

**Keynote Address by Sir John Holmes
Under-Secretary General and Emergency Relief Coordinator
“Health and Emergency Response: Emerging Humanitarian Challenges”
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I am very pleased and privileged to be here this evening to talk to you about how global challenges may be changing the humanitarian operational landscape and what this will mean for humanitarians, in particular for health interventions, in the years to come.

I fear I am not going to cheer you up much by what I say, so I apologize for that in advance. But it's important to remain optimistic, despite everything.

I. Overview of global challenges

Let me first give the overall picture as I see it. Demands for humanitarian assistance are likely to grow, and dramatically so, in the coming years. One of the most important drivers is climate change, which is making current vulnerabilities significantly worse. Nine out of ten disasters are now climate related, and the number of natural disasters related to climate events has doubled in the past two decades. These numbers represent what we now tend to call the ‘new normal’ of extreme weather.

Scientists say we should expect an increasing number of more severe floods, droughts, storms and heat waves. Warming temperatures could promote the growth of new viruses and the spread of some diseases to new areas. Rising sea levels could force the relocation of tens of millions of people. Glacier melt in the Himalayas could drive out hundreds of millions by changing the nature of the main life-giving rivers of the Indus, Ganges and Brahmaputra. Increased water scarcity and climatic variations could seriously affect agricultural productivity. Indeed, climate change may well usher in widespread, chronic hunger and malnutrition across large swathes of the developing world. Last, but not least, climate change could precipitate resource conflicts- above all, for energy, arable land and fresh water.

We must also consider the consequences of rapid population growth in the developing world. The combination of rapid urbanization, environmental degradation and population growth means increasing numbers of people are now at risk.

We may well see an increase in the intensity of internal, often asymmetrical conflicts, with civilians serving as principal targets and victims. Meanwhile, access and security for humanitarians are increasingly perilous and respect for international humanitarian law is on the wane in key hotspots, including Sudan, Iraq, Somalia, Afghanistan, Sri Lanka and the Democratic Republic of the Congo.

Compounding the challenges of climate change and armed conflict are recent trends in soaring food and fuel prices which have led to violent protests in many countries. The global food

crisis, which continues today, has the potential to increase further the incidence and depth of food insecurity.

Taken in combination, these trends will potentially create millions more people needing humanitarian assistance. In brief, the need for more timely, effective and equitable humanitarian assistance will continue to grow.

I am sure I am not saying anything you do not already know. These global trends and challenges surely figure prominently in your thinking. Nevertheless, let me take a further risk of telling you what you know by highlighting a few of the current major health challenges which I see facing humanitarian agencies around the world.

II. Current challenges in health responses

The background is that the UN Secretary-General has made global health a priority for his tenure. This reflects the broad recognition that investing in health is critical to promoting human development, economic growth, and peace and security. Based on the Millennium Development Goals, the Secretary-General has set three key priorities: improving women's health, strengthening national health systems, and responding to neglected tropical diseases.

Let me touch on these briefly in turn.

Women's health is a critical indicator of a society's overall well-being and development. However, the international community has made the least progress in meeting the Millennium Development Goal to improve maternal health. Estimates for 2005 indicated that every minute a woman dies of complications related to pregnancy and childbirth, equating to more than 500,000 women a year - almost all in developing countries.

Strong and affordable health systems are, of course, a prerequisite for achieving all health-related goals. Yet, in many countries, health care is beyond the reach of the poorest and most vulnerable, even though they often need assistance the most. Health systems suffer not only from weak infrastructure and insufficient financing, but also an inadequate number of qualified health workers, especially in rural areas.

Neglected tropical diseases afflict one billion of the world's poorest people, despite the fact that they are largely treatable. These diseases not only unnecessarily kill millions of people a year, but they also contribute to economic loss and cycles of poverty.

Health workers responding to humanitarian emergencies are central players within the global response to achieving the health related Millennium Development Goals. However, the grim reality is that conflict and disaster situations often set back significantly progress in meeting the Millennium Development Goals. Health related infrastructure may be damaged or destroyed, health workers may be killed, displaced, or unable to reach those in need, vital health care may be disrupted, and poor sanitation or cramped camp conditions may prompt the spread of water borne and infectious diseases.

Against this background, let me highlight three particular major impediments to meeting the global health objectives in our current emergency operations: gender-based violence, health worker safety and access, and infectious diseases.

b) Gender-Based Violence

Gender-based violence, or GBV, pervades many conflict and disaster situations, resulting in serious health and human rights challenges. While women and girls are the most likely to experience sexual violence, we know that men and boys are by no means immune. Sexual violence can cause not only immediate physical trauma and death, but also long-term psychological scars and reproductive and sexual health problems.

In conflict and disaster situations, refugees and internally displaced persons face a heightened risk of gender-based violence. Rape continues to be a weapon of war and even in some cases a means to attempt a kind of ethnic cleansing by impregnating women and girls from different ethnic or religious groups. Recipients of aid may be forced to exchange sex for food, water, or medicine. Essential daily tasks like gathering firewood, water and other basic necessities place women and girls at particular risk. GBV also heightens the risk for HIV and sexually transmitted diseases and unwanted pregnancies. In many emergency operations, particularly conflict situations, the breakdown in rule of law makes it difficult to hold perpetrators accountable. Women's options are further limited by the fact that in some countries abortion is restricted, and may not be legal on the grounds of rape.

Some important advances have been made in addressing GBV. Rape is now widely recognized as a war crime under international law. Humanitarian agencies fully acknowledge gender-based violence as an issue to be addressed within all aspects of the response, and strategies now attempt to incorporate GBV considerations into all operations, from camp design to food distributions. The UN also requires its staff to abide by a mandatory Code of Conduct, prohibiting sexual exploitation and abuse by aid workers and peacekeeping staff, though as we all know there have been terrible breaches of this. Community based anti-GBV initiatives within conflict-affected communities have proven successful in some places.

However we still face many challenges. In a newly released report, Medecins Sans Frontieres highlights the critical importance of providing immediate care within days of sexual assault. In addition to immediate life-saving medical care, early interventions within the first three days can help prevent an HIV infection, and provide emergency contraception within five days. Still more needs to be done to educate humanitarian workers about GBV, and we need to continue to reach out to donors to ensure they fund GBV activities as a priority emergency intervention. The underlying reality is that, while we may be getting better at treating the effects of GBV, we have so far made virtually no progress in reducing or preventing it, for example in areas of extreme concern such as the east of the Democratic Republic of Congo.

c) Health workers safety and access, and respect for international law

We know that an effective emergency response demands that health workers can quickly and safely reach populations in need. Unfortunately, respect for international humanitarian law,

especially the responsibility to protect civilians, is at a low point in many parts of the world. Maintaining humanitarian access for aid workers, to allow them to act effectively and neutrally, independent of political and military objectives, is increasingly difficult. Our status as neutral and independent is under challenge, which complicates access to those in need, as we know from our attempts to help in places like Somalia or Afghanistan, and the attacks UN and NGO workers have had to face. One of the major effects of the recent expulsion of the key NGOs from northern Sudan is likely to be on health- both healthcare provision and broader health surveillance and early warning.

Tragically, there are an increasing number of incidents in which relief workers are being targeted in conflict zones where they are no longer considered to be neutral. Most recently, three MSF workers were abducted in Darfur, even if they were thankfully released unharmed a few days later. Others have not been so lucky. In August 2008, as I am sure many of you remember, three women working with the International Rescue Committee were killed while working in Afghanistan. Such incidents make it clear to the United Nations and to the humanitarian community as a whole that flags no longer offer protection.

Long-standing norms of humanitarian law regarding protection of medical staff and facilities are also under threat. In Sri Lanka on the 3rd of February, a bomb attack in the northern conflict zone forced an evacuation of the region's last functioning hospital. In total, the attack killed 52 civilians and wounded 80 others in and outside of a previously identified "safe zone." Of the dead, twelve had been patients in the hospital. This incident had been preceded by international calls, including by myself, for the parties to the conflict to ensure that civilian populations caught amidst the fighting could move freely and have access to basic humanitarian assistance. However, as I speak, we estimate 150,000 to 200,000 civilians still remain trapped within the conflict zone, facing death and injury every day, as well as squalid, cramped living conditions in shelters without adequate food, medical assistance, or clean water.

Health assistance was also severely impacted during the recent events in Gaza. A February assessment from the WHO-led Health Cluster reported that 1,380 Palestinians were killed, and 5,380 were injured, and 14 Israelis killed and 183 injured. The Palestinians included 16 health workers killed and 25 injured while on duty. Some 15 hospitals and 41 primary health care clinics were damaged, and an additional 29 ambulances damaged or destroyed, during the strikes. Security problems severely disrupted access to reproductive and child health services, as well as treatment for chronically ill patients. UNFPA reported an increased number of miscarriages and higher neonatal mortality during the military operations. Shortages of fuel, electricity and water also seriously hindered service delivery in hospitals and clinics.

Disasters caused by natural hazards also pose huge challenges for health. The 2004 Indian Ocean tsunami in 2004 damaged 61% of health facilities in Indonesia's Aceh province, and killed nearly a third of the area's midwives, a major loss for women's health. The May 2008 Wenchuan earthquake damaged more than 11,000 medical institutions, forcing tens of thousands of people to seek treatment elsewhere.

Various efforts are underway to respond to these complex challenges. On the security side, the June 2008 Independent Panel on Safety and Security of United Nations Personnel and

Premises, also known as the “Brahimi Report,” called for the organization to move “towards a culture of security and accountability.” However, the uncomfortable reality is that necessary security requirements may impede direct humanitarian action, and are particularly restricting for international staff. This in turn puts more pressure on national staff, whose lives are of course just as valuable, risking the creation of double standards for the safety of national and international aid workers. We are working hard to push for further progress in the Security Council and General Assembly on promoting respect for international humanitarian law and ensuring humanitarian access, and urging Member States to do more at all levels. But it is an increasingly uphill struggle.

On the health side of this problem, the World Health Organization has dedicated the 2009 World Health Day to the issue of ensuring the safety of health facilities and the ability of health workers to respond in emergencies. This will be an important campaign for highlighting the specific response challenges in both disaster and conflict settings.

d) Infectious diseases

We all know that emergency situations place people at a heightened risk of contracting infectious diseases. Displaced people, children, and the elderly are particularly vulnerable. For example, UNICEF reports that 75% of children’s deaths, which represent the highest mortality rates in emergencies, are attributed to communicable diseases.

This is hardly surprising, given the basic facts. For example, more than 1 million people a year are killed by malaria, despite the fact that we know that insecticide-treated bed nets are highly effective in preventing the disease. In 2007, across the globe, an estimated 33 million people were living with HIV/AIDS, with some 7,500 people newly infected each day, and 5,500 people dying from AIDS each day- equating 2 million deaths in 2007. Tuberculosis also killed 1.7 million people in 2006 alone, with an estimated 14.4 million people infected. So it is inevitable that these diseases, and others such as cholera, meningitis, and measles, pose immediate threats in crisis situations.

Emergency health workers know that the key is to act quickly to prevent their spread in emergencies. Interventions need to begin as soon as possible when health service capacities are weakest, but health threats are at their strongest. Preventive efforts, such as vaccinations, early diagnosis, ensuring the continuity of anti-retroviral treatments for HIV, and the provision of mosquito nets, can quickly and effectively reduce mortality rates.

But the current cholera outbreak in Zimbabwe shows the difficulties of this. The outbreak was caused by a lack of safe drinking water, inadequate sanitation, and declining health care infrastructure within an already overburdened health care system. This was compounded by the long-term shortages of treatment materials, scarcity of health care providers and overall limited access to care. As of 24 March, almost 93,000 suspected cases of cholera had been reported across the country, with over 4,000 people having reportedly died from the disease. Unfortunately, the outbreak has taken an unconscionably long time to bring under control, and we are not even there yet. A particular part of the challenge was the failure of health care workers reporting to work given the dire economic situation in the country. Sporadic telephone networks and electrical supplies also limited communications and information on the spread of the disease. The situation

would not have deteriorated so far had international aid workers been able to assess and address the problem earlier and more effectively. As first responders in emergencies, humanitarians are used to problems such as dangerous access, poor roads, limited supplies, and overwhelming needs. But Zimbabwe was another challenge altogether, where those trying to help were faced with a complete collapse of the health sector, not brought about by a conflict or natural disaster.

III. Emerging global challenges and opportunities

I have outlined these current challenges because as we shift our focus to the future, it is important to remember that these problems are not likely to go away. “Mega-trends” such as climate change, urbanization, population growth, and food insecurity, which will determine the future, will be overlaid upon the existing humanitarian landscape. We need to use our imagination to understand how all these changing realities will intersect to form the humanitarian operational landscape of the 21st century. So, let me next look at some of these mega-trends.

a) Climate change

I spoke at the beginning about how climate change has significant implications for humanitarian operations. Climate change is not just an environmental issue. It threatens all of our goals for development and social progress. It is also a genuinely existential threat for the planet, and as such is the biggest risk to human and national security. And its effects are already with us. In many small island states, sea level rise is already making people’s homes vulnerable to increasingly high tides and storm surges, while water supplies and soil fertility are threatened by the intrusion of salt water. By 2025, the number of people living within 60 miles of a coastline is expected to increase by 35 percent over 1995 levels, exposing 2.7 billion people to the effects of rising sea levels and other coastal threats posed by climate change.

In other parts of the world, climate change is expected to cause intensified periods of drought, increasing water stress and desertification in regions already struggling to meet basic water requirements. Some experts estimate that desertification will put the health and well-being of 1.2 billion people in 100 countries at risk. Millions of people are already internally displaced due to disasters and conflict. Displacement within and across international borders is expected to grow as a consequence of climate change, as people seek improved livelihood opportunities. Traditional morbidity patterns of diseases such as malaria and dengue fever are likely to change and spread to reflect changing environmental conditions.

We are not helpless in the face of this. We can adapt to climate change, as well as trying to stop and eventually reverse it. Disaster risk reduction and risk management are our first line of defense against the impacts of climate change. We need to intensify our current efforts to reduce vulnerability and build resilience to extreme events. Doing so will help avoid human and economic losses in the short-term, as well as secure development gains and provide sustainable basis for longer-term measures to adapt to climate change. A key component of these activities will be anticipating the health related risks associated with the impacts of climate change. Perhaps most important is the recognition that repeated, small scale disasters occurring in the same place have the capacity to overwhelm health service structures- perhaps even more than one extremely large event. So risk reduction measures must include building local and national health care

structures that can maintain operational capacity despite natural hazards and surges in demand. The Secretariat for the International Strategy for Disaster Reduction and WHO are already partnering with Governments and other international partners to raise awareness and promote risk reduction measures to ensure that health facilities can survive disasters and continue to function afterwards. The physical health benefits of this are obvious. But the psychological importance for crisis-affected people of the survival – or disappearance – of key public institutions like hospitals and schools should not be underestimated.

b) Population growth and urbanization

Current projections estimate that by 2025 the global population will have reached almost 8 billion people. This is a huge problem, even if the international community has, bizarrely to my mind, almost stopped talking about it. Over half of these 8 billion people are expected to live in urban areas, an increase from just over 3 billion in 2005 to almost 5 billion just 20 years later. The majority will be in poor countries, where rapid, haphazard urban development is already overburdening infrastructure and essential public services such as solid waste management and the provision of safe water and sanitation. For example, in Tanzania's capital Dar es Salaam, the city's population is already doubling every twelve years, and the results are only too visible.

As urban areas continue to expand, and the poorest crowd into the most vulnerable locations, such as the flood-prone areas where no one else wants to live, these densely populated zones will pose major health risks, not least those associated with overcrowding and pollution. Already in a 1993 report, the World Health Organisation found that poor populations in urban areas face high rates of maternal mortality, and infant mortality and morbidity. Other prominent health risks include sexually transmitted diseases, violence, diarrheal and parasitic diseases, malaria, and an overall increase in mental health conditions.

Compounded with their extra vulnerability to natural disasters or violent conflict, these areas present very difficult operational environments for humanitarians. We have not generally worked extensively in urban areas. It should in theory be easier for mobile health teams and community based clinics to provide assistance to beneficiaries concentrated in smaller geographical areas. But this assumes that as aid workers we have the capacity to distinguish between a person who should receive humanitarian assistance because of the effects of a disaster or conflict, and another who is just "poor." I will come back to this "philosophical" issue in a moment.

c) Food insecurity

Although the prices of global food commodities have fallen, no one should take false comfort in believing that the food crisis is over. This is a long-term threat. To feed the world's rapidly growing population, experts estimate that by 2025 agricultural production would have to increase by 50 percent over current levels. It is now widely estimated that some 1 billion people suffer from hunger and malnutrition, a significant increase from previous estimates of 854 million people in early 2008. In many countries, reduced global prices have not cascaded down to national and local markets, where basic food commodities continue to be beyond the reach of a growing number of poor people. Furthermore, food security relies on a strong agricultural sector,

which as we have already seen, has been and will be negatively affected by climate change. A strong agricultural sector also demands reliable water sources. However, water shortages are already estimated to affect 1 billion people worldwide, a number that could triple by 2025. Climate change is projected to decrease rainfall dependent agricultural production by half by 2020 in some African countries- and 93% of agriculture in Sub-Saharan Africa is still rain-fed.

Under these circumstances, the food riots of 2008 could become a common feature in the years to come. In any case, the likely immediate consequence of growing food insecurity is a greater prevalence of chronic and acute malnutrition and micronutrient deficiencies, particularly in areas such as urban slums. Health workers should also anticipate that an increasing number of people might be forced to adopt negative coping strategies to meet household food needs, including foregoing education and healthcare, and even survival prostitution with all of its associated risks.

d) Financial Crisis

The global financial and now economic crisis is not itself a mega-trend. It should be more temporary than that (we hope). But it is compounding and will exacerbate the effects of these longer-term trends. It's had at least two effects: on supply, and on demand. On the supply side, informal conversations with humanitarian donors suggest that governmental aid agencies may not feel the effects of reduced financial commitments in 2009, as budgets were largely set in 2008 before the extent of the crisis had become evident. However 2010 and 2011 may be more difficult. And individual and corporate giving is already suffering.

Moreover, on the demand side, the financial and economic crisis is bound to have the worst implications for the poorest and most vulnerable countries, and for the poorest and most vulnerable communities in these countries, affecting groups that are highly likely to require extra humanitarian assistance. As foreign investment and commodity prices fall, job losses spread, remittances decline and household incomes decrease, more people will fall below the poverty line. Women will bear the brunt of this. Facing their own financial constraints, national governments may also be forced to cut social safety nets, such as food assistance and free health care, at the very time when people need help the most. Budget cuts may also mean a reduced investment in national and local health services, and a potential reduction in the number of health care workers and the training they receive. This is not a happy prospect for the next few years.

IV. The humanitarian landscape in the 21st century

a) Intersection of mega-trends

These mega-trends I have talked about – climate change, population growth, urbanization and food insecurity – are not the only ones. There are others, such as energy scarcity, and environmental degradation. They are all interlinked. And the biggest threats may be ones we have not even thought of yet. Yet too often we apply a 'silo or CNN approach' to analysis, focusing only on the narrow impacts of the most commonly discussed trends or only highlighting an issue once it is declared a 'crisis'. This is particularly shortsighted when we can already see how far any one of these trends impacts on and exacerbates the impact of others.

Understanding these trends is difficult enough; confronting them is even tougher, as unintended consequences multiply. For example, addressing climate change by promoting bio-fuel production may contribute to food shortages and negatively affect energy markets. And even if clear solutions could be devised, best estimates indicate that financing an appropriate response to some of these trends will require alarmingly large funding needs. Last year it was estimated that confronting climate change would require US\$ 50 to \$100 billion annually, while some US\$ 25 to \$40 billion extra would be needed to address the food crisis. You may argue, as I have, that if we can find trillions to fund financial crisis stimulation and bailout packages, a few hundred million should not be beyond our grasp. But as we all know, it does not usually work like that.

b) *The new humanitarian landscape*

So what might we see in the years to come? As Yogi Berra once said, “It is dangerous to make predictions, especially about the future.” But we have to try.

It is not hard to see, as I have suggested, that the mega-trends of climate change, globalization, and the food crisis are likely to ‘drive’ humanitarian need by creating higher incidence of poverty and vulnerability; increased levels of inequality within states; increased unemployment; increased uncertainty and frequency of natural disasters; a modification of morbidity patterns and incidence of disease; greater conflicts; and migration on a scale we can only guess at now. What we do not know, and can hardly guess at, is how far human ingenuity and adaptability, technological innovation, new institutions and norms, and new international agreements may mitigate these trends.

This is where the optimism comes in – a bit late, you may think. Mega-trends may not be all ‘doom and gloom’. They should prompt positive counter-trends and innovations. Increasing corporate responsibility and more interstate reciprocal responsibility may provide the world with new inventions and new tools. Technological trends, such as wider cell phone access and better GIS mapping, for example, should expand early warning and response capacities, resulting in better targeted aid and calculation of risk.

We have become, in recent years, much better at responding effectively to disasters in a coherent, coordinated, well-financed and fair way and, as those of us on the inside know all too well, can still improve a lot more.

In the field of health we have already seen how advances in therapeutic feeding have greatly strengthened aid workers’ ability to respond to acute malnutrition. Anti-retroviral treatments have made it possible for millions of people living with HIV to pursue active lives. Millions of dollars are now being invested in deadly diseases such as malaria and tuberculosis which over the years should translate not only into improved treatment, but also into prevention.

So let us not just simply extrapolate existing trends into the future as if there will be no reaction to them, and thereby deepen our futuristic gloom unnecessarily. And many in this room can at least take comfort from the fact that humanitarians are not likely to be facing the dole queue any time soon.

But one thing we can definitely see is that the impacts of mega-trends are bound to blur the traditional humanitarian/development divide, already artificial as it is. So, while humanitarian caseloads may grow, they may also become harder to define and the profile of those who are vulnerable may change radically. We will need to get away from regarding humanitarian action as something triggered only by disaster or conflict, and look much more towards how we respond to chronic humanitarian needs, for example in areas affected by recurring and intensifying drought. The distinction between a victim of a disaster and someone who is “just” living in extreme poverty will be even more impossible to maintain, as I suggested earlier.

In general we will also, I believe, need to move towards what has been called a new “business model” for humanitarian action, with much less emphasis on international response, and much more on building local, national and regional capacity, and on prevention, risk reduction and preparedness. This will fit better with what I also believe is likely to be a less western-centric model of international relationships, including in the humanitarian field, where, like it or not, respect for national sovereignty and capacity will be needed much more, except in really extreme cases.

c) Are we prepared?

So are we really ready for this? Not yet. But we have to be. We need to look at all our operations and all our research and analysis to ask if we are fully and genuinely anticipating the challenges of the future. We need to make sure we are not planning for the last war- or the last international health crisis- but for the next one, even if we cannot yet know what it will be. So flexibility and adaptability will be crucial.

V. Conclusion

Let me leave you with a final thought. The greatest risk that we as a humanitarian community face is not from nature, but from human nature, in other words our own propensity for not acting radically and courageously ahead of time, before disaster, conflict, or some other new challenge occurs. Climate change is after all a man-made threat, but we are not really treating it with the seriousness with which we treat a war or even a financial crisis. The lesson is that working together, we must redouble our efforts and work even more cohesively not only to respond to both “traditional” and “new” crisis situations, but also in particular to reduce vulnerability to any and all crises. As I have already suggested, that means strengthening the ability of local and national governments, who retain primary responsibility, to prepare for and respond to humanitarian needs. Local answers are usually more effective and cheaper, but only if the right measures are taken in advance.

I apologize again if I have at times painted a bleak picture. I recognize that fear of the future often paralyzes rather than motivates. But in most cases, and health is certainly one of them, we know pretty much what to do. We just need to find the will and resources to do it.