

CHAPTER 2.1

SAVING LIVES AND REDUCING HARM

'Right now, we need assistance – there is no food, no medicine, we have malnutrition, pregnant women are dying.'

– *Emergency Response Room volunteer, Sudan*

The humanitarian system delivered effective responses where it was adequately resourced and access was possible – the 2022 Somalia famine response, the polio campaign in Gaza and nutrition programming in Ethiopia were amongst the clearest examples. Interagency analysis concluded that the system played a crucial role in averting the worst potential outcomes across several crises and there were examples of progress from pandemic investment, to community health, cash programming, and support for the informal system. However gains were uneven, sometimes reversed by funding cuts and hard to demonstrate convincingly. Moreover, adequate resourcing and access were rarely obtained at scale across the 2022–25 period. The system delivered effective rapid responses but struggled to contain epidemic disease, protect civilians or sustain shelter and education outcomes in the face of conflict, obstruction and funding cuts. People affected by crisis asked for more support for livelihoods and education, seeing self-reliance as lifesaving in its own right.

Why effectiveness mattered

Between 2022 and 2025, against a backdrop of deepening crises and shrinking budgets, humanitarian action reached more people in need than ever before. But did it work? With aid budgets collapsing and the sector's value under open political challenge, the question carried more weight than at any point in *The State of the Humanitarian System* (SOHS) series. This chapter steps back from the political moment to ask what the evidence actually showed: the effects humanitarian action had on the people it reached, where it fell short and why.

The short answer is that the system did demonstrate that it could save lives and alleviate suffering under some conditions. Humanitarian effectiveness

also depended on whose priorities were being assessed. Many people living through crises did not separate immediate and longer-term needs the way the system did. In Somalia, a lack of livelihood opportunities ranked above food insecurity as the biggest issue people faced, while in Chad people's top priorities centred on livelihoods and education – despite severe food and water shortages.¹ Some people saw support for self-reliance as lifesaving in its own right, rather than a luxury to be addressed once survival was secured.

The system did demonstrate that it could save lives under some conditions

This chapter is structured by sector because that is how the humanitarian system organises itself and how most evidence is generated and reported. Several qualifications run through everything that follows. Measurement focused on outputs rather than outcomes, making it difficult to fully assess what was achieved – or what was lost. Moreover, the formal system's performance was only part of the picture; it often did not capture the responses of local organisations, diaspora networks or mutual aid (documented in [Chapter 4.1](#)).

Food and famine

The 2022 SOHS² was cautiously optimistic about how the system was responding to hunger: lessons from the four famines of 2017 appeared to have been learned and there was evidence of effective responses. However, the report also raised concerns regarding the resurgence of conflict-driven famine, manipulation of food security data and an overemphasis on food aid. Would the lessons of 2017 stick?

Hunger rose sharply during this 2022–25 study period, driven by escalating need, contracting resources, obstruction of aid and political failures. Famines were also declared in Sudan and Gaza, and, in addition to these declarations, there was a resurgence of catastrophe conditions (Integrated Food Security Phase Classification (IPC) Phase 5) in contexts of armed conflict.³ Despite formal famine warnings in Gaza and Sudan and catastrophe conditions (IPC Phase 5) in Haiti, operational constraints, chronic underfunding and obstruction of aid prevented an adequate response. In Haiti, IPC classifications technically functioned as intended – they consistently documented a protracted crisis in which nearly half the population faced acute food insecurity (Phase 3 or above) between August 2024 and February 2025, including 2 million in emergency (Phase 4)⁴ – yet these classifications were unable to trigger an adequate response because gang violence made access impossible. In Sudan, the IPC's Famine Review Committee noted that humanitarian aid could only prevent



famine temporarily and in limited areas, unless broader conflict drivers were addressed.⁵

The period saw Sudanese⁶ and Israeli⁷ authorities challenge the IPC's findings, as well as debate about whether the IPC's famine thresholds were fit for purpose. Researchers called for updates to the classification system, arguing its mortality threshold of two deaths per 10,000 people per day was designed for rural African settings. In their analysis, meeting the threshold in a context like Gaza (where pre-war baseline mortality was below 0.1 deaths per 10,000 people per day) would require a more than 20-fold increase in non-trauma deaths, compared to the six- or seven-fold increase required in rural Somalia or South Sudan.⁸ Researchers also argued that the requirement for all three IPC Phase 5 indicatorsⁱ to be met simultaneously also incentivised authorities to restrict data access.⁹ In several contexts, restrictions on data access made the true scale of need harder to establish.

The most positive evidence of effective famine response came from Somalia. During the 2022–23 drought that occurred during ongoing political instability, an estimated 74,700 people died: a devastating toll, but one that interagency analysis suggests would have been tens – possibly hundreds – of thousands higher without the massive scale-up of humanitarian assistance.¹⁰ The Inter-Agency Humanitarian Evaluation's (IAHE) conclusion relied on counterfactual analysis using IPC trend data: famine was predicted, predicted trends did not materialise and humanitarian aid appeared to be a determining factor. The IAHE concluded that humanitarian assistance 'helped prevent famine and saved many lives'.¹¹ Similarly, in Afghanistan, the IAHE found food and livelihood assistance played 'an essential role in ensuring access to food, relieving pressure on household budgets, and halting the extremely adverse trends in food insecurity'.¹² Again, the IAHE used IPC trend data, albeit drawing correlations with food security indicators rather than famine-outcome data.



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In both these and other food security responses, organisations were able to address malnutrition despite enormous constraints. In northern Ethiopia, for example, the United Nations Children's Fund's (UNICEF) Severe Acute Malnutrition treatment programmes demonstrated resilience to operational adversity in ways that other sectors did not. Therapeutic feeding exceeded Sphere standards (globally recognised minimum requirements for humanitarian response), with

ⁱ The famine indicators are: 1) at least 20% of households face an extreme lack of food; 2) Global Acute Malnutrition prevalence exceeding 30% among children under five years; and 3) death rate exceeding two per 10,000 people per day, or an under-five mortality rate exceeding four deaths per 10,000 children under-five per day.



cure rates of 88–95% and mortality rates well below Sphere thresholds,¹³ despite operating under extreme access and funding constraints that left most other sectors underperforming.¹⁴



Across multiple contexts, cash transfers significantly improved consumption, food expenditures, food security and nutritional status



A 600-paper review found strong evidence for the effectiveness of cash transfers and several other food security strategies. Across multiple contexts, cash transfers significantly improved consumption, food expenditures, food security and nutritional status. A meta-analysis found these strategies also significantly reduced stunting and improved dietary diversity in children under five, though no effect on wasting was found. However, results varied significantly by context, and in several settings cash only improved child-nutrition outcomes when combined with behaviour-change communication.¹⁵

Other interventions included programmes to help farmers access better crop varieties, store harvests more safely and access training and information.¹⁶ A range of other approaches looked promising, from growing more nutritious crops to improving weather forecasting, but these had not been studied widely enough to draw firm conclusions.

Delivering aid before rather than after a climate shock could improve food security and avoid harmful coping strategies. However, recipients did not always prioritise food; a study of protracted displacement in South Sudan found most households used anticipatory transfers to improve shelter ahead of flooding, producing mixed results on food security outcomes¹⁷ (see [Chapter 2.2](#) for a discussion on anticipatory action).

Despite the success in preventing famine, the Somalia IAHE found that some targeting methods eroded resilience. For example, as food responses scaled up, people were incentivised to abandon sites that offered durable solutions and to re-register as newly displaced elsewhere in order to qualify for assistance.¹⁸ The IAHE raised the question of whether responses should concern themselves with medium-term outcomes, including negative aid effects. The World Food Programme's (WFP) summary of 23 programme evaluations found emergency support persistently failed to connect to longer-term programming across multiple contexts, suggesting the same pattern elsewhere.¹⁹

The picture was considerably bleaker in other famine contexts. The Sudan famine was the largest and most complex in recent decades. In Gedaref and Kassala, families we spoke to waited three to four weeks between food distributions,

and some sites went five months without any aid at all. In Eastern Sudan, farmers abandoned planting for fear of Rapid Support Forces (RSF) incursions. While Emergency Response Rooms and the associated community kitchens²⁰ mounted an extraordinary response, their efforts struggled to address a crisis that left over 19 million people²¹ in acute hunger. Moreover, the humanitarian system was unable to compensate for the simultaneous collapse of health; of water, sanitation and hygiene (WASH); and of agricultural systems on which food security depends. Local organisations told us that deaths from hunger were directly attributed to humanitarian resource gaps. Meanwhile, our survey among aid recipients in Sudan found that only 17% of people said they received sufficient quantities, 25% said aid was timely and 31% said they had been consulted about the aid – the lowest figures of any country context we surveyed.

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The United States Agency for International Development (USAID) previously funded approximately half of the global supply of ready-to-use therapeutic food – the frontline treatment for severe acute malnutrition in children under five.²² Donor cuts triggered temporary plant closures, staff reductions and raw-material expiry across the supply chain,²³ as well as cost increases. Funding cuts also disabled key data infrastructure: for example, the Famine Early Warning Systems Network (FEWS NET) – a major US-funded system underpinning humanitarian planning across more than 30 countries – was shut down in January 2025 and remained offline for approximately five months before partially resuming operations in June 2025 under US State Department management.²⁴ The 2026 *Global Report on Food Crises* reported data losses in 18 countries.²⁵

There was evidence of targeting and prioritisation decisions reducing effectiveness (see [Chapter 1.2](#)). WFP generally opted to reduce rations rather than caseloads, but concluded that this had led to assistance being ‘spread too thinly’, raising questions about whether it could realistically hope to improve food security outcomes.²⁶ Its reduction of rations included those for households classified as IPC phases 4 and 5, in some contexts,²⁷ and it directed funding towards crisis response over resilience and addressing root causes.²⁸ Over 90% of WFP’s in-kind food rations in 2023 did not meet nutritional needs; while this had improved slightly by 2024, 80% of rations remained nutritionally inadequate. This sometimes created tensions: in Nigeria, for example, communities refused to participate in vulnerability-ranking exercises, while in other places, people said they would refuse aid entirely if only some received it.



Senior practitioners also worried that deep cuts in assistance in locations like Mali, where 0.9 million people were facing crisis (IPC Phase 3) in 2025,²⁹ would create problems at the community level. One said:



'How do you do programming that is accepted by community? It's quite problematic from a security standpoint. It is hard to do hyper-targeting. It's a very Western notion. Strong social networks that mean doing assistance for one person and not others doesn't work.'

A Global Brief concluded that WFP should 'provide a meaningful level of assistance or don't assist at all'.³⁰ Its 2026–29 strategic plan committed to reach fewer people with higher-quality and better tailored assistance³¹ – a shift that raised hard questions about who would be left out.

These funding and prioritisation decisions had consequences for food security outcomes. At its peak, food assistance in Yemen reached half of the population;³² but by the time the 2024 Humanitarian Response Plan was published, nearly half of all children under five suffered moderate to severe stunting. In Ethiopia, ready-to-use therapeutic food (RUTF) stocks were projected to run out;³³ in May, the Ethiopian Ministry of Health reduced the dose of RUTF that each child would be given to stretch supplies, while WFP warned that it risked halting treatment for 650,000 mothers and children.³⁴ In Bangladesh, UNICEF recorded a 27% surge in children presenting for severe acute malnutrition treatment in Rohingya refugee camps, which was attributed to disease outbreaks and ration cuts.³⁵ UNICEF – which estimated that at least 14 million children worldwide faced disruptions to nutrition services³⁶ – continued efforts to diversify RUTF procurement towards manufacturers in high-burden countries³⁷ and ran trials on alternative formulations using locally available ingredients.³⁸ In a move towards more joined-up nutrition programming, UNICEF and WFP launched a Joint Action to Stop Wasting in late 2024, with the aim of aligning their prevention and treatment roles and coordinating RUTF supply chains.

New research illustrated how humanitarian engagement with people affected by famine could make famine survival harder, which was particularly important given the scale of triage decisions being made. The social fabric that enables communities to survive hunger includes networks of mutual obligation and norms around asking for help.³⁹ Anthropological work in South Sudan documented how 'hunger courts', while enforcing a mutuality that saved lives, publicly shame families for failing to provide for hungry relatives and transfer blame onto kin rather than the political and economic systems that caused the famine in the first place.⁴⁰ Famine-related songs also shaped community memory around personal



and family failure.⁴¹ The consequences of this were important for humanitarians. Across famine contexts, shame shaped whether and how people sought help: some socioeconomic groups were too ashamed to ask for help, some mothers did not bring visibly malnourished children to clinics, and families grieved privately rather than mobilising.⁴² How humanitarians engage with people affected by famine may compound these dynamics.

Epidemics and morbidity

The conditions that drove food insecurity in this period also created an environment in which epidemic diseases spread. Cholera deaths reached their highest level in more than a decade, mpox was declared a Public Health Emergency of International Concern twice, and polio resurged in endemic and non-endemic countries alike. The humanitarian system again demonstrated it could respond rapidly when resources and political will were present; but it could not deliver sustained, equitable health access to contain outbreaks. Early data revealed that, when aid cuts hit, communities reported closure of health and nutrition facilities.⁴³



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The humanitarian system was capable of rapid initial responses to well-resourced epidemic emergencies. An evaluation of the Directorate-General for European Civil Protection and Humanitarian Aid Operations' (DG ECHO) epidemic response found 'very strong evidence' of rapid response.⁴⁴ In the Democratic Republic of the Congo (DRC), local humanitarians told us that the World Health Organization (WHO) and Médecins Sans Frontières (MSF) collaborated

rapidly in response to the mpox outbreak in North Kivu, deploying mobile clinics to areas without hospitals. Perhaps most impressively, in Gaza in mid-2024, daily, nine-hour, area-specific humanitarian pauses were secured after a 10-month-old baby was confirmed paralysed by polio. A coalition coordinated 708 vaccination teams and 2,700 health workers, 'carrying out this campaign at unprecedented scale and speed under the toughest conditions in Gaza'.⁴⁵ A large-scale assessment of the Covid-19 pandemic found that, when forced to act at speed, the system demonstrated it could simplify, flex and coordinate effectively.⁴⁶ Yet the same review found that these gains were reversed once the emergency phase ended, when institutions reported a rapid return to 'business as usual'.⁴⁷



Throughout the study period, conflict-driven displacement spread disease faster than surveillance and response systems could keep pace. When fighting intensified in South Kivu, patients fled mpox treatment centres during gunfire incidents and returned to their communities before completing isolation. Other patients crossed into Burundi with active infection, creating (as a Provincial Health Division described it) 'a vicious cycle that hinders efforts to stop the spread'. The same dynamic operated in cholera contexts. In Sudan, continuous displacement drove three successive waves of cholera by pushing millions into congested conditions with inadequate water and sanitation, while health centres were destroyed or repurposed as shelters and frontline workers went unpaid for months.⁴⁸ Practitioners noted that the erosion of civilian surveillance capacity had likely slowed the identification of outbreaks, including Ebola in DRC, raising the risk that future outbreaks would not be picked up early enough.



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A systematic review of 51 studies across 13 disease categories found that conflict drives infectious disease through multiple intersecting pathways: displacement into overcrowded settings, destruction of WASH infrastructure, breakdown of health surveillance systems, loss of healthcare personnel and disruption of vaccination programmes.⁴⁹ Health disinformation also increased. Critical factors for containing outbreaks included collaboration between international agencies, governments and local frontline organisations; bio-surveillance information-sharing; and political commitment to access⁵⁰ – none of which were reliably delivered during this period.

Indeed, while the system delivered rapid responses, it struggled with outbreak control. Cases of cholera rose year on year over 2021–24, reaching 560,000 cases across 60 countries.⁵¹ In Yemen, there was no pre-existing response plan, the initial plan missed key actions (such as community-directed WASH),⁵² and vaccines were not delivered until 16 months into the outbreak.⁵³ Globally, the International Coordinating Group was forced to shift to a single-dose Oral Cholera Vaccine and suspend some preventative campaigns due to an acute global shortage. Tensions rose between agencies; MSF described the situation as 'incredibly frustrating'.⁵⁴ At the same time, the manufacturer of the Dukoral cholera vaccine reported a 72% increase in sales driven by demand from high-income-country travellers who faced negligible risk⁵⁵ – a repeat of vaccine-equity challenges identified during Covid-19 and mpox.



However, the system did show some evidence of learning, especially in relation to mpox. In DRC, the government strengthened its One Health Framework, which aimed to support multisectoral coordination across human, animal and environmental health.⁵⁶ One Health platforms operated in multiple provinces, operational plans and roadmaps decentralised surveillance and response,⁵⁷ and a 2023 pilot integrated data.⁵⁸ A Pandemic Fund-supported project also provided more investment in lab and workforce capacity and surveillance.⁵⁹



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cause more deaths
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Some of the most rigorous evidence from the period concerned how epidemics and crises affected existing health systems and morbidity burdens. Indirect effects (such as insufficient WASH, inadequate housing, food insecurity and the breakdown or overwhelming of already fragile public health systems) accounted for 70-90% of excess deaths in many crises.⁶⁰ In Yemen, a review of healthcare accessibility found that a diphtheria

outbreak was 11 times more likely to occur in districts facing ongoing conflict;⁶¹ and there were 57% more diphtheria cases in 2023 than in 2021 and 2022 as a direct consequence of collapsed vaccination systems. In Gaza, adherence to medical follow-up among patients with non-communicable diseases declined from 96.7% before the war to 40.7%; more than 90% of primary healthcare facilities reported shortages of insulin, antihypertensives and dialysis supplies; and only 14 of 36 hospitals remained partially functional.⁶² In general, maternal mortality was also significantly higher in conflict-affected countries, and progress in addressing it had stalled since 2016;⁶³ yet WHO case studies from Ethiopia, Myanmar, Ukraine and Colombia found that mobile health teams, skilled-birth attendants and community-based midwifery produced measurable improvements, even in conflict conditions.⁶⁴

The humanitarian health sector entered the period with the benefits of expanded community-based delivery and improved epidemic-response infrastructure from Covid-19, and growing evidence on anticipatory action for health. In 2024, WHO published its H3 Package:⁶⁵ an integrated services framework to include non-communicable disease, palliative and rehabilitative care alongside communicable disease and maternal health. However, the US accounted for approximately 45% of development assistance for health between 2019 and 2022.⁶⁶ The global health financing architecture had been 'inherently vulnerable' and the sector had not, by the end of the review period, developed a systematic contingency plan for a withdrawal of this scale.⁶⁷



One area where evidence supported a lower-cost approach to maintaining basic health delivery was investment in community health workers. Previous research found that community health workers in humanitarian settings often continued to provide services during crises, including those involving prolonged conflict and population displacement.⁶⁸ The 2024 World Health Assembly resolution on health emergency preparedness explicitly recognised that these community health workers and capacitated volunteers were at the forefront of emergency preparedness, prevention, response and recovery.⁶⁹ However, the evidence also pointed to structural limitations of this model, including attrition,⁷⁰ a narrow scope of practice, and dependence on supply chains and referral pathways.



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Protection and wellbeing

Beyond food and disease response, people living through crises in this period faced threats to their physical safety, psychological wellbeing and dignified survival. Protection was chronically underfunded relative to need, and the system struggled to gain traction on collective protection objectives across the IAHEs.⁷¹

Sexual and gender-based violence and child protection.

UN-verified cases of conflict-related sexual violence increased during this period, and gender-based violence (GBV) was assessed as severe or extreme in 22 of 25 countries experiencing humanitarian crises.⁷² The Johns Hopkins–*Lancet* Commission estimated that 21% of forcibly displaced women experienced sexual violence.⁷³ In DRC, an MSF-Epicentre survey on health consequences included injury or disability in 51% of cases, sexually transmitted infections in 34%, extreme relational disruption in 30%, reproductive complications including miscarriage in 20% and stigma in 15%.⁷⁴

There was some evidence of improvements in sexual and GBV programmes in the period. For example, in Uganda, results improved when CARE International combined multiple pathways for supporting women.⁷⁵ In DRC, MSF supported more survivors by combining door-to-door community outreach (which identified and escorted survivors to services) with free treatment (delivered through a local health centre), bringing more survivors into care within the critical 72-hour window than national and provincial averages.⁷⁶ In Sudan, where the RSF has inflicted sexual violence,⁷⁷ Women's Emergency Response Rooms (WERRS) provided an important protection function; each WERR had its own small pot of funds that could be used to support survivors, and the WERR was not required to report on it in order to protect privacy and strengthen community trust.⁷⁸



Across GBV and child-protection efforts, many programmes relied on referral systems and partnerships with state infrastructures that were often under strain



Across GBV and child-protection efforts, many programmes relied on referral systems and partnerships with state infrastructures that were often under strain. In Sudan, widening gaps in referral pathways held back attempts to follow through on protection cases, line ministriesⁱⁱ lacked staff trained in protection, and camps had limited security. In Gaza, civil society actors coordinated referrals across GBV, child protection and psychosocial support but struggled to meet demand (for example, interviewees told us that Sawa received over 2,000 calls a day to the GBV

and protection hotline). Research demonstrated the importance of child-friendly spaces,⁷⁹ but these seemed to be cut in several contexts, with one Emergency Response Room volunteer telling us:



'We have rape among children. 11–12 year [old] girls are being raped ... We had protection activities for women and children: safe spaces, [psychosocial support], [sexual and reproductive health] awareness, dignity kits ... We stopped in Feb 2025, since the funding stopped coming ... Now, no organisation is providing any protection activity.'

Mine action and land rights

The Afghanistan IAHE highlighted mine action and land rights as strong areas of protection programming.⁸⁰ While some donor conditions hindered humanitarian engagement with the Directorate of Mine Action Coordination, the evaluation indicated that intervention significantly reduced the risk of death or injury and that the Housing, Land and Property sub-cluster enabled people affected by crisis to claim their rights through combined legal advice.⁸¹ Other reports tied mine-action interventions to more positive food security outcomes in Lebanon,⁸² and the Mines Advisory Group's work in Iraq improved communities' perceptions of safety and enabled some to resume their livelihoods activities.⁸³ Protection specialists also deemed collective advocacy important to supporting the Declaration on the Use of Explosive Weapons in Populated Areas,⁸⁴ which was followed up with an international conference in 2024 to support implementation.ⁱⁱⁱ On land rights, the Global Protection Cluster compiled a review of lessons learned to improve support on legal rights and justice (see [Chapter 3](#) for further discussion of the system's commitments to protecting people affected by crisis).⁸⁵

ii District-level offices of government ministries with specific sectoral mandates.

iii There was still work to be done by the end of 2025 to translate the Declaration into national policies and shifts in military doctrine, as well as to strengthen civilian harm-tracking (see GPC (2026) <https://globalprotectioncluster.org/publications/2401/reports/report/global-protection-forum-2025-official-report>).



Shelter

Coverage was a major challenge for the shelter sector. In 2024, shelter partners reached just 18% of the 93 million people needing shelter and non-food items.⁸⁶ The UN High Commissioner for Refugees' (UNHCR) *2024 Global Report* found that only 42% of refugees and asylum seekers, and just 29% of internally displaced people, had access to habitable housing.^{iv}

In 2024, shelter partners reached just 18% of the 93 million people in need

In early 2024, a rapid assessment of 33 sites operated by the UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) in Gaza found as little as 1 m² of covered living space per person.⁸⁷ Evaluations in Yemen⁸⁸ and Haiti⁸⁹ documented concerns with durability and quality of materials; recipients stated the need for more permanent solutions. Structural problems included Sphere's 3.5 m² of living space remaining the primary operationalised standard for shelter, as well as ambiguity around the terms 'dignity' and 'privacy' in the dominant definition of 'shelter' and these being dependent on a reader's knowledge.^v One shelter specialist told us they were 'almost never' able to provide 'safe, dignified and adequate shelters' in camps and spontaneous settlements, and instead had to consider practical constraints like whether families would be able to move with and rebuild the shelters if they were displaced again. The Global Shelter Cluster sought to improve standards through the Shelter Severity Classification System, finalised in 2022 after a pilot in north-west Syria, where it assessed need across three dimensions: the shelter structure, living conditions inside it and access to services around it.

In general, there was limited evidence available on the outcomes for the shelter sector, and direct links between shelter conditions and health, education and livelihoods outcomes remained poorly understood. However, two approaches showed particular promise for replication: in Ukraine, cash offered a model that integrated temporary accommodation into the private rental market and supported displaced people's own priorities; and in the Philippines, a diaspora remittance-loan model for home retrofitting improved access to finance for female-headed households, supported adherence to building standards and produced shelter that was therefore more resilient against future climate shocks.

Privacy loss and violence were consequences of overcrowding and disproportionately affected women and girls.⁹⁰ However, the system's technical orientation meant these tended to be treated as issues of protection rather than

iv These figures used UNHCR's own definitions of habitability rather than the Sphere minimum of 3.5 m² per person (see UNHCR (2025) <https://www.unhcr.org/publications/global-report-2024>).

v The Sphere definition reads: 'Shelter is the household living space, including the items necessary to support daily activities'. The DG ECHO's Key Results Indicator framework operationalises the Sphere space standard into a measurable indicator, phrased as 'basic, safe and dignified shelter solutions'. Save the Children and other implementing organisations use the same formulation as their standard indicator.



shelter quality – and, as such, they fell out of shelter monitoring entirely. Studies reported that people found it traumatic to be in chaotic or poorly organised shelter, and overcrowding was a determinant of both physical and mental health outcomes.⁹¹ In both Gaza and Sudan, people living in poor shelters expressed frustration at the lack of privacy. Inadequate shelter led to disease transmission and increased GBV risk, but this was poorly documented, making the broader impacts of shelter systematically undervalued. One aid worker told us:



'The main issue is privacy. [Internally displaced people] are extremely vulnerable ... One of the key ways to protect dignity ... is by ensuring privacy for families.'

WASH

Inadequate water and sanitation is a factor in disease control, malnutrition and infection control within healthcare facilities. Researchers tracking US WASH disbursements against reported deaths showed that funding declines coincided with increased cholera mortality; by mid-2025, Angola, DRC, Sudan and South Sudan alone saw more than 3,000 deaths.⁹² A 2023 cohort study in India found a 30% lower risk of cholera in households practising improved WASH measures over five years, with children under five experiencing the most significant benefits.⁹³ However, it is not always possible to establish clear outcomes. Recent research also emphasised that WASH should be understood as a fundamental right to safety and dignity.

The WASH sector continued to struggle to meet minimum standards^{vi} and the Inter-Agency Standing Committee (IASC) independent review on internal displacement found that millions of people were living without basic clean water.⁹⁴ From 2021 to 2025, funding against requirements never exceeded 35% on average,⁹⁵ and funding to the WASH sector fell by 50%^{vii} in 2025 compared to 2024.⁹⁶ UNHCR reported that its refugee operations provided an average of 18 litres of water per person per day in 2023 and 2024 – below the minimum standard of 20 litres for protracted situations.⁹⁷

Needs varied significantly by context and WASH practitioners emphasised the measurement challenge. The Household Water Insecurity Experiences Scale gained traction as a complementary experiential measure of service quality. By 2024, only 53% of refugees had access to a safe household toilet: down from 63% in 2023.⁹⁸ The lack of resourcing for WASH was a factor, as well as inadequate sludge management, pit-latrines collapse and resources being diverted to new displacements. In northern Ethiopia, water-trucking targets were reduced to 5 litres per person per day during the Tigray blockade due to lack of fuel and cash, and menstrual health standards were not met in any of the three regions affected

vi The 2022 SOHS identified WASH as the sector with the most documented failures against Sphere minimum standards, although this may be partially due to the lack of cross-context threshold-referenced data for many other sectors.

vii Percentages from this report differ from the data in Figure 1.14 that uses FTS data examining funding requirements and funding received for all response plans.



by conflict.⁹⁹ In Yemen, sewage tanks overflowed and sites for internally displaced people lacked basic sanitation, which was attributed to inadequate oversight, underfunding and access constraints.¹⁰⁰ Across 30 countries, 1,738 people affected by crisis said the biggest WASH gaps were in basic services to enable access to safe water (23%), sanitation (19%) and hygiene items (19%).¹⁰¹

A fundamental challenge was the project-based model of WASH,^{viii} which repeatedly produced unrealistic funder expectations, failed handovers and weak accountability to intended users.¹⁰² A senior WASH expert explained that in camps and displacement settings there was rarely an agreed design life for WASH infrastructure – without specifying whether a water system needed to serve a population for five, 10 or 20 years, investment in durable infrastructure was discouraged in favour of short-term fixes. However there were positive examples: in Cox's Bazar, Bangladesh, the WASH cluster continued to improve its 197 faecal sludge treatment plants and implemented an innovative underground network of tanks with a lifespan of around a decade moving sludge at a fraction of the cost of trucking.¹⁰³ In Goma, DRC, the International Committee for the Red Cross (ICRC) and World Bank pioneered a blended finance model aiming to bring water to 11 million people across a growing pipeline of projects.¹⁰⁴ Such initiatives provide important learning for the sector in moving towards longer-term infrastructure.

Longer-term harms and outcomes

Livelihoods and resilience

Of the aid recipients we surveyed, 17% said the main way that aid providers could improve would be to 'help us become independent and resilient'. In protracted crises, this figure rose, cited by 28% of respondents in DRC and 24% in Haiti. The tension between lifesaving priorities and resilience-building ran through many of the LAHEs – yet, even in protracted crises, funding pressures repeatedly led to organisations prioritising immediate relief.¹⁰⁵ In Ethiopia, agriculture was underfunded throughout the responses and livelihood assistance was a major gap.¹⁰⁶ In Yemen, underfunding limited efforts to combine short-term assistance with longer-term strategies.¹⁰⁷ In Somalia, scaling back livelihood and resilience activities to fund short-term lifesaving responses 'contributed to an erosion of the resilience of affected communities'.¹⁰⁸



While there were some examples of progress in linking humanitarian response to longer-term resilience, these were the exception, not the rule



viii With discrete projects, rather than sustained investment in water and sanitation systems and services. For example, building a borehole, latrine block or water point does not guarantee operation, maintenance or long-term functionality once the project ends.



Restrictive legal environments, discrimination and trauma made livelihoods support hard to deliver, and development actors rarely extended their systemic approaches to displaced populations the way they did for host communities.¹⁰⁹ Progress in some host countries had come through policy reforms driven by the Global Compact on Refugees, and there were promising early results from a Ugandan graduation programme.¹¹⁰ Social protection also offered a route to more durable support, though the links to humanitarian cash were still rare (see [Chapter 2.2](#)). While there were some examples of progress in linking humanitarian response to longer-term resilience, these were the exception, not the rule (see [Chapter 5.1](#)).

Education

Around 103 million children in the world's most violent and fragile^{ix} countries were out of school in 2024.¹¹¹ Girls remained banned from secondary and university education in Afghanistan, and attacks on education sites or teachers, as well as the military use of schools, increased by nearly 20% globally in 2022 and 2023 compared to the previous two years.¹¹²



There was greater investment in evidence around education in emergencies, as well as increased interest in how technology could bridge education gaps



There was greater investment in evidence around education in emergencies, as well as increased interest in how technology could bridge education gaps. UNICEF reported that 99% of out-of-school children aged 10–14 years who completed accelerated education programmes in Ethiopia transitioned into formal primary school in 2024.¹¹³ An EdTech Hub review found that radio-based learning had the strongest positive evidence for feasibility and effectiveness, while evidence on internet-based learning was mixed.¹¹⁴ An International Rescue Committee/Sesame

Workshop Ahlan Simsim programme found that Syrian refugee preschool children achieved literacy and numeracy gains comparable to one year of in-person preschool after just 11 weeks.¹¹⁵ However, success of EdTech interventions correlated strongly with socioeconomic status.¹¹⁶

Mental health

Evidence from Ukraine during the period illustrated the effects of conflict on wellbeing: in 2023, UNICEF reported that many Ukrainian children were exhibiting signs of learning loss, lack of routine and distress.¹¹⁷ Similarly, survey data from 2022 found that adult civilians living in heavily bombarded areas reported elevated rates of suicidal ideation and feelings of helplessness

^{ix} The World Bank listed 39 countries in conflict or fragile in 2024 (see World Bank (2024) <https://thedocs.worldbank.org/en/doc/b3c737c4687db176ec98f5c434d0de91-0090082024/original/FCSListFY25.pdf>).



compared to those in moderately damaged areas.¹¹⁸ WHO's October 2024 health needs assessment found mental-health concerns were the most prevalent health issue, affecting 46% of Ukrainians.¹¹⁹ These findings are likely to be relevant in other contexts of protracted conflict. Another cohort study from Malawi in *The Lancet*, which followed children through to adolescence, found links between severe childhood malnutrition and mental-health symptoms years later, even where other long-term risks were not evident.¹²⁰

There was increased investment in mental health, including the Greentree Acceleration Plan, announced in September 2025 and backed by a US\$13.2 million grant from the Wellcome Trust, which targeted mental health in humanitarian settings, beginning in Chad and Lebanon. In Ukraine, the government led the process to develop a roadmap for mental health and psychosocial support,¹²¹ and agencies aligned their services; for example, the International Organization for Migration (IOM) delivered services for 6.5 million people,¹²² and EdCamp Ukraine supported schools to integrate social, emotional and ethical learning.¹²³



A literature review on health evidence found that mental health and psychosocial support had become the most-researched area of humanitarian health

A literature review on health evidence found that mental health and psychosocial support had become the most-researched area of humanitarian health, with 104 papers and a trend towards research on nonspecific distress and wellbeing.¹²⁴ For example, a meta-analysis covering 43 randomised controlled trials found that cognitive behavioural therapy may improve depression symptoms in children and young people affected by humanitarian emergencies (though creative activities sometimes worsened symptoms).¹²⁵

A 2025 WHO meta-analysis found children and adolescents who received targeted interventions reported fewer stress symptoms, and the positive effects were sustained at follow-up.¹²⁶ Digital mental-health support scaled to reach more people across more crises, though broader evidence for digital mental-health interventions underscored concerns about safety in acute distress.

The evidence gap

Humanitarian response is premised on the assumption that it saves lives – yet the precise extent to which deaths were averted across different responses over 2022–25 was difficult to assess. Mortality estimates are not only technical outputs; they shape the scale of a response and influence diplomatic and



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military decisions – and ‘damaged infrastructure, security disruptions and political motivations’ all suppress counts.¹²⁷ There was some innovation in mortality estimation: the Somalia Mortality Estimation Database integrated mortality estimates with upstream risk factors (including drought indices, disease outbreaks and food security classifications); retrospective analysis suggested it could have identified mortality hotspots months before the peak of the 2022–23 drought.¹²⁸

Analysis of the use of mortality data in three contexts (Central African Republic, Somalia and Cox’s Bazaar in Bangladesh) found that measurement was shaped as much by politics, security and bureaucracy as by method. Funding for mortality measurement rose with each new crisis and then fell away; as a result, Somalia’s monitoring system lost capacity between droughts, and the Somalia Mortality Estimation Database’s 2022 findings came too late to inform the response.¹²⁹ Data was also politically sensitive: in Central African Republic, a survey estimated mortality at four times higher than UN figures.¹³⁰ However, there was some evidence that, when evidence *did* reach decision-makers, it made a difference. Earlier Somali modelling was credited with faster scale-up in 2017 and 2022.¹³¹ Interviewees also described how mortality data had been used within donor agencies and foreign ministries to inform decision-making; however, this was not always visible due to political sensitivities.

Over the period, there were efforts to generate stronger evidence of the type of aid that was most effective, including for food security, health, multipurpose cash and WASH. However, large evidence gaps remained, especially for people experiencing the greatest vulnerability and for contexts receiving the least funding.¹³² In the nutrition sector, for example, data on school-age children and adolescents was scarce, especially for boys;¹³³ most non-communicable disease evidence came only from the Middle East;¹³⁴ and evidence on food security interventions targeting the most vulnerable populations (including women, refugees, internally displaced people and people living with disabilities) was limited.¹³⁵ ALNAP’s 2024 synthesis of evidence and learning for people-centred action concluded that ‘outcome-level evidence is scarce’ – both for inclusion, accountability and localisation specifically and for overall response effectiveness more broadly.¹³⁶ Some efforts to address this emerged during the period, including research agendas within the WASH cluster, but these remained small relative to the size of the gap.¹³⁷

At the response level, evaluations relied on assumed-benefit arguments, which held that if food was delivered at scale and targets were met, then planned outcomes could be inferred.¹³⁸ The strongest of the evaluations used data from IPC trend analysis,¹³⁹ but this data was not always available. An evaluation of WFP targeting in seven contexts found that only Jordan systematically compared food security outcomes between people who participated in the programme and those who did not; in the other contexts monitoring tools had not been designed to assess whether targeting worked.¹⁴⁰ The 2026 IAHE synthesis concluded that the humanitarian system 'played a crucial role in averting the worst potential outcomes of crisis situations, even while it has sometimes struggled to address the wider humanitarian agenda short of this catastrophic level'.¹⁴¹ However, it found that coverage and programme reach fell well short of priority needs, key sectors (including WASH, protection and livelihoods) were routinely underfunded, and families in protracted crisis remained caught in cycles of vulnerability.¹⁴²

IAHE concluded that the humanitarian system 'played a crucial role in averting the worst potential outcomes of crisis situations, even while it has sometimes struggled to address the wider humanitarian agenda'

Conclusion

The humanitarian system delivered important documented results in the period: in Somalia's 2022–23 drought where assistance averted tens of thousands of deaths, through nutrition programmes in northern Ethiopia, in Gaza's polio vaccinations and DRC's mpox response. There was also growing evidence around the effectiveness of cash transfers and successes in mine action and integrated programming. However, in the crises that defined the period, deliberate obstruction and denial of access constrained the system. While the worst outcomes could often be avoided, people affected by crisis wanted more support for longer-term outcomes like education and livelihoods. Innovations such as the Somalia Mortality Estimation Database show that more investment in measurement infrastructure would allow the system to better demonstrate results.

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