions turn manageable illness into preventable disability and death. With advances in medicine, public health, and technology, these outcomes are avoidable in the 21st century, yet persist because inequity, weakened political commitment, and sustained underinvestment have eroded the systems needed to prevent, absorb, and recover from shocks.

The result is predictable: international law is stripped of consequence, humanitarian principles are selectively applied, and survival is deliberately rationed rather than guaranteed on the basis of rights and need. A humanitarian system that cannot protect civilians and health care in line with international law and humanitarian principles is no longer fit for purpose. These patterns are not incidental; they reflect how power, resources, and accountability are structured across the humanitarian system, and how operational decisions are made under conditions of political constraint.

What this Commission delivers and the power shift it requires

This Commission has three core objectives: to diagnose the systemic barriers and enabling conditions shaping humanitarian health action, to centre the priorities and dignity of communities affected by conflict and forced

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*Chair

†Commissioner

‡Co-Chair

§Next Generation Scholar

¶Senior author

Department of International Health and Center for Humanitarian Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA (Prof P Spiegel MD, O Abrahim MD, C Altare PhD, K K Alier MPH, K Falb ScD, C Polinori MPI)**; College of Law, Governance, and Policy, The Australian National University, Canberra, ACT, Australia** (Prof E Martinez MD)**; Massachusetts General Hospital, Harvard Medical School, Boston, MA, USA** (O Abrahim, A Saadi MD)**; Baobab Research Programme Consortium, Population Council, Nairobi, Kenya** (C-C Undie PhD, S Muthuri PhD)**; Geneva Centre of Humanitarian Studies, Faculty of Medicine, University of Geneva, Geneva, Switzerland** (B Schmid MSc, R Jouhaud MDRes, V Kampalath MD, J Polonsky PhD, Prof K Blanchet PhD)**; Department of Infectious Diseases, Imperial College London, London, UK** (A Abbara MDRes)**; Department of Community Medicine and Public Health, Faculty of Medicine and Health Sciences, University of Aden, Aden, Yemen** (A Bahattab PhD)**; Center for Research and Training in Disaster Medicine, Humanitarian Aid and Global Health, Department for Sustainable Development and**

Ecological Transition, Università del Piemonte Orientale, Novara, Italy (A Bahattab)**; Department of Population Studies, El Colegio de La Frontera Norte, Tijuana, Mexico** (Prof I Bojorquez PhD)**; Refugee Law Initiative, School of Advanced Study, University of London, London, UK** (Prof D Cantor PhD)**; Feinstein International Center, Friedman School of Nutrition Science and Policy, Tufts University, Boston, MD, USA** (Prof D Maxwell PhD)**; School of Economics, Universidad de los Andes, Bogotá, Colombia** (A Moya PhD)**; Department of Public Health, Ankara University Faculty of Medicine, Istanbul, Türkiye** (E Ontas MD)**; BRAC James P Grant School of Public Health and Center of Excellence for Gender, Sexual and Reproductive Health and Rights, BRAC University, Dhaka, Bangladesh** (Prof S F Rashid PhD, I Jahan MSc)**; Cambridge Centre for Environment, Energy and Natural Resource Governance, University of Cambridge, Cambridge, UK** (M Rao PhD)**; Las Casas Institute for Social Justice, Blackfriars Hall, University of Oxford, Oxford, UK** (H Slim PhD)**; Chemical and Pharmaceutical Engineering Department, School of Applied Medical Sciences, German Jordanian University, Amman, Jordan** (Prof A Abdelhay PhD)**; Department of Community Medicine and Public Health, Faculty of Medicine and Health Science, University of Aden, Aden, Yemen** (Prof H Basaleem PhD)**; Ecole Regionale de Santé Publique, Université Catholique de Bukavu, Bukavu, Democratic Republic of Congo** (Prof G Bisimwa PhD, P Mwene-Batu PhD)**; International Public Health, Liverpool School of Tropical Medicine, Liverpool, UK** (Prof F M Fouad MD, I R Bou-Orm MD)**; Department of Epidemiology and Population Health, Faculty of Health Sciences, American University of Beirut, Beirut, Lebanon** (Prof F M Fouad)**; School of Population and Global Health, McGill University, Montreal, QC, Canada** (Prof J Liu MD)**; Centre Hospitalier Universitaire Sainte-Justine, University of**

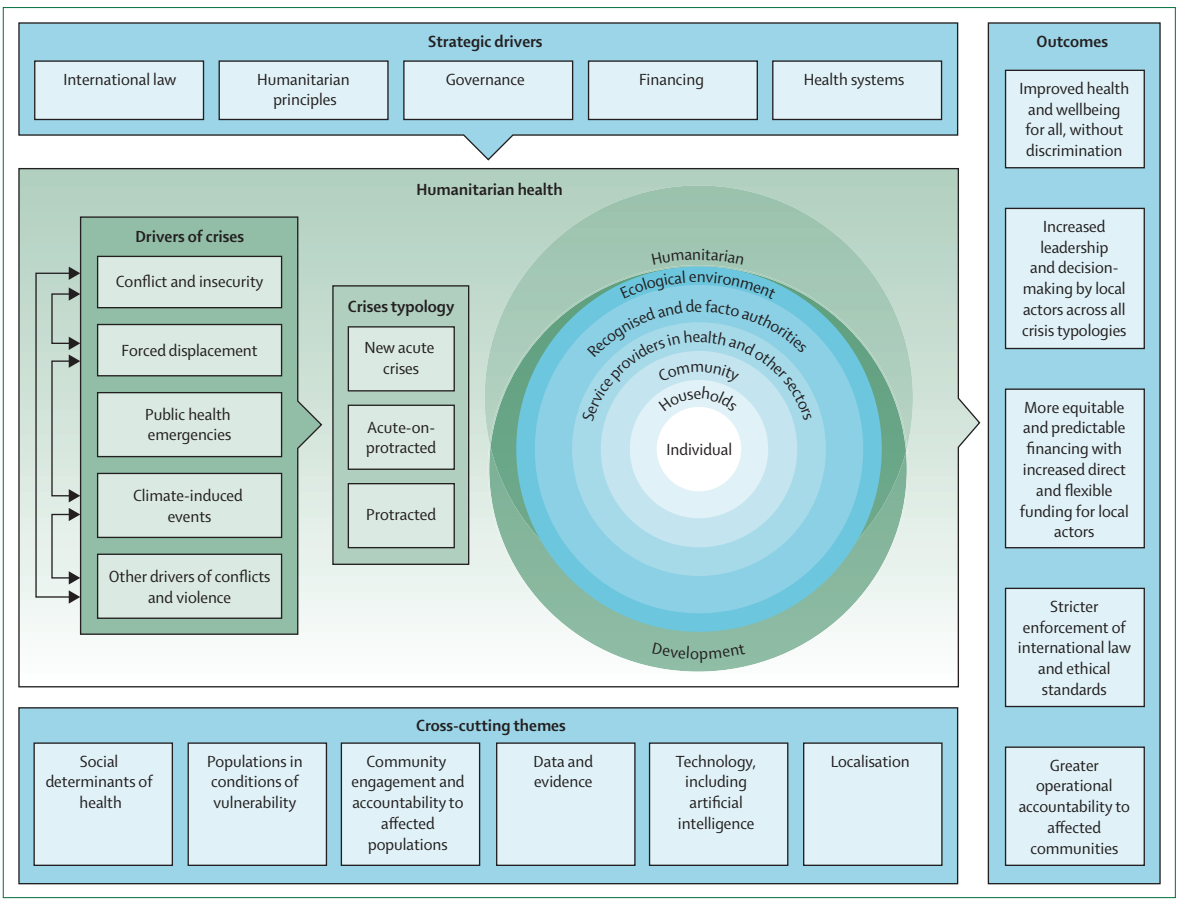

***Figure*: Conceptual framework**

displacement as the primary reference point for change, and to deliver evidence-informed, forward-looking recommendations grounded in realism and ambition. These objectives are pursued with urgency. This Commission is not another call to do better; it is a demand to do differently, and to do so now. Decades of diagnoses, frameworks, and pledges have failed to halt deepening crises, expanding impunity, and collapsing political commitment. The 2026 Global Humanitarian Overview confirms that even at maximum ambition, the system now operates as survival triage rather than universal protection. In this moment, incremental reform is not only inadequate; it is dangerous.

This Commission advances a bold, integrated, sequenced, and execution-oriented programme for transformation, grounded in a deliberate shift of power and resources toward affected populations and locally legitimate actors. This is not a menu of options, but a coherent framework (figure) designed to be operationalised, measured, and enforced, explicitly accounting for political resistance and unequal power dynamics. This framework is implemented through a structured, context-specific decision matrix (panel 1) that guides decision-making across crisis contexts, governance conditions, and levels of system capacity. Communities are placed at the centre, and protection, accountability, climate risk, and ethical obligations are treated as non-negotiable. Decolonisation is made practical through localisation with authority.

The Commission's framework is grounded in a streamlined crisis typology of acute, acute-on-protracted, and protracted emergencies, recognising that most humanitarian health needs now arise in acute-on-protracted and protracted emergencies. Governance, financing, and external engagement must therefore be calibrated together to each crisis type, using the decision matrix to avoid default coordination, financing, and delivery models. The typology serves as the organising anchor for how power, accountability, financing, and health system responsibilities are defined and operationalised throughout this Commission.

This Commission re-examines humanitarian principles as practical instruments of action rather than abstract doctrine. Humanity and impartiality are reaffirmed as non-negotiable.

> "I believe this remains one of the core principles—offering care without discrimination."
>
> *Health official, Burkina Faso*

Panel 1: Context-specific decision matrix for humanitarian and health action

This panel presents a decision matrix to operationalise the Commission's conceptual framework by translating commitments on localisation, equity, and accountability into concrete actions that shift power and resources closer to affected populations. It is designed to support real-time decision making in complex humanitarian and health settings.

The matrix integrates established principles and practices drawn from multiple sources, including WHO, the UN Office for the Coordination of Humanitarian Affairs, Health Cluster guidance, the Red Cross and Red Crescent Movement, and community-led approaches, into a streamlined, sequential model. Its added value is not in the introduction of new components, but in the organisation of existing ones into coherent decision making that, within a single tool, explicitly foregrounds equity, legitimacy, localisation, and accountability across diverse crisis typologies.

Depending on various degrees of subsidiarity, the matrix is structured around four sequential decision points, which guide practitioners from community priorities and lived realities, through authority, legitimacy, and protection responsibilities, to delivery-level and system-level capacity, performance and resilience. In doing so, the matrix deliberately inverts dominant top-down humanitarian planning approaches that begin with predefined service models or technical system assessments. Instead, it centres local trust, legitimacy, and decision making from the outset, and provides guidance on when and how external actors should engage to reinforce rather than replace local leadership and systems.

1. Community priorities and lived realities

Anchoring decisions in community-defined needs, trust, and accountability.

- Engage trusted local actors to co-assess needs and co-design solutions
- Embed community feedback mechanisms to support ongoing monitoring of services
- Assess how communities define or perceive legitimacy and trust, including how governing authorities and health actors are viewed, with attention to how authority is experienced across different population groups, particularly those who are marginalised or excluded

Decision point 1: are community needs, perspectives, and perceptions of legitimacy and trust sufficiently embedded to meaningfully inform planning, service design, and accountability mechanisms?

2. Authority, legitimacy, and responsibility for protection and health

Understanding who governs, who is trusted, and who is responsible for protection and health.

- Determine who the recognised (state) and de facto (non-state) authorities are, based on community trust and acceptance, their decision-making power, their track record in delivering impartial health services, and their capacity to coordinate and manage care across levels
- Assess how sanctions, counter-terrorism measures, and other external restrictions affect the ability of these authorities to fund, coordinate, and deliver equitable and impartial health services
- Where recognised or de facto authorities lack legitimacy, capacity, or the ability to ensure impartial health service delivery and protection, define the functions that must be temporarily assumed externally to secure rights and equitable lifesaving access, with explicit limits, safeguards, and benchmarks for transition to legitimate, accountable local leadership

Decision point 2: are the recognised and de facto authorities perceived as legitimate among affected populations, and do they have the power, capacity, and external operating space to coordinate, fund, and deliver accountable and impartial health services? If not, what time-limited external functions are required to protect rights and sustain access, and what indicators will trigger transition to legitimate local leadership?

(Panel 1 continues on next page)

Neutrality and independence are treated as context-dependent, mandate-based means to enable access and acceptance in many operational settings, applied according to context and risk, and not used to exclude actors providing impartial assistance. Alongside these, the Commission advances do no harm, solidarity, and accountability as additional core contemporary principles guiding operational decision-making and enforcement. Accountability extends beyond legal obligations to include responsibility for evidence-based action, effectiveness, continuity of care, and measurable outcomes. These principles guide operational decision making and enforcement.

Health is defined broadly, encompassing clinical care, public health, and the social determinants of health, because humanitarian health outcomes are inseparable from rights, dignity, gender, culture, and living conditions. If an intervention keeps people alive and protected, it is humanitarian health.

This Commission translates this framework into action through five strategic drivers (panel 2): international law, humanitarian principles, governance, financing, and health systems. Each driver includes actionable recommendations designed to convert commitments into enforceable change in contexts marked by political resistance, coercion, and impunity.

Power, decisions, and accountability: a pragmatic theory of change

The Commission is explicit that ideas alone will not shift the system; power will. The current moment—defined by

Montreal, Montreal, QC, Canada (Prof J Liu); **Département de Santé Publique, Unité de Formation et de Recherche en Sciences de la Santé, University of Ouagadougou, Ouagadougou, Burkina Faso** (Prof N Meda PhD, M Niaoné MD); **ODI Global, London, UK** (S Pantuliano PhD); **Center on Forced Displacement, Department of Biomedical Engineering, Boston University, Boston, MA, USA** (Prof M Zaman PhD, H Lindsay MPH); **David Nott Foundation Analysis, David Nott Foundation, London, UK** (M Alkhalil MD); **Syria Public Health Network, London, UK** (M Alkhalil); **Humanitarian Policy Group, ODI Global, London, UK** (K Holloway PhD); **Care and Public Health Research Institute, Department of Health, Ethics and Society, Maastricht University, Maastricht, Netherlands** (I Jahan); **Fletcher School of Law and Diplomacy, Tufts University, Boston, MA, USA** (T Kannan MA); **BRAC James P Grant School of Public Health and Climate Change, Environment and Health Hub, BRAC University, Dhaka, Bangladesh** (F Misha PhD); **Department of Health Policy and Management, Institute of Public Health, Jagiellonian University, Krakow, Poland** (I A Bielska PhD); **Department of Health Research Methods, Evidence and Impact, McMaster University, Hamilton, ON, Canada** (I A Bielska); **Juba Strategic Consulting, Juba, South Sudan** (K E Nasunbga Modi MD); **Department of Health Behavior and Society, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA** (M Niaoné); **Higher Institute of Public Health, Faculty of Medicine, Saint Joseph University of Beirut, Beirut, Lebanon** (I R Bou-Orm); **Department of Health Sciences, Universidad de las Américas Puebla, San Andrés Cholula, Puebla, Mexico** (C Rodriguez PhD); **Department of Paediatric Oncology, Shaukat Khanum Memorial Cancer Hospital and Research Centre, Lahore, Pakistan** (A Sadaf MBBS); **Geneva Digital Health Hub, Faculty of Medicine, University of Geneva, Geneva, Switzerland**

(C Perrin Franck PhD, M M Randriambelonoro PhD); **Department of Pediatrics, University of Pennsylvania, Philadelphia, PA, USA** (V Kampalath)

Correspondence to: Prof Paul Spiegel, Department of International Health and Center for Humanitarian Health, Johns Hopkins Bloomberg School of Public Health, Baltimore 21205, MD, USA **pbspiegel@jhu.edu**

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3. Local health systems and non-authority capacities

Determining who can deliver what, where, and with which gaps.

Local and national actors

- Map and assess non-governmental, faith-based, private, and informal health providers, examining legitimacy, service capacity, geographical reach, relationships with authorities, and responsiveness to community-defined health needs
- Identify gaps, overlaps, and opportunities for partnership to strengthen coordination, vertical integration (local to national), and cross-sector collaboration (including water, sanitation, and hygiene; nutrition; food security; shelter; and protection)
- Assess barriers to access for the identified services and providers, including financial, legal, social, and security-related constraints, with particular attention to women, people with disabilities, marginalised groups, and populations in contested or hard-to-reach areas

Decision point 3a: are local and national health actors, including non-governmental, private, and informal providers, sufficiently capable, accessible, and trusted to deliver essential health services on their own? If not, what specific gaps in capacity, access, or support need to be addressed?

Regional and international actors

- Based on identified gaps, determine which functions require complementary regional or international support and which actors are best placed to provide that support in ways that reinforce local leadership and align with community health priorities
- Assess transition strategies, including capacity transfer and responsible exit planning aligned with humanitarian–development–peace nexus principles, with clear benchmarks for handover

Decision point 3b: is regional and international engagement clearly justified, time-limited, and bounded to minimum functions required to protect rights and sustain equitable access and reinforcing local leadership and contributing to decentralised, community-aligned health systems with clear benchmarks for transition and handover?

4. Health system performance and resilience

The system must be able to withstand, adapt, and recover—not merely deliver for today

- Evaluate core health system functions, including service delivery continuity and equity, workforce capacity, sustainability, financing flows, governance arrangements, access to medicines and supplies, and health information systems, identifying crucial bottlenecks, fragilities, and risks to continuity
- Assess whether these core functions are operational and coherent across levels (local, subnational, and national), including in areas under de facto governance, given the delivery arrangements identified in decision points 3a and 3b
- Assess the current or planned humanitarian ecosystem, including humanitarian and development actors, and whether these actors are, or can be, effectively integrated into a coherent health system response that strengthens performance, resilience, and accountability across levels and that is time-bound and function-specific

Decision point 4: can the health system—across formal, informal, and de facto components—sustain core functions and respond to current needs? If not, how can the current or planned humanitarian ecosystem be configured to enhance system performance, resilience, equity, and accountability, as well as contribute to long-term recovery?

The decision matrix translates the conceptual framework into operational choices. However, the feasibility, sustainability, and equity of those choices depend on deeper structural conditions, including international law, humanitarian principles, governance, financing, and health system capacity. The section on strategic drivers examines these five system-level strategies that enable implementation across crisis typologies and underpin this Commission's recommendations for structural change.

budget contraction, donor-controlled financing, and institutional retrenchment—creates both acute risk and a narrow window for transformation. Past reforms were diluted or neutralised because they failed to confront how donor incentives, institutional mandates, and geopolitical priorities shape decisions in practice. As a novelty, this Commission therefore proposes a set of four overarching recommendations for transformation that are interdependent and mutually reinforcing, treats resistance to transformational change as a structural condition of the system, not an aberration, and explicitly incorporates political constraints and incentive structures within its theory of change.

First, invert the power by shifting governance, funding, and decision-making to affected communities and locally legitimate actors, and transforming existing humanitarian structures. Second, end impunity by enforcing accountability to affected populations through law, ethics, humanitarian principles, and action, recognising accountability as a continuous function across governance, financing, coordination, and implementation. Third, fix the money by ensuring humanitarian financing is needs-based, fair, flexible, and supports locally accountable decision-making, thereby driving equitable health outcomes and protecting resource allocation from political distortion. Fourth, uphold health for all as a non-negotiable right by delivering equitable, safe, climate-resilient, and locally anchored health care in crisis settings, with targeted approaches for populations facing heightened risks and vulnerabilities (panel 3).

***Panel 2*: Five strategic drivers for transforming humanitarian health**

International law and the health imperative in conflict: from commitments to compliance and accountability
International law is central to protecting civilians and health care in conflict, yet violations affecting health are widespread and largely consequence-free. Enforcement mechanisms are weak, accountability is fragmented, and legal obligations are rarely assessed against population health outcomes or continuity of care. The way forward requires treating international law as operational, strengthening documentation and enforcement, linking violations to political and financial consequences, and using health outcomes as concrete indicators of compliance.

Principled humanitarian action: navigating ideals and emerging realities
Humanitarian principles are foundational but are increasingly invoked rhetorically despite being inconsistently applied in practice. Political pressure, security constraints, and institutional risk aversion have hollowed out principles, particularly neutrality and independence, often enabling exclusion or inaction. The way forward is to operationalise principles as decision rules, reaffirm humanity and impartiality as non-negotiable, apply neutrality and independence contextually to enable access and acceptance, and embed do no harm, solidarity, and accountability into enforcement and practice.

From legacy to legitimacy: a new architecture for humanitarian and health governance
Humanitarian and health governance remains dominated by legacy institutions whose authority often lacks local legitimacy and accountability. Centralised decision making, parallel systems, and unclear mandates fragment responsibility and undermine national and local leadership, particularly in protracted crises. The way forward is to invert power toward affected communities and locally legitimate actors, clarify roles and accountability across crisis typologies, and establish time-bound entry, transition, and exit arrangements for international actors.

Financing future humanitarian action: from politicised short-term to equitable and predictable, needs-based financing
Humanitarian financing is shaped by donor concentration, political priorities, and short-term cycles rather than population health needs. Earmarking, volatility, and unpredictability distort priorities, undermine continuity of care, and shift risk onto affected populations and fragile health systems. The way forward is to rewire financing to follow assessed need and equity, reduce donor concentration and earmarking, and expand predictable, multiyear, and pooled financing that supports locally accountable decision making.

Health systems for crises: from emergency delivery to preparedness, continuity, recovery, and innovation
Humanitarian health action remains overly focused on short-term service delivery rather than sustaining health systems across crisis cycles. Fragmentation, disrupted financing, workforce losses, weak integration, and weak digital foundations undermine continuity, quality, and resilience, especially in protracted crises. Emerging technologies and artificial intelligence offer important opportunities to improve early warning, triage, supply chains, clinical decision support, and system planning, but without equitable access, regulation, and accountability they may also deepen exclusion and risk. The way forward is to prioritise health systems protection, ensure continuity and quality of care, integrate humanitarian and national systems where feasible, and invest in preparedness, workforce capacity, climate-resilient services, and ethically governed digital and artificial intelligence capacities that support more resilient, adaptive, and accountable health systems.

This Commission's conceptual framework and context-specific decision matrix, together with recommendations specific to each of the five strategic drivers, underpin actionable logic that is deliberately sequenced. Power must first be shifted to affected communities and locally legitimate actors, because exclusion from decision-making undermines justice, equity, effectiveness, and sustainability.

> "Now, it feels like there is no state; what governs the country are organisations [and] personal relationships between those in power. There was a state before the war, even with its flaws, [with] independent institutions and budgets. Now, the hospitals are working without a budget. When the support stopped months ago, the hospital shut down. It's the same issue; they're relying on support from the organisations. But how long can you rely on organisations?"
>
> *Staff at a national NGO, Yemen*

This shift cannot be sustained without credible accountability processes and enforceable consequences across the full chain of actors, including states, de facto authorities, donors, UN agencies, and humanitarian organisations. Without sustained political engagement and commitment, accountability itself cannot be exercised; in its absence, change remains performative.

> "Many reports about violations by ISIS [the Islamic State of Iraq and Syria] were produced by humanitarian organisations and effectively communicated to the media. In contrast, there was a lack of similar efforts or coverage concerning the attacks on health care in Syria by the Russian and Syrian regimes, as well as the Israeli attacks in Gaza. This discrepancy indicates a missing link. It seems that considerations are taken into account depending on the perpetrator and the victim."
>
> *Health professional, Syria*

Financing must then be rewired to follow need rather than political or institutional interests, through mechanisms that are fair, flexible, and accountable, and that support locally led decision making.

***Panel 3*: Four core interdependent recommendations for system change in humanitarian action**

Invert the power

Shift governance, funding, and decision-making to affected communities and locally legitimate actors, and transform existing humanitarian structures.

- Affected people as decision-makers and reference points
- Put community-perceived legitimacy at the centre of governance
- Make external leadership exceptional, time-bound, and conditional
- Build and support nationally led systems for health and social protection
- Redesign humanitarian architecture to serve local authority and accountability

End impunity

Enforce accountability to affected populations through law, ethics, humanitarian principles, and action, recognising accountability as a continuous function across governance, financing, coordination, and implementation.

- Make accountability to affected populations central, continuous, and enforceable
- Treat attacks by state and non-state actors on civilians and health care, and violations of humanitarian principles, as failures of obligation
- Use health outcomes and continuity of care as tests of compliance
- Strengthen and connect national, international, and political accountability mechanisms
- Apply accountability across the full chain of actors and decisions

Fix the money

Ensure humanitarian financing is needs-based, fair, flexible, and supports locally accountable decision-making, driving equitable health outcomes and protecting resource allocation from political distortion.

- Decouple financing from politics and re-anchor it in need, risk, and equity
- Use financing to correct power asymmetries in decision-making
- Align financing horizons with the realities of protracted crises
- Treat financing as a tool for accountability and protection
- Ensure financing supports future resilience, not just response

Uphold health for all as a non-negotiable right

Deliver equitable, safe, climate-resilient, and locally anchored health care in crisis settings, with targeted approaches for populations facing heightened risks and vulnerabilities.

- Make the right to health an operational decision rule
- Prioritise equity and essential services for those at greatest risk
- Make continuity of care and system integration the default
- Treat protection of health care and health-care workers as a non-negotiable right
- Embed climate-resilience and digital responsibility in health systems

> "Funding is a major issue. Humanitarian aid often depends on countries with political considerations that influence their decisions. Recently, many countries have withdrawn their funding from Burkina Faso and the broader Sahel region. Almost all NGOs have seen budget cuts, forcing them to downsise or even close offices."
>
> *Staff at an INGO, Burkina Faso*

Only on this foundation can health for all be upheld as a non-negotiable right in practice, shaping concrete choices about service delivery, system integration, protection, continuity of care, and the responsible use of technology in highly constrained settings across crisis types.

> "When essential services are shut down or temporarily unavailable, it exacerbates tension in the settlement. This leads to significant emotional distress, not only for the people in the community who rely on these services but also for us, the fieldworkers. We are caught in the middle—community members are right to feel abandoned, but we are left to manage these difficult situations without any resolution to offer them."
>
> *Community health volunteer, Bangladesh*

This Commission has purposefully designed these recommendations through a multisectoral lens, grounded in the experience of practitioners and people affected by conflict and forced displacement, to address the dual challenge of escalating humanitarian need and a humanitarian health system that is no longer fit for purpose, nor sustainable (panel 3).

This agenda of transformation explicitly recognises the shifting and increasingly complex geopolitical, financial, and environmental landscape requiring in-depth and multifaceted changes.

This Commission's analysis and recommendations are directed to states, non-state actors, donors, multilateral institutions, and humanitarian, health, and local leaders whose decisions determine whether protection, care, and accountability are realised or denied for populations affected by armed conflict and forced displacement. Although not all elements of these recommendations can be fully realised under current political and power dynamics, the depth of systemic failure renders incremental adjustment neither credible nor sufficient. This agenda therefore requires ambition tempered by realism, and action calibrated to what is politically possible without surrendering what is morally necessary. Implementation will require deliberate sequencing and prioritisation, guided by urgency, political feasibility, resource implications, and potential system-wide leverage, rather than attempting simultaneous system-wide changes. Even in a fractured political landscape, meaningful progress is still possible if those with power act with greater courage, consistency, and accountability.