Women’s and Children’s Health in Conflict Settings 1
The political and security dimensions of the humanitarian health response to violent conflict

The nature of armed conflict throughout the world is intensely dynamic. Consequently, the protection of non-combatants and the provision of humanitarian services must continually adapt to this changing conflict environment. Complex political affiliations, the systematic use of explosive weapons and sexual violence, and the use of new communication technology, including social media, have created new challenges for humanitarian actors in negotiating access to affected populations and security for their own personnel. The nature of combatants has also evolved as armed, non-state actors might have varying motivations, use different forms of violence, and engage in a variety of criminal activities to generate requisite funds. New health threats, such as the COVID-19 pandemic, and new capabilities, such as modern trauma care, have also created new challenges and opportunities for humanitarian health provision. In response, humanitarian policies and practices must develop negotiation and safety capabilities, informed by political and security realities on the ground, and guidance from affected communities. More fundamentally, humanitarian policies will need to confront a changing geopolitical environment, in which traditional humanitarian norms and protections might encounter wavering support in the years to come.

Introduction
Humanitarian health is full of contradictions: compassion and brutality, ideals and nightmares. Globally, humanitarian organisations seek to bring some measure of relief to people confronting the pervasive brutality of armed conflict, their claims to assistance based not on family or national identity, but merely on a shared humanity.1,2 Yet at the same time, the use of force has impeded the delivery of crucial assistance to millions of others. Despite the intentions of international humanitarian law (IHL) to protect civilians and humanitarian health providers from violent attack, both state militaries and armed non-state actors (ANSAs) deliberately and repeatedly violate these provisions and perpetuate violence against these protected groups.3 Between January and September, 2019, there were 825 confirmed attacks on health workers and facilities in areas of conflict, killing some 171 health workers and injuring more than 700 others. Hospitals and clinics continue to be attacked, and at least some are deliberately targeted.4 The discussion that follows does not attempt to reconcile these contradictions but rather to articulate their inner logic, outward impact, and ultimately their lessons for all those committed to preventing unnecessary harm and suffering in some of the most violent places on Earth.

The Lancet Series on women’s and children’s health in conflict settings
This four-part Series is directed at the special requirements of providing sexual, reproductive, maternal, infant, child, and adolescent health and nutrition services in areas affected by armed conflict. In this Series, the term women’s and children’s health (WCH) is used to represent these areas of concern and service. More than half of the world’s population of women and children are living in countries experiencing armed conflict, and all but one of the ten countries with the highest neonatal mortality rates in the world are in conflict.5,6 Approximately 71 million people were forcibly displaced in 2019, most remaining in their countries as internally displaced people. Women and girls represent approximately half, and children approximately 40%, of all internally displaced people, and sexual violence against women in conflict settings is extremely high.6–7 During 2018, the UN verified more than 24000 grave violations against children in 20 countries, including recruitment of child soldiers, killing or maiming, and sexual assault or abduction.8 The special health requirements of women, children, and adolescents in conflict settings have been outlined in previous reports and are addressed in detail in the other papers in this Series.9–13 Others have cogently articulated the broader humanitarian challenges generated by conflict.9,10

The goal of this Series is to build on these contributions by providing greater analytic and empirical insight into the nature and dynamics of WCH in diverse conflict contexts. Although the Series uses various technical and case-study methodologies, its central intent is inherently applied and directed explicitly to providing pragmatic guidance for all actors confronting the evolving challenges of WCH service delivery in politically unstable and insecure settings. In the second paper of this Series, Bendavid and colleagues10 estimate the impact of conflict on a broad array of non-violent outcomes for

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Key messages

- In areas of armed conflict, humanitarian access, effective health services for women and children, and the protection of humanitarian workers and facilities will increasingly require rapid adaptation to the changing nature of warfare and its combatants.
- Trends in adverse women’s and children’s health (WCH) outcomes suggest that the global commitment to improve these outcomes must more effectively confront the political and security challenges that define areas affected by violent conflict.
- The use of explosive weapons in cities can challenge humanitarian legal and operational provisions adopted since World War II; counterinsurgency strategies that involve the provision of WCH services can obscure distinctions between humanitarian and combatant activities; complex hybrid conflicts have introduced new forms of warfare, including cyber attacks and the manipulation of social media, that at times target humanitarian providers.
- The nature of combatants and the tactics they use are also evolving and will require new humanitarian strategies; the proliferation and fragmentation of armed non-state actors and their changing patterns of violence can complicate the negotiation of access to populations in need and the protection of humanitarian workers and facilities; these complexities can be exacerbated when combatants are heavily involved in criminal activities.
- COVID-19 is exacerbating conflict and weak governance through both the direct impact of caseloads and mortality and through the indirect effects generated by devastated family livelihoods; progress in medical and public health practice is also generating new opportunities but also new burdens for traditional humanitarian and WCH systems; advances in trauma care require moving medical care closer to the front lines, and new efficacy in managing chronic, non-communicable diseases require the development of long-term care systems and supply chains.
- Crafting responses to the changing nature of warfare and combatants and to the challenges of infectious outbreaks will require an enhanced ability to identify specific local and global health governance capacities that permit the delivery of high-priority WCH services; given the protracted nature of current conflicts, new approaches to coordinating humanitarian and development strategies will also prove useful, particularly when close relationships with a host government would challenge humanitarian neutrality and independence.
- The evolution of geopolitical power relationships has the potential to destabilise long-standing international support for humanitarian law and service delivery protections; emerging or resurgent local and global powers could increasingly exert their influence on global institutions, such as the UN, and ultimately on the parameters of humanitarian security, civilian protection, and health-care provision in areas of armed conflict.

The humanitarian challenge of armed conflict

Humanitarian practice and IHL must constantly respond to the human impact of modern warfare. An important concern of humanitarian law and practice is the direct effects of war, namely traumatic injury, both physical and mental, and death due to bombs and bullets during combat operations. However, war also has indirect effects, defined as death and suffering through the destruction of the essentials of life, including food, water, shelter, medical care, and security. These indirect effects are generally substantially larger than the direct effects, particularly for women, children, and adolescents. However, measuring civilian harm due to combat remains largely ad hoc and vulnerable to political manipulation. Although IHL is concerned with many aspects of war, including the treatment of enemy prisoners, it attempts to mitigate both direct and indirect effects through two related mechanisms: (1) preventing non-combatants from intentional attack and (2) responding with care and succour to non-combatants when protection fails. The primary factors that determine the risk to populations are outlined in the figure.

There is no definitive, day-to-day rulebook for protecting non-combatants and health providers in areas affected by violent, intrastate conflicts. Although many people might view war as inherently immoral, there is a long history of ethical reflection on the legitimacy of war and how its conduct can be restrained. This so-called just war tradition (panel 1) is currently rooted in the Geneva Conventions and their Additional Protocols. Over the past decade, there have been many changes to conventional consent on international human rights law. These international treaties were largely developed with wars between states in mind and outline rules to protect people who do not take part in warfighting, including civilians and medical and aid workers, as well as those who can no longer fight, such as wounded or captured combatants. It should be
recognised, however, that these treaties are not pacifist documents (panel 1); the just war doctrine and IHL permit war as much as they constrain it. They seek to limit the cruelty of war, advocating humanitarian protections while recognising that military necessity can result in civilian harm. Every civilian death, although clearly a tragedy, is not necessarily a violation of the Geneva Conventions or IHL.

WCH systems in conflict zones are not only shaped by the application of law but also by the pervasive menace of organised violence. Those actors who must negotiate humanitarian access and safety on the ground know this mix of ideals and pragmatic possibility all too well. In response, humanitarian actors, including UN agencies such as UNICEF, and non-governmental organisations, including Médecins Sans Frontières, have used a set of guiding principles to help to navigate this landscape. These principles recognise that the protection afforded to health workers in conflict environments comes with certain expectations regarding their behaviour. These principles can be summarised as humanity, impartiality, neutrality, and independence (panel 2). Although these principles form the central framework for humanitarian action, changes in how wars are fought, who is fighting these wars, and the aspiration to provide increasingly advanced health services are creating new challenges and opportunities for humanitarian health provision.

The changing nature of warfare
Over the past three decades, most conflicts have not been interstate wars (those between states), but intrastate, also termed civil conflicts, although many have complex international affiliations.2,3 These intrastate conflicts have also become increasingly protracted with an average duration of more than 20 years.25 Each conflict has a unique character, and a comprehensive review of current conflicts is beyond the scope of this Series paper. Nevertheless, there are several trends in warfighting that stand out as particularly important in assessing the challenges and risks that face WCH and related humanitarian activities.

Explosive weapons in urban settings
Urban warfare is not a new concept. However, the use of explosive and chemical weapons in densely populated areas of the Middle East and attacks on health facilities have caused large-scale civilian harm and challenged humanitarian norms developed since World War 2. Bombing campaigns were used strategically against civilians during World War 2 and, since 2015, by the Syrian Government and Russia in an attempt to break the will of civilian populations and erode their support for armed opposition.26,27 Explosive weapons have also been widely used tactically to seize urban territory from well dug-in defenders. For example, in 2016–17 during the battle for Mosul, Iraq, and Raqqa, Syria, the US-led coalition (including France, UK, Canada, Australia, Germany, Turkey, and the Netherlands) used precision munitions to take territory; however, the destructive impact was catastrophic.28–30 ANSA have also used explosive weapons, both tactically and strategically, including the 2017 double truck bombing (attributed to al-Shabaab) in Mogadishu, Somalia, killing more than 600 people. In Syria during 2018 alone, air strikes, barrel bombs, and cluster munitions resulted in almost 2000 casualties among children.5 The structures that allow cities to thrive can also make them vulnerable to assault. Urban infrastructure, such as water, sanitation, transportation, food supply, and health facilities are highly interdependent and damage to any one of these systems can have powerful reverberating effects.30,31 The destruction of the electric grid in Baghdad during the First Gulf War in 1991 severely affected the operations of water, sanitation, and health facilities, resulting in increased child mortality for months to come.32 IHL does not prohibit siege warfare but has provisions against the targeting of civilians, starvation, attacks on health facilities, and the prevention of civilian escape.33 Although dual-use structures might have both civilian and military value, their destruction can have indirect effects that can drastically outweigh military necessity.34–36 Some types of infrastructure, such as urban water systems, are designated for protection. Despite these protections, Saudi-led airstrike in 2015–18 on water infrastructure in Yemen have probably contributed to one of the most serious cholera outbreaks on record, with more than 2·1 million cases and 3700 deaths between 2017 and 2019.38 Urban warfare in peer or near-peer interstate wars in places such as the Korean peninsula could result in casualties and indirect effects at a scale likely to

Figure: Humanitarian mitigation of adverse health outcomes in areas of armed conflict
The conceptual framework is based on three related considerations: adverse health outcomes as a result of war (direct and indirect effects), humanitarian risk, and humanitarian mitigation. Humanitarian risk (ie, the mechanisms by which armed conflict increases the occurrence of adverse health outcomes in non-combatant populations) is the product of the nature of warfare and the nature of combatant groups. The extent to which humanitarian law and actions can reduce adverse health outcomes is related to protection of non-combatant populations from violent conflict, including through the Laws of War,29,30 and humanitarian responses to identified urgent (eg, trauma) and protracted needs (eg, nutrition) of non-combatant populations.
The so-called just war framework has traditionally addressed: the justification for the use of military force (jus ad bellum); the legitimate ways of fighting a war (jus in bello); and the just transition from war to peace (jus post bellum). 17

**Jus ad bellum (ie, right to war)**
This set of conditions addresses the legitimacy of waging a war that constitutes the primary protection for both civilians and combatants. The main criteria of jus ad bellum include:

- **Just cause**—the reason for going to war needs to be just. The UN Charter of 1945 permits only two exceptions to its general prohibition on the use of force: self-defense of a sovereign state (Article 51) and military measures authorised by the Security Council under Chapter VII of the Charter.
- **Legitimate authority**—war must be publicly declared by a legitimate authority. The traditional interpretation maintains that only sovereign states and the UN Security Council have the authority to wage war.
- **Reasonable prospects for success**—war should be waged only when there is a reasonable chance that the military action will be successful in meeting the defined threat.
- **Last resort**—the use of force can only be justified when all non-military options for preventing or resolving a crisis have been explored and lesser measures would not succeed.
- **Proportionality**—the expected benefits of waging a war must be proportionate to its expected harms and destruction.

**Jus in bello (ie, right conduct in war)**
Once war has begun, just war principles provide guidance on the just conduct of hostilities. The central elements of jus in bello include:

- **Discrimination (distinction)**—the principle of discrimination determines who are legitimate targets in war and excludes non-combatants, including civilians and surrendered or wounded enemy combatants.
- **Proportionality**—this principle determines the kind and level of force that is morally permissible in war. The harm to civilians or civilian structures must not be excessive compared with the anticipated military advantage gained by an attack on a legitimate military target.
- **Military necessity**—this principle maintains that attacks must be in direct service of defeating the enemy. Collaterally harming non-combatants is permissible only if the least harmful means feasible are chosen.

**Jus post bellum (ie, justice after war)**
A more recent addition to just war principles concerns the transition of a just war to a just peace. 18 Although less addressed in international humanitarian law, the central elements of jus post bellum include:

- **Rights vindication**—the peace should ensure the rights whose violation justified the war.
- **Proportionality**—the settlement should not represent revenge but rather measured and reasonable attributes.
- **Discrimination**—distinctions should be made between leaders, soldiers, and civilians in the determining of punitive post-war measures.
- **Punishment**—prosecution of those responsible for the violations of rights and international law and can include mechanisms of transitional justice, such as truth commissions.
- **Compensation**—financial restitution can be instituted, subject to proportionality and discrimination.
- **Rehabilitation**—steps can be taken to demilitarise or politically rehabilitate the aggressor state to reduce the threat of future conflict.

Panel 1: Principles guiding the protection of civilian populations in war

The changing nature of combatants
The risk to civilians and providers of WCH and other health services in conflict settings not only reflects how
war is being fought but also who is fighting. Ensuring access and protection for WCH programmes, including nutrition, maternal health, and vaccinations among others, depend on some understanding of the evolving identity, interests, and patterns of violence of combatant groups. This task has been complicated by the global proliferation and fragmentation of ANSAs and their ever-changing operational networks and alliances. Ongoing violence in the eastern Democratic Republic of the Congo, north and west Africa, and Syria has involved hundreds of distinct armed groups.

ANSA violence can be highly dynamic and adapt to opposition tactics and strategic opportunities. Groups of ISIL-KP and Boko Haram in northern Nigeria have altered their use of force in response to their ability to hold territory. Community-based armed groups such as the Mai Mai militias of the eastern Democratic Republic of the Congo were formed to resist Rwandan forces and their Congolese affiliates in the mid 1990s, whereas the Yan Gora Civilian Joint Task Forces in northern Nigeria emerged for self-defense against Boko Haram fighters in 2015. However, both the Mai Mai militias and the Yan Gora forces have extended their self-defense activities to advance political or criminal ambitions. ANSAs can also harbour a deep distrust of international humanitarian agencies, particularly when these agencies comply with international anti-terrorism regulations, cooperate with state militaries, or have not adequately disassociated themselves from their US, European, or colonial roots. For some groups, attacks on international humanitarians could represent a kind of anti-normative political affront, using such attacks as a dramatic recruiting tool or for building a distinct, if ruthless, public identity.

Criminality
Financing a war is a central requirement of winning a war, and can generate real but often obscured risks for providers of humanitarian and WCH services. Efforts to dichotomise a combatant group’s motivation as purely political or criminal, concerned with grievance versus greed, is likely to prove futile. Although violent conflict has long involved a volatile mix of political ambition, taxes, and looting, virtually all intrastate conflicts over the past two decades have depended on organised criminal enterprises, including the trafficking of valuable resources (eg, oil, rare minerals), drugs (eg, opium, cocaine), or vulnerable humans (eg, kidnappings, migrants, sex workers, and child trafficking). ISIL-KP, ostensibly motivated by religious and political ideologies, has relied on illicit oil trading to finance its operations. Paramilitary groups in Colombia used illicit drug trafficking in the early 2000s to advance the election of sympathetic legislators. This complex interplay between ideological, political, and criminal motivations can be difficult for humanitarian actors to discern, thus enhancing their vulnerability to attack.

Panel 2: Humanitarian principles

The Protection of Civilian Populations
Based on the Geneva Conventions of 1949 and their Additional Protocols of 1977, civilians and all people not taking part in combat can under no circumstances be the object of attack and must be spared and protected. Humanitarian action is governed by the two foundational principles, humanity and impartiality, and two operational or instrumental principles, neutrality and independence.

Humanity
This foundational principle endeavours to prevent and alleviate human suffering wherever it might be found. Its purpose is to protect life and health and to ensure respect for the human being.

Impartiality
This foundational principle requires that efforts to protect life and alleviate human suffering should be delivered on the basis of need and individual suffering, with no discrimination as to nationality, race, religious beliefs, social class, or political opinions. It also seeks to give priority to the most urgent cases of distress.

Neutrality
This operational principle requires that humanitarian actors cannot take sides in hostilities or engage at any time in controversies of a political, racial, religious, or ideological nature. This principle helps to ensure that humanitarian actors will have the confidence of all parties and to maintain access to people in need.

Independence
This operational principle requires that humanitarian actors must always maintain their autonomy from states, combatants, and other local or international authorities, so that they can at all times access populations in need and to act in accordance with the principles of humanity and impartiality.

Sexual violence
Sexual violence and rape are considered to be mala in se (evil in themselves) and are explicitly prohibited in customary international law. Nonetheless, sexual violence is pervasive in every contemporary armed conflict. WCH, reproductive, and mental health and social services are crucial in responding to the profound and complex health effects of sexual assault. The motives and frequency of sexual violence in conflict can vary dramatically, and a group’s pattern of violence can include strategic assaults (using rape as a weapon of war), opportunistic assaults (rape for subjective reasons), and assaults as a practice (rape that is tolerated by commanders). Regardless of why sexual violence is perpetrated, it should be of the highest priority for protective actions and WCH care. Although traditional humanitarian doctrine has typically grouped women’s standing with that of children and the elderly, there is a growing appreciation of the resilience and agency of women in areas of conflict, including service as warfighters, peace builders, and political leaders. In addition, the disruptive power of war and resulting widespread displacement have in some settings weakened long-standing constraints on women’s freedom and have created new opportunities for women to assume non-traditional roles in public life.
Ensuring access and safety of the humanitarian response

The effective use of IHL and humanitarian principles requires navigating the reality of conflict on the ground. Areas affected by conflict should not be seen as ungoverned settings. Rather, they should be approached as contested settings, in which an array of state and non-state actors exert or vie for control. In these environments, political order does not often turn to anarchy, but rather resides with ANSAs that can obstruct or facilitate the provision of essential services. The features of these power structures might not be obvious, however, and building relationships between humanitarian groups and local leaders might be the most useful means of navigating this complex security landscape.

It is also important to recognise that as the medical capability of humanitarians grows, too does the burden on humanitarians to provide it equitably to the people in conflict settings who need it. This technical imperative to deliver new, efficacious medical capabilities can place new burdens on traditional WCH and humanitarian strategies. In an attempt to mimic military trauma systems that emphasise rapid stabilisation, WHO deployed humanitarian medical groups with Iraqi security forces in frontline locations during the 2017 battle of Mosul, Iraq. Although there is evidence that this strategy did indeed save both military and civilian lives, the positioning of humanitarian medical workers alongside combatants has been challenged as a serious violation of the long-standing humanitarian principles of neutrality and independence.

Strategic governance, non-conflict violence, and the humanitarian-development nexus

The protracted nature of current conflicts has highlighted the need to link humanitarian interventions with more long-term development strategies. This so-called humanitarian-development nexus emphasises the integration of humanitarian services into broader efforts to strengthen government health systems and societal resilience to conflict. Problems with an integrated humanitarian-development agenda can emerge, however, when the host state ignores its citizens’ needs or is one of the belligerent parties in a conflict. Traditional development policies generally emphasise long-term commitments to strengthening state institutions. By contrast, humanitarian strategies seek neutrality and independence and might have to contend with attempts by local communities to actually insulate themselves from what they perceive as an intrusive or predatory state.

In areas of conflict, WCH services might need to address urgent, focused needs, rather than the broader development approaches that enhance state capacity and emphasise long-term investments in economic growth, infrastructure, and education and health systems. By contrast, WCH interventions in conflict areas are most often designed to require minimal governance and security conditions to be able to function successfully in areas where more comprehensive, longer-term programmes cannot be contemplated. As the case studies documented in this Series suggest, a so-called whole governance capacity might not be needed per se. Rather, a strategic governance strategy could be sufficient, in which the minimal governance conditions required to implement the specific WCH interventions are met.

Immunisation programmes could have far different governance requirements than the initiation of a microcredit system or new industrial policy.

The traditional boundaries between humanitarian and development activities can also break down when security conditions are extremely poor but a traditionally defined state of conflict does not exist. Most violent deaths in the world do not occur in areas considered to be in armed conflict. Syria has the highest rate of violent deaths in the world; however, next on the list are El Salvador, Honduras, and Venezuela that have higher violent death rates than Somalia or Iraq, countries widely recognised to be long-term settings of catastrophic armed conflict. Extremely high levels of violence and reduced state services can also be highly localised in areas dominated by criminal gangs, such as in the favelas (low-income, informal urban settlements) of Brazil and some regions of central America and Mexico. The need for humanitarian WCH services in these areas can be profound, and the state’s ability to monopolise violence and provide public services can be similar to that in many settings of protracted conflict. New, highly integrated humanitarian and development strategies could be essential in these areas, particularly given the scale of humanitarian needs and the forced migration flows that result from the threat of economic and physical insecurity.

Violence, governance, and pandemics

Few things test a people’s relationship with its government more than war and disease. Whenever a society is confronted with a catastrophic threat, technical knowledge becomes inextricably linked to questions of social history, political legitimacy, and societal trust. This link is particularly true for pandemic control strategies that require substantial trust in state information and actions. In conflict or highly divisive political settings, the state might not command sufficient legitimacy to implement essential public health interventions. In such security and political environments, the only real alternative to legitimacy is coercion, in which compliance with infection control measures rests not in the authority of trusted leaders and institutions but in the fear of the police and army. Trust-based and coercive strategies are often combined, and the resulting complexity can obscure the reality of communities vigorously trying to control the pandemic but considered to be uncooperative or resistant by state authorities. The failed attempt by the
Liberian Government to forcibly quarantine the West Point neighborhood of Monrovia, Liberia, during the 2013–15 West Africa Ebola virus outbreak stood in contrast with strategies of non-governmental organisations that engaged local community action.\textsuperscript{48} The response to COVID-19 in areas of conflict and weak governance reflects these technical and political dynamics. Instability can also be exacerbated by both the direct effect of the incidence, prevalence, and mortality from disease, as well as the indirect effects generated by devastated family livelihoods. In some settings, such as Mexico and Afghanistan, criminal groups have expanded their influence by imposing public health measures and distributing food and other supplies to enhance their legitimacy with local populations.\textsuperscript{36}

**Humanitarian deconfliction and risk management**

The use of explosive weaponry in fast-moving conflicts has required special mechanisms to protect humanitarian activities.\textsuperscript{85} Deconfliction protocols endeavor to create a so-called no-strike list by communicating to combatants the location coordinates of static and mobile humanitarian operations. The UN’s Office for the Coordination of Humanitarian Affairs often assumes the part of trusted interlocutor, receiving information from humanitarian groups and passing it on to combatants. However, these communication systems can be ad hoc, using phone or email to communicate critical information, and have experienced important failures, such as the devastating US airstrike in 2015 on a hospital run by Médecins Sans Frontières in Kunduz, Afghanistan.\textsuperscript{86} The scale of deconfliction requirements can also be overwhelming. In Yemen alone, the UN reports that some 30,000 deconfliction sites have been identified; Saudi officials reportedly list 60,000 protected sites.\textsuperscript{87} A reliance on basic technologies can also make this sensitive information vulnerable to cyber attack. Distrust can render deconfliction protocols ineffective, especially when combatant groups have targeted civilians and health facilities. Deconfliction requires precise execution but when it fails, either through incompetence or active transgression, such as the Syrian military’s attack on the Urum al-Kubra aid convoy in 2016,\textsuperscript{89} it requires full accountability, a requirement that over the past decade has rarely been met.\textsuperscript{36,69}

Some risk mitigation strategies have relied on enhanced physical security, also termed bunkerisation,\textsuperscript{90} which restricts humanitarian personnel to well protected compounds. Alternative approaches depend on relational security measures that emphasise deep engagement with affected communities and a reliance on local protection.\textsuperscript{1} However, many large humanitarian organisations are increasingly dependent on the remote management of risk by relying on local or national workers for field operations, while maintaining international workers in relatively secure locations. Mobile technology can facilitate these remote strategies. However, these strategies can also result in local nationals working for international humanitarian organisations bearing the brunt of violence directed at humanitarian workers.\textsuperscript{92}

Although many cultural and religious traditions emphasise the humane treatment of non-combatants in war, multilateral organisations backed by US and western European power have provided much of the institutional scaffolding for humanitarian protections in areas of violent conflict.\textsuperscript{1} Over the past decade, however, the USA, the EU, and a growing number of countries facing security threats have implemented a series of counterterrorism strategies that have resulted in the criminalisation of humanitarian, medical, and WCH services. IHL has long protected the ability of humanitarian organisations to negotiate access with all belligerent parties and to provide WCH impartially without concern for their patients’ beliefs or affiliations. However, domestic counterterrorism laws have made health workers vulnerable to prosecution\textsuperscript{96} and US and EU security policies can threaten humanitarian organisations with financial sanctions if they engage with organisations considered to be security risks. The seriousness of these emerging hazards has generated considerable uncertainty in how humanitarian organisations can cooperate or even negotiate with armed groups that control access to affected populations. The criminalisation of humanitarian services challenges long-standing principles and lies in troubling contrast with UN Security Council resolution 2286, adopted in 2016,\textsuperscript{97} and subsequent pronouncements, which condemn threats and attacks against the wounded and sick and against medical workers exclusively engaged in their medical obligations.

**Evolving global commitment to humanitarian protections**

The implementation of IHL and the safe provision of humanitarian WCH services in areas of conflict have depended on a collective global order and the support of powerful states.\textsuperscript{1} The rise of nationalism and anti-immigrant resentment in the USA and western Europe, however, have the potential to destabilise long-standing commitments to international institutions and cooperation, a trend exacerbated by the fractious response to COVID-19. Moreover, in an increasingly multipolar world, other global powers, such as China and Russia, will probably exert their own interpretation of IHL and humanitarian strategies. This evolving geopolitical environment has crippled the ability of global institutions to implement effective protective mandates, particularly when a global power or regional ally is an active belligerent. Over 2019 and 2020, in direct disregard for resolution 2286, Russian attacks on hospitals have continued in Syria, as have Saudi-led airstrikes in Yemen, with US backing.\textsuperscript{36,94,95}

Although the greatest responsibility for protecting civilians in war resides with the warring parties themselves, the UN has been the primary international
institution charged with protecting vulnerable populations from the ravages of violent conflict. It endeavors to meet this challenge through negotiation and norm development, as well as through the direct actions of its operational agencies. After the failed protective records in Rwanda (in 1994) and Yugoslavia (in 1995), the UN has embraced two general protective frameworks: the Protection of Civilians, primarily as a component of peacekeeping mandates, and the Responsibility to Protect, which holds sovereign states responsible for protecting their citizens and provides procedures for an international response if sovereign states fail to do so.93 These two frameworks heralded a shift in UN concern from the long-standing focus on the security of sovereign states to that of individuals residing within these states.

Although a lack of consensus among global powers has constrained the Responsibility to Protect’s provisions for the use of force, the framework continues to provide normative support for the protection of civilians and human rights in conflict.94,95 Protection of Civilians strategies have also had to face new obstacles, as the UN Security Council since 2016 has generally included the protection of civilians within recent peacekeeping mandates but without the requisite resources or capabilities to accomplish this mission. Peacekeepers themselves have also committed sexual assaults and other violations of human rights.95 More fundamentally, UN peacekeeping missions have included a mandate to protect civilians but without a concomitant political commitment to broker a meaningful peace.89 Peacekeepers can find themselves acting as a substitute for diplomatic and political action, which can leave both the peacekeepers and their intended protectees vulnerable to the changing levels of violence during protracted civil war.

In this context, it is important to recognise that although local communities can endure great suffering and pervasive risk, they are almost never passive. Local humanitarian responses are often the first and most trusted forms of community-based protection and can help to ensure the effectiveness of international assistance.95,96 These local strategies can include appeals to common traditions, religious values, or pragmatic negotiations involving financial agreements or counter-threats of violence.97,98 Responding to infectious outbreaks has also required local leadership and action.91 These local approaches, however, might not be recognised or valued by global humanitarian actors and might not conform to classic interpretations of humanitarian principles or IHL.99,100 Accordingly, international humanitarian efforts would benefit from a deeper exploration and appreciation of the varied protective actions local communities have taken when they are threatened.95,96,101

Conclusion
The fundamental challenges confronting humanitarian WCH services in areas of conflict are generated less by failures in the body of IHL but by the disregard of IHL, the impunity with which state militaries and ANSAs attack civilians and systems of health care, and the inability of international institutions to prevent and mitigate the direct and indirect effects of war.99 More complicated still are emerging forces, such as the climate crisis and urbanisation, that can alter both the determinants of conflict and the parameters of humanitarian response.10,99

As the other papers in this Series outline in greater detail than we do here, WCH strategies must adapt to the unremitting reconfiguration of violent conflict in different political and security settings around the world. Meeting this challenge will require that the WCH community seek insights from diverse fields, including law, military strategy, political science, anthropology, medicine, and public health, among others. This Series paper has attempted to focus attention on specific insights from these diverse disciplines. However, this broad interdisciplinary mandate has also meant that this paper cannot examine these insights in any depth or complexity. Rather, the paper is intended to outline the contours of a strengthened adaptive capacity for WCH systems in an intensely dynamic and violent world.

Perhaps most important will be an increased respect for local creativity and resilience and for the lessons generated by communities tormented by conflict, women confronting conflict as they struggle for greater social freedom, children deprived of stable nurture and education, adolescents losing hope in the promise of adulthood, and combatants responsible for protecting non-combatants while their comrades die around them.98

As with war itself,101 the future of humanitarian WCH practice is difficult to predict, except to say that it must always be able to adapt quickly to the evolving political and security dimensions of armed conflict. For in the end, it will be the effective negotiation of these dimensions that will best ensure that health workers can continue to convey some pragmatic expression of humanitarian compassion to those enduring the horrors of war.

Contributors
PHW conceptualised and analysed the paper, and drafted and critically revised the text. AS and NS analysed the available data on conflict, and interpreted the military and security literature. EB, TF, RJW, KB, PBS, RD, AZ, RB, MFG, and ZAB substantially contributed to the design of the paper, and critically revised the manuscript. JW contributed to the methods and analysis, drafting of the two panels, and critically revised the manuscript. VP-B, DP, SS, MB, DMG, and HP contributed to literature and data interpretation and critically revised the manuscript. All contributors approved the final version and agree to be accountable for all aspects of the submitted manuscript.

Declaration of interests
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