HEALTH STRATEGY
2020–2023
1. EXECUTIVE SUMMARY

Health Strategy 2020–2023 builds on Health Strategy 2014–2018 and addresses the increasing volume of unmet humanitarian health needs, many of which result from: protracted conflict, poverty and climate-related shocks; severe shortages in the global health workforce and weakened health systems; and the increasingly challenging and complex humanitarian space. This strategy, supplemented by a four-year implementation roadmap, guides health operations for the period 2020–2023. It is aligned with the ICRC Strategy 2019–2022, in that it emphasizes ensuring humanitarian action is people-centric, delivered in collaboration as much as possible, and forward-looking (i.e. seeking to make a sustainable humanitarian impact).

The strategy is anchored in three guiding principles: first, putting people and their needs at the centre, second, making optimal use of resources within an integrated public health approach to have a larger impact, and third, ensuring that health activities follow a continuum of care approach and therefore connect with existing health systems and their components.

The objectives in the field of health for the period 2020–2023 are:

STRATEGIC OBJECTIVE 1: Strengthen the ICRC’s capacity to deliver quality essential health services and address life-saving needs in a timely and effective manner across all health programmes in support of the ICRC’s overall emergency response.

STRATEGIC OBJECTIVE 2: Contribute to sustainable health outcomes by actively bolstering the resilience of both health systems and communities amidst crises.

STRATEGIC OBJECTIVE 3: Influence practice and policy in key areas of health expertise, particularly the clinical management of people wounded by weapons, the provision of health care to people deprived of their liberty, the rehabilitation of persons with physical disabilities, and the provision of mental health and psychosocial support services to people affected by armed conflict and other violence.

This strategy also makes a strong commitment to embed into ICRC health programming actions to prevent and reduce attacks on health-care workers and infrastructure and ambulance services. It also emphasizes the value of multidisciplinary action in addressing other factors that impact health outcomes, including water and sanitation, economic security and protection. Moreover, it outlines the inter-dependency of health operations with: effective people management, the development and maintenance of relevant and sustainable partnerships, and the safe use of health data and digital technologies.

At the time of publication (Q4 2020), health systems worldwide are focusing on the COVID-19 pandemic. The crisis is evolving rapidly, and there is not yet a clear indication of what the breadth of the impact will be on populations and health systems, or whether new outbreaks will emerge during this strategy’s timeframe. As such, the strategy refers to pandemics and/or epidemics in general, rather than discussing the specific aspects of COVID-19. The impact of the pandemic has, however, demonstrated the need for a more intentional commitment to building local capacity – including contributing to the strengthening of health systems – and for stronger collaborative work within and beyond the International Red Cross and Red Crescent Movement.
2. BACKGROUND

Over the past five years the ICRC has consolidated its provision of health-care services to people affected by armed conflict and other situations of violence (hereinafter “armed conflict and other violence”) by focusing on delivering quality services, developing a continuum of care approach and strengthening programme design, monitoring and evaluation as well as health staff development.¹


As the ICRC’s operational environment faces new challenges and evolving needs, this strategy aims to adapt the ICRC’s health-care activities to those changes and strengthen collaboration across teams within the ICRC and outside the organization. This approach closely aligns with organization-wide efforts to build sustainable humanitarian impact (ICRC Strategic Orientation 2) and emphasizes working with others to enhance impact (ICRC Strategic Orientation 3), in particular other components of the Movement, who play an important role in health-care delivery. This strategy and the ICRC’s overall strategy are aligned in other ways as well: health advocacy and diplomacy to ensure access

¹ For a full report on the implementation of the Health Strategy 2014–2018, see “Additional reading” below.
² ICRC Assistance Policy, policy document 49, 2004. See particularly the topics in the “Guiding Principles” section: taking the affected groups and its needs into account; effective humanitarian assistance of high quality; ethical norms; responsibilities within the Movement; and partnerships with other humanitarian actors.
to health care, for instance, is linked to influencing behaviour to prevent violations of international humanitarian law and alleviate human suffering (ICRC Strategic Orientation 1); the importance of communities of practice and better data management for quality monitoring is linked to embracing the digital transformation (ICRC Strategic Orientation 5); and the emphasis on further development of the organization’s health personnel is linked to efforts to create a more inclusive and diverse working environment (ICRC Strategic Orientation 4).

3. CHANGING HUMANITARIAN ENVIRONMENT

Over the past few years there have been significant shifts in the global humanitarian environment that have created challenges for the health-care landscape. The ICRC must adapt its health operations to meet these challenges and align operations with the ongoing internal transformation in order to better respond to the needs of people affected by armed conflict and other violence.

SHIFTING GLOBAL PATTERNS

At the time of publication, the COVID–19 pandemic has reached a scale that the world has not seen since the 1918 influenza pandemic. Ebola in the Democratic Republic of the Congo, cholera in Yemen, and polio in Afghanistan and Pakistan have in recent years provided telling illustrations of what happens when the effects of conflict and transmissible pathogens combine. Until a vaccine is widely available, it is clear that COVID–19 will produce a series of cascading crises: extreme pressure on national health-care systems, crippled global and local economies and the repercussions of the containment measures on groups that are already at high risk.

Beyond pandemics, other factors – including radicalized and polarized political and ideological agendas, and the breakdown of established global governance and economic frameworks – have led to many crises becoming protracted, with periodic, and often significant, eruptions of violence. In addition to being longer–lasting, conflict and violence are also urbanizing, in keeping with overall urbanization trends. Years of unresolved conflict have eroded entire systems across Africa and the Near and Middle East and left millions of people in need of humanitarian aid due to a lack of access to essential services. Health-care systems are particularly vulnerable in conflict because it can result in decreased funding and investment, looting and destruction of infrastructure, the loss of skilled health-care personnel, and the disruption of medical supply chains.

The burden posed by climate change is also felt in the health-care sector. Rising temperatures have shifted patterns of transmissible diseases (e.g. mosquito–borne), and unpredictable weather patterns have resulted in the loss of lives, crops and livestock and therefore increased communities’ needs. Furthermore, lack of food security is linked to population movements, deteriorating nutritional status and increased morbidity and mortality, particularly for women of reproductive age and children. In some crises, fighting over scarce resources has also increased the number of people wounded in war and in need of care.

Shifting policies, for example on migration or counterterrorism, have put certain categories of people at greater risk, such as internally displaced people and refugees, and have left them exposed to further hardship. Moreover, the multiplicity of parties to conflict and their radicalization have in some crises exerted further pressure on the space available to deliver neutral, impartial and independent humanitarian assistance to the wounded and sick.

Finally, certain groups of people are at increased risk due to marginalization and discrimination resulting from personal, social, economic and political factors which render them and their physical and mental health needs invisible. For example: women might live in communities or circumstances

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3 The ICRC has been present in its 11 largest operational contexts for over 36 years.
4 The UN estimates that two-thirds of the world population will be urban by 2050. See United Nations, World Urbanization Prospects 2018: Highlights, ST/ESA/SER.A/421, United Nations Department of Economic and Social Affairs, Population Division, 2019.
where their needs are not a priority, children or older people’s needs might not be catered to by local responders, persons with disabilities might not have access to health-care facilities, and people suffering from mental health conditions and survivors of sexual violence might face discrimination. Armed conflict and other violence only exacerbates these challenges.

A CHALLENGING HEALTH OPERATING ENVIRONMENT

The volume of unmet health needs in the places where the ICRC works continues to grow owing to protracted conflict: the periodic crises generate a large number of people in need of care at a time when health systems, including infrastructure, are dysfunctional or non-operational. In addition, there is a growing worldwide shortage of health-care workers able to provide high-quality services, exacerbated in conflict zones by the exodus of workers (i.e. brain-drain), lower numbers of workers finishing training, and direct threats or attacks against them.

Health needs are spread across all levels of care, from primary (including community-level care), through secondary and tertiary care (i.e. specialized clinical services), and are particularly acute in emergency and life-saving medical and surgical care. In these fragile contexts, where people are already at higher risk, the threat posed by outbreaks and epidemics is also a significant concern.

The shortage of health-care workers is worldwide, but especially acute in conflict settings, and is compounded by the trend of early clinical specialization, which means there are fewer generalists able to work in these environments. At the same time, compliance and regulatory frameworks are getting stricter and the expectations in terms of quality of services delivered and accountability to affected populations are increasing. The push to improve the quality of services is welcome. However, it requires investment, to further develop the skills and knowledge of health-care workers, and particularly of humanitarian health-care workers.

Gaining access to people affected by armed conflict and other violence and, conversely, their ability to access essential and often life-saving services continues to be a challenge. Sustained efforts are needed at both the global and local levels to try to make health-care spaces the safe refuges they are meant to be for the wounded and sick and the broader civilian population. And while many ICRC health activities require close proximity to communities, and this remains the preferred mode of action, alternatives must be explored.

The fast-approaching 2030 deadline for the world to achieve “health for all” has sharpened governments’ and agencies’ focus on addressing the gaps in health care in fragile environments, including those affected by armed conflict and other violence. As a result, several new health-care providers have emerged on the front lines. While this is generally positive, a great deal of caution must be exercised to avoid unintentionally shrinking the space for principled humanitarian assistance or worsening parties’ compliance with international humanitarian law.

Finally, as protracted conflicts become the norm rather than the exception in the ICRC’s work, the humanitarian landscape is expanding beyond addressing a recurrent series of emergency needs to addressing chronic, longer-term needs and systemic dysfunctions. A hybrid approach is now required, combining emergency work with longer-term, system-oriented interventions. This requires the ICRC to expand its expertise to include new areas and/or mobilize others with development capacity. Basic life-saving assistance nevertheless remains essential, including being able to meaningfully contribute to managing outbreaks or epidemics in conflict-affected settings.

6 Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages
ONGOING ORGANIZATIONAL TRANSFORMATION

There is inherent tension between efforts to streamline and strengthen overall monitoring and accountability mechanisms for health programmes and the growing pressure to carry out specific institutional initiatives, which often have different monitoring and reporting requirements. This means that technical adjustments are required, and new indicators need to be incorporated into programmes and the continuum of care, at a time when effective support tools are still being developed or honed.

Time is still needed to finish restructuring the ICRC’s operational – protection and assistance – set-up. The vision, strategic orientations and objectives provided in this strategy will inform the change process and should not be affected by it, but the details and breadth of implementation could be. Part of what remains is just establishing the formal working relationships and points of internal collaboration as the new structure takes shape. The bulk of the remaining work, however, depends on how well ambitions align with capacity and resources following the restructuring, given the organization-wide priorities. Consequently, working plans will need to be adjusted continually and outcomes managed and monitored carefully.

Finally, health outcomes depend on several socioeconomic and environmental factors that are influenced by the work of units other than Health, such as Water and Habitat, Economic Security and Protection/Prevention. The current programmes and reporting systems are geared towards single objective planning and monitoring, but there is a pressing need for a way to plan and assess multidisciplinary or cross-cutting work.

4. STRATEGIC VISION AND GUIDING PRINCIPLES

The ICRC’s Health Vision

The ICRC will meet the health needs of people affected by conflict and other violence by providing quality health care that is people-centric and follows an integrated public health and continuum of care approach with the aim of preventing and alleviating suffering and protecting life and dignity.

This strategy is based on three guiding principles – reaffirming a people-centric approach, consolidating a public health approach, and strengthening the continuum of care. These principles shape the strategic objectives and the associated commitments, and also guide the cross-cutting enablers.

PEOPLE-CENTRIC APPROACH

In this strategy, as in the ICRC’s overall strategy, the commitments are centred around people, both those affected by armed conflict and other violence and those who deliver health care to them – often under challenging circumstances. As health-care professionals are responsible for the quality of care they deliver to individuals and communities, and therefore their outcomes, this strategy for the next few years focuses on strengthening professional development, effective tools and guidance, and appropriate organization-wide decision-making mechanisms.

In carrying out assessments and in planning and delivering health-care projects, including when projects are remotely managed, the ICRC will continue to promote active and participatory engagement with communities and individuals, and base its operational decisions primarily on the needs identified (i.e. needs-based programming). For health care, this means strengthening the community components of primary health care in areas such as maternal and child health, mental health and

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psychosocial support, physical rehabilitation and inclusion of persons with disabilities. This also means strengthening patient-centred care as a key driver of quality and health outcomes.

The ICRC will also be proactive in identifying, reaching and including groups of people who are often marginalized, such as women, children, detainees, older people, persons with disabilities and/or mental health conditions and survivors of sexual violence. This “making the invisible visible” approach aims to ensure that people in areas affected by armed conflict and other violence who need health care have access to it, not simply those who can be reached or consulted more easily. This approach reinforces the ICRC’s principle of impartiality and commitment to accountability to affected people.

Under this approach, proximity is an integral part of health care. Having health-care personnel on site and deliberately building connections based on trust with individuals and communities, both digitally and in person, allows the ICRC to get feedback on changing needs and quality of care, understand the broader operating environment and identify those at greater risk. Critically, proximity also allows the institution to effectively follow-up on projects through on-site programme monitoring and ensures the services delivered are of high quality.

PUBLIC HEALTH APPROACH

In the humanitarian field, the ICRC’s integrated public health approach offers considerable value, as health is not solely the absence of disease but a complete state of physical, mental and social well-being. Under this approach, addressing the physical and mental health needs of populations affected by conflict and other violence requires the ICRC to conduct a comprehensive analysis of the various factors influencing health outcomes and design multidisciplinary responses that go beyond directly providing health services to include other areas of support (e.g. nutrition, infrastructure, protection, safety). It also includes integrating humanitarian health operations into existing local health systems and structures wherever possible, without departing from the ICRC’s mandate and principles.

From solely a health programming perspective, a public health approach calls for providing the best possible services to the largest possible number of people, including those who are often marginalized or whose needs are invisible, within a given set of resources. This ensures that resources are used efficiently and maximizes health outcomes for people affected by armed conflict and other violence. All ICRC health-care programmes apply this principle by focusing largely on primary and secondary health care (see figure on page 8), because these levels of care handle the majority of people’s health-care needs. This approach also explains why, in principle, the ICRC is not involved in providing highly specialized care at tertiary level (e.g. treatment for cancer or chronic kidney failure), as it reaches a smaller number of people at a higher cost. This is in addition to ethical considerations emanating from the inability to sustain highly specialized services in volatile environments.

This approach does not, however, prevent the ICRC from carrying out specific disease-based projects (e.g. for leishmaniasis, cholera or malaria) if they respond to a clearly identified public health concern and no other organization is able to do them owing to security constraints or a lack of access. These projects should be part of a continuum of care, or be handed over to more specialized organizations as soon as feasible. Nor does this approach exclude health activities – such as war surgery – which by comparison may not benefit the majority of people affected, but which align with the principle of impartiality (i.e. greatest need) and the ICRC’s added value in conflict settings.

Finally, in addition to their innate health value, the ICRC’s health programmes – together with other ICRC assistance and protection programmes – also help protect people affected by conflict and other violence by bolstering their resilience and by influencing the behaviour of authorities (e.g. detaining authorities) and weapon bearers (e.g. in the context of Health Care in Danger activities).

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9 This is aligned with objectives set out in the ICRC’s Vision 2030 on Disability.
10 This is consistent with the ICRC’s Accountability to Affected People: Institutional Framework.
11 World Health Organization: https://www.who.int/about/who-we-are/constitution
12 The term “resilience” was defined in 2019 for the ICRC’s protection and assistance programmes as “The ability of individuals, communities, institutions and systems to anticipate, absorb, adapt, respond to and/or recover from shocks and stressors derived from conflict, violence and hazards without compromising their long-term prospects.”
Continuum of care is defined as having access to comprehensive services and interventions that address a person’s well-being and health needs, from the time a health condition is identified until the person recovers a functional state consistent with the context. A continuum of care builds on the ICRC’s multidisciplinary capacities, such as expertise in health programmes and in areas of knowledge beyond health, such as infrastructure, water and sanitation, economic security and protection.

A continuum of care does not, however, mean a continuum of ICRC operations. Rather than providing the whole range of health services in a given context, the ICRC must be able to collaborate or partner with organizations, particularly National Red Cross and Red Crescent Societies (National Societies) and ministry of health components that provide the services needed by the affected populations that have been assessed. Despite these efforts there will be cases where working with others might not be a viable option because of potential divergences from the ICRC’s principles and/or technical standards. In such cases, the ICRC would fill as many gaps as possible by focusing on capacity-building or by prioritizing other activities where the continuum of care is stronger.

Given that people’s health status is the result of several interlinked factors, multidisciplinary assessments must be conducted of their needs, locally available resources, and risks and protective factors. Consequently, the greatest impact will derive from programmes that target critical gaps (i.e. are needs-based) and that address a range of determinants for a given health issue.

Insisting on a continuum of care draws attention to the obligation under international humanitarian law to allow for and safeguard health-care services in conflict settings. Influencing parties to conflict, authorities and other organizations on this issue, through the Health Care in Danger initiative.

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13 For more information, see https://collab.ext.icrc.org/sites/TS_ASSIST/WIKIHealthUnit/Pages/Health%20Strategy.aspx#key
and other means, is critical. Health care in conflict settings is on the front lines of numerous critical international humanitarian law and policy issues, including the denial of assistance or destruction of essential infrastructure as tactics of war; the involvement of non-neutral actors in front-line emergency responses, where impartiality might be doubtful; and the issue of distinction, proportionality and precautions in the conduct of hostilities. Access to health care is therefore a central part of protection and prevention efforts – including protection dialogue, humanitarian and health diplomacy and law and policy. These efforts help to create a more conducive operating environment for the ICRC’s health activities – and health care generally.14

5. STRATEGIC OBJECTIVES

STRATEGIC OBJECTIVE 1: DELIVERING QUALITY ESSENTIAL HEALTH-CARE SERVICES

Between now and 2023 the ICRC continues to address life-saving needs of people affected by armed conflict and other violence through the timely and effective delivery of quality essential health-care services.

The ICRC’s responses are designed to meet the health needs identified in a given population, which requires the institution to maintain and strengthen its unique multidisciplinary approach and draw expertise from across all health-care programmes – trauma first aid and prehospital emergency care, primary health care, hospital care, physical rehabilitation, health care in detention, and mental health and psychosocial support – and from its other areas of expertise and those of other components of the Movement.

Responding to health emergencies remains a cornerstone of the ICRC’s humanitarian work and the institution is well placed to serve people affected by armed conflict or other violence, often by supporting local health authorities’ responses and in line with national plans. However, to remain relevant, the ICRC needs to increase its emergency-response capacity and agility. This is particularly important for areas of expertise involved in “front-line” responses such as prehospital emergency care and surgical and hospital care. It requires the ICRC to continue taking a proactive role in developing the skills and expertise of professionals able to work in areas affected by armed conflict and violence (both from the ICRC and from National Red Cross and Red Crescent Societies), through training and capacity-building programmes designed and delivered in collaboration with the relevant partners.15

Other disciplines, such as mental health and psychosocial support, physical rehabilitation, primary health care and health care in detention, also need to maintain and strengthen their capacity to plan and implement emergency responses at short notice with highly experienced personnel. In areas outside of the ICRC’s expertise, the ICRC will continue to develop and adopt complementary responses, with the support of, and in coordination with, other components of the Movement (e.g. community-based maternal and child health-care services, outbreak surveillance, comprehensive management of epidemics in conflict-affected settings) or systematically request support from other partners (e.g. academia, the private sector or non-governmental organizations).

In the case of epidemics in conflict- and violence-affected contexts, the ICRC will strive to mitigate their consequences by focusing on supporting essential services (e.g. health, water and sanitation) and on intervening in fields of expertise and areas in which it can have the greatest impact (e.g. working with vulnerable groups, such as people deprived of their liberty and/or in places others may be unable to access). Furthermore, the ICRC will ensure its actions are delivered in a collaborative and complementary manner to those of the rest of the Movement and United Nations agencies to maximize the effectiveness of crisis-response operations.

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14 See, for example, UN Security Council Resolution 2286, 2016.
15 The ICRC’s Assembly approved in December 2019 a four-year surgical capacity-building project aimed at strengthening Movement and local capacity in the field of hospital and surgical emergency care.
The low level of resources in the settings where many of the ICRC’s health-care activities take place raises difficult questions about acceptable quality. The delivery of health care is highly regulated by ethical, legal and technical standards, and departure from established frameworks could lead to injury, disability or death and therefore heightened legal, reputational and/or security risks. As a result, health-care activities must be designed to do no harm, achieve maximum impact for communities and meet recognized and adopted standards for humanitarian action.

**Delivering quality health care is not an operational choice – the ICRC is bound to it by ethical, legal and technical frameworks.**

Ensuring the quality of health-care services requires the ICRC to build and maintain professional skills and expertise to effectively navigate complex and challenging operational environments, and to establish strong internal accountability. Any potential departure from quality standards either in terms of practice or planning must be adequately discussed and documented, and done and managed with full consideration given to technical and ethical arguments. Quality therefore serves as a fail-safe for internal decision-making on health-care activities, ensuring that once all considerations are weighed, the appropriate standards of care are followed. Quality also acts as a guide for collaboration and partnerships, setting the boundaries of professionalism and practice.

The commitment to quality sometimes conflicts with the criteria used to determine whether to act (e.g. leveraging health-care services to enable broader operational goals in a given context) and demands consideration for what that decision-making process should be. These are ongoing challenges for the ICRC that can be navigated by ensuring that decision-making on health takes into account input from the ICRC’s health-care specialists and that there is internal accountability for those decisions globally and locally as well as at technical and managerial levels.

The ICRC recognizes that specific groups of people are at increased risk and have health-care needs that stretch across several technical programmes, requiring a multidisciplinary approach. The ICRC will place special emphasis on meeting the needs of women and children and survivors/victims of sexual violence – within a comprehensive “all victims of violence approach” – by facilitating access to services while reducing the risk of stigmatization. The ICRC will also work more proactively through the Health Care in Danger initiative to try to reduce attacks on health-care workers and facilities and on ambulance services and to improve affected people’s access to services.

Finally, because health care is constantly evolving, the ICRC needs to ensure that relevant digital technologies and innovative clinical approaches that could make the ICRC’s health-care responses more efficient and effective are analysed and tested, and, if appropriate, incorporated into field programming.

**Commitments**

- The ICRC will strengthen its capacity to deliver quality prehospital and hospital care (including surgery) to people wounded in conflict and people requiring life-saving surgical management, by proactively building up its hospital and surgical expertise in collaboration with partners in the Movement, academia and other humanitarian organizations.
- The ICRC will increase its capacity to launch timely emergency responses under all health programmes by ensuring that staff are adequately trained and onboarded and have reliable health data-management tools and logistical support.
- The ICRC will clarify the decision-making processes on proposed health-care activities that deviate from standards or usual ICRC practice and will promote internal accountability for institutional decision-making both at technical and managerial levels.
- The ICRC will continue to strengthen its capacity to care for groups most at risk, either by delivering services itself or through sustainable partnerships, in particular with National Societies.
- The ICRC will continue to embed in all its health programmes practical actions aimed at reducing attacks on health-care workers and facilities and ambulance services and at mitigating the consequences of those attacks on people affected by armed conflict and other violence.
STRATEGIC OBJECTIVE 2: CONTRIBUTING TO SUSTAINABLE HEALTH OUTCOMES

Between now and 2023, the ICRC continues to meet emergency needs while actively contributing to sustainable health outcomes for people and systems impacted by armed conflict and other violence.

Given the scale and duration of many conflicts, addressing the resulting humanitarian needs requires a twofold approach that combines emergency responses with activities aimed at supporting weakened or failing health-care systems, strengthening local capacity and/or supporting communities’ and individuals’ resilience. Given the ICRC’s expertise, the areas of focus for supporting health-care systems are rehabilitation and inclusion of persons with physical disabilities, penitentiary health and hospital care. However, all health programmes will incorporate aspects of both emergency and longer-term responses, as appropriate, to maintain services during crises and lay the foundation for eventually rebuilding the broader system and creating a continuum of care. ICRC teams need to systematically reflect, from the outset, on how local capacities and resources can be integrated into or strengthened in each emergency-response project. Moreover, it is critical to consider how the ICRC’s multidisciplinary action addresses other social determinants of health16 that are severely impacted in conflict settings and to identify partners that could support these efforts (e.g. other humanitarian organizations, development agencies).

In order for the outcomes of health-related humanitarian work to be sustainable, the ICRC needs to play a key role in supporting the development of local health staff’s capacity, either by transferring skills to health-care personnel directly or by engaging with academia or other actors to support on-site training and capacity-building activities. Given the current worldwide shortages in health-care personnel, a strong emphasis needs to be placed on providing quality emergency care (both at prehospital and hospital levels) and hospital care, with emphasis on life-saving emergency surgical care. Building local capacity in associated domains (e.g. sanitation, clinical waste management) and improving and developing local infrastructure are also critical. These efforts will support local authorities in scaling-up their responses during crises while maintaining the quality of services delivered.

Owing to the ICRC’s unique mandate to engage impartially with all parties, including non-state actors and other “state adversaries”, dilemmas arise when providing support for systems that are managed by authorities or organizations that are considered party to a conflict. Managerial and health teams must continually weigh humanitarian principles against pragmatic action, confidentiality against advocacy and international postures and positions against local responses.

Commitments

• The ICRC will address emergency health needs while engaging in dialogue early on with local and national health and other authorities and development actors to ensure sustainable outcomes, seek complementarity and strengthen local capacity.

• The ICRC’s health-care activities will, by default, continue to support existing health systems and facilities while acknowledging that stand-alone emergency responses will be required in specific contexts and/or circumstances.

• The ICRC will continue to develop its partnerships and network of expertise (e.g. humanitarian, academic) to support the strengthening of local health-care capacities.

• The ICRC will strengthen its capacity and expertise in supporting health-care systems by developing in-house knowledge and skills across the relevant units and departments and by strengthening collaboration with relevant development actors.

16 Social determinants of health are the conditions in which people are born, grow, live, work and age. They include factors like socio-economic status, living environment, social support networks, education, and access to health care: https://www.who.int/social_determinants/en/
STRATEGIC OBJECTIVE 3: INFLUENCING PRACTICE AND POLICY IN KEY AREAS OF HEALTH EXPERTISE

Between now and 2023 the ICRC continues to drive best practices in areas of health where it has expertise: management of people wounded by weapons, provision of health care to people deprived of their liberty, the rehabilitation of persons with physical disabilities and the provision of mental health and psychosocial support services to people affected by armed conflict and other violence, and effectively influences policy at the national, regional and global levels in these fields.

Over the past few years the humanitarian health landscape has experienced shifts associated particularly with: the recognition that the health needs in contexts that are fragile or affected by armed conflict or other violence need to be addressed if the Sustainable Development Goals are to be attained, a heightened awareness of global health security and the risks associated with pathogens of concern to public health, and a push by donors to build local capacity and diminish dependency on aid. These factors all affect the ICRC’s operating environment and the way humanitarian aid is delivered to people affected by armed conflict and other violence. To influence these shifts, and shape issues such as the militarization of health-care delivery, the engagement of private contractors on the front lines and progressive task-shifting to non-skilled health-care workers, the ICRC needs to continue engaging with a wide range of counterparts at diplomatic, policy and technical levels.

Moreover, the ICRC plays – and is expected to continue playing – a prominent role, given its mandate and expertise, in influencing the global health agenda on access to health care for people affected by armed conflict and other violence. The ICRC is duty-bound to continue shaping the technical aspects of clinical management of patients wounded by weapons, the provision of health care for people deprived of their liberty, the rehabilitation of persons with physical disabilities and the provision of mental health and psychosocial support services to people affected by armed conflict and other violence. To do so, the ICRC needs to make constant efforts to maintain and strengthen these areas of expertise.

The ICRC is also well placed to advocate – in close collaboration with other components of the Movement and others who have a role in humanitarian and development work – for more investment and action in areas that are often overlooked in humanitarian crises, such as the provision of essential maternal and child health-care services and the effective management of non-communicable or chronic diseases.

Commitments

- The ICRC will continue to promote the adoption of principled approaches and best practices in the fields of weapon-wounded care, health care in detention, physical rehabilitation, and mental health and psychosocial support, at local, national, regional and global level and will actively contribute to developing or updating relevant technical guidelines and protocols.
- The ICRC will strengthen persuasion and mobilization efforts with authorities and relevant actors to ensure that populations affected by armed conflict and other violence have access to essential health-care services and will actively support the development of policies aimed at protecting health-care workers and facilities and ambulance services.
- The ICRC will systematically document its health-care activities and exchange knowledge and expertise with others (e.g. components of the Movement, local partners and health-care workers, and humanitarian organizations) in order to influence practices.
6. CROSS-CUTTING ENABLERS

In order to fulfil the ICRC’s commitment to addressing the critical health-care needs of people affected by armed conflict and other violence, operational priorities need to be clearly set, resources need to be allocated to these priorities, and support must be provided in other key areas such as people management, partnership development and the safe use of health data and digital technologies. Because these support mechanisms must function effectively in order for the health strategic objectives to be met, this strategy describes what must be done in each area to enable progress. The commitments in these areas go beyond the Health Unit and as such require active engagement and contribution from other units and departments.

EFFECTIVE PEOPLE MANAGEMENT

Given the needs-based nature of the ICRC’s work, a significant number and range of health-care professionals are required to deliver services in areas affected by armed conflict and other violence. Health-care professionals account for around one-third of all staff that the ICRC sends to the field each year.

In addition, more than 30% of the ICRC’s health-care assignments in the field are short-term, either because of the type of response (i.e. emergency) or because regulations in the health-care sector make it difficult for health-care professionals to go on long humanitarian assignments without adversely affecting their careers in their home countries or losing their licences to practice. As a result, ensuring continuity in health operations requires management and strategic planning of large pools of pre-selected and pre-trained professionals who can go on humanitarian assignments on a regular basis. Managing these pools and planning their assignments requires agile, coordinated and efficient HR support systems.

Given the worldwide shortage of health-care workers, which also affects the humanitarian sector, effective recruitment, retention and development processes are paramount for the ICRC to continue fulfilling its commitments in the field of health.

Health and information technology are transforming the way that health care is delivered. However, humanitarian health action remains dependent on proximity and therefore human resource-intensive. Effective people management and strategic workforce planning are therefore cornerstones of the ICRC’s delivery of health-care services.

Finally, to ensure that the people the ICRC serves get the best possible care, and to comply with legal, ethical and accountability requirements, the ICRC needs to take a more proactive stance on capacity-building, and on specific training and onboarding for health-care professionals delivering care to people affected by armed conflict and other violence. The aim is to improve clinical and surgical management of patients, strengthen the delivery of health-care programmes and improve compliance with, and awareness of, the ICRC’s humanitarian principles, code of conduct and security measures.

Commitments

• The ICRC will maintain a critical mass of health projects to ensure the retention of trained and skilled health-care personnel.
• The ICRC will provide adequate resources to effectively retain and manage its health-care personnel and to support the development of their technical and managerial competencies.
• The ICRC will ensure that HR tools and systems are designed and updated based on users’ identified needs and that they are fit for purpose: user-friendly and interconnected.
• The ICRC will actively explore the use of new technologies for training and building the capacity of its health-care workforce, while ensuring the utmost quality in areas where hands-on training cannot be replaced as yet (e.g. surgical care of wounded people).
RELEVANT AND SUSTAINABLE PARTNERSHIPS

Chronic needs have a cumulative and interdependent effect that makes it difficult to address any single one in isolation. Moreover, the health status of populations is highly dependent on non-health social and environmental determinants. To address these needs, health activities must have synergies – both internally with other units/departments and externally through partnering. These synergies need to be integrated into the design of health-care activities, with the ultimate goal of strengthening service delivery and addressing a larger volume of unmet health-care needs. Internally, synergies take the form of multidisciplinary working groups, platforms (e.g. detention platform) or initiatives (e.g. Health Care in Danger).

Externally, the increased global interest in improving health outcomes in fragile environments and areas affected by armed conflict or other violence, together with the ICRC’s twofold approach of handling emergencies and creating a sustainable humanitarian impact, have expanded and diversified the potential funding and operational partners. The ICRC needs to manage both its longstanding and its emerging health partnerships effectively. One longstanding partnership is with other components of the Movement, and managing it is an issue of scale. In contrast, partnerships with large international financial institutions, development donors and private corporations are still relatively new, and therefore require more clearly defined areas of intervention and formats of operational collaboration.

Commitments

• The ICRC will continue to partner with others where it is unable to respond to identified unmet needs or to support the quality of service delivery, including via remote management when access is limited. Partnerships will be guided by humanitarian principles and the ICRC’s mandate and confidential approach, and adequately address issues related to risk transfer and compliance.
• The ICRC will ensure there are adequate resources to support and manage partnerships in health care and actively identify areas of health-care delivery that could be undertaken by international or local partners.
• The ICRC will continue to identify partners in academia and the private sector that can contribute to improving the efficiency, scope and quality of health-care programmes through innovative approaches.
• In line with the Health Care in Danger initiative and the framework on accountability to affected people, the ICRC will continue to work with health-care communities to design locally anchored proposals aimed at reducing attacks and violence against health care and limiting their impact on communities.

HEALTH DATA AND DIGITAL TECHNOLOGIES THAT IMPROVE ACCESS TO HEALTH CARE AND DRIVE EVIDENCE-BASED PRACTICE

The ICRC has developed two health data tools that serve different purposes. The medical activities database (MAD) allows follow-up of programmes using population-based data and is already connected to annual planning and institutional reporting. PEARL is a comprehensive digital solution that enables health-care practitioners working on ICRC projects to adequately follow up on the clinical management of individual patients and monitor the quality of service delivery. In the period 2020–2023 both tools will need to be seamlessly connected to the ICRC’s operational data and reporting mechanisms while retaining their specificity, value and security. This will allow the ICRC to continue shaping its humanitarian health responses as well as global health-care policy and practice.

Health data that is accurate and, timely is essential for managing patients and monitoring and evaluating programmes. Such data can also be used to analyse health trends and outcomes, plan resources efficiently, implement quality-assurance mechanisms, and conduct research leading to evidence-based practices.
Building on past and current experiences, the ICRC will continue to leverage digital technologies to improve access to health-care services for populations affected by armed conflict and other violence. The tools selected will be evidence-based, scalable by design and relevant for the low-resource settings where the ICRC operates. Moreover, in line with data protection requirements, they will contribute to strengthening local health systems, building capacity and achieving sustainable health outcomes.

**Commitments**

- The ICRC will continue to support the **consolidation, use** and updating of **health data tools that** improve clinical practice and support local health surveillance mechanisms and data collection.
- The ICRC, together with partners, will continue to explore the use of **relevant digital technologies** that improve access to health care and strengthen internal and local capacity-building.
- The ICRC will **facilitate field operational research** in order to further develop its capacity to **drive evidence-based health practice** in areas affected by armed conflict and other violence.

### 7. ADDITIONAL READING

Executive summary of the Health Strategy 2020–2023, external version
Roadmap for Implementing Health Strategy 2020–2023
Summary of the implementation of Health Strategy 2014–2018
The ICRC helps people around the world affected by armed conflict and other violence, doing everything it can to protect their lives and dignity and to relieve their suffering, often with its Red Cross and Red Crescent partners. The organization also seeks to prevent hardship by promoting and strengthening humanitarian law and championing universal humanitarian principles.