Geneva Health Forum

Access to Care in Crisis Settings:

Rethinking Cooperation in Practice

Roundtable

Tuesday 19 May 2026

Campus Biotech, Geneva

During the 79th World Health Assembly

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Introduction

Access to healthcare in armed conflict is not a new challenge. The legal framework protecting it is robust and unambiguous, international humanitarian law, the Geneva Conventions, UN Security Council Resolution 2286 (2016)[1], and has been for decades. And yet attacks against healthcare services continue to rise. Hospitals are damaged or destroyed, health workers are threatened or killed, supply chains are disrupted, and access to essential medical services is severely curtailed for civilian populations. Conflict-affected and fragile states carry a disproportionate burden of the world's disease and mortality, and that burden is growing.[2]

Two converging pressures make this moment particularly urgent. The first is a dramatically changed funding landscape[3]: the contraction of humanitarian financing is forcing every actor to make difficult choices about who receives care and who does not. The second is an unprecedented level of attacks on the medical mission, occurring with near-total impunity across multiple active conflicts simultaneously[4].

Against this backdrop, the Geneva Health Forum convened a 3.5-hour working session on 19 May 2026 at Campus Biotech, Geneva, as part of the 79th World Health Assembly. The session brought together over 80 — to be confirmed] participants from across the humanitarian and global health landscape, practitioners, researchers, policymakers, and civil society representatives. It was part of GHF's 2026 theme — Rethinking Cooperation in Global Health — and built on prior discussions at the Humanitarian Networks and Partnerships Weeks in March 2026[5]. Rather than adding to the existing body of diagnosis, it was designed to move from evidence to action: to map the systemic barriers that prevent solutions from being implemented, and to identify the shifts required at system level to make access to care in crisis settings the norm rather than the exception.

Objectives

- A structured mapping of the main systemic barriers to access to care in crisis settings, linked to practical actions
- Identification of at least three priority shifts at system level, to be refined through subsequent events
- Reinforced momentum for rethinking cooperation across policy, operational, and field actors
- Entry points for continued engagement toward AidEx (October 2026) and the GHF biennial conference (November 2026)

What the Session Produced

Three thematic roundtables on localization and local actors, health workforce and capacity, and continuity of essential health services, produced structured mappings of systemic barriers alongside practical actions and responsible actors. A plenary synthesis identified three cross-cutting priority shifts, while five themes emerged consistently across all three roundtables.

The discussion brought together the following participants:

- Flore Ganon, Acting deputy director of advocacy at Action Contre la Faim (ACF) France.
- Avril Patterson, Head of the Health Unit at International Committee of the Red Cross (ICRC).
- Laurence Gaubert-Henry. Response to Disaster Unit Manager at Terre des hommes.
- Sylvain Perron, Deputy Program Manager at Médecins Sans Frontières (MSF).
- Moumouni Kinda, Chief Executive Officer of The Alliance for International Medical Action (ALIMA)Sylvain Perron: Humanitarian Program Manager for Sudan at Doctors Without Borders (MSF).
- Marine Vignon, Project manager and regional coordinator at the Alliance for International Medical Action (ALIMA).
- Cora Portais, Communication officer at the Alliance for International Medical Action (ALIMA).
- Chantal Autotte Bouchard, Responsible of Public Health within Technical Services and Knowledge Management (STC) at Première Urgence.
- Louise Logre, Head of Technical Services and Knowledge Management (STC) at Première Urgence.
- Alessandro Lamberti-Castronuovo, Emergency Physician, Primary Health Care Focal Point at EMERGENCY NGO
- Patrick Musole Bugeme, Physician and Field Epidemiologist, Uvira, Eastern DRC, Institute of Global Health, University of Geneva.
- Bruno Lab, Head of Humanitarian Affairs & International Cooperation - Hôpitaux Universitaires Genève (HUG).
- Lai Ling Lee Rodriguez, Deputy General Director at Médecins Sans Frontières (MSF).

Opening Remarks

Avril Patterson

Head of the Health Unit, International Committee of the Red Cross (ICRC)

"The problem is not the law itself, but adherence to it."

Avril Patterson opened the session by establishing that the legal framework protecting access to healthcare in armed conflict is strong and unambiguous. Under international humanitarian law, medical facilities, personnel, transport, and the wounded and sick must be respected and protected in all circumstances. Under international human rights law, the right to healthcare is explicitly recognized in multiple major international treaties — the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, and others. The legal architecture exists. The problem, she emphasized, is adherence to it, and the increasingly loose interpretation of rules that were designed to be clear.

She framed the challenge facing health systems in conflict as a triple problem: a massive increase in demand, a decrease in capacity, and the often-deliberate undermining of the right to access healthcare for populations. Each dimension compounds the others. Crises generate increased numbers of wounded and sick, a greater burden of disability, worsening mental health, increased disease exposure, and population displacement. At the same time, health infrastructure is damaged or destroyed, supply chains are disrupted, and the health workforce is reduced — often through direct attacks. Critically, she noted that disruption does not fall equally: structural discrimination means that people with disabilities, the elderly, women, and children face compounded vulnerability. And treatment for non-communicable diseases and mental health conditions does not stop being necessary just because a crisis has arrived. As she put it: "just because there's a crisis doesn't mean your high blood pressure suddenly normalizes."

Key figures underlined the disproportionate burden carried by conflict-affected and fragile states: conflict-affected and fragile states host more than 70% of epidemic-prone diseases, 60% of preventable maternal deaths, 53% of deaths under five, and 45% of infant deaths.

She cited the 10th anniversary of UN Security Council Resolution 2286 (2016), which demanded that all parties to armed conflict fully comply with their obligations to respect and protect medical personnel, facilities, and transport, and to facilitate safe and unimpeded access for humanitarian personnel. Two weeks before this session, a joint statement by the ICRC President, the WHO Director-General, and the MSF International President put it starkly: "The situation is even worse compared to 10 years ago. Today, we mark not an achievement — we mark a failure. That is not a failure of the law. It is a failure of political will."

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[1] United Nations Security Council. Resolution 2286 (2016) on the Protection of the Wounded and Sick, Medical Personnel and Humanitarian Personnel in Armed Conflict. 3 May 2016.

[2] Safeguarding Health in Conflict Coalition. *Care in the Crosshairs: Violence Against Health Care in Conflict 2025*. 2026. https://safeguarding-health.com

[3] UN Office for the Coordination of Humanitarian Affairs. *Global Humanitarian Overview 2026*. https://www.unocha.org/global-humanitarian-overview

[4] MSF report reveals record level of attacks on medical care in armed conflict | MSF UK

[5] Geneva Health Forum. *Strengthening the Application of International Humanitarian Law to Guarantee Access to Healthcare*. Zenodo, June 2026. https://doi.org/10.5281/zenodo.20757332

Experiences from the field

Three field presentations grounded the discussion in operational realities, each speaking to a different dimension of access to care in crisis settings.

"Tdh in Afghanistan: ensuring access to primary healthcare in protracted and acute crises"

Laurence Gaubert-Henry, *Response to Disaster Unit Manager at Terre des hommes*

The first testimony presented experience of maintaining health services under severe access restrictions, including on female health workers. Key mechanisms included mobile health teams, crisis modifiers built into project budgets, and pre-negotiated access agreements with local authorities. The case illustrated what it takes to sustain community health responses when formal systems are under severe political constraint, and how flexibility, anticipation, and community-rooted approaches can maintain access where fixed services cannot.

"Crisis in Sudan: healthcare under fire and blockades"

Sylvain Perron, *Deputy Program Manager at Médecins Sans Frontières (MSF)*

The second testimony described experience of operating under armed group control in a context of near-total administrative blockade, where the organization shifted to a remote-support model relying almost entirely on local staff. Beyond the operational adaptations, the case raised profound questions that the session was designed to explore: what does duty of care mean when international staff can no longer be present? What does continuity of care require when the health system has nearly collapsed? And when risk cannot be mitigated from a distance, are we reducing it, or transferring it to local staff?

"Facing Ebola Epidemics: From Barriers to Field Solutions"

Moumouni Kinda, *Chief Executive Officer of The Alliance for International Medical Action (ALIMA)*

The third testimony drew on ALIMA's experience across multiple Ebola responses and crisis settings to illustrate three dimensions of what effective local engagement requires in practice: recognizing and resourcing local authorities as the legitimate coordinators of humanitarian response; trusting local expertise to reach areas where international deployment is not possible; and investing in operational innovation, including research conducted alongside healthcare delivery, to find solutions adapted to the specific conditions of each crisis. The cases demonstrated that access to care in acute outbreaks depends not only on technical capacity, but on how power, trust, and knowledge are shared between international and local actors.

Roundtables

Following the field testimonies, participants were invited to move into three thematic roundtables, each facilitated by a moderator and a note-taker. Each table could welcome up to 20 - 25 participants, who were free to choose their preferred theme. The three tables ran simultaneously for 45 minutes, with the goal of identifying key systemic barriers to access to care, defining practical actions and responsible stakeholders, and encouraging cross-sector dialogue grounded in the field experiences just shared. The outputs of each table were then brought back to a collective plenary synthesis.

Roundtable 1: Localization and the Role of Local Actors

Moderated by:

Marine Vignon, *Project manager and regional coordinator at the Alliance for International Medical Action (ALIMA).*
Cora Portais, *Communication officer at the Alliance for International Medical Action (ALIMA).*

The table converged on a substantive definition of localization: not representation within externally designed processes, but the genuine transfer of decision-making power and accountability to local actors with context-specific knowledge and proximity to affected communities. As one participant put it: "Any help that is done for me without me is done against me."

The main barrier identified was trust — between donors and local organizations, and between local organizations and what international actors report about their own activities. Behind this trust deficit lie deeper structural problems: local actors lack direct access to funding; projects arrive pre-designed before local actors are consulted; and coordination mechanisms frequently exclude local leadership. The table was also explicit about the role of donors: new consortium models are needed in which local and national organizations hold the same responsibility as international actors, not a subcontracted relationship.

The practical actions proposed centred on placing local actors at the centre of decision-making, building partnerships on equality, and ensuring that exit strategies and sustainability are built into interventions from the outset.

Roundtable 2: Health Workforce and Capacity

Moderated by:

Chantal Autotte Bouchard, Responsible of Public Health within Technical Services and Knowledge Management (STC) at Première Urgence.
Louise Logre, Head of Technical Services and Knowledge Management (STC) at Première Urgence.

The table organized its discussion around the health workforce as simultaneously a target of conflict and the strategic asset on which any health response depends. The central barrier named was that health workers are part of the crisis itself — attacked, morally injured, without tools or medicines, worried about their families, and increasingly criminalized for providing care. "Health workers are a military target now" was one formulation that emerged from the discussion.

A second cluster of barriers addressed preparedness and training: insufficient emergency-specific curricula, lack of adapted standard operating procedures, and a tendency to think only of doctors and nurses when the full range of responders — pharmacists, logisticians, community health workers — also need preparation. A third cluster addressed the shortage and instability of the workforce itself, compounded by salary competition between international organizations and national health systems.

The practical actions proposed included paying and protecting local staff, applying duty of care frameworks, publishing data on attacks and raising the alarm more loudly, mobilizing professional health associations through their networks, and building allies with media and civil society. The responsible actors named explicitly included states, international and local organizations, professional health workforce associations, and donors.

Roundtable 3: Continuity of Essential Health Services

Moderated by:

Alessandro Lamberti-Castronuovo, Emergency Physician, Primary Health Care Focal Point at EMERGENCY NGO.
Patrick Musole Bugeme, Physician and Field Epidemiologist, Uvira, Eastern DRC, Institute of Global Health, University of Geneva.

The table began by challenging a common misconception: continuity of care is not only about primary care. It spans every level of the health system: from screening and prevention through acute curative care to surgical and hospital services. The mere availability of primary care services does not equal accessibility; geographical, administrative, cultural, trust and security barriers prevent people from reaching them even when services exist.

The central barrier identified was this gap between availability and accessibility, compounded by the deprioritization of pre-existing needs when a crisis arrives — chronic disease patients, people requiring surgical care, and vulnerable populations whose needs do not disappear because a new emergency has occurred.

The solution the table converged on was a paradigm shift at the primary care level: rather than waiting for patients to come to services, health systems must proactively bring care to people through community health workers, volunteers, and community-linked approaches. Sudan's Emergency Response Rooms and community health workers in Ukraine were cited as examples of what becomes possible when local capacity is recognized and resourced. A second contribution added that this proactive approach must function as a connected continuum: community, primary health care, referral, and hospital coordinated across all levels rather than operating as separate silos. Coordination across levels, not just within them, is the central enabling mechanism.

Plenary Synthesis

Bruno Lab

Head of Humanitarian Affairs and International Cooperation at Hôpitaux Universitaires de Genève (HUG).

Rather than summarizing each table in isolation, he invited the moderators to name one barrier and one solution, a constraint that forced each group to identify what mattered most rather than report everything.

What emerged from that exercise was not three separate conversations but one. Each table had approached the problem from a different angle: power and accountability, workforce protection, continuity of care, and arrived at the same underlying diagnosis: the system is not failing because solutions are unknown. It is failing because the conditions that would allow those solutions to work — trust, funding architecture, political will, local ownership — have not been built. The barriers are structural, not technical.

Bruno Lab noted that the session had been designed in response to two converging pressures: a dramatically changed funding landscape affecting all humanitarian actors, and an unprecedented level of attacks on the medical mission. Both had shaped the choice of topic. The session did not resolve either, but it had, as he put it, created a space for meaningful dialogue and for identifying where joint effort might go next. The GHF, he noted, was at the disposal of any group of organizations willing to continue the conversation.

Closing Reflection

Lai Ling Lee Rodriguez

Deputy General Director at Médecins Sans Frontières (MSF)

"We need to mobilize more, we need to amplify our voices collectively, and we need to keep saying: stop bombing hospitals, stop bombing health workers, stop bombing patients."

Lai Ling Lee Rodriguez opened her reflection by acknowledging the pragmatism and constructiveness of the afternoon's discussions — the barriers named, the solutions proposed, the cross-cutting themes of trust, funding, and health worker protection. But she immediately asked participants to step back and look at the world in which those discussions were taking place.

What she described was a set of dangerous political trends unfolding simultaneously and in the same contexts where the organizations in the room work every day: the erosion of protection for civilians and communities; IHL violations continuing with impunity; the increased politicization of aid and active attempts to discredit the humanitarian system and health workers themselves; and the attack on the reputation of humanitarian organizations at an all-time high. In Gaza, Sudan, South Sudan, DRC, Burkina Faso, these realities are not sequential, she noted, but superimposed.

She named two specific trends that went beyond the afternoon's discussion. First, the Ebola outbreak in DRC, active at the moment of the session, as a reminder that health crises do not wait for political conditions to improve. Second, the use of drones, not only to attack humanitarian workers but to terrorize communities psychologically, entering people's homes and cars. Technology, she observed, can amplify voices and strengthen advocacy, but it is also being weaponized in ways that demand a response.

Her call to action was direct: mobilize more, amplify voices collectively, and keep saying: stop bombing hospitals, stop bombing health workers, stop bombing patients. And her closing vision was deliberately idealistic: a world without war, as the only truly durable solution to what the afternoon had spent three hours trying to address.

A Shared Diagnosis

Five themes emerged with striking consistency across all three roundtables, cutting across the different angles each table took and pointing toward the same underlying diagnosis.

Localization means power transfer, not representation. The debate is not about including local actors in processes designed elsewhere. It is about transferring decision-making authority, accountability, and financial control to those with context-specific knowledge and proximity to affected communities. Without that transfer, localization remains a label rather than a practice.

The political is inseparable from the operational. Administrative blockades, the criminalization of health staff, the weaponization of aid, and the deliberate targeting of health facilities are primary drivers of system failure. No practical solution that ignores who controls access, funding, and decisions can be complete.

Community is the system. The community level is the primary unit of resilience in crisis settings, and the most chronically underinvested. Emergency Response Rooms in Sudan, community health workers in Ukraine, and mobile response units in Uganda all illustrated what becomes possible when local capacity is recognized and resourced before the crisis arrives.

Funding architecture drives behavior. Short-term project cycles, ready-made templates designed by international actors, and accountability structures that flow only to donors rather than to affected communities are structural causes of the localization gap, not incidental features that can be adjusted at the margins.

Preparedness must begin before the crisis. Response capacity cannot be built during an emergency. Health system strengthening, community preparedness planning, and pre-negotiated access agreements must be established in advance, and community actors must be part of that planning from the outset.

Running through all of these themes is a more fundamental question that the session surfaced but did not fully resolve: is healthcare treated as an investment and as a human right, or as a cost to be managed and a service to be rationed? The evidence on the economic returns of investing in health systems is substantial and well-documented. The commitment to health as a universal human right is enshrined in international law. And yet both are systematically set aside in the funding decisions and political choices that shape access to care in crisis settings. Addressing this gap, between what is known, what is committed to, and what is actually done, may be the most important shift of all.

Key Messages

The session did not produce new knowledge. It produced convergence: participants from across the humanitarian and global health landscape arriving at the same conclusions from different starting points. That convergence is itself the message.

Localization must be defined operationally, not rhetorically. Genuine local ownership means the transfer of decision-making authority, accountability, and financial control, not representation in externally designed processes.

The health workforce crisis is a political crisis. Attacks on health workers occur with impunity across multiple active conflicts. The solution is not better training or greater resilience, it is accountability, advocacy, and the political will to enforce existing law.

Continuity of care requires a system, not just a service. Bringing care to communities is necessary but not sufficient. Genuine continuity requires coordination across the full health pathway, from community health worker to hospital, as a single connected system. Proximity is not continuity.

Preparedness is the missing link. Crisis response capacity cannot be built during a crisis. Investment in community-level preparedness, local health system strengthening, and pre-negotiated access agreements must happen before the emergency, not in response to it.

The barriers are systemic, not technical. The capacities to respond often exist. What prevents their deployment is power: who controls funding, who makes the decisions, and who is accountable to whom.

What's Next: Continuing the Process

Throughout 2026, the Geneva Health Forum is developing its guiding theme — Rethinking Cooperation in Global Health — through a series of strategic events designed to build intellectual and political continuity rather than produce isolated discussions. The May session is one step in that sequence. The outputs generated here are not endpoints; they are starting points for continued collective reflection and action.

The sequence is deliberate. In March 2026, during the Humanitarian Networks and Partnerships Weeks, GHF examined access to care from a legal and protection perspective. In May, the focus shifted to operational realities: identifying systemic barriers, proposing practical actions, and naming the system-level shifts required. What comes next moves from diagnosis to evidence and, ultimately, to commitment.

AidEx — October 2026

GHF will host two one-hour panel sessions at AidEx in Geneva, building on the discussions from the May session. The first focuses on localization in health, the second on continuity of care. The sessions move the conversation from "what needs to change" to "who is already doing it, and how." Rather than revisiting the barriers, each panel brings together practitioners who

have found concrete, field-grounded responses — locally-rooted organizations that have led health responses without international backing, and organizations that have genuinely restructured how they work with local partners.

GHF Biennial Conference — November 2026

The November conference is the culmination of GHF's year-long thread. Building on the field cases surfaced at AidEx and the systemic barriers identified in May, the conference is willing to bring together practitioners, donors, policymakers, and researchers to move from collective reflection to collective action. Small group discussions will work toward concrete, named commitments that can be captured, published, and followed up. The measure of success for November is both what happens in the room and what happens afterward: whether participants leave with something they are willing to act on, and whether the conversation continues beyond the conference itself.

As part of the November conference, GHF has launched a call for submissions of field experiences on access to care in crisis settings. Organizations and practitioners working on localization in health, continuity of care, or health workforce protection in conflict or protracted crisis settings are invited to submit a short abstract describing a concrete experience — what was done, in which context, and what it produced. Further information is available at Geneva Health Forum : Together, let's build the health of tomorrow!

The Lancet Commission as Evidence Anchor

The CHH-Lancet Commission on Health, Conflict, and Forced Displacement, whose landmark report was launched the day after this session at the same venue in Geneva, provides an important evidence anchor for this process. The Commission concludes that the global humanitarian system is no longer fit for purpose, overwhelmed by escalating conflicts and forced displacement while relying on politicized funding models that ration survival rather than save lives. Its call for a fundamental rethink of how humanitarian health responses are designed, governed, financed, and delivered is strikingly consistent with what the May session produced from the field. The convergence between what practitioners said in the room and what an independent research commission found in the evidence is itself significant, and a reminder that the diagnosis is not in dispute. What remains is the will to act on it.

Annex

The following tables present the systemic barriers and practical actions identified by each roundtable during the session. They reflect the facilitators' synthesis of each table's discussion and have been reviewed by the preparation committee. Responsible actors are not included, as not all tables formally named them during the session.

Table 1 — Localization and the Role of Local Actors

Systemic Barrier	Practical Actions
Trust deficit between international and local actors	Transparency reporting by INGOs on activities and impact; shift to local actors as primary recipients of donor funding
Financial dependency: those who hold the money hold the power	Redesign consortium structures so local and national organizations are equal partners, not implementers; donor criteria requiring funding to flow to local actors first
Fragmented coordination, often excluding local leadership	Government-led coordination where feasible; structured inclusion of local community knowledge in hazard and vulnerability assessments
Decision-making power concentrated in donors and INGOs; local actors treated as executors	Local and national actors hold final decision-making authority and full accountability to affected populations; international actors provide expertise and exit-oriented support
Political instability limits government-led coordination	Context-dependent adaptation; identify the decision-holder with legitimate authority and community trust, not necessarily the formal government

Table 2 — Health Workforce and Capacity

Systemic Barrier	Practical Actions
Health workers are targets and victims of conflict, not just providers	Publish incident data; amplify IHL sensitization campaigns; raise alarm through professional networks and media; end impunity for attacks on health workers
Moral injury and burnout: workers face powerlessness, lack of tools and medicines, family vulnerability	Duty of care frameworks for all employing organizations; MHPSS coverage for health staff; peer support networks
Insufficient preparedness: no emergency-specific guidance, SOPs, or training at system level	Integrate humanitarian health response into medical and health curricula; develop rapid emergency SOPs; extend training to pharmacists and logistics staff
Chronic shortage of trained, available, and funded workforce at local level	Sustained funding for local health workforce; harmonize salary grids among actors to avoid system depletion; localize workforce to strengthen access
Siloed response: lack of multidisciplinary approach and community integration	Embed community actors in workforce planning; coordinate across organizations; leverage community-based networks including pharmacists and volunteers

Table 3 — Continuity of Essential Health Services

Systemic Barrier	Practical Actions
Availability of services does not equal accessibility: geographical, administrative, and security barriers remain	Proactive, anticipatory outreach through community health workers and volunteers; strengthen transport, referral support and navigation through administrative barriers.
Pre-existing needs are deprioritized by crisis-related needs, creating inequitable access	Systematic needs assessment accounting for pre-existing burden; maintain a minimum package of essential services and monitor how resources are distributed across emerging and ongoing needs.
Lack of informational continuity: patients receive fragmented, uncoordinated care	Patient documentation systems; coordination platforms among facilities and referral feedback; telemedicine where infrastructure allows
Parallel humanitarian systems undermine and deplete local public health systems	Embed interventions within local health systems from day one; design with explicit transition to local ownership and sustainability plan.
Crisis response begins too late: preparedness plans exclude community and civil society actors	Involve community-based organizations and civil society in national contingency planning from the outset, especially in chronic crisis hotspots

The Geneva Health Forum is a non-profit initiative launched in 2006 by Geneva University Hospitals and the University of Geneva. It provides a neutral platform for dialogue and collaboration between public stakeholders, academia, civil society, and the private sector.

It collaborates with its partners to create synergies to address public health challenges.

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