# Health, Conflict, and Forced Displacement: health in a world of crises and impunity

Report of the Johns Hopkins Center for Humanitarian Health – *Lancet* Commission

Johns Hopkins Bloomberg Center · Washington DC · 2 June 2026

# A humanitarian system not fit-for-purpose

**239M**
people in need of humanitarian assistance in 2026

**87M**
prioritised for survival — triage as policy

**\$44B → \$29B**
global appeal cut mid-2025 (only 55% funded)

**123M**
forcibly displaced worldwide — highest number ever recorded

**3,663**
attacks on healthcare in 2024 — highest on record & 18% increase from 2023

- **Near doubling of conflict-related deaths** between 2021 and 2024.
- **\$23 billion** = cost of meeting most life-threatening needs is <**1% of global military spending.**

The system meant to respond has been gutted at exactly the moment need has peaked.

# Forcibly displaced persons (1980-2024)

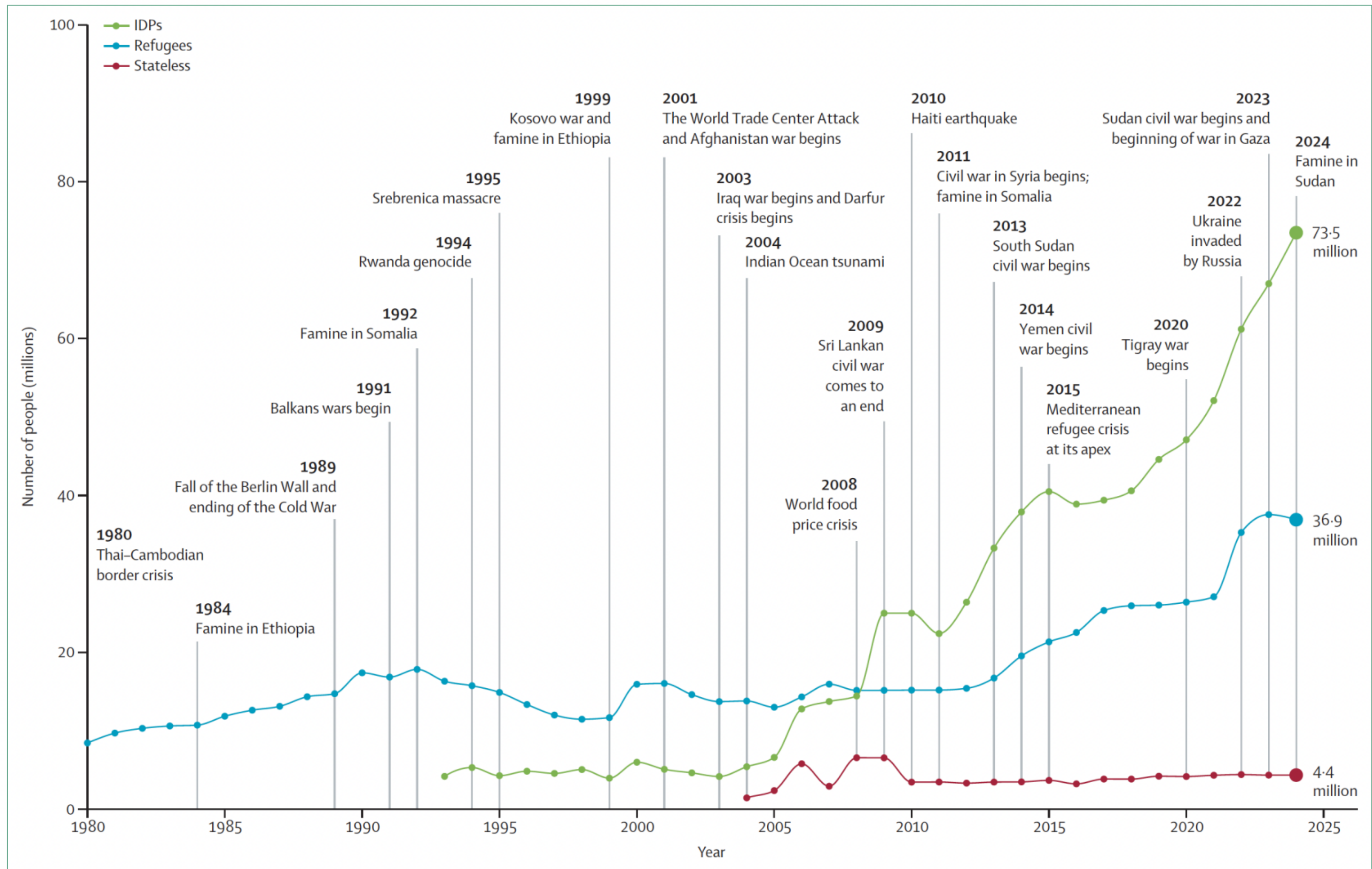


*Figure 1*: **Forcibly displaced persons and statelessness from 1980–2024 with key events**

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# Reported attacks on health care worldwide (2018-24)

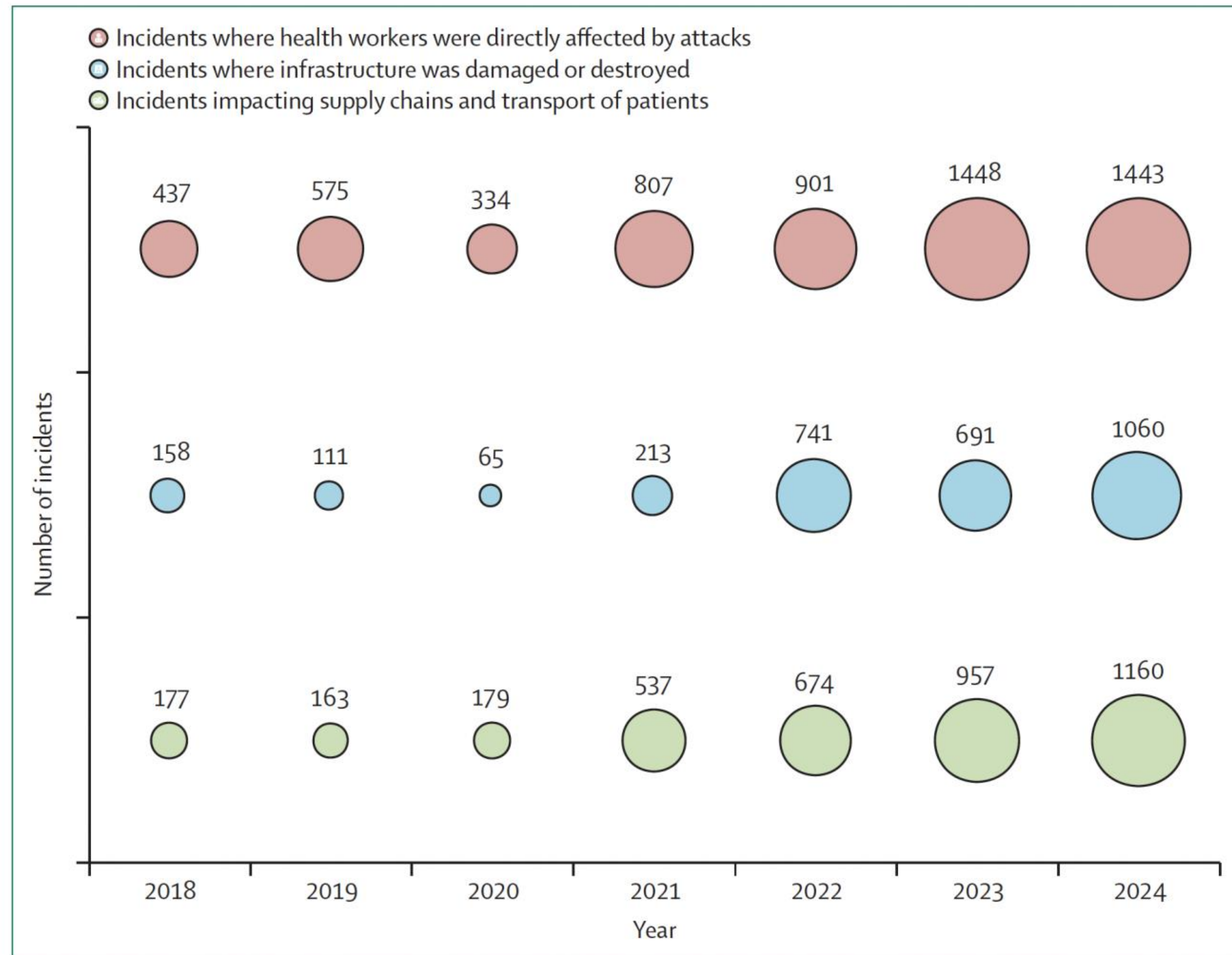


***Figure* 6: Reported attacks on health care worldwide (2018–24)**
The dataset was obtained through personal communication (C Wille, Insecurity Insight).

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# Direct Funding to Local and International Recipients

LNNGOs LNAs International first-level recipients

International humanitarian assistance (%)

100 80 60 40 20 0

2016: 96·9%, 2·8%, 0·3%
2017: 95·9%, 3·7%, 0·4%
2018: 96·1%, 3·5%, 0·4%
2019: 97·7%, 1·9%, 0·4%
2020: 96·8%, 2·9%, 0·3%
2021: 98·2%, 1·5%, 0·3%
2022: 97·3%, 2·5%, 0·2%
2023: 94·5%, 4·7%, 0·8%
2024: 95·7%, 3·6%, 0·7%

Year

*Figure 11:* **Proportion of direct funding to LNAs, LNNGOs, and international first-level recipients**

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# Global IDP burden and humanitarian funding by top ten countries (2009-2024)

| Year | Global IDP population | Humanitarian funding received |
|---|---|---|
| 2009 | 68·8% | 40·9% |
| 2010 | 67·9% | 43·5% |
| 2011 | 65·8% | 35·1% |
| 2012 | 69·6% | 33·8% |
| 2013 | 74·6% | 36·0% |
| 2014 | 70·9% | 29·1% |
| 2015 | 66·4% | 38·8% |
| 2016 | 70·1% | 41·7% |
| 2017 | 69·7% | 48·1% |
| 2018 | 71·0% | 53·5% |
| 2019 | 74·2% | 50·1% |
| 2020 | 67·8% | 39·8% |
| 2021 | 67·6% | 44·6% |
| 2022 | 54·6% | 38·6% |
| 2023 | 65·7% | 35·7% |
| 2024 | 65·2% | 33·9% |

Proportion (%) — Year

*Figure 8:* **Percentage of the global IDP population originating from the ten most frequently listed countries* and the percentage of global humanitarian funding allocated to these countries (2009–24)**

# Through Their Lens: Youth Voices from Displaced Communities in Türkiye

**Double displacement**

In Hatay, 12 years into displacement and still living in the shadow of an earthquake's destruction, a young, displaced woman captures a street where order was not yet restored. Around her stand crumbling houses, and walls scarred by time and disaster. "Some have no choice, but to live in these places because of their socioeconomic situation."

**Social isolation**

The second photograph shows the outer walls of a school and a tenth-year student, a displaced youth, speaks of stigmatisation and social isolation. "They were punished several times, but they keep doing the same things" she explains. The absence of people in her image might show the absence of belonging she feels within those walls, despite social cohesion efforts.

**The taste of solidarity**

The third photograph shifts the tone. A young, displaced girl explains that this pot with cooked food was brought by her Turkish neighbour when her mother was sick. "If I had a chance to take something out of this pot, I would take out freedom and happiness... for everybody." In her photograph, the meal is more than nourishment; it is a sign of social cohesion, a quiet moment where compassion crosses cultural lines, reminding us that solidarity can find a way in, improving the wellbeing of many refugees.

*Figure 3:* **Through their lens—youth voices from displaced communities in Türkiye who participated in a Photovoice study**

# Challenging power structures and amplifying voices

## AMBITION

To rethink the strategies, governance, and delivery of humanitarian health — and to amplify the voices of those the system is meant to serve.

**Not another call to do better.**
**A call to do differently — and to do so now.**

| | |
|---|---|
| >2 | Years the Commission researched this report |
| 42 | Commissioners and Next-Gen Scholars from the Global South and North |
| 29 | Advisory Committee members — donors, UN agencies, other multilateral organisations, NGOs |
| 533 | Affected populations and humanitarian workers interviewed in 12 countries |
| 13 | Thematic working groups; multi-disciplinary expert reviews |

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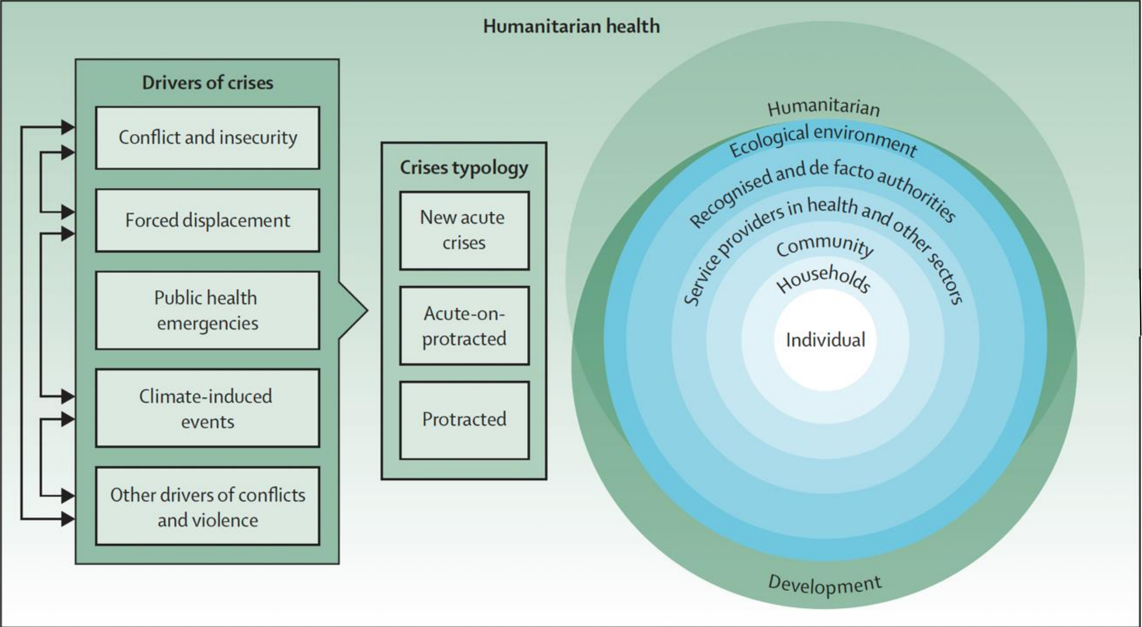
# Conceptual framework



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# Conceptual framework

**Strategic drivers**

- International law
- Humanitarian principles
- Governance
- Financing
- Health systems

**Humanitarian health**

**Drivers of crises**

- Conflict and insecurity
- Forced displacement
- Public health emergencies
- Climate-induced events
- Other drivers of conflicts and violence

**Crises typology**

- New acute crises
- Acute-on-protracted
- Protracted

Humanitarian
Ecological environment
Recognised and de facto authorities
Service providers in health and other sectors
Community
Households
Individual
Development

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**Cross-cutting themes**

Social determinants of health | Populations in conditions of vulnerability | Community engagement and accountability to affected populations | Data and evidence | Technology, including artificial intelligence | Localisation

# INVERT THE POWER

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

> *"Decisions are often made in the capital or internationally, far from local realities, which leads to delays."*
>
> *— Health provider, DRC*

# INVERT THE POWER

## Examples of key actions

### Apply a crisis typology & decision matrix

Use a decision matrix to guide context-specific governance models and clarify the rationale, scope, and duration of regional and international actor involvement.

### Subsidiarity by default

Shift governance, funding, and decision-making to affected communities and locally legitimate actors — not just as a principle, but as the operational default.
International leadership should be used only as an exceptional, time-bound, and conditional measure where legitimate local alternatives are absent.

### Consolidate the UN system

Move toward a single, integrated, accountable operational entity.
Replace the Cluster System and Refugee Coordination Model with fit-for-purpose incident management systems that deliver clear leadership and measurable results.

OPERATIONAL TOOL

# CRISIS TYPOLOGY & DECISION MATRIX

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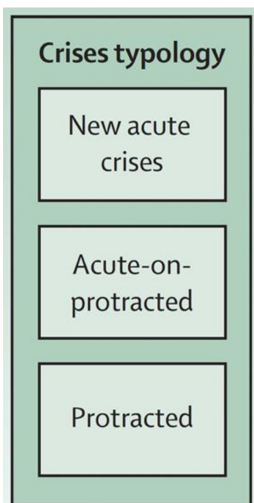
*A sequential, community-anchored decision logic for humanitarian health action.*




### 1 Community priorities

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

**Decision:**
*Are community needs and trust embedded in planning?*

### 2 Authority & protection

Identify who governs, who is trusted, and who protects health.

**Decision:**
*Are authorities legitimate and capable?*

### 3a Local health systems

Map local actors and capacities; identify access barriers and coverage gaps.

**Decision:**
*Can local actors deliver — and where are the gaps?*

### 3b External support

Justified, time-limited international support to fill specific gaps, with clear handover benchmarks.

**Decision:**
*When and how should external actors step in — and exit?*

### 4 Performance & resilience

Sustain delivery, equity, and accountability over time.

**Decision:**
*Can the health system hold, adapt, and recover?*

# END IMPUNITY

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

> *"If I treat a member of an armed group responsible for killing my brothers, it tests my patriotism. If the government finds out, I could face repercussions. Yet, if I report it, I risk being seen as an enemy by the armed groups, which could endanger my life. We've even seen health centres attacked, including an [INGO] facility."*
>
> — *Health official, Burkina Faso*

# END IMPUNITY

## Examples of key actions

### Global Health Protection Alliance

Establish an Alliance of States, UN entities, and NGOs to systematically act — not just condemn — when health protections are violated.

### Five core principles

Apply humanity, impartiality, do no harm, solidarity, and accountability as the framework for principled action.
Neutrality and independence remain essential, context-dependent means to ensure access.

### Health outcomes as accountability

Use health outcomes as measures of system performance, indicators of IHL compliance, and triggers for formal investigation and accountability.

# FIX THE MONEY

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*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.*

> *"This is a field that is largely shaped by donors. We are in a position where we do whatever the donor asks us to do. Of course, NGOs conduct needs assessments and evaluations, but, if a donor says that psychological support will not be provided within the scope of this fund, NGOs generally do not reject this."*
>
> — Field Coordinator at a local NGO, Türkiye

# FIX THE MONEY

## Examples of key actions

### Independent pooled fund

Governed independently of UN agencies and bilateral donors.
Allocations based on assessed need and equity — not donor priorities.

### Expand cash-based assistance

Give affected populations agency over their own lives.
Strengthen local economies and support more efficient, equitable delivery.

### Integrate with national systems

Ensure displaced populations access health and social protection through national systems — not parallel humanitarian structures.

### Innovative financing

Implement context-specific innovative financing instruments to diversify donor pools and leverage new funding sources.

# UPHOLD HEALTH FOR ALL

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

*"There are many Syrian refugees in the camp who are in medical fields: nurses, doctors, pharmacists, dentists, and lab technicians. If they were given professional practice licenses, they could work within the community and help improve services."* — Refugee, Azraq camp, Jordan

RECOMMENDATION 4 OF 4

# UPHOLD HEALTH FOR ALL

## Examples of key actions

### Right to health for all

Anchor health responses in the right to health.
Prioritise equity and essential services for those at greatest risk: women, children, older adults, and people with disabilities.

### Continuity, quality, safety

Deliver essential services based on need and adapted to context.
Ensure continuity and quality of care across crisis settings — locally anchored, accountable, and reaching those most excluded.

### Protect health care

Ensure protection of health care and health workers as a non-negotiable right — shared across states, non-state actors, and the humanitarian ecosystem.

### Climate & technology

Integrate climate resilience and deploy technology — including AI — as core enablers of system performance, with safeguards for equity, data protection, and human oversight from the outset.

ONCE-IN-A-GENERATION MOMENT

# Out of crisis comes a rare opportunity — the chance to remake humanitarian and health action

### THE DIAGNOSIS

The problem is not only underfunding, fragmentation, or coordination.
The deeper problem is power: who defines needs, who controls resources, and who is held accountable.

### THE MOMENT

Humanitarian Reset, UN80, and Accra Reset have created political space for change — but space is not enough.
This moment must be seized before it is absorbed by the system it seeks to transform.

### THE DEMAND

This Commission is not a diagnosis, but a demand.
The 533 lived experience voices behind this report calling for a system where affected people are equal actors, decision makers, and rights holders.

*"The real issue is that some donors not only expect you to remain neutral but also threaten to suspend your funding if you show any [perceived] bias toward the victims."*

— Health professional, Syria

THE CALL

# Not another call to do better.

## *A call to do differently — and to do so now.*

### AFFECTED POPULATIONS

Claim care, rights, data control, and accountability.

### NATIONAL & SUBNATIONAL AUTHORITIES

Protect civilians, lead coordination, and integrate displaced populations.

### LOCAL & NATIONAL NGOS

Assert leadership, demand equitable partnerships and real cost recovery.

### REGIONAL BODIES

Govern cross-border, strengthen regional health and protection.

### INTERNATIONAL NGOs

Enable local systems, transfer power and resources.

### UN & MULTILATERALS

Slim down, coordinate, don't compete, give up power.

### DONORS

Pool funds, predictable, multi-year and depoliticized funding.

### ACADEMIC & RESEARCH INSTITUTIONS

Generate evidence, shape policy and guide public discourse.

# Johns Hopkins Center for Humanitarian Health – *Lancet* Commission on Health, Conflict, and Forced Displacement

## Health in a World of Crises and Impunity

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THE LANCET