RAPPORT 2025

How can healthcare access be strengthened in settings where explosive weapons are being used?

Understanding challenges and gaps, and exploring practical measures, approaches and opportunities

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Acronyms

ANSA	Armed non-state actors
AOR	Area of Responsibility
CMHR	Civilian Harm Mitigation and Response
EMT	Emergency medical team
ERR	Emergency response room
ERW	Explosive remnants of war
EWIPA	Explosive weapons in populated areas
GBV	Gender-based violence
HCT	Humanitarian Coordination Team
HI	Humanity & Inclusion – Handicap International
ICRC	International Committee of the Red Cross
IHL	International Humanitarian Law
IHRL	International Human Rights Law
INGOs	International non-governmental organisation(s)s
ISIS	Islamic State
KII	Key informant interview
MAG	Mines Advisory Group
MHPSS	Mental health and psychosocial support
MSF	Médecins Sans Frontières
MSNA	Multi-sectoral needs assessment
NGOs	Non-governmental organisation(s)
NWS	Northwest Syria
OCHA	Office for the Coordination of Humanitarian Affairs
oPt	occupied Palestinian territory
PTSD	Post-traumatic stress disorder
SSA	WHO Surveillance System for Attacks on Health Care
UN	United Nations
UNICEF	UN Children’s Fund
US	United States
UXO	Unexploded ordnance
WHO	World Health Organization

Executive Summary

Background

The use of explosive weapons in populated areas (EWIPA) is the leading cause of civilian casualties in armed conflict.[1] Nevertheless, their use has only escalated in recent years. The health needs of the civilian population drastically increase when EWIPA are used. The injuries inflicted by explosive weapons are often significant and life-changing,[2] and require immediate and long-term complex treatment and care, including rehabilitation. Beyond the physical wounds, EWIPA exposes civilians to extreme emotional and psychosocial trauma beyond the "expected" stressors of exposure to conflict and violence, and can lead to intergenerational mental health issues.[3]

Although explosive weapons do not discriminate between civilians, they affect diverse population groups differently, exacerbating existing vulnerabilities and inequalities. Women, children, persons with disabilities and older persons are some of the groups most severely impacted by the use of explosive weapons, with **children seven times more likely to die from blast injuries than adults.**[4]

The use of EWIPA also severely degrades people's health by seriously damaging or destroying health systems and interdependent networks and infrastructure, such as water and sanitation, power, communications and roads; especially where, as is often the case, attacks are ongoing and recurrent. **2023 saw at least 763 incidents in which explosive weapons damaged or destroyed health facilities, a staggering 12% increase from 2022.**[5] **Attacks have not spared health workers, with a record high number of 209 health workers killed.**[6] The figures for 2024 are expected to be even worse.[7] This is despite a strong and long-established normative framework[8] that protects civilians and access to healthcare in conflict.

Recognising the humanitarian impact of EWIPA, in November 2022,[9] 83 states – a number that now stands at 88 - endorsed the *Political Declaration on strengthening the protection of civilians from the humanitarian consequences arising from the use of explosive weapons in populated areas*. On endorsement, countries commit to taking concrete actions to address the harm caused by EWIPA, not least by restricting or refraining from using explosive weapons in areas where civilians live and work.

The Political Declaration explicitly acknowledges the devastating impact of EWIPA use on affected populations' health and the provision of health services. It specifically requires endorsing states to protect "civilian objects", including hospitals, during and after armed conflict, and to

[1] INEW (2024) A decade's data: 9/10 casualties in armed conflicts are civilians when explosive weapons are used in towns and cities. In some cases, as in Gaza, intense and frequent bombardment of highly concentrated areas caused tens of thousands of deaths and injuries in a matter of months.

[2] Andre Pennardt (2021) Blast Injuries. See also: Center for Disease Control and Prevention (2003) Explosions and Blast Injuries: A primer for clinicians.

[3] Humanity & Inclusion (2020) Death Sentence to Civilians: The Long-Term Impact of Explosive Weapons in Populated Areas in Yemen.

[4] This is especially true for younger children, due to their size, age and physiology. Watchlist on Children and Armed Conflict (2024) Explosive Weapons and the Children and Armed Conflict Agenda.

[5] INEW (2024) Explosive Weapons Monitor 2023

[6] Insecurity Insight (2024) The Effects on Healthcare of the Use of Explosive Weapons in 2023

[7] Insecurity Insight (2024) Explosions and Airstrikes Devastate Lebanon's Health System, Killing Health Workers and Straining Services Amid Ongoing Conflict This is due in part to the deadliest unprecedented attacks yet in Lebanon. These attacks began in September 2024 and have continued to devastate the country's health system, which was already under strain, destroying health facilities and killing health workers.

[8] ICRC (2015) The implementation of rules protecting the provision of health care in armed conflicts and other emergencies: A guidance tool

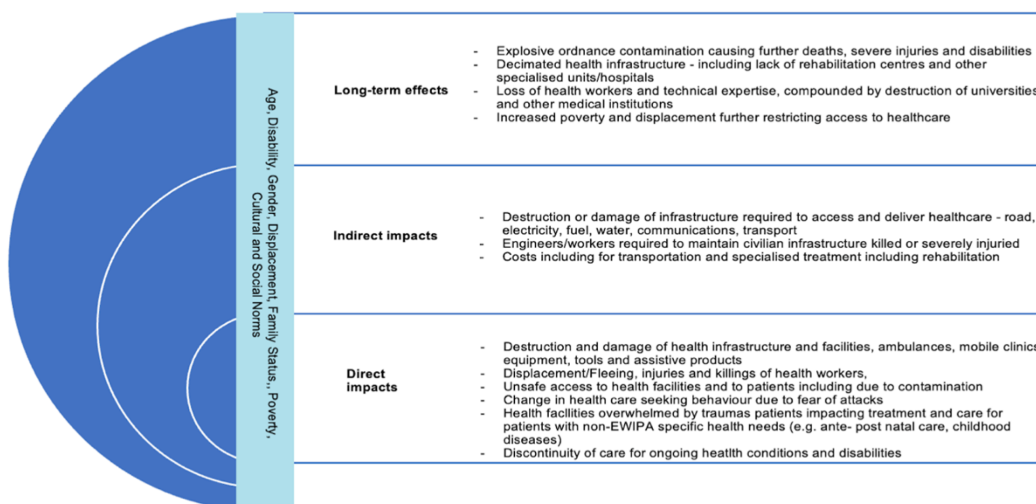
[9] INEW (2022) Dublin Conference to Adopt the Political Declaration on Explosive Weapons

"provide, facilitate, or support assistance to victims" in a way that is "holistic, integrated, gender-sensitive, and non-discriminatory". The Political Declaration thus provides an opportunity to both increase the visibility and understanding of the specific impacts of the use of EWIPA on healthcare access, and to foster collective, coordinated and practical action to prevent and reduce harm to healthcare and populations' health.

Against this background, this report explores the main challenges and gaps in accessing healthcare in EWIPA contexts, and considers practical and innovative strategies and tools to implement the Political Declaration's commitments on victim assistance, and improve humanitarian access to affected populations. The report is part of a process undertaken by Humanity & Inclusion - Handicap International (HI)[10] to support the implementation of the Political Declaration's humanitarian commitments. Its content draws on data and findings from desk-based research with a primary focus on specific country contexts (Gaza, Northwest Syria [NWS] and Ukraine), key informant interviews (KIIs), and discussions from a multi-stakeholder in-person workshop that took place in Brussels on 12-13 November 2024.

The report considers the most pressing challenges and gaps in accessing healthcare in EWIPA settings identified by the research and the workshop's participants, before exploring and spotlighting practical mitigation and adaptation measures, tools, guidance and policy and advocacy approaches that provide critical solutions and strategies to move the agenda forward.

Key research findings



Summary of key effects and impacts of EWIPA use on healthcare access.

- EWIPA use disproportionately affects the availability, accessibility, and quality of healthcare services in the short and longer term due to both the direct and indirect or reverberating impacts of explosive weapon attacks on healthcare. This severely compromises or prevents affected populations from accessing medical care and treatment

[10] In early 2024, Humanity & Inclusion - Handicap International (HI), Article 36 and Insecurity Insights, members of the International Network on Explosive Weapons (INEW), initiated a multi-stakeholder process that aims to support the effective implementation of the commitments under the Political Declaration on Explosive Weapons. The process is structured around four key humanitarian issues chosen to reflect areas where there are particularly acute challenges in EWIPA contexts and where there are notable gaps in awareness, understanding and decisive action. The first workshop, held online in May 2024, focused on the key and overlapping challenges related to safe humanitarian access by local and international humanitarian actors, including health workers, in EWIPA contexts, both during and after conflict. For more details, see the workshop's outcome document: Humanity & Inclusion – Handicap International (2024) Towards the implementation of the Political Declaration, REPORT – Online Workshop – 30 May 2024: How Can the Political Declaration on Explosive Weapons in Populated Areas Promote Safe and Principled Humanitarian Access?

at a time when both EWIPA-specific and other health needs increase exponentially. This is especially the case for rehabilitation and mental health and psychosocial support services (MHPSS) despite staggering levels of need. Intersecting identities such as age, gender, and disability further heighten healthcare access challenges, with specific groups such as women, children, persons with disabilities and older persons – in their diversity – bearing the brunt of health services being wiped out, out of reach, diverted or at breaking point.

- Critical shortcomings in humanitarian assistance exacerbate healthcare access challenges, in particular due to gaps between needs and realities in affected areas, and funding and programming priorities. In particular:

- Humanitarian responses tend to lack an inclusive and intersectional approach, leaving behind the people with the highest health needs.
- Rehabilitation services are usually not considered an essential component of the acute phase of the response, and are therefore not prioritised (or adequately funded). The complex and heightened mental health needs of EWIPA-affected populations are also not resourced or adequately targeted.
- The specific security and mental health needs of national health workers and their ability to deliver health services are not reflected in policy and practice.
- Survey and clearance activities are significantly underfunded as donors prioritise trauma and emergency needs, disregarding the significant and harmful consequences of unexploded ordnance on populations and health workers.
- Local and national organisations providing healthcare services to EWIPA-affected populations who are either not reachable or excluded from the response do not receive enough financial and technical support.
- Poor collaboration and sharing, and the lack of an inclusive approach undermine data collection and use.
- Multi-stakeholder and cross-sectoral political, diplomatic and advocacy efforts are insufficient to raise awareness and understanding, mobilise, and influence policy and practice.

- Different types of approaches and strategies have been used by health workers, humanitarians, states, diplomats, advocates and researchers to strengthen civilian access to healthcare in EWIPA settings. They have done so by adopting practical and innovative adaptation measures and tools; alternative models of healthcare delivery; developing guidance to strengthen collaboration and coordination; generating compelling evidence on the effects of EWIPA use on healthcare, and harmonising data collection and dissemination efforts; advocating for greater action and political leadership, including to foster the implementation of the Political Declaration's commitments on victim assistance in the context of healthcare access in EWIPA settings.

- There are opportunities to increase collaborative efforts, strengthen synergies between advocacy agendas and across sectors, and learn from existing and related initiatives, such as the 2015 Safe School Declaration - Global Coalition to Protect Education from Attack (GCPEA), and the Children in Armed Conflict (CAAC) agenda.

Moving forward: An Agenda for Action for Strengthening Healthcare Access in EWIPA Settings

A multi-pronged agenda must drive collective efforts towards strengthening healthcare access. The report sets out an Agenda for Action – or roadmap - that rallies stakeholders and sectors behind a set of concrete solutions and recommendations. It is structured around three objectives and is driven by six Priority Action Areas.

Objectives

1. Deliver inclusive, holistic and non-discriminatory healthcare to EWIPA-affected civilians in their diversity
2. Mitigate the short and long-term and multiple impacts of EWIPA use on health systems
3. Foster the meaningful participation, leadership and empowerment of EWIPA-affected communities and local actors

Priority Action Areas and Key Recommendations

The full list of recommendations is available in the final section of the report.

Priority Action Area 1: Political leadership and humanitarian diplomacy

EWIPA Political Declaration's signatory states to:

- Issue individual and joint statements publicly condemning unlawful EWIPA attacks against healthcare and calling for the protection of health workers and health facilities. This includes considering the adoption of resolutions in multilateral and regional forums as well as official, including media, statements.
- Seize key opportunities, including at relevant meetings of the UN Security Council and other UN bodies, regional and national forums, to raise understanding and foster action on EWIPA attacks on healthcare access.

OCHA to:

- Better reflect the impacts of EWIPA use on healthcare access and delivery, and civilians' health needs, both EWIPA-specific (in particular MHPSS and rehabilitation), and non-EWIPA health requirements, in the annual Humanitarian Needs Overview, and Humanitarian Response Plans for countries where EWIPA are being used.

Priority Action Area 2: Funding

UN agencies, donors, and INGOs to:

- Prioritise funding that addresses the specific, direct and indirect impacts of EWIPA use on healthcare access and delivery. This includes providing funding for Explosive Ordnance Risk Education (EORE) and demining during the emergency phase of the response, and for alternative models of health delivery, such as mobile clinics. It should also cover costs towards increasing the protection and safety of health systems, including health workers. This should be done by integrating protection and safety as part of core costs.
- Provide and increase flexible and unearmarked funding that allows organisations to quickly pivot and adapt health delivery interventions based on the rapidly-changing needs of populations. Funding should also be long term and support the delivery of healthcare for non-EWIPA specific injuries and health needs, and ongoing medical conditions.

Donors to:

- Provide long-term sustainable funding to plan and provide adequate and predictable health services, in particular chronic care, rehabilitation, MHPSS, and rebuilding of health infrastructure and other essential systems that are critical to healthcare delivery.

Priority Action Area 3: Humanitarian programme planning, delivery and coordination

Rehabilitation:

UN and INGOs to:

- Include rehabilitation as an essential health component of acute-phase responses.
- Ensure appropriate resources for the provision of adapted early and longer-term rehabilitation care within all health programmes – including the provision of assistive products – to respond to the diverse needs of trauma patients (including children and women) and persons with disabilities.
- Improve coordination between trauma care and disability services, and facilitate stakeholder mapping to strengthen referral pathways to rehabilitation services.

Inclusion and Diversity:

UN and INGOs to:

- Ensure and prioritise the participation of specific groups, including women, children, older persons and persons with disabilities in their diversity in the planning, delivery and monitoring and evaluation of health service delivery, including rehabilitation and MHPSS.

UN and INGOs to:

- Provide local and national partners and health workers with security and mental health support based on their needs and priorities.
- Include local and national organisations providing health services to specific groups who are most likely to be invisible in the response in humanitarian coordination mechanisms, including HCTs.

Priority Action Area 4: Tools, training, guidance, practical measures

UN and INGOs to:

- Explore opportunities for online training for health professionals, including national and local staff operating in EWIPA settings.
- Ensure the promotion and dissemination of successful examples of practical mitigation and adaptation measures, including by consolidating and making accessible examples of practical measures successfully implemented in EWIPA settings.

Priority Action Area 5: Cross-sectoral and peer-to-peer learning, and facilitation of knowledge/good practices

Designated signatory states to:

- In line with Priority Action Area 1, following the setup of a country-led implementation network, prioritise attacks against healthcare as the primary and initial focus area.

- Convene a high-level country-led roundtable on signatory states' role in strengthening inclusive healthcare access in EWIPA settings, with a focus on practical steps and sharing of good practice.

Priority Action Area 6: Advocacy and data

UN and INGOs to:

- Use existing country-level and global advocacy fora, mechanisms, and relevant policy processes to increase understanding and awareness of the impacts of EWIPA use on healthcare access and the promotion of key messages, including on the need to include rehabilitation in the acute phase of responses, and non-EWIPA health requirements. Key fora and opportunities include INGO Forums and HCT's Advocacy Working Groups, and country-level and global Health and Protection clusters.
- Mainstream reporting on EWIPA attacks against healthcare into relevant existing humanitarian reporting mechanisms, such as humanitarian access dashboards and protection assessments.

Introduction

Explosive weapons are some of the deadliest for civilians in modern armed conflicts,[11] particularly when used in villages, towns and cities and other areas where civilians are concentrated. When explosive weapons are used in such populated areas, nine in every ten casualties is a civilian.[12]

Bombing also damages or decimates hospitals and health facilities, it damages or destroys ambulances, and it kills or severely injures health workers. By doing so, the use of EWIPA can wipe out entire health systems, depriving affected populations of vital access to healthcare. The impacts of EWIPA use on healthcare are severely exacerbated by their indirect or reverberating effects on infrastructure critical to the functioning of health systems, including power networks, water and sanitation systems, and roads.

Over the past few years, the use of explosive weapons in populated areas has dramatically affected populations' access to healthcare.[13] In 2023, at least 822 incidents of EWIPA use against healthcare systems, including health facilities and health workers, were reported across 20 countries. More than 80% of incidents documented occurred in the occupied Palestinian territory (oPt), Ukraine and Myanmar.[14] Syria and Sudan also saw a rise in the use of EWIPA against healthcare, compared with previous years.

Health facilities and workers have also been increasingly intentionally targeted rather than being collateral war casualties, and national health systems are bearing the brunt of the attacks. In Syria[15] and Gaza, the weaponization of health[16] has been used as a strategy against civilians to violently and systematically deprive them of access to medical services by deliberately attacking the health facilities, hospitals and health workers needed to provide healthcare.

Protection of healthcare in EWIPA settings

There is a strong normative framework protecting health in times of conflict. International Humanitarian Law (IHL) and International Human Rights Law (IHRL) protect access to healthcare through respect for and protection of health personnel, facilities and medical transport, and the wounded and sick.[17] The Statute of the International Criminal Court further criminalises violence to the life and person of the wounded and sick, and the acts of intentionally directing attacks against buildings, equipment, medical units, transport and personnel using the distinctive emblems of the Geneva Conventions in conformity with international law, as well as against hospitals and places where the sick and wounded are collected.[18]

A significant milestone towards the protection of civilians from EWIPA-related harm was achieved in November 2022, when 83 states endorsed the Political Declaration on Strengthening the Protection of Civilians from the Humanitarian Consequences Arising from the Use of Explosive

[11] International Committee of the Red Cross (ICRC) (2022) Explosive weapons with wide area effects: a deadly choice in populated areas.
[12] Action on Armed Violence (2024) Explosive Violence Monitor 2023.
[13] Insecurity Insight (2024) The Effects on Health Care of the Use of Explosive Weapons in 2023.
[14] Ibid.
[15] Fouad M Fouad, Annie Sparrow, Ahmad Tarakji, Mohamad Alameddine, Fadi El-Jardali, Adam P Coutts, Nour El Arnaout, Lama Bou Karroum, Mohammed Jawad, Sophie Roborgh, Aula Abbara, Fadi Alhalabi, Ibrahim AlMasri, Samer Jabbour (2017) Health workers and the weaponisation of health care in Syria: a preliminary inquiry for The Lancet–American University of Beirut Commission on Syria.
[16] Center for Conflict and Humanitarian Studies (2023) Israel's weaponisation of medical and humanitarian aid.
[17] ICRC (2015) The implementation of rules protecting the provision of health care in armed conflicts and other emergencies: A guidance tool
[18] International Criminal Court (1998) Rome Statute of the International Criminal Court.

Weapons in Populated Areas[19] (Political Declaration). The Political Declaration - now endorsed by 88 states - sets new international standards for the protection of civilians from the use of EWIPA specifically. It also reaffirms existing IHL and IHRL obligations to protect civilians during conflict.

The Political Declaration acknowledges the consequences of the use of EWIPA on population health, specifically the “blast and fragmentation effects” that “cause deaths and injuries, including lifelong disabilities”, as well as their effects on “critical civilian infrastructure”, such as hospitals. It also recognises the ‘indirect’ or ‘reverberating’ effects of explosive weapons on the provision of health services. By endorsing the Declaration, states commit to strengthen the protection of “civilian objects” during and after armed conflict, to address the humanitarian impacts of the use of EWIPA, and to “provide, facilitate, or support assistance to victims”.

The recently adopted Pact for the Future[20] reiterates one of the Political Declaration’s core commitments, calling on states to “restrict or refrain, as appropriate, from the use of explosive weapons in populated areas when their use may be expected to cause harm to civilians or civilian objects”, including essential civilian infrastructure and medical facilities.

The effects of EWIPA use on health needs

While all conflicts cause civilian harm and affect essential infrastructure and systems, the use of EWIPA in particular causes a distinct, widespread, and well-documented pattern of harm: a pattern that is compounded when their use is repeated over weeks, months and years. When explosive weapons are deployed in towns and cities, their impacts are not confined to the immediate aftermath of a detonation. Instead, by severely damaging and destroying hospitals and other infrastructure, such as power, water and sanitation, they reverberate beyond the immediate location or time of a blast to cause further waves of harm. The scale and level of killings, injuries, harm, violence and destruction that we are witnessing in Gaza, Ukraine, Myanmar, Syria and Sudan, where explosive weapons are being used, bear no comparison.

> *“In May 2022, there was particularly strong, powerful shelling and our house was hit by shrapnel from cluster munitions and two missiles from a self-propelled artillery system. They badly damaged our building, including the walls. The metal doors which closed the entrance to the corridor near the lift were torn out and injured us, alongside concrete shrapnel from the ceiling and the walls. My husband also got hurt standing in line to buy drugs from the pharmacy. He sustained knee and shoulder injuries and lost some of his hearing.” (Olha Lieshukova, Survivor advocate, Ukraine, KII, October 2024).*

[19] Political Declaration on Strengthening the Protection of Civilians from the Humanitarian Consequences Arising from the Use of Explosive Weapons in Populated Areas (2022).
[20] United Nations (2024) Pact for the Future.

Box 1. What are explosive weapons?

Explosive weapons are a subset of what is commonly referred to as "conventional weapons". They cover a wide range of weapons, such as aerial bombs, rockets, artillery projectiles, mortars, and missiles, which share a common central characteristic: they affect a target by detonating explosive materials, exerting powerful heat, blast and fragmentation effects in the area around the point of detonation. The size of the area affected by these weapons varies depending on the amount of explosive material used, the inaccuracy of their delivery, and whether multiple munitions are fired.[21] Not all explosive weapons detonate immediately and can lie dormant for years.

These features – individually or in combination – extend the heat, blast and fragmentation effects of an explosive weapon across a wider area. This, in turn, increases the likelihood of harm to civilians and civilian infrastructure, especially when they are used in built-up areas or populated areas where civilians are concentrated.

The use of EWIPA dramatically escalates a population's health needs. Explosive violence creates complex and potentially life-changing health needs on an often unforeseen scale. Due to the powerful heat, blast and fragmentation effects of explosive weapons, the initial traumatic physical injuries caused by EWIPA are notable for their severity, complexity and scale. Explosive weapons have been noted by medical authorities for their ability "to cause multisystem, life-threatening injuries in single or multiple victims simultaneously".[22] The injuries caused not only require advanced medical interventions but necessitate specialised care and long-term rehabilitation. The invisible wounds caused by the use of explosive weapons are as traumatic and severe, and can also affect populations for years. For children the profound effect of EWIPA use on mental health can have a lasting impact on long-term development and health.[23] EWIPA use also affects diverse population groups differently, preying on inherent and existing vulnerabilities and inequalities.

About the report

Against this background, this report explores the main challenges and gaps in accessing healthcare in EWIPA contexts, and considers practical and innovative strategies and tools to implement the Political Declaration's commitments on victim assistance.

Specifically, this report is part of a process undertaken by Humanity & Inclusion - Handicap International (HI)[24] to support the implementation of the Declaration's humanitarian commitments. Its content draws on data and findings from desk-based research, key informant interviews (KIIs), and discussions from a multi-stakeholder in-person workshop that took place in November 2024.

[21] Article 36 and PAX for Peace (2018) Explosive Weapons: Factors that Produce Wide Area Effects.

[22] Andre Pennardt (2021) Blast Injuries. See also: Center for Disease Control and Prevention (2003) Explosions and Blast Injuries: A primer for clinicians.

[23] Action on Armed Violence (2020) The impact of explosive weapons on children in Syria.

[24] In early 2024, Humanity & Inclusion - Handicap International (HI), Article 36 and Insecurity Insights, members of the International Network on Explosive Weapons (INEW), initiated a multi-stakeholder process that aims to support the effective implementation of the commitments under the Political Declaration on Explosive Weapons. The process is structured around four key humanitarian issues chosen to reflect areas where there are particularly acute challenges in EWIPA contexts and where there are notable gaps in awareness, understanding and decisive action. The first workshop, held online in May 2024, focused on the key and overlapping challenges related to safe humanitarian access by local and international humanitarian actors including health workers, in EWIPA contexts, both during and after conflict. For more details, see the workshop's outcome document: Humanity & Inclusion – Handicap International (2024) Towards the implementation of the Political Declaration, REPORT – Online Workshop – 30 May 2024: How Can the Political Declaration on Explosive Weapons in Populated Areas Promote Safe and Principled Humanitarian Access?

Drawing upon several country contexts - primarily, Gaza, Northwest Syria (NWS), and Ukraine – the report looks at the specific challenges and gaps in relation to healthcare access. The report considers barriers to reaching care and treatment for EWIPA specific health needs and other health conditions and requirements. Due to the disproportionate effects of EWIPA use on populations' physical and mental health, the report specifically explores access challenges for post-injury rehabilitation and mental and psychosocial support (MHPSS). The report also considers the varying experiences of specific population groups, including children, women, persons with disabilities and older persons and highlights the neglected yet profound consequences of intersecting identities on health needs and access to healthcare. Finally, referencing identified adaptation and good practices, existing tools, policies and innovative initiatives, the report sets out concrete and relevant action areas for key stakeholders.

Box 2. Research methodology

The content of this report is based on an in-depth literature review, and 14 key informant interviews conducted with field doctors, humanitarian actors, survivors and academics. The interviews provided key and practical examples of the specific challenges, adaptation measures and best practices in key contexts. It is also informed by the contributions and takeaways from a two-day in-person workshop that took place in Brussels in November 2024. More details about the workshop are included in Section 2 of the report.

Section 1: Accessing Healthcare in EWIPA Settings: Challenges and Gaps

The impact of explosive weapons on healthcare systems is profound and multifaceted, affecting not only the immediate delivery of healthcare services but also the long-term sustainability and resilience of health infrastructure years after a conflict has ended. This in turn affects people's health needs and their ability to access critical and multiple health services long after a conflict has ended. In Iraq, Mosul's healthcare system was virtually decimated in a nine-month battle lasting from October 2016 to July 2017 between Iraqi security forces and the Islamic State (ISIS), and has still not recovered to its former capacity. This is in spite of substantial international humanitarian aid provided between 2017 and 2020.[25] In 2023, health needs remained high and people were still struggling to access healthcare.[26]

In this section, we explore the complex and overlapping short and longer-term challenges derived from the use of explosive weapons on healthcare access. We also spotlight specific healthcare access priorities, and consider how the diverse and overlapping identities of population groups create additional challenges when trying to get adequate medical treatment and care. Finally, we highlight the most pressing shortcomings in the delivery of health programmes and services in humanitarian responses in EWIPA settings.

1. How is the use of EWIPA affecting healthcare access?

The use of EWIPA has a much greater impact on populations and infrastructure, including health facilities, compared with other weapons used in conflict, due to their widespread and far-reaching consequences on people's health needs and health systems in the short and longer term. The availability, accessibility, and quality of healthcare services is significantly reduced, severely compromising or even preventing affected populations from accessing medical care and treatment, at a time when health needs increase exponentially.

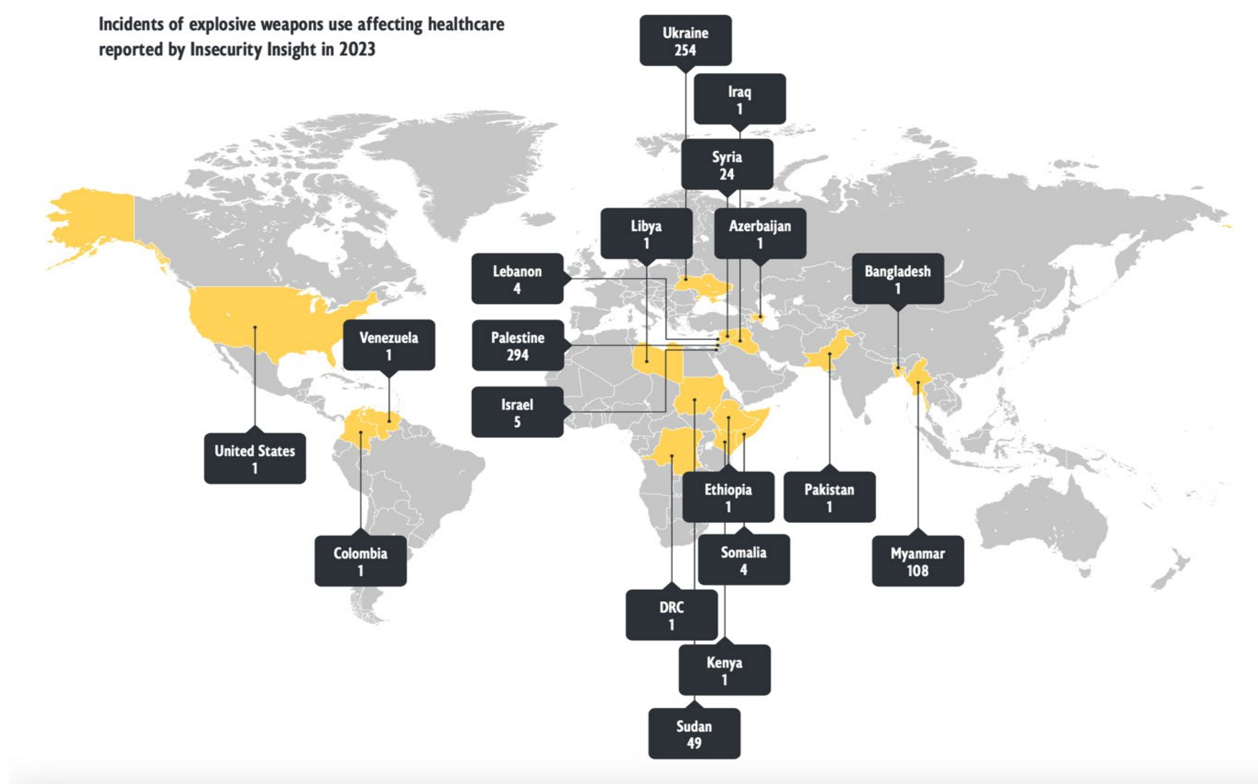
Fewer and less accessible health facilities: Destruction and damage to health infrastructure

The use of explosive weapons in populated areas frequently results in the direct physical destruction of health facilities and vehicles through a combination of shockwaves, blast pressure, and fragmentation. Hospitals and primary health facilities, including maternity and children's hospitals, may be bombed or shelled, leading to the extensive damage or destruction of medical buildings, destruction of medical equipment, and loss of critical supplies. This ultimately leads to the pausing, relocation, drastic reduction or cancellation of medical services.

In 2023, 488 health facilities and 129 health vehicles were damaged or destroyed,[27] exacerbating an existing trend that saw attacks and deliberate targeting of health facilities increase. Last year, the highest number of incidents against healthcare involving explosive weapons were documented in the oPt, Ukraine, and Myanmar, followed by Sudan, Syria and the Democratic

[25] Camille Molyneux (2024) The Impact of Explosive Weapons on the Provision of Healthcare in Mosul, Iraq, 2017-2024.
[26] Ibid.
[27] Insecurity Insight (2024) The Effects on Health Care of the Use of Explosive Weapons in 2023.

Republic of the Congo, where attacks on health buildings and transport attacks were also reported.



Source: Explosive Weapons Monitor 2023[28]

Ukraine: 773 explosive weapons attacks have damaged or destroyed hospitals and clinics in Ukraine.[29]

> *"We need help for the injuries we sustained from the explosions but the main emergency assistance point was completely destroyed, and there was no other place to go. A lot of medical professionals have left the city because it was too dangerous to live there, so it is very difficult to find doctors." (Olha Lietuva, Survivor advocate, Ukraine, KII, October 2024)*

In 2022, a few weeks into Russia's full-scale invasion, there were constant daily attacks on Ukraine's healthcare system. According to a report by Physicians for Human Rights, an average of four to five hospitals and other health facilities were attacked and damaged for 35 consecutive days. Explosive weapons have now damaged and destroyed hundreds of health facilities,[30] including the maternity and paediatric units of Mariupol's Hospital,[31] which were severely damaged by bombing, killing and injuring patients and staff. More than two years on, attacks on healthcare continue. In July 2024, multiple strikes by Russia in Kyiv severely damaged the country's largest children's hospital, including its intensive care units and oncology and surgical wings. The toxicology and traumatology departments were completely destroyed. A maternity hospital nearby also sustained damage due to falling debris.

[28] Explosive Weapons Monitor 2023.
[29] As of July 2024. Insecurity Insight (2024) The Effects on Health Care of the Use of Explosive Weapons in 2023.
[30] Insecurity Insight (2023) Two Years of Global Harm to Civilians from the Use of Explosive Weapons (2021-2022).
[31] Human Rights Watch (2024) "Our City Was Gone" - Russia's Devastation of Mariupol, Ukraine.

Sudan: In 2023 the use of explosive weapons was involved in at least 54 incidents impacting healthcare, compared to one in 2022.[32]

Health facilities have also been repeatedly bombed or shelled in other settings. In May 2024, an airstrike damaged a paediatric hospital in El Fasher, North Darfur, forcing it to shut down and causing the death of two children and at least one caregiver.[33] In August 2024 a maternity hospital was bombed in Omdurman, Khartoum State, partially destroying it.[34] In Khartoum, several hospitals, including El Shaab hospital, one of the country's biggest hospitals, were repeatedly and severely damaged in the early days of the conflict, causing them to shut down. In Gaza, within the first 36 hours after the 7 October attacks, several hospitals were allegedly bombed by Israel, including the Indonesian Hospital in Bait Lahia, Nasser Hospital in Khan Yunis, and Al-Quds Hospital in Gaza City. By 24 November 2023 – just six weeks after the October 7 attacks, 30 of Gaza's 36 hospitals had been bombed, some repeatedly, alongside ambulances.[35]

> *"Hospitals are the targets – that is the new norm. Healthcare workers are a symbol of hope. If you crush them, hope and resilience go." (Dr Hamza al-Kateab, Action for Sama, Protection Forum, Oslo, April 2024)*

Such destruction and repeated attacks incapacitate healthcare delivery and make it impossible to rebuild health facilities.[36] They also create extremely unsafe environments for health workers and patients. Even when facilities are not directly targeted, the blast waves can cause significant structural damage and render the buildings unsafe for medical use. Repeated incidents and assaults on health facilities and vehicles further exacerbate the devastating effects of the use of EWIPA.

> *"In Gaza, there is no infrastructure left. We can't reconstruct Gaza. There is nothing left of the so-called hospitals." (Dr Younis Al Khatib, Palestine Red Crescent Society, Protection Forum, Oslo, April 2024)*

Fewer health facilities, including specialist units or hospitals, mean people often have to travel long distances to reach health services when multiple life-threatening and traumatic injuries require immediate, complex and specialist treatment and care, or when other health emergencies necessitate urgent medical assistance. The sheer number of people who can be critically injured by explosive weapons can also result in those specialist facilities or staff becoming rapidly overwhelmed[37] in the event of an attack, with resources being diverted away from specialist or ongoing care to trauma response. For example, by April 2023 in Sudan,[38] a maternity hospital in El Fasher, North Darfur, was the only functioning hospital left in the city. As such, it was turned into a multifunctional trauma centre for civilian casualties and rapidly became overwhelmed by an influx of civilians with blast injuries, adding to the existing burden of sick patients and pregnant women being treated right next to injured people.

> *"After I got injured, I waited for an ambulance that never came. Ambulances don't reach you because they don't want to put themselves at risk or because they have to deal with hundreds of people injured at the same time. I got to the hospital in a normal car but there was no room for me so I was taken to another hospital but it took 12 hours to get there due to the multiple roadblocks and security checks. I was unable to lie down for the whole*

[32] Ibid.
[33] Médecins Sans Frontières (2024) Sudan: Bomb puts El Fasher paediatric hospital out of action.
[34] Radia Dabanga (2024) Sudan: Omdurman hospital bombed, deadly violence in North Darfur and El Gezira.
[35] Aljazeera (2023) Israeli air strike on ambulances kills 15, injures 60, Gaza officials say.
[36] Haar R, Rayes D, Tappis H, Rubenstein L, Rihawi A, Hamze M, Almhawish N, Wais R, Alahmad H, Burbach R, Abbara A. (2024) The cascading impacts of attacks on health in Syria: A qualitative study of health system and community impacts.
[37] HI (2019) THE WAITING LIST - Addressing the immediate and long-term needs of victims of explosive weapons in Syria.
[38] The Guardian (2023) Supplies running out at Sudan's remaining hospitals as healthcare disaster looms.

journey. I finally got surgery and I needed blood but there was none available, and staff at the hospital had already donated as much blood as they could. Surgeries are done in every empty space available at the hospital even if it is covered in blood. Doctors also have to deal with war injuries but they are not prepared as it is not something they have learnt." (Marwar Almbaed, Survivor advocate, Syria, November 2024)

Even when health facilities resume treatment and care, not all services may be fully reinstated, in particular because reopening trauma units is the priority.[39] In addition, admitted patients may be discharged early due to the risk of the facility or hospital being attacked, or lack of beds and resources, impacting the quality of care.

Similarly, attacks on health transport prevent health workers from accessing patients and providing emergency care. In the context of Syria, a 2021 report[40] by the International Rescue Committee noted that:"*[e]ach intensification in violence yields a surge in conflict-related injuries, placing added strain on intensive care units and trauma specialists, while simultaneously obstructing access to care with attacks on first responders and ambulances. The barbaric use of "double-tap" strikes, where first responders are hit with a second strike, has become a common feature of the air campaign in Syria."*

Gaza: 84% of health and rehabilitation facilities have been damaged.[41]

Destroyed and non-operational health facilities may require health workers to make decisions about how to minimise the risks of attacks and where to prioritise human resources, leading to "trade-offs" between protecting health facilities from attacks, for example by relocating to more secure locations away from the frontlines, which could then restrict access, or fortifying existing health facilities, and finding alternative locations in the same areas.[42] Adaptation measures can lead to a fragmentation and uncoordinated delivery of health services, which also results in inequities in healthcare services for different communities, for instance if more health workers and other health professionals are available in safer areas than in dangerous locations.

Spotlight 1. The unique link between the use of EWIPA and rehabilitation needs

What is Rehabilitation?[43]

Rehabilitation is a set of interventions designed to optimise the physical, social, and mental functioning of individuals in interaction with their environment. Rehabilitation is person-centred and encompasses a broad range of therapeutic measures. These include provision of assistive technologies and devices, as well as training and exercise, education, and support and counselling.

Rehabilitation is an essential health service[44] *and a critical component of victim assistance. It influences patients' health outcomes, including their chance of survival, their quality of life, and the risk of complications. It also promotes long-term recovery and facilitates independent living. Rehabilitation supports MHPSS efforts by alleviating signs of depression and low self-esteem often associated with trauma. Beyond health, rehabilitation is also a key determinant of patients' employment and education outcomes, impacting patients' ability to contribute to and participate in society.*

[39] Ibid.
[40] The International Rescue Committee (2021) A Decade of Destruction: Attacks on health care in Syria.
[41] Protection Cluster (oPt) (2024) Material Assistance Shortages: Impact on the Protection Situation in Gaza.
[42] Haar R, Rayes D, Tappis H, Rubenstein L, Rihawi A, Hamze M, Almhawish N, Wais R, Alahmad H, Burbach R, Abbara A. (2024) The cascading impacts of attacks on health in Syria: A qualitative study of health system and community impacts.
[43] Humanity & Inclusion, Rehabilitation Matters, Dedicated website.
[44] WHO (2024) Rehabilitation.

Not only do explosive weapons in populated areas cause complex and often multiple types of injuries requiring rehabilitation, but because they often injure large groups of people at the same time, they lead to a dramatic surge in rehabilitation requirements and assistive technology needs.

Explosive weapons' most common injuries requiring rehabilitation include brain, neck and spinal injuries, and traumatic amputation of limbs, particularly lower limbs. Civilians are also exposed to traumatic EWIPA injuries due to unexploded ordnance (UXO) during and after the conflict has ended.

Survivors of primary blast injuries require complex procedures, early rehabilitation to help them regain the functionality of their limbs or prepare them for prosthetics and orthoses, and ongoing rehabilitation services. Rehabilitation needs for children differ from those of adults and require treatment and care adapted to their growth and physiological needs.[45]

"In the tent, we have a two-year-old child with lower limb amputations, children with destroyed faces." (Abed El Hamed Qaradaya, Médecins Sans Frontières, Gaza, KII, September 2024)

The use of EWIPA has a devastating impact on existing but very often already underfunded and under-resourced rehabilitation facilities and services. Many different types of rehabilitation specialists have fled or been killed, equipment and tools have been destroyed, and existing services are unable to deal with the surge in demand. In Gaza, the intensity and ongoing bombing campaigns have virtually decimated rehabilitation services, and at least 21,000 children are suffering from conflict-related injuries. At least 25% (5,230) require significant rehabilitation. Gaza's only limb reconstruction and rehabilitation centre became non-functional in December 2023 due to a lack of supplies and specialised health workers, and was severely damaged in air strikes in February 2024,[46] *depriving children and adults of life-changing services for disabilities.*[47]

"The lack of medical personnel and essential supplies in Gaza is preventing the surgical interventions required to prepare the stump. In the context of war injuries caused by explosive weapons, multiple operations, including limb reconstruction and plastic surgery, are often needed. These procedures are currently unavailable in Gaza, and people will have to wait a long time for a prosthesis." (Reham Shaheen, HI Rehabilitation Expert, February 2024)[48]

"People are using trees to make crutches." (Abed El Hamed Qaradaya, Médecins Sans Frontières, Gaza, KII, September 2024)

Patients requiring rehabilitation also face significant and overlapping physical, safety and financial challenges, such as transport and treatment costs, insecurity, and long waiting lists to access care and equipment (often not available). The rehabilitation requirements for amputations in particular are costly and spread across years, especially for children. Prosthetic limbs – one of the main health requirements for EWIPA-related injuries – are expensive (and in the case of children must be changed regularly as the child grows), and rehabilitation may require daily visits that are often impossible to make due to travel costs when centres are located miles away. In Ukraine[49] *and NWS,*[50] *the increased prices of drugs and transport, and poverty, have become major barriers to healthcare access.*

[45] Jain RP, Meteke S, Gaffey MF, Kamali M, Munyuzangabo M, Als D, Shah S, Siddiqui FJ, Radhakrishnan A, Ataullahjan A, Bhutta ZA.(2020) Delivering trauma and rehabilitation interventions to women and children in conflict settings: a systematic review.
[46] WHO News (2024) WHO analysis highlights vast unmet rehabilitation needs in Gaza.
[47] WHO (2024) Estimating Trauma Rehabilitation Needs in Gaza using Injury Data from Emergency Medical Teams.
[48] Humanity & Inclusion (2024) Rehabilitation needs growing rapidly in Gaza.
[49] ACAPS (2023) Ukraine: Impact of the conflict on the healthcare system and spotlight on specific needs.
[50] KII, Humanity & Inclusion.

The lack of or the deterioration of assistive products can also make a disability more severe and worsen challenges in accessing essential services.[51] *In addition to traumatic physical injuries, persons with disabilities are confined to a place and not able to move, which in turn has implications on their ability to protect themselves.*

Gender[52] *and age can often dictate who gets to access rehabilitation when families are struggling to put food on the table, and cultural norms further influence health-seeking behaviour. For example, women with disabilities requiring rehabilitation are more likely to face financial barriers to accessing services, including assistive technology,*[53] *while in some contexts, children may not be prioritised by their families who need to earn a living.*

"[In Gaza], we've got a 16-year-old girl who has a spinal cord injury and can't live in a tent. We can't discharge her because she's only got an uncle. She hasn't got female relatives to do the medical care that she'd need. She can't pray anymore. The support she needs is really complex (...) Our rehab team has been looking after patients with rehabilitation needs because we have to keep them long term, as they have no place to go." (KII, Global, October 2024)

"A large majority of our [rehabilitation] patients are men. That is because men are the breadwinners and need to be able to get back into the labour market. Women and children often stay at home. We don't see a lot of children who are deprioritised because families need to earn a living. Social stigma also impacts patients' access to services, with women and girls often being hidden away." (KII, NWS, September 2024)

Finally, multiple displacements also mean that people lose access to existing services and may not find out how to locate new rehabilitation support where they now live.[54]

Extensive damage to civilian infrastructure and systems disrupts health services and health facilities' ability to operate

The healthcare system is also affected by the indirect or "reverberating" consequences of attacks on critical civilian infrastructure, such as communications, roads, energy and water supply and waste management systems. This erodes the capacity of hospitals and health facilities,[55] as well as ambulances, to respond to both traumatic EWIPA injuries and to treat other health issues, by causing severe disruptions or the interruption of health services, including emergency surgeries and ongoing medical treatment.

In Gaza, persons with disabilities and their families are no longer able to access services due to the impact of EWIPA use on organisations providing services.[56] For example, the headquarters of Stars of Hope Society, one of the very few remaining organisations delivering rehabilitation and MHPSS services to women with disabilities, was partially destroyed as a result of the bombing of the neighbourhood in which it is located. Explosive weapons destroyed a large amount of assets and equipment, and damaged vital systems for running the organisation, including communications, water and electricity systems in the building.

The war in Gaza has also massively disrupted patients' continuity of care as a result of hospitals being damaged or unable to function due to a shortage of commodities compromised by attacks

[51] Humanity & Inclusion (2016) Syria, a mutilated future.
[52] ReLAB HS (2021) Rehabilitation through a gender lens.
[53] Ibid.
[54] KIIs.
[55] Article 36 (2020) Health and Harm: Protecting Civilians and Protecting Health.
[56] Stars of Hope Society (2024) A War without Human Rights Cutting off All Means of Survival: Organizations Working in the Field of Disability in Light of the Genocide.

on civilian systems. In October 2023, The Turkish-Palestinian Friendship Hospital was severely damaged and ran out of fuel. It had to suspend its operations, leaving around 10,000 oncology patients in the Gaza Strip without the necessary specialist care and treatment.[57]

A recent report[58] by the UN Human Rights Monitoring Mission has documented how extensive damage to electricity systems has affected the provision of healthcare in Ukraine, impacting hospitals' and other health facilities' access to electricity for medical procedures, equipment and cold storage of drugs. Although, when available, hospitals and clinics have used backup generators, they use significant amounts of fuel on a daily basis.[59] Generators also do not generally power lifts, making it challenging to move patients to safety or to other medical facilities. The Monitoring Mission also found that services in smaller health facilities have been reduced or rescheduled as backup energy supply is insufficient. In Sudan, damage to water infrastructure in Khartoum affected the functioning of hospitals, some of which were forced to stop providing critical services, including surgery, due to a lack of water.[60]

Ukraine: Between March and August 2024 there were nine waves of coordinated attacks against electricity infrastructure, striking facilities in 20 of the 24 regions in government-controlled areas, including Kyiv.[61]

The destruction of roads and other transport infrastructure is also having significant consequences in terms of both accessing populations in need, especially as ambulances and other health vehicles also face risks of attacks, and populations reaching health facilities.

> *"Roads have been severely damaged by the conflict, making it challenging for people to move from one place to another, including to seek healthcare." (KII, NWS, September 2024).*

Spotlight 2. Healthcare access challenges are increased by chronic underinvestment and poor resourcing of health systems

The use of EWIPA has direct and indiscriminate effects on healthcare across all settings. However, their impacts are compounded by weak and under-resourced health systems, often as a result of recurrent conflicts and crises, combined with lack of investment in health system strengthening.[62] The global COVID-19 pandemic also devastated already fragile health systems,[63] diverting human and financial resources, and causing severe disruptions to health services.

In Gaza, decades of underfunding, the effects of a 16-year blockade,[64] and insufficient resourcing had severely weakened the health system before October 2023, when only 2,500 hospital beds were available for a population of over 2 million. Sudan's health system was also very fragile before the conflict, with insufficient investment in healthcare infrastructure, political instability,[65] and COVID-19 exacerbating health access and delivery challenges.

[57] Insecurity Insight (2024) Occupied Palestinian Territory – Violence against healthcare in conflict 2023.
[58] Office of the High Commissioner for Human Rights. UN Human Rights Monitoring Mission in Ukraine (2024) Attacks on Ukraine's Energy Infrastructure: Harm to the Civilian Population.
[59] Ibid.
[60] Human Rights Watch (2023) Sudan: Explosive Weapons Harming Civilians - Limited Access to Water, Electricity, Medical Care Fuels Humanitarian Crisis.
[61] Office of the High Commissioner for Human Rights. UN Human Rights Monitoring Mission in Ukraine (2024) Attacks on Ukraine's Energy Infrastructure: Harm to the Civilian Population.
[62] ACAPS (2023) Sudan: Impact of the conflict on children.
[63] Haileamlak A. (2021) The impact of COVID-19 on health and health systems.
[64] British Medical Journal (2014) Rebuilding health services in Gaza won't be possible while Israel maintains blockade, says report.
[65] Hemmeda L, Ahmed AS, Omer M. (2023) Sudan's armed rivalry: A comment on the vulnerable healthcare system catastrophe.

"The health system, which was already under-resourced, cannot deal with the overall health needs due to the war. Services lack capacity." (KII, mental health service provider, Ukraine, 3 September 2024)

Killed and displaced healthcare workers limit availability and quality of care

Health workers are directly affected by the use of explosive weapons, both as civilians who experience the physical and mental trauma of war, and as medical personnel who have to treat trauma patients daily, working in extreme hardship in damaged buildings, and without the necessary equipment and resources they need.

In 2023, more than 209 medical professionals[66] in health facilities or in health vehicles were killed by explosive weapons, representing a 207% increase from the 68 deaths that occurred in 2022. The dramatic rise in the deaths of health workers is largely attributable to the siege in Gaza.

2023: Local staff represented 84% of health workers killed by explosive weapons globally.[67]

A large majority of health workers killed are local staff working in national health structures.[68] In countries where health specialists, including mental health, physiotherapists and occupational therapists, are often rare or poorly resourced or prioritised, the loss (including as a result of health workers fleeing conflict) of this expertise has a significant impact on healthcare delivery for patients with complex and traumatic injuries.[69] In Gaza, one of the only two psychiatrists was killed during the conflict, and in the West Bank, there are only 11 practising psychiatrists within the national health system.[70] In Syria, the killing of health workers and the "brain drain" of specialists who have fled the war, has significantly impacted the availability of medical specialists, including oncologists.[71]

> *"Our healthcare workers in Lebanon got bombed. 70% of them are women. The facilities where women come and access life-saving reproductive services were destroyed." (Dr Alvaro Bermejo, International Planned Parenthood Federation).*[72]

Although health workers are often considered as a homogeneous group, their level of exposure to harm from explosive weapons may be influenced by their specific role. For example, in Ukraine, WHO Surveillance System for Attacks on Health Care (SSA) identified a trend whereby ambulances and other medical personnel servicing health transport are more likely to be targeted. Out of the 68 attacks verified by WHO between January and April 2024, nearly 20% were aimed at Emergency Medical Services, with health transport workers such as paramedics in ambulances facing a risk of injury and death three times higher than that of other health workers.[73] In Gaza, ambulances and mobile clinics have also been directly and systematically

[66] Insecurity Insight (2024) The Effects on Health Care of the Use of Explosive Weapons in 2023.
[67] Ibid.
[68] Ibid.
[69] Humanity & Inclusion (2022) Ukraine, where sirens sound day and night: A focus on persons with disabilities and provision of emergency health services.
[70] Think Global Health (2024) Gaza and the West Bank: Reflections From a Psychiatrist; Q&A with a Doctors Without Borders physician working in a traumatized region.
[71] Relief International (2023) Out of sight - Obstacles in accessing breast cancer screening and treatment for women in Northwest Syria (NWS).
[72] International Planned Parenthood Federation (2024) Statement on Escalation of Violence Against Health Care Workers.
[73] WHO (2024) Triple risk of harm for Ukraine's health transport workers over other health-care staff, WHO data indicates.

targeted alongside health facilities.[74] As a result, taxis and private cars have increasingly been used to transfer injured people to health facilities to avoid attracting attention.[75]

> *"The psychiatric hospital in Nikolaev was completely destroyed in the first few days of the war, and it was impossible to get to the hospital because of the constant shelling. It was scary to leave the house, and maybe there were doctors somewhere, but we had no information about where to go, and it was very difficult to get to them because of the constant shelling and alarm." (Olha Lieshukova, Survivor advocate, Ukraine, KII, October 2024)*

While access to healthcare is limited by the reduced number of health workers, the quality of care is also compromised. Due to the shortage of specialists, medical students and general practitioners end up carrying out surgeries and other specialist treatment as demand outstrips availability of qualified health professionals, including trauma surgeons and maternal and child health specialists. Task-shifting is also a strategy used by health workers to mitigate the effects of the conflict on medical care delivery. Yet those strategies may come at the expense of quality of care for patients.[76]

Box 3. Traumatic injuries and antimicrobial resistance

Patients with traumatic burn and blast injuries caused by explosive weapons often arrive at health facilities with contaminated wounds that require urgent treatment. Attacks on health facilities and hospitals often destroy or limit access to drugs and medicines, including appropriate antibiotics, which severely increases patients' (especially children) vulnerability to bacterial infection[77] and fuel antimicrobial resistance,[78] especially when combined with other factors such as limited resources, mass casualties, destruction of laboratories, poor access to infection specialists, suboptimal infection prevention and control practices, environmental pollution and toxic substances released from explosives.[79]

The killing, mental trauma, and displacement[80] of health workers, alongside the destruction of medical schools and institutions will severely impact the capacity of national health systems to respond to the growing, complex and longer-term health needs of populations bearing the physical and mental scars of the conflict for generations to come. In Myanmar, more than 70% of health workers are thought to have left the country following the February 2021 coup,[81] while in Sudan a majority of public health workers fled the conflict.[82]

> *"[In Ukraine], specialist care has been affected by a massive loss of staff." (Mental health service provider, Ukraine, KII, September 2024)*

[74] The Conversation (2023) Decades of underfunding, blockade have weakened Gaza's health system – the siege has pushed it into abject crisis.
[75] AlJazeera (2023) Gaza medics say Israel targeting ambulances, health facilities.
[76] Fardousi N., Douedari Y., and Howard N. (2019) Healthcare under siege: a qualitative study of health-worker responses to targeting and besiegement in Syria
[77] Mayhew, Emily et al. (2024) Antimicrobial resistance in paediatric blast and crush injuries.
[78] Devex (2022) The war in Ukraine is fueling antimicrobial resistance.
[79] Moussally, Krystel et al. (2023) Antimicrobial resistance in the ongoing Gaza war: a silent threat.
[80] ACAPS (2023) Ukraine: Impact of the conflict on the healthcare system and spotlight on specific needs.
[81] Think Global Health (2024) In Myanmar, Health Care Has Become a Battleground.
[82] Dafallah, A., Elmahi, O.K.O., Ibrahim, M.E. et al. (2023) Destruction, disruption and disaster: Sudan's health system amidst armed conflict.

Spotlight 3. Invisible wounds – The unique impacts of EWIPA use on mental health

"There is a Gaza syndrome. It is more than PTSD, more than depression, more than trauma." (KII, Gaza, September 2024)

The use of EWIPA causes significant and long-term damage to mental health and psychological wellbeing beyond the "expected" stressors of exposure to conflict and violence, with intense and relentless attacks and years of exposure to EWIPA, such as in Syria, Yemen, and Gaza, leading to intergenerational mental health issues.[83]

The mental health impacts of EWIPA use are primarily two-fold. Ongoing and repeated exposure to bombing and shelling, the fear and anticipation of further attacks, the lack of safe place or shelter, and the "invisible threat"[84] *of unexploded ordnance are causing extreme and multiple mental health conditions. EWIPA injuries, including amputations and other severe traumatic injuries, also cause unique psychological and psychosocial impacts which must be addressed alongside physical rehabilitation. For victims, surviving is just the beginning of a long journey.*

While the mental health impacts of the use of EWIPA affect adults and children, children are particularly vulnerable due to their psychological development, and will have the cognitive, social and emotional aspects of their development affected. The trauma is even greater for children with disabilities.[85] *In Gaza, just two weeks after the 7 October attack, children were showing severe trauma symptoms, such as convulsions, bed-wetting, fear, aggressive behaviour, nervousness, and not leaving their parents' sides.* [86] *According to UNICEF, almost all children in Gaza are in need of MHPSS.*[87]

"Children don't want to be touched by health workers, people in uniforms, even if it is a blouse, so we are working with counsellors. I have never seen this level of injury and trauma in children. Adults are equally traumatised. They have lost everything. People don't see a future, so they think there is no point in living." (Abed El Hamed Qaradaya, Médecins Sans Frontières, Gaza, KII, September 2024)

Some children have experienced multiple periods of intense bombardment in their lives over the past 15 years, exacerbating the impacts of the current and unprecedented bombing campaign. In Northwest Syria, ongoing bombing is the main cause of psychological stress in children's daily lives,[88] *while in Ukraine, an estimated 1.5 million children are at risk of depression, anxiety, and post-traumatic stress disorder.*[89] *Persons with disabilities are also likely to experience heightened levels of mental and psychological issues due to the loss or lack of access to healthcare and disability-inclusive services and places, support networks, and assistive devices.*

The use of EWIPA also severely affects health workers' mental health for multiple and overlapping reasons. They have to work in extreme, exhausting, traumatic and unsafe environments with scarce resources,[90] *such as drugs and equipment. In Gaza, doctors are performing surgeries, such as*

[83] Humanity & Inclusion (2020) Death Sentence to Civilians: The Long-Term Impact of Explosive Weapons in Populated Areas in Yemen.
[84] Humanity & Inclusion (2024) Out of Reach: The Impact of Explosive Weapons in Ukraine – Focus on hard-to-reach areas.
[85] Human Rights Watch (2024) 'They Destroyed What Was Inside Us': Children with Disabilities Amid Israel's Attacks on Gaza.
[86] The Guardian (2023) Children in Gaza 'developing severe trauma' after 16 days of bombing.
[87] ACAPS (2024) Palestine - Impact of the conflict on mental health and psychosocial support needs in Gaza.
[88] Save the Children (2017) Invisible Wounds: The Impact of Six Years of War on Children's Mental Health.
[89] Action on Armed Violence (2023) Children in Ukraine endure a year of horror amid escalating conflict.
[90] HOPE (2023) Health Workers Near Breaking Point in Sudan.

children's amputations and caesareans, without anaesthesia and with flash lights.[91] *They may be unable to provide the care required due to mass casualties and damaged health facilities and equipment, among other factors. This potentially impacts their longer-term ability to provide healthcare. In addition, they may have lost colleagues*[92] *and they have to live the daily realities of being a civilian, including multiple displacements.*[93]

Similarly to rehabilitation, access to mental health services is significantly compromised in EWIPA settings due to a combination of challenges related to extreme service disruption, and existing gaps, such as a lack of MHPSS services and specialists, and at the individual level, stigma and discrimination by family and community members.

"Even if services are available, it does not mean that people will go to see experts. Stigma is a very big issue. There is a strong stigma associated with mental health services in Ukraine." (KII, Mental health service provider, Ukraine, September 2024)

Unexploded ordnance contamination restricts access to healthcare during and after the conflict due to safety risks

As their design and use are inherently inaccurate,[94] many explosive weapons fail to explode upon impact. They contaminate land with UXO or explosive remnants of war (ERW), which are either exposed or hidden under rubble or underground, and therefore invisible. In some EWIPA settings, including Gaza, Syria, and Ukraine, the land was already contaminated by prior (and repeated) conflicts with the financial costs of clearance often making it challenging for governments to remove UXO without international funding assistance.

Land contamination severely restricts access to and the delivery of healthcare, both during and long after bombing ends. In Iraq, while some medical facilities in Ninewa district – where the health sector was the most severely damaged by the war – have been rebuilt, land contamination prevents people from reaching them.[95] Similarly, in Yemen,[96] patients cannot access healthcare when they need it due to safety risks. In Syria, health programmes have been postponed, moved or cancelled because of the locations contaminated with UXO.[97]

> *"Ordnance contamination will be an enormous challenge to rebuilding Sudan. It will be the war after the war." (Ziggy Garewal, Danish Refugee Council Country Director in Sudan, April 2024)*[98]

The numbers are staggering. In Ukraine, 29% of land is estimated to be contaminated with UXO,[99] while Israel is reported to have dropped at least 45,000 bombs on Gaza, 9–14% of which failed to detonate.[100] Mine experts believe that it could take 14 years to make the Gaza Strip safe - one of the most densely populated areas in the world - from unexploded bombs.[101] According to HI, UXO

[91] British Medical Journal (2024) Gaza: Doctors of the World office destroyed, as medics are forced to amputate without anaesthetic.
[92] ACAPS (2024) Palestine - Impact of the conflict on mental health and psychosocial support needs in Gaza.
[93] KIIs, Gaza.
[94] Humanity & Inclusion (2021) No safe recovery: The impact of Explosive Ordnance contamination on affected populations in Iraq.
[95] Ibid.
[96] Humanity & Inclusion (2021) Reverberating effects of explosive weapons on the health system in Yemen.
[97] Humanity & Inclusion (2019) THE WAITING LIST - Addressing the immediate and long-term needs of victims of explosive weapons in Syria. See also: Mine Action Syria Response (2022) Explosive ordnance in Syria: impact and required action.
[98] Danish Refugee Council (2024) Sudan: The war after the war.
[99] ACAPS (2024) UKRAINE Humanitarian implications of mine contamination
[100] Arab Center Washington DC (2024) Explosive Remnants of War in Gaza: A Long-Term Threat to Palestinian Life.
[101] UN News (2024) Unexploded ordnance leaves dark legacy for Gaza, warn mine action experts.

are likely to cost more lives in Gaza and cause temporary or life-long disabilities that require emergency medical treatment, with affected populations also suffering from psychological trauma.

Fear of attacks, long distances to travel, and reduced services affect people's health-seeking behaviour

Safety fears about attacks on healthcare facilities, especially ongoing bombing, affect populations' health-seeking behaviour.[102] Unless they absolutely need lifesaving treatment, patients and their families often decide not to travel to seek medical care, or they will discharge themselves from the hospital for fear of the building being attacked. Hospitals, which used to be considered places of safety as explicitly protected under IHL, are now deliberately targeted, putting health workers and patients at increased exposure to harm. For example, a study[103] carried out in NWS found that on average, an attack on a health facility was associated with 51% and 38% reductions in outpatient and trauma consultations the following day, with significant reductions continuing for 37 and 20 days respectively. Attacks on health facilities were also associated with an average 23% reduction in the number of births at that hospital the second day after an attack, with significant reductions in attendance continuing for more than five weeks.

> *"People are scared of going to hospitals because healthcare is a target. Unless there is a huge need they can't handle, they won't go. People refuse to stay in hospital even if they need to be hospitalised for a week. They say "It's safer for me to be at home than in a hospital". (Dr Hamza al-Kateab, Action for Sama, Syria, KII, August 2024)*

Awareness about the lack of staff and reduced services further deters people from seeking medical treatment, as they know they will not get the care they require. That includes sexual and reproductive health, as well as treatment for children's diseases. The building or relocation of medical facilities away from the frontlines further limits access to healthcare, as affected communities often opt for community-based strategies instead of travelling to reach medical services.

> *"Affected populations know there are no staff and drugs at health facilities (via word of mouth) so even if physical access is available, services and quality of care is not." (Doctor, Global, KII, August 2024)*

Cultural and social norms – although not specific to EWIPA contexts – further impact health-seeking behaviours and access to health services. Women and children's needs may be deprioritised for financial (and social) reasons, while stigma around mental health also prevents people from seeking support.

Spotlight 4. Healthcare access challenges are heavily influenced by gender, age, disability and social, cultural and economic factors

Although explosive weapons do not discriminate between civilians, the health impacts of EWIPA use differ based on a person's gender, age and disability (as well as other socio-economic factors, such as displacement and family status), and how these factors intersect. This is recognised in the Political Declaration, which calls for the adoption of a "holistic, integrated, gender-sensitive, and non-discriminatory approach" to victim assistance in the short and longer term, and with specific consideration of the rights of persons with disabilities. Some of the population groups most affected

[102] Humanity & Inclusion (2019) The Waiting List - Addressing the immediate and long-term needs of victims of explosive weapons in Syria.

[103] Burbach, Ryan and Tappis, Hannah and Abbara, Aula and Albaik, Ahmad and AlMhawish, Naser and Rubentein, Leonard and Hamze, Mohamad and Gasparrini, Antonio and Rayes, Diana and Haar, Rohini Jonnalagadda (2023) Quantifying The effects of Attacks on Health Facilities on Health Service Use in Northwest Syria: A Case Time Series Study from 2017-2019.

by the health impacts of the use of EWIPA and healthcare-related challenges include children, persons with disabilities, older persons and women and girls.

Children are more exposed to the direct effects of the use of EWIPA, *including unexploded ordnance.*[104] *Their smaller, younger and still growing bodies make them more vulnerable to penetrating and multiple injuries from an explosion.*[105] *Explosive weapons kill and injure more children in conflict than other types of conventional weapons.*[106] *Research in Syria found that they are seven times more likely to die from blast injuries than adults,*[107] *while in Yemen – eight years after the war - UXO (as well as landmines) account for one in five child casualties compared with around one in 10 overall casualties.*[108] *Children also have greater requirements for EWIPA care and treatment*[109] *(including surgery)*[110] *than adults, due to the disproportionate intensity and complexity of their injuries. As a result, they need more and specialist treatment, including multiple surgeries, and rehabilitation over a longer period of time. The emotional trauma they experience also necessitates skilled and trained professionals. Aside from EWIPA injuries, children require access to preventative healthcare, including vaccinations, treatment for childhood diseases, and a range of infections and health conditions to which children are more vulnerable than adults, such as malnutrition and water-borne diseases. The influx of EWIPA-related injuries, severely damaged health facilities, in particular children's hospitals and wards, and critical infrastructure, such as water and power systems, and fewer qualified health specialists impact children's access to timely and quality treatment and care, subsequently exposing them to more risks of infections and preventable deaths. In Gaza, attacks on water and sanitation infrastructure have led to the resurgence of polio, a childhood preventable disease eradicated for 25 years.*[111]

Persons with existing disabilities[112] *have a high risk of being injured or killed by EWIPA as they are less likely to be able to evacuate and flee,*[113] *and may lose their assistive devices in the event of attacks.*[114] *Persons with new disabilities or injuries caused by explosive weapons also face more barriers to accessing health services.*[115] *This can be due to a lack of physical access to health facilities and unavailability or a shortage of health workers with specialist skills to treat or rehabilitate complex injuries, such as trauma surgeons, burns specialists, physiotherapists and occupational therapists. Existing social disadvantage, structural exclusion and poverty further impact persons with (new and existing) disabilities' access to health services.*[116] *A January 2024 MSNA*[117] *conducted in Ukraine found that households with members with disabilities have higher health-related needs and face more barriers to accessing medication and healthcare. Service providers also often lack the necessary skills or knowledge to effectively cater to their specific needs.*[118]

[104] Save the Children (2023) Watching Our Every Step: The deadly legacy of explosive ordnance for children in Yemen.
[105] Centre for Blast Injury Studies (2017) The Impact of Blast Injury on Children: A Literature Review.
[106] Action on Armed Violence (2021) Childhood under Attack: A timeline of harm following an explosive blast.
[107] Save the Children (2019) Blast Injuries: The impact of explosive weapons on children in conflict.
[108] Save the Children (2023) Watching Our Every Step: The deadly legacy of explosive ordnance for children in Yemen.
[109] Ibid.
[110] International Committee of the Red Cross (2023) Childhood in Rubble: The Humanitarian Consequences of Urban Warfare for Children.
[111] Save the Children (2024) Aid agencies and medical professionals warn of dangers of a mass polio outbreak without urgent action, endangering a generation of children in Gaza.
[112] Humanity & Inclusion (2022) Ukraine, where sirens sound day and night: A focus on persons with disabilities and provision of emergency health services.
[113] Ibid.
[114] Office of the High Commissioner for Human Rights (2024) A tragedy within a tragedy: UN experts alarmed by harrowing conditions for Palestinians with disabilities trapped in Gaza.
[115] Humanity & Inclusion, supra at 101.
[116] H4D Helpdesk Report (2017) Women and girls with disabilities in conflict and crises.
[117] REACH (2024) Multi-Sectoral Needs Assessment (MSNA): Gender, Age and Disability Situation Overview - January 2024 | Ukraine.
[118] KIIs with service providers in Northwest Syria and Gaza.

__Older persons__ are more likely to have at least one form of disability and be suffering non-communicable diseases.[119] *They face specific challenges, including mobility and financial barriers to accessing healthcare in particular for ongoing medical conditions. Wherever available as an adaptation measure, online platforms and telehealth options are also less accessible to older persons due to lower digital literacy.*[120] *In Ukraine, research found that older persons' lack of access to healthcare has increased the risk of disease, disability, and multi-morbidity among that population group, as well as delays in new diagnoses and timely access to treatment, and disruptions in continuity of care, long-term and palliative care, and access to medications.*[121]

__EWIPA attacks on healthcare also disproportionately impact women and adolescent girls__ who are left without or have limited access to lifesaving sexual health and reproductive as well as maternal health services.[122] *In addition, while EWIPA injuries affect both women and men, blast waves can also have specific consequences on women. For example, EWIPA can damage the placenta in pregnant women and cause miscarriage. Miscarriages are also caused by lack of access to antenatal care during their first few months of pregnancy, and the mental and emotional trauma of living under attack. In Gaza, the number of miscarriages has increased by 300%.*[123] *In South Darfur, Sudan, Médecins Sans Frontières (MSF) reported that from January to August 2024 pregnancy-related complications in MSF-supported facilities represented 40% of the total number of maternal deaths reported across MSF operations globally in 2023, and around 78% of 46 maternal deaths occurred in the first 24 hours following admission as a result of women arriving in a critical condition after being unable to access timely healthcare due to the scarcity of functioning health facilities*[124] *and unaffordable transport costs.*[125] *Although not specific to EWIPA contexts, cultural and gender norms also worsen the challenges women and girls face.*

__Intersecting factors such as gender, age and disability, as well as displacement status, increase the risk of exposure to EWIPA-related harm__[126] *__and make it even more challenging for specific population groups to access complex and adapted treatments and care for EWIPA-related injuries and for other essential health needs.__ In Gaza, women and children with disabilities are among the 70% of civilians killed and 75% of those reportedly injured.*[127]

Although relatively limited, existing evidence on the intersection between and among age, gender, and disability in EWIPA contexts shows that children[128]*, women*[129] *and older people with disabilities are more likely to be facing significantly more financial difficulties and barriers to accessing essential healthcare.*[130] *Women and girls with disabilities are more likely to be stigmatised and discriminated against, and to experience increased levels of gender-based violence (GBV). They are, however, less likely to be able to access (adapted) services.*[131] *Boys and girls also face different risks of exposure*

[119] HelpAge International (2024) A lifetime of suffering - The challenges faced by older people in Gaza.
[120] CARE (2024) Ukraine Rapid Gender Analysis. Also see: HelpAge International (2023) I've lost the life I knew: Older people's experiences of the Ukraine war and their inclusion in the humanitarian response.
[121] HelpAge International (2024) "At Home, Even the Walls Help": Exploring the Palliative Care Needs, Experiences, Preferences, and Hopes of Older People with Serious Illness in Ukraine.
[122] UN Women (2023) Women and newborns bearing the brunt of the conflict in Gaza, UN agencies warn.
[123] International Planned Parenthood Federation (2024) Gaza nine months on, pregnant women carry the burden of conflict.
[124] UNFPA (2024) Attacked, understaffed, underfunded: Healthcare shortages endanger pregnant women in north-west Syria.
[125] Médecins Sans Frontières (2024) Driven to oblivion: the toll of conflict and neglect on the health of mothers and children in South Darfur.
[126] Save the Children (2023) Watching Our Every Step: The deadly legacy of explosive ordnance for children in Yemen.
[127] OHCHR (2024) Onslaught of violence against women and children in Gaza unacceptable: UN experts.
[128] Human Rights Watch (2024) Interview: Children with Disabilities Struggling in Gaza.
[129] H4D Helpdesk Report (2017) Women and girls with disabilities in conflict and crises. Humanity & Inclusion KIIs (Syria, Gaza).
[130] Protection Cluster & UNHCR (2024) Persons with Disabilities Protection Barriers Report in North-West Syria
[131] ACAPS (2023) UKRAINE: Impact of the conflict on the healthcare system and spotlight on specific needs. This was also reported in KIIs conducted as part of the research for this report.

to EWIPA due to both their interaction with and exposure to blasts and their physiology. Although limited, data points to more boys being killed and injured than girls by blasts.[132]

"You are talking about a system that didn't cater for the needs of persons with disabilities before the war. Resources are extremely limited. Children with disabilities require support but there is nothing. There is no occupational therapy or physiotherapy. There are even more problems with children with hearing and visual impairments and the process of involving them in rehabilitation. Persons with disabilities face a double burden – the burden of trauma and the burden of the consequences of their new disabilities." (KII, Gaza, September 2024)

2. What are the most pressing gaps in humanitarian action affecting inclusive and adequate healthcare delivery in EWIPA contexts?

"The international system as we know it is not fit for purpose in EWIPA settings." (HI Workshop participant)

Healthcare access in EWIPA contexts is further compromised by gaps in the planning and delivery of humanitarian responses. Although the gaps identified by our research are well-acknowledged across humanitarian response settings, they are widened by the specific and unique health effects of explosive weapons in populated areas. The use of EWIPA creates complex and acute health needs that require tailored responses to match the widespread destruction of health (and interconnected) infrastructure, the massive loss of health workers, and the scale of injuries and suffering.

The main challenges affecting the delivery of inclusive and adequate health interventions are largely compounded by funding-related barriers and the failure to target the diverse health needs of EWIPA-affected populations by donors and humanitarian and health actors. The lack of an inclusive and intersectional approach to health programming also severely impacts healthcare access challenges faced by specific groups, such as adults and children with disabilities, with gender and age magnifying barriers. Finally, data gaps, in particular the lack of disaggregated data, insufficient data sharing, and weak coordination and collaboration impede the use of evidence that can provide critical information for programming planning and delivery, funding, and policy and advocacy.

Funding and programme priorities do not match the needs on the ground

The prioritisation of needs, including in funding, all too often fails to reflect the direct and indirect impacts of the use of EWIPA on people's health needs and their access to lifesaving and critical services in the short and longer term. The financing gap also leads to "trade-offs" in interventions and the health needs to be prioritised.

"The prioritisation of health interventions does not match people's specific health needs in EWIPA contexts." (Sarah Alrashdan, Humanity & Inclusion, NWS, KII, September 2024)

"Generally speaking, because it's all donor driven – it will determine what kind of healthcare you are getting. Each year has a theme for donors. 2013 was maternal care, but funding was

[132] Save the Children (2019) Blast injuries.

stopped in 2024 (no more mobile clinics). For mental health, it was 2018 and 2019". (Dr Hamza al-Kateab, Action for Sama, Syria, KII, August 2024)

Specifically:

- Rehabilitation services are considered secondary and not an essential component of the acute phase of the response.

"After my surgery, my therapy consisted of being seated for 30 minutes a day. The rest of the time I was laid down. I could not talk to any doctors. Rehabilitation is expensive but it is not good enough. I was given a wheelchair but it was so big that another person could have sat in it. It was not good for my spine. Here in Germany, patients with the same kind of injuries have access to a variety of rehabilitation therapies. (...) Provision of essential medical supplies and equipment is needed." (Marwa Almbaed, Survivor advocate, Syria, November 2024)

Civilians' rehabilitation needs have skyrocketed due to the increased use of EWIPA and relentless bombing campaigns, including in Ukraine and Gaza. Ten children per day are losing one or both of their legs in Gaza[133] in a conflict that has become an "amputation crisis".[134] In Ukraine, the demand for rehabilitation services has reached a critical level, with over 250,000 patients in need of care and treatment annually,[135] while approximately 3 million Syrians have been injured, and almost half of them have permanent impairments, including 86,000 amputations.[136]

Despite the extreme level of need, lack of access to rehabilitation is one of the main gaps in humanitarian responses in EWIPA contexts.

"We are treating people without equipment. We are using local carpenters for crutches and sand and socks for weight." (Abed El Hamed Qaradaya, Médecins Sans Frontières, Gaza, KII, September 2024)

The role of rehabilitation as an essential health service in emergencies was reiterated in the May 2023 World Health Assembly resolution 76.6.[137] It is stated in global emergency guidelines, and rehabilitation professionals are included in emergency medical teams (EMTs). However, it remains largely deprioritised or excluded from the acute stage of conflict responses. Funding[138] and programming for rehabilitation are woefully inadequate, despite the surge in rehabilitation needs resulting from the widespread use of EWIPA and the fact that rehabilitation services are paramount for preventing further health complications and ensuring the best possible recovery for survivors.

Several factors compound this gap. They include the perception of rehabilitation as a longer-term and non-essential intervention, and a poor understanding of its benefits beyond health, and its essential role in preventing further health complications and potentially deaths.[139] The widening gap in humanitarian financing, combined with an increasing number of donor governments cutting

[133] Le Monde (2024) UNRWA reports 10 children lose legs every day in Gaza.
[134] AlJazeera (2024) The amputee crisis in the war on Gaza.
[135] Momentum Wheels for Humanity (2024) Rehabilitation for Ukraine.
[136] Humanity & Inclusion and World Health Organization (2017) The WHO and HI draw attention to the needs of people inside Syria living with injuries and disabilities.
[137] WHO (2023) Strengthening rehabilitation in health systems.
[138] World Health Organization (2024) Addressing the increasing burden of trauma in humanitarian settings in the Eastern Mediterranean Region.
[139] Gosling J, Golyk V, Mishra S, Skelton P. (2024) We must not neglect rehabilitation in Ukraine.

down on aid and the downgrading of several conflicts, such as Syria and Myanmar, further contribute to this gap.

> *"The focus of the response is on lifesaving interventions. Assistive equipment is not seen as a priority in the response. We had five wheelchairs when 50 people needed one in the past week (...) Rehabilitation by itself is not a secondary phase, it is part of the acute phase. If you don't get it quickly, it will have major implications for people in the future." (Abed El Hamed Qaradaya, Médecins Sans Frontières, Gaza, KII, September 2024)*

> *"We are trying to push the rehabilitation agenda within emergency responses. A lot of the time, it's the negotiation with the Ministry of Health that is difficult as well. I went into Ukraine at the very beginning with our first team on the ground. We set up a primary care response that was actually in the west, south of Lviv (...) I was talking to the MOH, trying to engage with the local oblast leaders, trying to find out where rehab was happening and push that agenda, but there was a lot of, "we're in the business of saving lives, we're not in the business of rehabilitation." (KII, Global, October 2024)*

- The complex and heightened mental health needs of EWIPA-affected populations are not resourced or adequately targeted

> *"My husband and I both suffer from severe post-traumatic stress disorder. We experience constant insomnia, panic and fear. We have an acute reaction to any loud noises, sirens, and any aeroplanes" (Olha Lieshukova, Survivor advocate, Ukraine, KII, October 2024)*

In Syria, one of the most underfunded humanitarian crises, 80% of people injured by explosive weapons show signs of high psychological distress,[140] and MHPSS needs[141] among the population have reached an alarming level. In Gaza, virtually all of the estimated 1.2 million children are in need of MHPSS,[142] and the war has magnified an existing and severe mental health crisis.[143]

Despite the prevalence of mental health needs in EWIPA contexts,[144] MHPSS is insufficiently prioritised and under-resourced, including in the acute stage of the response. This is primarily due to a lack of funding that forces humanitarian agencies to prioritise lifesaving interventions over other essential programmes, even when those health interventions are not provided by the state.[145] In Ukraine, more than 10 million Ukrainians have been in need of psychological support since the start of the conflict.[146]

MHPSS is also commonly delivered separately from emergency responses and is often not considered a cross-cutting priority or integrated within different sectoral components. Most importantly, MHPSS programming largely fails to cater for and target the specific needs of different populations groups, including persons with disabilities, and groups with intersecting factors of vulnerability, who are therefore at a heightened risk of experiencing mental health conditions.[147]

[140] Humanity & Inclusion (2016) Syria, a mutilated future.
[141] OCHA (2024) Syrian Arab Republic: 2024 Humanitarian Needs Overview.
[142] UNICEF (2024) Humanitarian Action for Children 2024 - State of Palestine, Revision 3 (June 2024).
[143] ACAPS (2024) Palestine - Impact of the conflict on mental health and psychosocial support needs in Gaza.
[144] Médecins Sans Frontières (2024) Gaza's survivors face the mental challenge of ongoing acute stress.
[145] Médecins du Monde (2024) Syria: Médecins du Monde & Mehad call for urgent action to prevent funding cuts from halting essential health programmes in Syria.
[146] Humanity & Inclusion (2024) Two years on, Ukraine's health crisis is worsening.
[147] UNICEF (2024) Humanitarian Action for Children 2024 - State of Palestine, Revision 3 (June 2024).

The lack of investment and focus on MHPSS is all the more detrimental due to health systems' inability and incapacity to cope with the exponential mental health needs that arise in EWIPA contexts. Very often, governments had not prioritised mental health prior to the conflict, and therefore disruption of services, including through shortages of mental health professionals and destruction of infrastructure, has a catastrophic impact on MHPSS.

- The impacts of the use of EWIPA on health workers' ability to deliver health services are not reflected in policy and practice

Efforts to reduce the security risks[148] and mental health challenges experienced by health workers in EWIPA contexts; especially local health professionals and volunteers, and those who fall outside the humanitarian response, are largely missing from the response.

> *"Mitigating measures for the protection of health workers need to be funded, which is, however, not often accepted by donors." (HI Workshop participant)*

The number of national health workers killed in EWIPA contexts has reached unprecedented levels but efforts to increase health workers' security and support their mental health needs remain largely unacknowledged by donor governments[149] and poorly addressed by international organisations. The "double standard" between international and local staff in terms of security-related support, including practical measures and funding to better protect themselves and their working environments,[150] often stems from donors' reluctance to fund security costs (which they often consider as overheads, and therefore have no dedicated budget lines).[151]

> *"NGOs took a while (2017) to fund sandbags as awards don't include construction. There is generally a lack of protective and logistical components to funding and programming." (Dr Hamza al-Kateab , Action for Sama, Syria, KII, August 2024)*

> *"I have a family. I am working in unsafe circumstances. My colleagues and I are being targeted to destroy the health systems. I'm a refugee now, I'm displaced, so I left my home, I need to take care of my family, I need to stand in a queue for water, to search for food, or for different things, just to provide my family with the minimum living conditions that they require every day in this situation. Also, we lack money, specifically cash, we don't have cash. If things are available in the market, it's very expensive for us, we cannot afford them." (KII, Gaza, September 2024)*

- Surveys and clearance activities are significantly underfunded as donors prioritise trauma and emergency needs, disregarding the significant and harmful consequences of UXO on populations and health workers.

Funding for the mine action sector is chronically under-resourced and subject to significant fluctuations between years.[152] For example, there was a substantial increase in funding with 20% of the funding allocated to Ukraine. Donor fatigue and funding cuts are also severely impacting support for mine clearance. In Syria, activities have had to stop or be reduced due to underfunding and the deprioritisation of demining activities by donors.[153] Similarly to other healthcare-related sectors that are critical in EWIPA contexts, international organisations have to adjust their activities and priority areas, with some needs deemed less essential.

[148] Humanity & Inclusion, Action Against Hunger and Médecins du Monde (2023) '"The risks we face are beyond human comprehension"': Advancing the protection of humanitarian and health workers.
[149] European Interagency Security Forum (2013) The Cost of Security Risk Management for NGOs.
[150] Action contre la Faim, Federation Handicap International – Humanity & Inclusion and Médecins du Monde (2023) The risks we face are beyond human comprehension: Advancing the protection of humanitarian and health workers.
[151] Ibid.
[152] Geneva International Centre for Humanitarian Demining (2024) Innovative Finance for Mine Action: Needs and Potential Solutions.
[153] Humanity & Inclusion (2022) Explosive ordnance in Syria: impact and required action.

Humanitarian responses lack an inclusive and intersectional approach, leaving behind the people with the greatest health needs

In spite of multiple commitments to "leave no one behind" and recognition amongst humanitarian actors that conflicts impact diverse population groups differently, action on the ground largely fails to apply an inclusive lens and intersectional approach to the planning and delivery of programmes. Women, men, and children are often considered in humanitarian responses as single cohorts and homogenous groups; in turn this renders invisible the experiences and needs of people with specific needs and those with intersecting vulnerability factors who face more barriers accessing healthcare.

> *"The current system does not include or provide for women with disabilities. Health and protection clusters provide for everybody but they don't take into account the specific needs of specific groups of people, let alone women with disabilities." (KII, Gaza, September 2024)*

> *"The services provided are not disability-inclusive." (KII, Gaza, September 2024)*

> *"Persons with disabilities are not on the agenda or priorities of services." (KII, Gaza, September 2024)*

The lack of an inclusive and intersectional approach has a significant impact on specific groups' ability to access healthcare for non-EWIPA specific conditions. EWIPA-related traumatic injuries conceal a largely hidden emergency of non-communicable diseases (NCD) and other health needs, including disabilities that are not being addressed in humanitarian action.[154] This is often because they are not routinely considered for inclusion in Humanitarian Response Plans and flash appeals.

> *"Older people are systematically neglected in the humanitarian programming cycle." (Dr Favila Escobio, HelpAge International, Global, KII, October 2024)*

> *"Healthcare access needs to be thought of holistically – e.g. providing a ramp is not enough – protection elements are needed. Protection should be part of healthcare funding." (Dr Hamza al-Kateab, Action for Sama, Syria, KII, August 2024)*

Humanitarian responses in EWIPA settings largely focus on traumatic injuries, which severely limits the implementation of continuous and comprehensive NCD care, with older persons and persons with disabilities (in their diversity), disproportionately affected.

> *"All NGOs focus on trauma cases in those settings." (Dr Hamza al-Kateab, Action for Sama, Syria, KII, August 2024)*

In Ukraine, 50% of older people have no access to essential health services,[155] which exposes them to life-threatening complications. Persons with disabilities also fall through the cracks and often do not have access to humanitarian aid, including financial assistance for medical and transport costs, because they are not included or they lack access to adapted information or services.

> *"I have to take medicines for high blood pressure and diabetes, but I could not take them as I didn't have any, and my health deteriorated to the point that I was very weak (...) My 70-year-old mother's health also deteriorated. She suffers from a heart condition and high blood pressure. She started suffering from a constant headache. In 2023, she was admitted to a neurological clinic which had been repaired. Eight days after she started treatment, the clinic*

[154] World Health Organization (2024) Inclusion of noncommunicable disease care in response to humanitarian emergencies will help save more lives.
[155] HelpAge International (2024) Ukraine: Older People unable to afford food, medicines, other essentials.

received an influx of wounded soldiers and all civilians were taken out of the hospital, because all places were occupied, and there was not enough space in the corridors to treat them." (Olha Lieshukova, Survivor advocate, Ukraine, KII, October 2024)

Older persons, women and children with disabilities are also more likely to be left out of humanitarian programmes due to the disconnect and lack of coordination between organisations whose programmes focus on specific groups and agencies delivering services for persons with disabilities.[156]

"There is no permanent follow-up for persons with disabilities and people with NCDs." (KII, Gaza, September 2024)

"We held a workshop with various clusters, and the protection cluster said they were interested in including persons with disabilities" (KII, NWS, September 2024)

Funding allocation does not reflect the role of local and national organisations providing healthcare services

Local and national organisations, including women-led and women's rights organisations (WLOs/WROs), as well as disability organisations, are the first and primary responders in emergencies. They provide lifesaving and essential healthcare and other services to affected populations. They also serve groups that are out of reach and/or often excluded from or not prioritised enough in humanitarian action. In many cases, they have been operating for years, if not decades, supporting the needs of populations including women and girls, and persons with disabilities.[157] They also know about communities' needs and requirements, and have a long-standing relationship with them.

In EWIPA contexts, those organisations operate under extreme circumstances with depleted human and financial resources and damaged infrastructure, with staff and volunteers exposing themselves to daily harm in order to provide health services, while facing the harsh realities of conflict, such as multiple displacements and losing family members and friends.

However, funding and support to those organisations remains woefully inadequate. Donors' requirements further impair their ability to access international financing. In Gaza, just 0.09% of funding to the 2023 Flash Appeal has directly been allocated to national or local women's rights organisations,[158] and in Ukraine, (as of March 2024) only 0.07% of total funding has gone directly to Ukrainian organisations.[159] In Sudan, Emergency Response Rooms (ERRs)[160] – volunteer-run initiatives - which have been delivering medical services to communities out of reach for international agencies, are overstretched, underfunded and lack resources.[161] Although some INGOs are supporting them, progress remains slow in scaling up funding, especially due to UN agencies' lack of flexibility in their funding, and bureaucratic funding requirements.[162]

Local and national organisations in EWIPA settings are also facing funding cuts and aid diversion from donors, and the interruption of international funding for health projects. In Gaza, the conflict

[156] HelpAge International (2018) Missing millions: *How older people with disabilities are excluded from humanitarian response.*
[157] Stars of Hope Society (2024) A War without Human Rights Cutting off All Means of Survival: Organizations Working in the Field of Disability in Light of the Genocide.
[158] UN Women (2024) Gender alert: The gendered impact of the crisis in Gaza.
[159] Refugees International (2024) New Study Shows Local Organizations in Ukraine Significantly More Cost-Efficient than International Organizations.
[160] Shabaka (2023) Sudan's Emergency Response Rooms.
[161] Humanitarian Outcomes (2023) Humanitarian Access SCORE Report: Sudan - Survey on the Coverage, Operational Reach, and Effectiveness of Humanitarian Aid.
[162] DAWN (2024) Grassroots Aid Networks Are a Lifeline Amid Sudan's Humanitarian Catastrophe.

has shifted donors' attention to providing emergency programmes to the detriment of other initiatives benefiting communities most at risk of being left out of health, protection and social protection services.[163] The implications of funding shortfalls and lack of support are catastrophic in EWIPA contexts, when health and other humanitarian needs are staggering and international organisations are often not able to access and reach affected populations.

Local and national organisations, such as WLOs/WROs, organisations of persons with disabilities,[164] and disability organisations, are often excluded from or not able to participate meaningfully in broader (and internationally-led) humanitarian coordination efforts, including emergency response planning and delivery. This often results in the exclusion and/or poor targeting of groups whose health is most at risk and most impacted in EWIPA settings.

Poor collaboration and sharing, and the lack of an inclusive approach undermine data collection and use

> *"Donors need to plan their humanitarian and medical response accordingly. Protection and documentation are needed. Donors need to invest in protection and the military needs to see how healthcare facilities can be protected; data is crucial." (HI Workshop participant)*

The importance of data collection on the impacts of the use of explosive weapons on civilians is expressly acknowledged in the Political Declaration. It urges states to prioritise gathering and sharing disaggregated data on civilian casualties and damage to civilian objects caused by explosive weapons. Data collection should therefore extend beyond counting the number of people killed and injured by explosive weapons, and document the reverberating effects of EWIPA on essential systems, such as healthcare.

The sheer number of and increase in attacks on healthcare using explosive weapons in populated areas is recorded and documented through several data-collection systems and tools that use different approaches, such as "incidents-based approaches" (e.g. Safeguarding Health in Conflict Coalition & Insecurity Insight; World Health Organization's SSA) and "impact-based approaches" that focus on qualitative types of data and largely rely on field research. Other methodologies encompass statistical estimates and digital investigations.[165]

However, several gaps and challenges in data collection limit understanding of the direct and indirect impact of EWIPA on civilians' health needs. They include insufficient collaborative and coordinated efforts,[166] the lack of engagement of state actors and health workers, the lack of participation of affected groups and organisations that serve them, and the absence of synergies between initiatives. The lack of collective and aligned efforts also prevents data collection gaps being filled, including quality, disaggregation, geographical coverage, and scope.[167] For example, even data on the direct effects of the use of explosive weapons (injury and death) on children,[168] women, and persons with disabilities are not (or insufficiently) collected, and virtually non-existent for sub-population groups. Additional gaps include limited data on the rehabilitation needs of

[163] Palestinian NGO Network (2024) Initial Rapid Assessment of CSOs in The Gaza Strip.
[164] Humanitarian Practice Network (2024) Is the localisation agenda working for women-led organisations?
[165] UN Institute for Disarmament and Research and Explosive Weapons Monitor (2024) Working paper: Strengthening the collection of data on the indirect or reverberating effects of the use of explosive weapons in populated areas.
[166] Ibid.
[167] International Peace Institute (2022) Strengthening Data to Protect Healthcare in Conflict Zones
[168] Watchlist on Children and Armed Conflict (2024) Explosive Weapons and the Children and Armed Conflict Agenda.

EWIPA injured patients, the long-term impact of EWIPA injuries on functioning, and the absence of standardised reporting on paediatric traumatic injuries caused by explosive weapons.[169]

Multi-stakeholder and cross-sectoral political, diplomatic and advocacy efforts are insufficient

> *"There are examples that show that the military can make a choice to mitigate harm to civilians; it is a choice." (HI Workshop participant)*

The adoption and endorsement of the EWIPA Declaration by 87 states to date has been a critical milestone in advancing the EWIPA agenda. The Declaration is the first tool to foster concrete and tangible actions towards better protecting civilians, including through strengthening their access to healthcare, and provides strategic opportunities to advance and foster a far-reaching and multi-faceted issue.

However, advocacy and political efforts on EWIPA remain largely driven by the disarmament, defence/military and mine clearance sectors, with little engagement of a wider range of relevant areas including health, children, women, and older people's rights. They are also poorly connected to intertwined agendas and initiatives and processes, including the Children and Armed Conflict, and the Women, Peace and Security agendas.

The lack of collaboration, coordination and cooperation among signatory states to foster lesson learning, exchange of good practice, and individual and collective advocacy on responses to attacks on health systems, is also severely impeding the creation of strong, decisive and influential country-led political leadership.

> *"NATO member states signed the EWIPA Declaration because they wanted to show themselves to be militarily responsible compared with other nations, but they are mute and silent when it comes to the conduct of their partner nations." (KII, Global, August 2024)*

> *"We need to think about how we use the Declaration, because generally, the states that have signed on are not necessarily the ones that are using them. They should be using their influence on other states that might be using them. And that's where we are seeing a big gap in the current context." (KII, Global, August 2024)*

Lack of coordination internally, with no focal points on EWIPA, also impacts the coherence and depth of engagement on EWIPA beyond the Ministry of Defence.

> *"We all have our coordination challenges internally and externally." (HI Workshop participant)*

The drastic increases in EWIPA attacks against health systems have also raised questions about the relevance and effectiveness of existing humanitarian civil-military mechanisms and arrangements, including notification systems, humanitarian corridors, evacuations, humanitarian ceasefires, among others, especially when IHL is being ignored by parties to the conflict, including by state and non-state actors.[170] The unprecedented and relentless attacks on health facilities and civilians trying to access healthcare have also highlighted the need for increased – and adapted - humanitarian diplomacy, in particular greater consideration of how humanitarian actors engage

[169] Wild H, Reavley P, Mayhew E, Ameh EA, Celikkaya ME, Stewart B. (2022) [Strengthening the emergency health response to children wounded by explosive weapons in conflict](#).

[170] Handicap International (2024): Towards the implementation of the Political Declaration, REPORT – Online Workshop – 30 May 2024: How Can the Political Declaration on Explosive Weapons in Populated Areas Promote Safe and Principled Humanitarian Access?

with conflict parties, and what narrative is needed to convince, and stronger emphasis on coordination between humanitarians and diplomats to effect change in military policy and practice.

> *"The message is not reaching the people it should be reaching (...) Political leaders decide, not the military." (HI Workshop participant)*

3. Conclusion

The challenges and gaps in accessing and delivering health treatment in EWIPA settings are many and complex. However, opportunities and concrete solutions do exist, and we need to use them, starting with promoting good practice and practical measures that are being implemented in affected areas, fostering collective and cross-sectoral responses, exploring synergies and collaboration with other processes and initiatives, and encouraging promising examples and political leadership from countries.

Section 2: Practical Adaptation and Mitigation Measures, Policies, and Opportunities to Strengthen Access to Healthcare in EWIPA Settings

In this section, we consider different types of practical and policy measures, tools and approaches adopted by various actors, including health workers, to deliver healthcare and strengthen health systems, increase patient access to emergency care, and improve medical interventions that meet the needs of civilians. We also explore strategic opportunities to foster the implementation of the Political Declaration's commitments on victim assistance in the context of healthcare access.

1. Practical measures and adaptation strategies in affected areas

Protection of health facilities

Health workers delivering health services in EWIPA settings have had to adapt their ways of working and use practical measures to be able to continue working.[171] These include:

- Establishing medical facilities in unconventional places, such as homes, cellars, and places of worship.
- Dividing hospitals into smaller sites and distributing health services across several locations. This has sometimes resulted in reduced or no access for affected populations due to the distance.
- Retrofitting and reinforcing (with concrete, sandbags and other construction materials where available) existing buildings, which are too large/well-known, making them difficult to conceal.
- Abandoning the upper levels of buildings and relocating services, such as intensive care units, into lower and basement levels; and rehabilitating empty buildings.

Good practice: Adapting protection and mitigation measures in Syria[172]

Protection and mitigation measures were introduced soon after 2010, when violence with heavy weapons and other attacks on healthcare services began in NWS, and were regularly adapted as the weapons used changed and there was greater access to the internet. Private and public hospitals were the main focus of protection and mitigation measures. The measures adopted evolved and changed with the type of explosive weapons used, demonstrating the critical importance of flexibility and adaptability in EWIPA settings.

In 2010, health facilities restricted the use of space, for example only using the ground floor in a five-floor hospital to absorb the damage from explosive weapons and provide extra layers of

[171] Examples collected through KIIs.

[172] Case studies based on examples of good practice featured in WHO (2023) Prevention and protection against attacks on health care: good practices.

protection. Glass windows were replaced with plastic, and wooden doors with aluminium. False ceilings were also removed as they collapsed easily, and plastic sheets were painted black to avoid light being reflected outside the building at night, which was when most attacks occurred. In 2013, when barrel bombs were used and whole buildings were destroyed, medical services were moved underground, and patients and staff were relocated to another facility that had been pre-identified. In 2014, fortified underground hospitals were designed to improve protection for patients and health workers. They were located away from communities, leaving medical vehicles more exposed to danger. Some vehicles were hand-painted black and stripped of their lights to make them less visible. Cameras held up at the front served as guidance systems. When more elaborate weapons were used, the switch was made towards a "quasi-mobile approach" with small structures in high-risk areas that reduced the evacuation time when a health facility came under threat. Risk analyses and assessments were required and undertaken constantly, and protection and mitigation measures were reassessed.

Given the interdependence of health and power infrastructure, and the vulnerability of generators to attacks, these were kept as far away as possible from a hospital or health building, along with fuel and medical stocks. Ambulances were also kept at a distance, in a separate area. Larger warehouses were located further away, near the Turkish border, with variable distribution rhythms.

Key lessons learned were:

-The measures were necessary and vital for staff and patient survival and for the continuation of healthcare services.
-The importance of linking up with partners before relocating and ensuring interorganizational referral systems and resourcing back-up are set up.
-The impact on protection of staff and patients was variable but largely positive.
-The system was high maintenance but necessary in the context. Its efficiency and effectiveness varied.
-The basic concept of introducing protection measures should be replicated but adapted to the context.

Increase healthcare access and reduce EWIPA-related deaths

Several initiatives have also been set up in order to strengthen healthcare access in emergency contexts. Although not specifically designed for EWIPA settings, a number of projects are relevant and have been implemented in such settings.

The **Emergency Medical Teams (EMT) initiative** is led by WHO and launched in 2013. Its aim is to improve the timeliness and quality of health services provided by deploying highly-trained multidisciplinary teams, including rehabilitation and mental health specialists, to human-made and natural crises. EMTs provide teaching and training, in the form of capacity-building and technical direction, alongside hands-on support to WHO and humanitarian actors. EMTs are requested and coordinated by the respective government of the affected country. Coordination with national EMTs, relevant ministries and international organisations is done through a National Focal Point designated by the Ministry of Health. EMTs have intervened in several EWIPA contexts, including currently in Gaza. As of 15 September 2024, there were 15 emergency medical teams (EMTs) supporting the local healthcare workforce, including three in northern Gaza. So far in 2024, 37 EMTs have provided over 1.4 million medical consultations, performed 29,230 surgeries and treated 56,500 patients with noncommunicable diseases. Six field hospitals have been established by health partners and 500 additional beds provided to compensate for the dramatic reduction in hospital bed capacity.[173]

[173] OCHA (2024) Gaza Humanitarian Response Update | 2-15 September 2024.

First responder training has also been delivered to increase timely access to emergency care by targeting community members. **WHO Community First Aid Responder Training** equips community members with the knowledge and skills to provide lifesaving care, connect patients with the healthcare system, and reduce preventable deaths. In Iraq, the training was recently scaled up to a community first aid responders training of trainers programme, cascading training to community first responders across the country.[174] Although not specifically designed for EWIPA contexts, the training can help provide immediate treatment for traumatic injuries when it may take patients hours to reach the nearest health facility. The training is integrated with mine action activities with communities as part of explosive ordnance risk education and may reduce UXO deaths,[175] an opportunity being explored by the Mines Advisory Group (MAG). In Burkina Faso, MAG is piloting, in partnership with local health actors, a Layperson First Responder Training of Trainers to improve lifesaving care close to the point of injury for explosive weapon casualties.[176]

Mobile clinics have been an essential component of healthcare delivery and have become an integral part of healthcare systems. Although they are not able to meet all health needs, and traditionally have primarily focused on preventative interventions,[177] mobile clinics have been critical in providing a wide range of integrated health services in EWIPA contexts. Some interventions, such as the provision of prosthetic limbs (Gaza),[178] MHPSS, and cash assistance (Ukraine) have also been included.

> *"We have integrated cash assistance as part of our social protection support provided by mobile teams, so if someone needs an orthopaedic device or a special orthopaedic mattress because of their disability, they can pay for it." (Mental health service provider, Ukraine, KII, September 2024)*

> *"When we run the mobile clinics, the numbers have been much higher than we would probably expect. We do surveys and speak with patients and the feedback we often get from them is that if the services had not come to them, they would not have come to us." (KII, August 2024)*

In NWS, acute shortages in health services have contributed to the spread of mobile clinics delivering primary care to displaced and affected populations. In Idlib, the Health Directorate launched a mobile clinics project supported by NGO partners, which dispatches ambulances with medical staff (a doctor, midwife, nurse, pharmacist and community worker) and the necessary equipment to provide medical services. For women[179] and children, mobile clinics have been a lifeline in contexts where traumatic injuries are overwhelming existing health services and insecurity deters people from travelling.

Mobile medical points have also been an important strategy to maintain some level of healthcare access for EWIPA-affected communities. In some contexts, such as Gaza, mobile medical points have been set up by communities themselves, with civilians turning their shops or tents into medical points, and community members with medical training providing services.[180]

Most recently, and in the context of the war in Sudan, WHO collaborated with the Federal Ministry of Health and the Ministry of Social Development to deliver a training course on rehabilitation to

[174] WHO (2023) WHO enhances community first aid responders training programme.
[175] Hannah Wilde (2024) Bringing Victim Assistance Closer to the Point of Injury. Reducing preventable death and impairment among civilian casualties of explosive weapons.
[176] International Blast Injury Research Network. Operations.
[177] CARE (2024) GAZA CARE Mobile Health Teams To Provide Care For Pregnant Women And Vulnerable Families In Gaza.
[178] Africanews (2024) Jordan sets up mobile clinics in Gaza to aid amputees.
[179] UNFPA (2024) "They are like family": Mobile health workers care for women and girls uprooted by conflict.
[180] Xinhua (2024) Gazans establish mobile clinics to provide health services for displaced.

health workers.[181] It was the first of its kind to be delivered in the region and took place in May 2024 in Port Sudan. The training included practical sessions on prioritising patients, clinical scenarios, and an in-depth overview of managing complex health conditions, such as burns and spinal cord injuries. Participants also took part in a simulation exercise on managing a surge of injured persons needing early acute rehabilitation at a hospital. Following the training, participants and local stakeholders developed a roadmap and action plan to scale up essential rehabilitation services during the conflict. The training model is expected to be rolled out across the Eastern Mediterranean region in conflict-affected settings.

Engaging communities to inform a needs-based health response

Community engagement initiatives delivered in EWIPA contexts have also contributed to providing more adapted and targeted healthcare services and increasing patients' access to information. They have also bolstered data collection that reflects communities' lived realities and adapts/better responds to their contexts.

Risk Communication and Community Engagement (RCCE) has been used to inform health priorities and reflect communities' needs in the response by directly involving them in the planning and implementation of health responses. RCCE has also been implemented to reduce the risk of EWIPA-related harm, support communities in caring for their members, and increase community acceptance. In Ukraine, RCCE has been used to connect affected civilians to healthcare providers.[182] It has been essential in targeting people with health information and advice, for example, recognising signs of sepsis so that medical mobile teams could evacuate those patients first, and how to access antenatal care for women. RCCE has also been important in terms of delivering adapted and targeted health advice, as telecommunications have been damaged by the conflict, making access to online medical services more challenging. In Gaza, UK-Med has 11 trained community mobilisers who bridge the communication gap between affected communities and healthcare providers. The community mobilisers collect and address weekly feedback, ensuring that the voices of community members are heard, and their concerns addressed in health programming. RCCE has also been key in ensuring that displaced civilians are informed about services that are available to them: this is one of the key healthcare access challenges across EWIPA contexts.

> *"Community engagement in those environments where you have blast injuries, as there is a lot of confusion and people are displaced so many times. RCCE can help with reuniting families and reduce trauma." (KII, October 2024)*

In Gaza, UK-Med is piloting Nurturing Assistance for Families Amidst Strife (NAFAS), an innovative MHPSS using a participatory approach. NAFAS aims to implement a holistic, Community-Based Participatory Research (CBPR) approach to non-specialised MHPSS. This approach involves meaningful community engagement in planning, execution, and evaluation to ensure interventions are culturally sensitive and based on the community's needs. It relies on the socio-ecological model, targeting the community and family levels, and seeks to mitigate psychological trauma and promote psychosocial wellbeing among children and families affected by the conflict. The early findings from the pilots show that community participatory approaches in designing non-specialised MHPSS interventions are crucial, especially in acute emergencies like Gaza. These approaches ensure culturally-relevant, sustainable, and effective interventions, and have a vital role in humanitarian response strategies. As community leadership is harnessed, they

[181] WHO (2024) Sudan: WHO trains health workers on rehabilitation in conflict.
[182] WHO (2024) Risk communication, community engagement and infodemic management in humanitarian emergencies: lessons from the Ukraine war.

foster resilience and promote long-term psychosocial, family and community functioning and wellbeing, highlighting their vital role in humanitarian response strategies.

2. Guidance, tools and initiatives to address the specific health impacts of the use of explosive weapons.

Guidance and several tools have been developed to strengthen the delivery of healthcare and victim assistance more broadly in emergency contexts, including where explosive weapons are being used.

WHO's "Red Book"[183] provides guidance for EMTs responding to health emergencies in armed conflicts and other insecure environments. The guidance includes security management for medical teams and covers a wide range of health needs that they should be able to manage, including trauma care, MHPSS and rehabilitation. Humanity & Inclusion has also worked with the EMT Initiative to expand the Minimum Technical Standards and Recommendations for Rehabilitation, ensuring that all deployed organisations consider early rehabilitation and continuity of care as part of their response.[184]

The **Paediatric Blast Injury Field Manual**[185] was published in 2019 in order to improve blast-related care for children. The manual provides technical guidance for first responders, doctors, surgeons and health workers providing aftercare for children affected by blast injuries. The Field Manual has paediatric-specific sections on pre-hospital care and transport; damage control, resuscitation, surgery and intensive care; surgery (thoracic-abdominal, limb, burns); neurological injury, rehabilitation, MHPSS, and ethics and safeguarding. Originally written by health workers in Syria, the manual has been distributed to several conflict zones worldwide and is available in eight languages. It is also complemented by an interactive online course.

Some of the doctors we spoke to also highlighted that they had developed **treatment and care guidance** that they shared with doctors and medical workers.

> *"We are producing a document for doctors listing what we call minimum symptoms to diagnose the 10 most common epidemics that might happen. We are sending it to the doctors. We have also developed a manual of medications, including minimum medications available, the use of those medications, when to prescribe medication, when to avoid prescribing medications (...) I'm not saying that we are achieving best practice, but we are trying to improve ourselves all the time, and we are responding according to the situations that we are facing from time to time." (KII, Gaza, September 2024)*

Guidance: *Joint Operational Framework – Health and Protection*

Although not specifically targeted at EWIPA settings, the 2023 Joint Operational Framework – Health and Protection[186] "provides guidance and examples of good practice to address clusters' siloed ways of working and mutually inform and support health and protection actors across the six core functions of cluster and cross-sectoral coordination". It recommends practical ways of strengthening health and protection cluster coordination, including through engaging the health sector in protection analysis (and vice versa), and aligned indicators between Health and Protection clusters to harmonise monitoring and reporting of joint programming. It also recommends joint

[183] World Health Organization (2021) A guidance document for medical teams responding to health emergencies in armed conflicts and other insecure environments.
[184] Humanity & Inclusion. Rehabilitation in emergencies.
[185] Imperial College London and Save the Children (2019) The Paediatric Blast Injury Field Manual.
[186] Health Cluster and Global Protection Cluster (2023) Joint Operational Framework – Health and Protection.

monitoring of attacks on civilians and civilian infrastructure, including healthcare and health workers, with the support of the Office for the Coordination of Humanitarian Affairs (OCHA), WHO, and the Humanitarian Coordination Team (HCT). This would strengthen the evidence base used to identify global and context-specific trends and patterns of violence, and would support advocacy on civilian protection. The Framework also highlights several promising examples of good practice from EWIPA contexts that should be considered and whose progress and impacts should be monitored, with a view to adapting and/or replicating in other EWIPA settings.

In Syria, the Mine Action sub-sector collaborated with the Physical Rehabilitation and Disability Working Group and Child Protection Area of Responsibility (AoR) to set up a Victim Assistance Working Group to coordinate actors working in protection, health, livelihoods and education, and improve access to services, such as health interventions for persons with disabilities, including survivors of explosive ordnance. Over 250 services in 13 governorates were identified and a service mapping dashboard developed. The searchable dashboard includes details of relevant service providers, such as their location and type of service provided, and specifically covers services targeted at people with disabilities, including needs assessment, physical rehabilitation, assistive devices for hearing or visual impairment, psychiatric services, prostheses, occupational therapy, and speech therapy. It also complements the Protection Resource Matrix and other sectoral mapping, such as GBV and Child Protection services, and represents the primary source of information at cluster level on disability-inclusive services available across all sectors.

In Ukraine, the Protection Cluster is working with the Trauma & Rehabilitation Working Group and the MHPSS Working Group (both within the Health Cluster) on guidance on how to develop a joint referral network for specific vulnerable groups, such as children and adults with disabilities, for mental health conditions, chronic disease or injuries and other health needs.

In Ukraine, the United Nations Development Programme (UNDP) has introduced a new **Model of Victim Assistance**.[187] The model is aligned with International Mine Action Standard (IMAS) 13.10 and fosters collaboration among national and local authorities, international partners and civil society, and is designed to provide comprehensive support, including urgent and longer-term medical care, rehabilitation, provision, maintenance, and repair services for prosthetics, psychological support, and socioeconomic integration for those impacted by mines, explosive remnants of war, and unexploded ordnance.

Partnerships and other collaborative initiatives on healthcare in the context of explosive weapons have emerged. For instance, the **Explosive Weapons Trauma Care Collective (EXTRACCT)** is a multisectoral initiative established to improve care for injured civilians in settings impacted by explosive weapons through research, fieldwork, and evidence-based advocacy. It aims to minimise preventable death and disability among civilian casualties of explosive weapons, by enhancing coordination between humanitarian mine action and health actors in conflict settings. The initiative is pioneering an adaptation of the WHO's Community First Aid Responder Training programme through a training-of-trainers (ToT) approach to build trauma care capacity in contexts affected by explosive threats. EXTRACCT also supports activities under the Chain of Civilian Casualty Care (C-CCC), an integrated set of practices to improve trauma care for civilian explosive weapon casualties through enhanced humanitarian mine actor engagement.

[187] UNDP (2023) UNDP introduces new model to support victims of explosive ordnance.

3. State Policy, Practice and Engagement

Some state-led diplomatic efforts on mitigating and responding to civilian harm have been emerging and provide important steps towards increasing the protection of healthcare in EWIPA settings.

The US Civilian Harm Mitigation and Response Action Plan (2022)[188] – published in the context of the Political Declaration - and the US Department of Defense Instruction on Civilian Harm Mitigation and Response (CHMR) (2023),[189] have set out the US's commitments towards improving its CHMR approach and have served as blueprints for other countries to review their own approaches.

As part of the implementation of these policies, the Defense Department has established the Civilian Protection Center of Excellence to serve as the Department's hub for analysis, learning, and training related to CHMR, and to facilitate the institutionalisation of good practices across the force. It has also created a new stand-alone Directorate for Civilian Harm Mitigation and Response Policy to provide policy guidance and oversight for CHMR issues relevant to the joint force and to address a wide range of CHMR issues related to the Defense Department's work.

The Netherlands has created an internal task force focused on civilian protection and conducted a baseline study into current CHMR mechanisms in the Dutch military with a view to identifying best practice, areas for improvement and recommendations. Brazil has established a national commission for the dissemination of IHL and the development of new policies and national action plans.

The US, alongside other states, has also started to incorporate a definition of civilian harm that goes beyond civilian casualties, and instead includes the reverberating effects of military action.[190]

Box 4. Bridging the gap between guidance and practical implementation

Guidance, examples of good practice and other handbooks have been published and provide comprehensive practical measures and recommendations on mitigating and reducing the impacts of the use of EWIPA on essential services, including healthcare. They include: ICRC's 2020 *Protecting healthcare: Guidance for the Armed Forces*; ICRC's 2021 *Reducing Civilian Harm in Urban Warfare: A Commander's Handbook*; *ICRC's 2023 handbook*[191] *for armed groups to reduce civilian harm in urban warfare*; ICRC's 2024 *Expert Meeting report: Preventing and Mitigating the Indirect Effects on Essential Services from the Use of Explosive Weapons in Populated Areas*, and OCHA's 2017 *Compilation of military policy and practice to reduce the humanitarian impact of the use of explosive weapons in populated areas.*

However, the current state of play highlights the gap between guidance and knowledge, advice and recommendations, and actual practice in affected areas. There are opportunities to bolster both efforts and discussions on practical ways to mitigate and reduce the impacts of EWIPA use on healthcare, and the exchange of good practice. This should start with strengthening armed actors' understanding of the indirect impacts of EWIPA use on healthcare, and exploring ways of

[188] United States Department of Defense (2022) Civilian Harm Mitigation and Response Action Plan
[189] United States Department of Defense (2023) Instruction on Civilian Harm Mitigation and Response
[190] OpinioJuris (2024) Policy Recommendations to Meaningfully Mitigate Civilian Harm in Military Operations: A View from the Netherlands (Part I).
[191] ICRC (2023) Reducing Civilian Harm in Urban Warfare: A Handbook for Armed Groups.

fostering dialogue, exchange of good practice, and sharing challenges, lessons and successful practical measures. For example, an International Contact Group[192] on Civilian Harm Mitigation and Response comprising over a dozen countries meets at least twice a year under the auspices of the US, and can provide a forum to promote exchange of good practices and practical ways to strengthen the normative and practical implementation of healthcare protection in EWIPA settings.

Similarly, the Political Declaration's international review meetings and regional and national-level implementation workshops can also foster greater communication and collaboration between signatory states, and drive collective efforts. More needs to be done to engage with ANSAs, including as part of the implementation of the Political Declaration. Geneva Call's track record of engagement and constructive dialogue with ANSAs on explosive weapons[193] provides an opportunity to build on existing positive developments.

4. Advocacy

Advocacy efforts on protecting healthcare facilities and health workers in EWIPA contexts have been driven by humanitarian organisations, individually and collectively through the International Network on Explosive Weapons (INEW), including through policy dialogue and engagement with states, UN agencies and other relevant actors, collection and dissemination of data, and storytelling by humanitarians, health workers and survivors.

> *"The testimonies of those affected are very important for states' civil servants as they bring the "human" back into the words we are negotiating." (HI Workshop participant)*

The Political Declaration has provided critical impetus for increased advocacy on the issue. The sustained engagement of several countries, such as Ireland and Norway, and of the European Commission, has helped to create spaces for dialogue and lesson exchange, and provide platforms of engagement and action for victims, survivors, humanitarians and health workers. They have successfully done so through events at high-level global processes, such as the United Nations General Assembly, Protection of Civilians Week, and the Global Protection Forum, as well as flagship events in advocacy capitals. The first international follow-up conference on the Political Declaration took place in Oslo in April 2024, and included important discussions on healthcare access challenges.

Box 5. HI workshop on strengthening access to healthcare in EWIPA contexts

HI's November 2024 in-person workshop brought together 40 participants including representatives from signatory states, OCHA, ICRC, I/NGOs, civil society-led coalitions, academia, survivors and health professionals, including rehabilitation specialists. Several sectors were represented, such as defence and disarmament, health, children and armed conflict, persons with disabilities, and humanitarian action more generally. The discussions considered the specific impacts of the use of EWIPA on healthcare access, bringing out the most pressing gaps and challenges, before exploring practical measures, approaches and tools/guidance that can reduce the effects of EWIPA use on health systems and increase the delivery of health services to

[192] US Department of Defense (2024) Readout of International Contact Group Meeting on Civilian Harm Mitigation and Response.
[193] Geneva Call (2017) In Their Words: Six armed non-State actors share their policies and practice with regards to protecting civilians from explosive weapons.

patients in their diversity through a holistic and multi-pronged "Agenda for Action" that can be used to foster the implementation of the Political Declaration's commitments on victim assistance in the specific context of healthcare.

The workshop's focus on multi-stakeholder and cross-sectoral contributions was praised by the participants whose diversity of thought, ideas, experiences, skills and expertise provided invaluable insights and practical recommendations and solutions. The workshop ended with participants sharing what next steps they will be taking as a follow-up to the meeting, and ways they will promote the Agenda for Action on Strengthening Healthcare Access and Delivery in EWIPA Settings in 2025.

"Due to the current erosion and lack of respect for international norms, it is the best way forward to work with a committed group of states, the UN, survivors and campaigners to move things forward." (HI Workshop participant)

"States can build coalitions for joint statements to streamline the political declaration in them." (HI Workshop participant)

Spotlight 5. Key advocacy opportunities

Annual EWIPA Political Declaration Follow-up Conferences

European Humanitarian Forum

Human Rights Council Sessions

Humanitarian Networks and Partnerships Week

World Health Assembly

Protection of Civilians Week

UN General Assembly

High-Level Political Forum

Release of UN Secretary General's Report on Children and Armed Conflict

Anniversaries of EWIPA conflicts

International days: e.g. World Humanitarian Day and World Children's Day

Nevertheless, there are also opportunities to increase collaborative advocacy, strengthen synergies between advocacy agendas and across sectors, and learn from existing and related initiatives, such as the **2015 Safe School Declaration - Global Coalition to Protect Education from Attack (GCPEA)** and the **Children in Armed Conflict (CAAC) agenda**. Other new advocacy campaigns and initiatives such as "**Protect Humanitarians**"[194] also provide potential entry points to link up on the protection of health workers, including the need to focus more on their mental health and security, and speak out about EWIPA attacks on national health workers, including volunteers.

[194] Protect Humanitarians

5. Data

Data is key to ensuring programmes are based on solid and adapted evidence that can inform targeted and strategic interventions. It is also critical in strengthening advocacy (and political) efforts both in-country and globally. There are growing efforts to foster collaboration amongst data collection initiatives, fill data gaps on the direct and indirect effects of EWIPA (including on healthcare), and increase transparency in data dissemination. In 2024, UNIDIR and the Explosive Weapons Monitor organised a multi-stakeholder workshop[195] that explored ways to enhance and harmonise data collection efforts on the indirect effects of EWIPA use, including on healthcare, and produced concrete recommendations. Key steps identified for improving data-related efforts include the need to consider various stakeholders' objectives for data collection; strengthen the engagement of local and national organisations, and foster multi-stakeholder and cross-disciplinary dialogue and collaboration on the collection of data on the effects of EWIPA.

> *"Data and information need to be used in the right way for advocacy. There needs to be an overarching and harmonised database to provide a full picture of the impacts of EWIPA on health systems. Real time data is needed, too." (HI Workshop participant)*

Box 6. Better monitoring and reporting to increase action and accountability

There are opportunities to learn from and link up with related initiatives to strengthen monitoring and reporting of attacks on healthcare in EWIPA settings, including through better data collection and analysis, and greater state-led engagement. By doing so, responses to attacks can be improved and accountability can be fostered.

The **Global Coalition to Protect Education from Attack (GCPEA)**[196] is a coalition that engages in a number of diverse but interconnected initiatives to advocate for stronger protection for education. The Coalition promotes the Safe School Declaration and collects examples of good practice by states in implementing it to protect education from attack in national legislation, policy, and military doctrine, and seeks to mainstream the issue of attacks on education into various relevant agendas to foster greater policy coherence. The GCPEA coordinates the state-led implementation network[197] which is open to countries that have endorsed the declaration. The network provides states with technical assistance. It also acts as a space for countries to learn from each other, and share experiences and good practice. Information on the scope and impacts of attacks on education remains limited or variable across countries and over time. The GCPEA has also produced a toolkit[198] for collecting and analysing data on attacks on education and increasing understanding of the scope and impact of attacks. While the toolkit does not specifically focus on EWIPA, it provides useful guidance that can strengthen monitoring systems and harmonise the terminology used in data collection on EWIPA use against education.

The **UN Monitoring and Reporting Mechanism (MRM)** on grave violations of children's rights in situations of armed conflict was established in 2005 by the Security Council to collect and report

[195] UNIDIR and the Explosive Weapons Monitor (2024) Understanding Civilian Harm from the Indirect or Reverberating Effects of the Use of Explosive Weapons in Populated Areas - Strengthening Data Collection to Implement the Political Declaration
[196] Global Coalition to Protect Education from Attack (GCPEA).
[197] State-led implementation network.
[198] GCPEA (2023) Toolkit for collecting and analyzing data on attacks on education.

data on six different violations.[199] Attacks on hospitals are covered under one of these six categories of grave violations of children's rights. This is potentially a useful tool to leverage greater commitments and action on EWIPA-related harm to children, and more broadly to strengthen linkages with the health sector. For example, WHO, humanitarians and health actors may contribute to the MRM through data collection and verification of EWIPA attacks on health facilities, hospitals, medical vehicles and personnel. As health cluster lead, WHO can also have an important role in strengthening the link between human rights and humanitarian responses in EWIPA contexts, and in strengthening advocacy with health authorities and parties to the conflict.[200] At the global level, the Working Group on Children and Armed Conflict may also convene state-level discussions on attacks on hospitals in EWIPA settings, while the annual UN Secretary General's Report on children and armed conflict provides useful data and information that can be used for advocacy purposes.

[199] UNICEF (2014) GUIDELINES Monitoring and Reporting Mechanism on Grave Violations against Children in Situations of Armed Conflict.

[200] Office of the Special Representative of the Secretary-General for Children and Armed Conflict, UNICEF and United Nations Department of Peacekeeping Operations (2012) Global Good Practices Study: Monitoring and reporting mechanism (MRM) on grave violations against children.

Section 3: Moving Forward: An Agenda For Action

We are currently witnessing some of the worst humanitarian tragedies ever. Despite legal protections, deliberate and indiscriminate EWIPA attacks against civilians, health workers and health systems are increasing, and are at risk of becoming the new reality of urban warfare. In response, we must come together collectively and inclusively to deliver a decisive Agenda for Action that will support the implementation of the humanitarian commitments in the EWIPA Political Declaration. In doing so, we hope to turn the tide against EWIPA attacks on healthcare.

Our Agenda for Action serves as a roadmap that rallies stakeholders and sectors behind a set of concrete solutions and recommendations. It is structured around three objectives and is driven by six Priority Action Areas.

Objectives

- Deliver inclusive, holistic and non-discriminatory healthcare to EWIPA-affected civilians in their diversity
- Mitigate the short, long-term and multiple impacts of EWIPA use on health systems
- Foster the meaningful participation, leadership and empowerment of EWIPA-affected communities and local actors

Priority Action Areas

Priority Action Area 1: Political leadership and humanitarian diplomacy

EWIPA Political Declaration's signatory states to:

- Issue individual and joint statements publicly condemning unlawful EWIPA attacks against healthcare and calling for the protection of health workers and health facilities. This includes considering the adoption of resolutions in multilateral and regional forums, as well as official, including media, statements.
- Within national governments, identify and establish focal points or champions for the implementation of the EWIPA Political Declaration responsible for internal and external coordination.
- Agree and proceed with the creation of a state-led EWIPA Political Declaration implementation network that will also be responsible for strengthening the follow-up process and establishing an implementation and reporting mechanism.
- Seize key opportunities, including at relevant meetings of the UN Security Council and other UN bodies, regional and national forums, to raise understanding and foster action on EWIPA attacks on healthcare access.
- Agree and proceed with the creation of a state-led implementation network.
- Use their political leverage to promote the universalisation of the EWIPA Political Declaration and the number of signatory states.
- Ensure the meaningful participation of national health workers and EWIPA survivors at relevant policy/advocacy events and in strategic political fora.
- Cultivate political champions, including through embassies and membership of high-level groups.

UN agencies to:

- Collectively publish and disseminate public statements condemning EWIPA attacks against healthcare, highlighting the impacts on civilians in their diversity, and expressly including women, children, persons with disabilities and older persons.
- Use their mandate and position to build momentum amongst constituencies of support for the agenda, including donors and governments.

In particular, OCHA to:

- Ensure the explicit inclusion of EWIPA in key advocacy messages and statements in EWIPA settings, and references to states' commitments to the EWIPA Political Declaration.
- Better reflect the impacts of EWIPA use on healthcare access and delivery, and civilians' health needs, both EWIPA-specific (in particular MHPSS and rehabilitation), and non-EWIPA health requirements, in the annual Humanitarian Needs Overview, and Humanitarian Response Plans for countries where EWIPA are being used.
- Specifically include EWIPA use and attacks on healthcare in HCTs' protection strategies, and explicitly explain the unique impacts of EWIPA attacks on humanitarian access and health workers' protection.
- Build Humanitarian Coordination Teams' capacity to speak out about the impacts of EWIPA on healthcare and civilians, and awareness of the Political Declaration as part of its advocacy with humanitarian actors and governments.
- Promote operational and institutional learning within states and their armed forces.

OCHA and ICRC to:

- Leverage their role in humanitarian diplomacy to foster greater action by signatory states and raise the awareness of non-signatory states about the myriad impacts of EWIPA use on healthcare, as well as their awareness of the Political Declaration.

Priority Action Area 2: Funding

UN agencies, donors, and INGOs to:

- Prioritise funding that addresses the specific direct and indirect impacts of EWIPA use on healthcare access and delivery. That includes providing funding for EORE and demining during the emergency phase of the response, and for alternative models of health delivery, such as mobile clinics. It should also cover costs towards increasing the protection and safety of health systems, including health workers. This should be done by integrating protection and safety as part of core costs.
- Provide and increase flexible and unearmarked funding that allows organisations to quickly pivot and adapt health delivery interventions based on the rapidly changing needs of populations. Funding should also be long-term and support the delivery of healthcare for non-EWIPA specific injuries and health needs, and ongoing medical conditions.
- Specifically provide and allocate funding that meets the health needs of women, children, persons with disabilities and older persons, and account for intersecting factors of vulnerability.
- Simplify and harmonise granting and reporting procedures; lightening due diligence processes for small actors, and provide more direct funding to local and national organisations.

Donors to:

- Provide long-term sustainable funding to plan for and provide adequate and predictable health services, in particular chronic care, rehabilitation and MHPSS and rebuilding of health infrastructure and other essential systems that are critical to healthcare delivery.
- Ensure that counter terrorism measures are in line with IHL and IHRL and that risk management measures do not hinder the delivery of healthcare by national and local humanitarian organisations.

INGOs and designated states to:

- Fund research to fill evidence gaps on the effects of EWIPA on healthcare access and delivery challenges.
- Fund a small Coordination Secretariat that is responsible for managing a state-led implementation network and for leading on collective advocacy in support of the EWIPA agenda. The first advocacy priority should be EWIPA attacks on healthcare.

Priority Action Area 3: Humanitarian programme planning, delivery and coordination

Rehabilitation

UN and INGOs to:

- Include rehabilitation as an essential health component of acute-phase responses.
- Ensure appropriate resources for the provision of adapted early and longer-term rehabilitation care within all health programmes, including the provision of assistive products, to respond to the diverse needs of trauma patients (including children and women), and persons with disabilities.
- Plan and deliver gender, age and disability-sensitive and responsive rehabilitation services, including through the provision of assistive devices that are suitable for children and women.
- Improve coordination between trauma care and disability services and facilitate stakeholder mapping to strengthen referral pathways to rehabilitation services.
- Provide cash transfers as part of rehabilitation interventions.

Inclusion and Diversity

UN and INGOs to:

- Incorporate intersectional approaches in needs assessments and community engagement tools (such as community perception surveys) to identify how health interventions can be improved, as well as in Risk Communication and Community Engagement.
- Ensure and prioritise the participation of specific groups including women, children, older persons and persons with disabilities in their diversity in the planning, delivery, and monitoring and evaluation of health service delivery, including rehabilitation and MHPSS.
- Deliver community gender, age and disability-sensitive First Aid Responder Training.
- Prioritise addressing healthcare access challenges (such as the lack of assistive devices to reach a health facility and financial barriers) faced by specific groups of people including women, older persons and persons with disabilities.
- Provide suitable healthcare for non-EWIPA health needs, including maternal healthcare and specific interventions for persons with existing disabilities.
- Ensure information on available medical points/mobile clinics and services is communicated via multiple mediums and a variety of accessible formats. Information about how people can protect themselves and where to get help in case of evacuation also needs to be provided.

- Exchange examples of good practices on intersectional approaches to health planning and programme delivery.

UN and INGOs to:

- Ensure that security and care and mental health support available to international staff is available to national and local health staff.
- Provide local and national partners and health workers with security and mental health support based on their needs and priorities.
- Include in humanitarian coordination mechanisms local and national organisations providing health services to specific groups who are most likely to be invisible in the response, including HCTs, Advocacy Working Groups, and health and protection clusters. Adequate measures should be taken to facilitate their participation including translation and communication support. INGO-led coalitions (e.g. INGO Forum) have a key role to play in advocating for the inclusion of local actors and ensure that their own ways of working do not perpetuate unequitable partnerships.
- Provide needs-based technical and capacity support to local organisations to strengthen their operational capacity and their ability to sustain their services, including those delivered prior to conflict.
- Provide platforms for health workers and survivors to tell their stories and experiences, provide contributions to discussions, and influence the design and implementation of health interventions and explosive ordnance risk education.

Priority Action Area 4: Tools, training, guidance, practical measures

UN and INGOs to:

- Raise awareness of the Joint Operational Framework: Health and Protection among health and protection clusters, partners and coordinators, Areas of Responsibility and relevant working groups, the Inter-Cluster Coordination Group (ICCG), and HCTs operating in EWIPA settings. This could include organising workshops focusing on implementing the Framework in order to identify specific actions in EWIPA settings.
- Ensure the wide dissemination, promotion and accessibility of existing manuals and guidance such as WHO's Red Book and the Paediatric Blast Injury Field Manual, and, in collaboration with national and local health workers and volunteers, develop further practical tools and guidance on addressing the most pressing challenges to healthcare delivery.
- Explore opportunities for online training for health professionals, including national and local staff operating in EWIPA settings.
- Ensure the promotion and dissemination of successful examples of practical mitigation and adaptation measures, including by consolidating and making accessible examples of practical measures successfully implemented in EWIPA settings.
- Scale up and deliver WHO's training of health workers on rehabilitation with special consideration for the specific needs and requirements of women, children, older persons and persons with disabilities.
- Deliver Community First Aid Training in EWIPA settings that are gender, age and disability-sensitive.

Priority Action Area 5: Cross-sectoral and peer-to-peer learning and facilitation of knowledge/good practices

Designated signatory states to:

- Forge/strengthen relationships with states that have spearheaded the state-led implementation network for the Safe School Declaration to explore the potential for a similar model to encourage and monitor implementation of the EWIPA Declaration.
- In line with Priority Action Area 1, following the creation of a state-led implementation network, prioritise attacks against healthcare as the primary and initial focus area.
- Convene a high-level state-led roundtable on signatory states' role in strengthening inclusive healthcare access in EWIPA settings, with a focus on practical steps and sharing of good practices.

UN and signatory states to:

- Organise governmental workshops on the Political Declaration and EWIPA attacks on healthcare across relevant departments to inform civil servants and explore ways to foster cross-sectoral policy and military responses.
- Deliver regional online webinars on healthcare access in EWIPA settings that focus on clear and action-oriented discussions and exchange of good practices.

Interested UN, states, INGOs, NGOs, health professionals, and other relevant actors, including researchers, to:

- Explore setting up a Community of Practice on healthcare delivery in EWIPA settings where diverse sources of information, evidence and research, and opportunities for collaboration can be discussed.

Designated NGOs to:

- Convene meetings with the Global Coalition to Protect Education from Attack Secretariat and Watchlist on Children and Armed Conflict to explore concrete and practical ways of amplifying the healthcare access agenda using a children's rights lens.

Priority Action Area 6: Advocacy and data

UN and INGOs to:

- Use existing country-level and global advocacy fora, mechanisms, and relevant policy processes to increase understanding and awareness of the impacts of EWIPA use on healthcare access and the promotion of key messages, including on the need to include rehabilitation in the acute phase of the responses, and non-EWIPA health requirements. Key fora and opportunities include INGO Forums and HCT's Advocacy Working Groups and country-level and global Health and Protection clusters.
- Mainstream reporting on EWIPA attacks against healthcare into relevant existing humanitarian reporting mechanisms, such as humanitarian access dashboards and protection assessments.
- Ensure collaboration with appropriate actors and coordination with relevant agendas to harness strategic advocacy opportunities on data collection and dissemination to increase evidence and understanding of the short and longer-term and direct and indirect effects of EWIPA use on healthcare access and delivery and health needs, including the specific health requirements of women, children, persons with disabilities and older persons.
- Organise consultations and coordinate on providing submissions to OCHA as part of the development of annual Humanitarian Response Plans in countries where EWIPA are being used to increase the visibility and focus of the response.

INGOs to:

- Link up with like-minded human rights and humanitarian organisations and initiatives not currently involved in EWIPA-specific related advocacy to help strengthen efforts, in particular around increasing the visibility of specific groups, such as women and older persons.

OCHA to:

- Organise workshops with government officials and military focused on healthcare access and the need for greater access to transparent disaggregated data, and steps that can be taken to mitigate the impacts of EWIPA use.

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Cover Photo: A medical centre destroyed in the city of Kharkiv, Ukraine's second largest city, in the Northeast of the country. © M. Monier / HI 2024