



European Medical Students' Association

Association Européenne des Étudiants en Médecine

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Healthcare of War Victims

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The European Medical Students' Association (EMSA) represents medical students across Europe. We envision a healthy and solidary Europe in which medical students actively promote health. EMSA empowers medical students to advocate health in all policies, excellence in medical research, interprofessional healthcare education and the protection of human rights across Europe.

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Problem statement.

Primum non nocere, “first, do no harm”, associated with the Hippocratic Oath, underlies the principle of non-maleficence, one of the four pillars of modern medical ethics (beneficence, non-maleficence, autonomy, and justice) (Beauchamp & Childress, as cited in Gillon, 2003; Gillon, 2003). These principles collectively oblige physicians to act in their patients’ best interest; avoid inflicting harm; respect patient autonomy, and ensure equitable access to care. In armed conflict, adherence to these obligations becomes stress-tested.

Healthcare systems and professionals operating in war zones face extreme constraints. Infrastructure breakdown; targeted attacks on medical personnel; plus weaponisation of healthcare, undermine both ethical practice and international humanitarian law. The Geneva Conventions (1949), their additional Protocols I and II (1977), and earlier Hague Conventions define the protections owed to the wounded, the sick, and civilians during armed conflict, but enforcement remains inconsistent (UN press release, 2024)

Accountability mechanisms are further limited. Instruments such as the Nuremberg Principles and the Rome Statute of the International Criminal Court define war crimes and crimes against humanity, yet gaps in international legislative authority, such as the United Nations General Assembly’s inability to enforce binding legal sanctions, prevent effective prosecution, compliance and accountability.

Data from the Aid Worker Security Database and UN agencies reveal an escalating crisis. In 2024, a record 281 humanitarian workers were killed, many due to politically targeted attacks in Gaza, Sudan, and Ukraine (UN OCHA, 2024; Reuters, 2024). The Safeguarding Health in Conflict Coalition reported 3,623 attacks on health facilities and workers in 2024, a 15% increase year-on-year, with Gaza, the West Bank, and East Jerusalem accounting for 37% of incidents (SHCC, 2025). Experts have coined the term “healthocide” to describe this systematic targeting of healthcare systems in conflict settings (BMJ Global Health, 2025). These attacks not only violate international law but also contravene Article 35 of the EU Charter of Fundamental Rights, which guarantees the right to healthcare.

The healthcare needs of individuals affected by armed conflict are multifaceted, encompassing immediate life-saving interventions, maintenance of essential medical services, and long-term rehabilitative care. Armed violence results in high incidences of penetrating trauma, blast injuries, burns, and crush injuries, necessitating advanced trauma management and surgical interventions (ICRC, 2022; WHO, 2023). Delays in accessing these services significantly increase morbidity and mortality, in direct contravention of obligations set out in the Geneva Conventions. The EU Civil Protection Mechanism, while robust in natural disaster response, lacks specific protocols for healthcare protection in conflict zones, a gap this policy seeks to address.

In addition to acute injuries, armed conflict disrupts continuity of care for chronic disease, including diabetes, hypertension, cardiovascular diseases, and HIV/AIDS. Interruptions in medicine supply, breakdowns in referral systems, and loss of medical records frequently result in avoidable complications and premature death (WHO, 2023). These disruptions violate both the ethical principle of beneficence and the legal requirement under international humanitarian law to ensure provision of medical care to all persons without adverse distinction (United Nations, 2024). The emerging European Health Data Space (EHDS) offers unprecedented

opportunities to maintain health records for displaced populations, yet current frameworks fail to address conflict-specific needs.

Maternal, newborn, and child health face particular vulnerabilities in conflict settings. Damage to maternity wards, shortages of skilled birth attendants, and the collapse of perinatal care services contribute to increased maternal and neonatal mortality. The suspension of immunisation programmes further increases the risk of outbreaks of vaccine-preventable diseases such as measles and polio (UNFPA, 2022; WHO, 2022). These failures directly undermine Europe's commitments under the Strategic Compass for Security and Defence (2022), which recognises health security as integral to regional stability.

The mental health consequences of war are profound and enduring. Exposure to violence, displacement, bereavement, and uncertainty contributes to elevated rates of post-traumatic stress disorder (PTSD), depression, anxiety, and other psychosocial disorders. Children are particularly susceptible to long-term psychological harm, with implications for cognitive development and social functioning (UNHCR, 2022). The provision of culturally sensitive, community-based mental health and psychosocial support services is therefore an essential component of post-conflict recovery (WHO, 2023).

The climate-conflict nexus further complicates healthcare delivery. Climate change acts as a threat multiplier, exacerbating resource scarcity and driving conflict while simultaneously degrading health infrastructure resilience (IPCC, 2023). The intersection of environmental degradation and armed conflict creates compound humanitarian crises that existing response frameworks are ill-equipped to address.

These violations directly affect the 1.2 million medical students across Europe who will encounter war victims in clinical practice, humanitarian missions, or through refugee healthcare provision. Medical students must be prepared to address the complex medical, ethical, and legal challenges presented by conflict-related healthcare, making this issue central to medical education and professional development. Current medical curricula, however, allocate insufficient attention to conflict medicine, with most programmes offering less than 10 hours of relevant training throughout the entire degree.

Our View. Aim

The European Medical Students' Association stands firmly for the equality and well-being of all individuals, regardless of race, gender, socioeconomic status, or geographic origin. EMSA recognises that war victims, including civilians, refugees, internally displaced persons, and military personnel, have fundamental rights to healthcare access that must be protected and advocated for at all levels.

With this policy paper, EMSA aims to highlight the healthcare challenges faced by war victims and advocate for systemic, inclusive, and sustainable solutions that align with the European Health Union's vision of protecting all Europeans and global citizens in times of crisis. EMSA believes that medical students must be empowered with education on conflict-sensitive healthcare, international humanitarian law, and trauma-informed care to effectively serve affected populations.

EMSA emphasises the critical importance of supporting healthcare workers operating in conflict zones through adequate resources, security measures, and psychological support systems. The

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systematic targeting of healthcare facilities and personnel represents not only a grave violation of human rights but also a direct assault on the fundamental principles of medical ethics that bind our profession. EMSA considers it essential that the EU leverages its diplomatic, economic, and humanitarian tools to prevent and respond to such violations.

EMSA advocates for a coordinated approach encompassing immediate emergency interventions, medium-term healthcare system strengthening, and long-term rehabilitation efforts to ensure comprehensive care for war victims. This approach must integrate with existing EU frameworks, including the Civil Protection Mechanism, NDICI-Global Europe instrument, and the emerging European Health Emergency Preparedness and Response Authority (HERA).

EMSA believes that the protection of healthcare in conflict is not merely a humanitarian imperative but a legal obligation under international law that all states must uphold. The principle of medical neutrality, whereby healthcare providers must be allowed to treat all individuals based solely on medical need, without discrimination or interference, forms the cornerstone of humanitarian medicine and must be defended vigorously through both diplomatic and legal channels.

Recommendations

EU Global Health Strategy (2022)

- Pillar 1: Delivering better health and well-being (through protection of healthcare in conflict)
- Pillar 2: Strengthening health systems (via capacity building and infrastructure protection)
- Pillar 3: Preventing and combating health threats (through rapid response mechanisms)

European Health Union

- Extending HERA's mandate to include conflict-related health emergencies
- Utilising rescEU medical stockpiles for conflict response
- Strengthening cross-border health threat preparedness

Legal Basis

- Article 168 TFEU: Provides competence for public health measures
- Article 214 TFEU: Humanitarian aid competence
- EU Charter of Fundamental Rights, Article 35: Right to healthcare

Financial Instruments

- EU4Health Programme (2021-2027): €5.3 billion available
- NDICI-Global Europe: €79.5 billion for external action
- European Peace Facility: Potential funding for medical protection measures
- Emergency Aid Reserve: Immediate response funding

The European Parliament Committee on the Environment, Public Health and Food Safety (ENVI)

EMSA calls on the European Parliament Committee on the Environment, Public Health and Food Safety (ENVI) to allocate €500 million from the EU4Health programme 2025-2027 for conflict zone healthcare infrastructure, distributed as follows:

- €200 million for mobile health clinics and surgical units,
- €150 million for telemedicine infrastructure and digital health records,
- €100 million for mental health and psychosocial support programmes,
- €50 million for medical supply prepositioning and logistics.

This allocation should be approved during the 2026 budget review, with quarterly implementation reports submitted to Parliament.

EMSA urges ENVI to mandate inclusion of conflict medicine as a 3 ECTS compulsory module in all EU-funded medical training programmes by 2026, developed in collaboration with WHO Europe and aligned with the European Qualifications Framework. The curriculum should include:

- 20 hours of theoretical instruction on IHL and medical ethics in conflict
- 15 hours of practical simulation training on mass casualty management
- 5 hours of psychological first aid training

EMSA recommends that ENVI establish a European Emergency Medical Stockpile specifically for conflict response by Q4 2025, with pre-positioned supplies in Warsaw, Athens, Helsinki, Madrid, and Strasbourg, each capable of treating 20,000 trauma patients within 48 hours of deployment.

The European Parliament's Subcommittee on Human Rights (DROI)

EMSA calls on DROI to establish a Healthcare Attack Monitoring Mechanism by March 2026, producing quarterly reports with mandatory EU response protocols triggered when:

- 10+ attacks occur in any quarter within a single region
- Any attack results in 5+ healthcare worker casualties
- Systematic targeting patterns are identified

Response protocols should include immediate diplomatic démarches, consideration of targeted sanctions, and activation of emergency medical support.

EMSA recommends DROI create a €100 million Rapid Protection Fund, accessible within 72 hours through simplified procedures, for:

- Physical security improvements (€40 million)
- Evacuation and relocation support (€30 million)
- Digital security and communication systems (€20 million)
- Legal aid for prosecutions (€10 million)

EMSA urges DROI to appoint a Special Rapporteur on Healthcare Protection in Conflict by June 2026, with a mandate to:

- Conduct fact-finding missions within 30 days of major incidents
- Report biannually to Parliament with actionable recommendations
- Coordinate with ICC on evidence collection and witness protection
- Annual budget of €2 million for operations and staff

The European Parliament's Committee on Foreign Affairs (AFET) & Committee on Development (DEVE)

EMSA calls for mandatory allocation of 25% of all conflict-related EU humanitarian aid to healthcare system support, with specific earmarks for:

- Primary healthcare services (40% of health allocation)
- Trauma and surgical care (30%)
- Mental health services (20%)
- Health system reconstruction (10%)

This should be formalised through an amendment to the Humanitarian Aid Regulation by Q4 2025.

EMSA urges the establishment of EU Health Corridors in active conflict zones, negotiated through EU Special Representatives, ensuring:

- Safe passage for medical supplies and personnel
- Temporary ceasefires for vaccination campaigns
- Protection zones around healthcare facilities
- Quarterly review by the Political and Security Committee

The Council of the European Union

EMSA calls on the Council to adopt comprehensive Conclusions on Healthcare Protection in Conflict during the Polish Presidency (H1 2025), mandating Member States to:

- Include conflict medicine in national medical curricula by 2026
- Contribute to joint procurement mechanisms for conflict zone medical supplies
- Establish national registers of healthcare professionals trained for deployment
- Report annually on implementation progress to the Health Security Committee

EMSA urges the Foreign Affairs Council to integrate healthcare protection into all EU Common Foreign and Security Policy (CFSP) instruments, including:

- Mandatory healthcare protection clauses in all peace agreements
- Systematic inclusion in EU Special Representatives' mandates
- Regular agenda item at Political and Security Committee meetings
- Integration into EU Delegation reporting requirements

The European Commission - DG ECHO (Directorate-General for European Civil Protection and Humanitarian Aid Operations)

EMSA recommends increasing mental health and psychosocial support to 15% of all humanitarian health budgets by 2026, with implementation through:

- Training of 500 MHPSS specialists annually (€5 million/year)
- Establishment of regional MHPSS hubs in Jordan, Poland, and Turkey (€15 million)
- Development of culturally adapted intervention protocols (€2 million)
- Integration with existing EU Civil Protection Mechanism deployments

EMSA calls for deployment of 20 EU Mobile Medical Units by the end of 2026, each equipped with:

- Surgical capacity for 100 operations/week
- Telemedicine connectivity to European medical centres
- 3-month autonomous operation capability
- Total investment: €100 million from Emergency Aid Reserve

EMSA urges the creation of a European Humanitarian Health Corps by 2026, comprising:

- 500 deployable healthcare professionals from Member States
- Standardised 2-week pre-deployment training
- Rotation system ensuring continuous availability
- Integration with the EU Civil Protection volunteer pool
- Annual operational budget: €25 million

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DG SANTE (Health and Food Safety)

EMSA calls on DG SANTE to propose a Directive on Minimum Standards for Healthcare in Conflict Zones under Article 168 TFEU by Q4 2026, establishing:

- Mandatory reporting of attacks on healthcare within 48 hours
- Minimum preparedness standards for Member States
- Coordination mechanisms for cross-border response
- Penalties for non-compliance

EMSA recommends establishing a European Conflict Medicine Research Programme with €10 million annual funding, focusing on:

- Evidence-based treatment protocols for conflict injuries
- Innovation in resource-limited settings
- Digital health solutions for conflict zones
- Annual research conference and publication of best practices

EMSA urges the creation of a European Conflict Medicine Training Centre in partnership with ICRC by 2027:

- Location in Brussels with satellite centres in Member States
- Standardised certification programme recognised across the EU
- Annual training capacity of 1,000 healthcare workers
- Initial investment: €30 million; operational: €5 million/year

DG EAC (Education and Culture)

EMSA calls for the creation of an Erasmus+ Conflict Medicine Track with 500 scholarships annually:

- 3-month placements in humanitarian organisations
- €3,000/month stipend plus travel and insurance
- Priority for students from conflict-affected regions
- Mentorship programme with experienced humanitarian doctors
- Total annual budget: €4.5 million

EMSA recommends the development of Micro-credentials in Humanitarian Health by 2026:

- Stackable 5-10 ECTS modules
- Digital badges recognised across the European Higher Education Area
- Online and hybrid delivery options
- Partnership with learning platforms

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The World Health Organization

EMSA calls on WHO Europe to establish a Regional Emergency Medical Team Coordination Group by Q2 2026, with the capacity to:

- Deploy assessment teams within 24 hours
- Coordinate up to 20 simultaneous emergency medical teams
- Maintain a real-time operational dashboard
- Budget requirement: €5 million annually from the WHO regular budget

EMSA urges the WHO to strengthen the Surveillance System for Attacks on Healthcare (SSA) through:

- Development of mobile reporting application by Q3 2026
- Integration with the EU Early Warning and Response System
- Automated alert system when attack patterns are detected
- Public dashboard with real-time data visualisation
- Investment needed: €2 million for development, €500,000 annual maintenance

EMSA recommends WHO develop Minimum Standards for Healthcare in Conflict by 2026:

- Based on Sphere Standards but specific to conflict settings
- Clear indicators and benchmarks
- Regular monitoring and evaluation framework
- Translation into all EU languages
- Estimated development cost: €1 million

To Member States' Ministries of Health

EMSA calls on Ministries to establish National Conflict Medicine Preparedness Plans by the end of 2026, including:

- Surge capacity protocols utilising final-year medical students
- National stockpiles for 10,000 trauma patients (minimum)
- Rapid deployment registers of trained healthcare workers
- Mutual aid agreements with neighbouring countries
- Annual simulation exercises

EMSA urges integration of conflict medicine into national medical curricula:

- Mandatory 3 ECTS module in all medical schools by 2026
- Annual competency assessments for emergency medicine residents
- Continuing medical education requirements for emergency physicians
- Partnership with national Red Cross/Red Crescent societies

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EMSA recommends the creation of National Humanitarian Health Units:

- Minimum 50 deployable healthcare professionals per country
- 2-week annual training requirement
- Integration with EU and WHO deployment mechanisms
- Protected status during deployment (salary continuation, insurance)

EMSA calls on European Institutions, Medical Schools, Hospitals and Research Institutes to:

- Suspend collaborations with healthcare institutions implicated in war crimes or crimes against humanity, including those providing medical justification for torture, discriminatory care, or denial of treatment to civilians.
- Exclude applicants for funds that partner with institutions complicit in attacks on healthcare or in systematic violations of human rights and international law.
- Not enter procurement or training contracts with suppliers, firms, or institutions linked to attacks on healthcare infrastructures or the targeting of patients based on ethnicity, religion, or political affiliation.
- Have mandatory human rights and medical ethics due diligence and an independent review of the institution they have partnered or seek to partner with.

EMSA calls on the healthcare workforce to:

- Collaborate with international humanitarian organisations to coordinate the delivery of healthcare services in conflict zones
- Document and report attacks on healthcare facilities and personnel, as well as other violations of medical neutrality, to the relevant authorities
- Advocate for long-term investments in the rehabilitation and rebuilding of healthcare infrastructure in conflict-affected areas
- To take initiative and explain the healthcare system to refugees, immigrants seeking treatment or connect them to relevant authorities.
- To delegate tasks to final year medical students and interns, promoting learning and reducing burden to focus on higher priority tasks

EMSA calls on Medical Students to:

- Seek lifelong education on the healthcare needs of war victims, including trauma care, mental health support, and humanitarian principles
- To raise awareness about the challenges faced by war victims in accessing healthcare and the importance of protecting medical neutrality during armed conflicts
- Support initiatives aimed at strengthening healthcare infrastructure and capacity in conflict-affected areas

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- Demonstrate cultural sensitivity, empathy, and respect for diversity in their possible interactions with war victims
- Respect at all times the principles of medical neutrality, impartiality, and confidentiality.
- To encourage civilians to learn about CPR, first aid, making temporary tourniquets, etc.
- To volunteer in emergencies or situations where a larger number of healthcare workers are required.

EMSA calls on healthcare professionals to:

- Document attacks using WHO SSA within 48 hours
- Complete IHL and medical neutrality training every 3 years
- Mentor students interested in humanitarian medicine
- Support colleagues returning from conflict deployments
- Participate in national deployment registers

EMSA calls on National Member Organisations to:

- Establish partnerships with humanitarian organisations by Q2 2026
- Create conflict medicine interest groups in all faculties
- Organise annual awareness weeks on healthcare in conflict
- Fundraise a minimum €1,000 annually for conflict-affected health systems
- Coordinate national advocacy campaigns targeting ministries

EMSA urges Local FMOs to:

- Organise quarterly educational events on humanitarian medicine
- Establish peer support networks for affected students
- Create buddy systems for international students from conflict zones
- Develop resource libraries on conflict medicine
- Partner with local hospitals treating refugees

Definitions

AFET (Committee on Foreign Affairs): A standing committee of the European Parliament responsible for the Union's foreign policy, including human rights, common security and defence policy, and relations with international organisations. In the context of healthcare in conflict, AFET plays a crucial role in ensuring EU external actions prioritise the protection of medical facilities and personnel (European Parliament, 2024).

Article 168 TFEU: The Treaty on the Functioning of the European Union article providing EU competence in public health matters, including addressing cross-border health threats and setting high standards of quality and safety for medical products (EU Treaties, 2012).

Article 214 TFEU: The Treaty provision establishing EU competence for humanitarian aid operations, conducted in compliance with principles of international law and impartiality, humanity, non-discrimination and independence (EU Treaties, 2012).

Autonomy: One of the four fundamental principles of medical ethics, referring to the right of patients to make informed decisions about their healthcare (Beauchamp & Childress, 2019). In conflict settings, autonomy is often compromised by displacement, lack of information, or coercion, requiring special measures to ensure informed consent (Rubenstein & Bittle, 2010).

Beneficence: The ethical principle requiring healthcare providers to act in the best interest of patients, promoting their well-being through positive actions (Gillon, 2015). During armed conflict, beneficence extends to advocacy for patient safety and access to care despite security challenges (Allhoff & Vaidya, 2008).

Chronic Non-Communicable Diseases (NCDs): Long-term health conditions, including diabetes, hypertension, cardiovascular diseases, chronic respiratory diseases, and cancer that require ongoing medical management (WHO, 2023). Conflict disrupts NCD care through medication shortages, destroyed health records, and breakdown of referral systems (Boulle et al., 2019).

Civil Protection Mechanism: The EU framework for coordinating disaster response among Member States, including deployment of emergency teams, equipment and supplies, currently underutilised for conflict-related health emergencies (European Commission, 2023).

Climate-Conflict Nexus: The interconnection between climate change and armed conflict, where environmental degradation acts as a threat multiplier, exacerbating resource scarcity and driving conflict while simultaneously undermining health system resilience (IPCC, 2023).

COREPER (Committee of Permanent Representatives): The committee comprising Member States' ambassadors to the EU, responsible for preparing Council meetings and crucial for building consensus on healthcare protection initiatives (Council of the EU, 2024).

DEVE (Committee on Development): European Parliament committee overseeing development cooperation policy and humanitarian aid. DEVE ensures that EU development assistance addresses health system strengthening in conflict-affected regions and supports long-term recovery (European Parliament, 2024).

DG EAC (Directorate-General for Education and Culture): The European Commission department responsible for EU policy on education, training, youth, sport, and culture. DG EAC can integrate conflict medicine into medical education through Erasmus+ and other educational programmes (European Commission, 2024).

DG ECHO (Directorate-General for European Civil Protection and Humanitarian Aid Operations): The European Commission's humanitarian aid department, providing emergency assistance to victims of natural disasters and conflicts. DG ECHO coordinates EU humanitarian health responses and funds mobile clinics, emergency medical teams, and health system support in crisis settings, with an annual budget exceeding €2 billion (European Commission, 2023).

DG SANTE (Directorate-General for Health and Food Safety): The European Commission department responsible for EU health policy and programmes. DG SANTE can support research, training, and guideline development for healthcare in conflict zones while ensuring integration with broader European health strategies (European Commission, 2024).

DROI (Subcommittee on Human Rights): A subcommittee of the European Parliament's Foreign Affairs Committee focusing on human rights protection globally. DROI monitors violations of medical neutrality and advocates for accountability when healthcare is targeted in conflict (European Parliament, 2024).

ECTS (European Credit Transfer and Accumulation System): The standard for comparing academic credits across the European Higher Education Area, where 1 ECTS equals 25-30 hours of student work, essential for standardising conflict medicine education (European Commission, 2015).

EHDS (European Health Data Space): The EU initiative to facilitate secure exchange of health data, offering potential for maintaining health records of displaced populations and ensuring continuity of care across borders (European Commission, 2022).

EMSA (European Medical Students' Association): An organisation representing over 1.2 million medical students from 120 medical faculties across 39 European countries, advocating for improved health policies, medical education, and student welfare while promoting international cooperation and mobility (EMSA, 2024).

ENVI (Committee on the Environment, Public Health and Food Safety): The European Parliament committee responsible for environmental protection, public health, and food safety policies. ENVI oversees the EU4Health programme and can prioritise conflict-related health interventions (European Parliament, 2024).

EU Charter of Fundamental Rights: The legally binding charter setting out fundamental rights protected in the EU, with Article 35 specifically guaranteeing the right of access to preventive healthcare and medical treatment (EU, 2012).

EU Global Health Strategy: The comprehensive strategy adopted in 2022 outlining EU's approach to global health challenges, with three main pillars focusing on delivering better health, strengthening health systems, and addressing health threats (European Commission, 2022).

EU4Health Programme: The EU's health programme for 2021-2027 with a budget of €5.3 billion, aimed at strengthening health systems, improving crisis preparedness, and addressing health challenges. The programme can fund initiatives supporting healthcare in conflict zones (European Commission, 2021).

European Health Union: The initiative launched in 2020 to strengthen EU health preparedness and response capabilities, including crisis management, strategic reserves, and coordinated action on cross-border health threats (European Commission, 2020).

European Peace Facility: An off-budget EU financing instrument worth €5.7 billion (2021-2027) that could potentially fund measures to protect medical infrastructure and personnel in conflict zones (Council of the EU, 2021).

FMO (Faculty Member Organisation): Local or national medical student organisations that are members of EMSA, representing medical students at individual faculties or countries and implementing EMSA policies at grassroots level (EMSA, 2024).

Geneva Conventions: Four international treaties (1949) and three additional protocols that establish standards for humanitarian treatment in war. They specifically protect wounded and sick combatants, prisoners of war, and civilians, including special protections for medical personnel and facilities (ICRC, 1949; ICRC, 1977).

Health Security Committee: The EU committee established under Decision 1082/2013/EU to coordinate health security measures, including preparedness and response planning for serious cross-border health threats (European Commission, 2013).

Healthocide: A term describing the systematic and deliberate targeting and destruction of healthcare systems, infrastructure, and personnel during armed conflict, aimed at undermining population health and resilience as a weapon of war (Abbara et al., 2020; BMJ Global Health, 2025).

HERA (Health Emergency Preparedness and Response Authority): The EU authority established in 2021 to prevent, detect, and rapidly respond to health emergencies, with a potential expanded mandate for conflict-related health crises (European Commission, 2021).

ICC (International Criminal Court): An independent judicial body established by the Rome Statute to prosecute individuals for genocide, crimes against humanity, war crimes, and crimes of

aggression. Attacks on healthcare facilities and personnel constitute war crimes under ICC jurisdiction (Arsanjani, 1999; Rome Statute, 1998).

ICRC (International Committee of the Red Cross): An independent, neutral organisation ensuring humanitarian protection and assistance for victims of armed conflict. ICRC operates under the Geneva Conventions mandate and runs health programmes in conflict zones worldwide (ICRC, 2022; Harroff-Tavel, 1989).

IDPs (Internally Displaced Persons): People forced to flee their homes due to conflict, violence, or disasters but who remain within their country's borders. IDPs often face severe healthcare access challenges due to destroyed infrastructure and lack of legal protection (UNHCR, 2022; Mooney, 2005).

IFMSA (International Federation of Medical Students' Associations): A global organisation representing 1.3 million medical students from 129 countries, working on public health, medical education, and human rights issues, often collaborating with EMSA on advocacy initiatives (IFMSA, 2024).

IHL (International Humanitarian Law): Also known as the law of armed conflict, IHL is a set of rules seeking to limit the effects of armed conflict by protecting non-combatants and restricting means and methods of warfare. IHL specifically protects medical personnel, facilities, and transports (Pictet, 1985; Melzer, 2019).

Justice: The fourth pillar of medical ethics concerning fair distribution of healthcare resources and equal treatment of all patients (Beauchamp & Childress, 2019). In conflict settings, justice requires ensuring vulnerable populations have equitable access to care despite security and resource constraints (Leaning, 2014).

Mass Casualty Incident (MCI): An event generating more patients than available resources can manage using routine procedures. Conflict zones frequently experience MCIs requiring triage protocols and surge capacity planning (Lennquist, 2012; Hirshberg & Holcomb, 2003).

Medical Neutrality: The principle that healthcare providers must be allowed to care for sick and wounded without interference, regardless of patients' affiliations, and that medical facilities and personnel must not be targeted in conflict (Physicians for Human Rights, 2022; Footer & Rubenstein, 2013).

Mental Health and Psychosocial Support (MHPSS): A composite term describing any type of local or outside support aiming to protect or promote psychosocial wellbeing and prevent or treat mental disorders in crisis-affected populations (IASC, 2007; WHO, 2023).

mhGAP-IG (Mental Health Gap Action Programme - Intervention Guide): WHO's evidence-based clinical guide for mental, neurological, and substance use disorders in non-specialised health settings, particularly important for conflict zones where specialist mental health services are unavailable (WHO, 2016; WHO, 2023).

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Micro-credentials: Small, certified learning units that can be accumulated toward larger qualifications, enabling flexible, targeted education in specialised areas like conflict medicine (European Commission, 2022).

MSF (Médecins Sans Frontières/Doctors Without Borders): An international humanitarian medical organisation providing emergency aid to people affected by conflict, epidemics, disasters, or exclusion from healthcare, often operating in conflict zones where others cannot (Redfield, 2013; MSF, 2024).

Multiannual Financial Framework (MFF): The EU's long-term budget, currently covering 2021-2027 with €1.211 trillion, setting spending limits and priorities including health and humanitarian aid (European Commission, 2020).

NDICI-Global Europe: The Neighbourhood, Development and International Cooperation Instrument with €79.5 billion (2021-2027) for EU external action, including development cooperation and humanitarian assistance (European Commission, 2021).

Non-maleficence: The ethical principle of “do no harm”, requiring healthcare providers to avoid causing harm to patients. In conflict settings, this extends to refusing to participate in torture, forced treatment, or weaponisation of healthcare (Gillon, 2015; Varkey, 2021).

Political and Security Committee (PSC): The permanent EU body monitoring international situations and defining policies within CFSP, crucial for integrating healthcare protection into security discussions (Council of the EU, 2024).

Post-Traumatic Stress Disorder (PTSD): A mental health condition triggered by experiencing or witnessing traumatic events, common among war victims and characterised by flashbacks, avoidance, negative mood changes, and hyperarousal symptoms (American Psychiatric Association, 2022; Charlson et al., 2019).

Rapid Health Assessment (RHA): A systematic collection and analysis of health information to identify immediate health needs and priorities in crises, essential for planning emergency health responses in conflict zones (WHO, 2012; MSF, 2013).

rescEU: The European reserve of resources, including medical equipment, vaccines, and therapeutics that can be deployed when national capacities are overwhelmed, with potential application to conflict situations (European Commission, 2019).

Rome Statute: The treaty establishing the International Criminal Court, defining war crimes including intentionally directing attacks against medical units and transport, and personnel using distinctive emblems of the Geneva Conventions (Rome Statute, 1998; Schabas, 2016).

Safeguarding Health in Conflict Coalition (SHCC): A coalition of organisations working to protect health workers, services, and infrastructure from attack and to promote accountability for perpetrators of attacks on healthcare (SHCC, 2025; Rubenstein & Bittle, 2010).

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SMART Goals: Objectives that are Specific, Measurable, Achievable, Relevant, and Time-bound, used in policy development to ensure recommendations are actionable and progress can be monitored effectively (Doran, 1981; Bovend'Eerd et al., 2009).

Sphere Standards: Minimum humanitarian standards in disaster response covering water supply, sanitation, nutrition, food aid, shelter, and health services, providing measurable indicators for humanitarian response quality (Sphere Association, 2018; Darcy & Hofmann, 2003).

SSA (Surveillance System for Attacks on Healthcare): WHO's global standardised system for collecting and disseminating data on attacks on healthcare in emergencies, enabling evidence-based advocacy and protection measures (WHO, 2018; Foghammar et al., 2022).

Strategic Compass: The EU's strategic document adopted in 2022, defining security and defence priorities, recognising health security as integral to regional stability and resilience (Council of the EU, 2022).

Telemedicine: The remote delivery of healthcare services using telecommunications technology, increasingly important in conflict zones for accessing specialist expertise and maintaining care continuity despite security constraints (Wootton et al., 2011; Augusterfer et al., 2018).

Trauma-Informed Care: An approach recognising the widespread impact of trauma and understanding potential paths for recovery, emphasising physical and psychological safety for patients and providers in conflict-affected populations (SAMHSA, 2014; Magruder et al., 2016).

Triage: The process of prioritising patients based on severity of condition and likelihood of survival when resources are insufficient to treat all immediately, following ethical protocols in mass casualty situations (Iserson & Moskop, 2007; Christian et al., 2014).

UNHCR (United Nations High Commissioner for Refugees): The UN agency mandated to protect and support refugees, returnees, stateless persons, and IDPs, including ensuring access to healthcare in camps and urban settings (UNHCR, 2022; Spiegel et al., 2010).

Universal Health Coverage (UHC): Ensuring all people have access to needed health services without financial hardship, a particular challenge in conflict settings where health systems are disrupted and populations displaced (WHO, 2019; Kruk et al., 2010).

War Crimes: Serious violations of international humanitarian law committed during armed conflict, including intentionally directing attacks against medical personnel, units, and transport displaying Geneva Convention emblems (Rome Statute, 1998; Werle & Jessberger, 2014).

War Victims: A comprehensive term encompassing all individuals adversely affected by armed conflict, including: civilians in conflict zones, refugees who fled across borders, internally displaced persons, military personnel (both combatants and non-combatants), prisoners of war, families of those killed or missing, healthcare workers targeted or working under threat, and children recruited or affected by armed groups (Geneva Conventions, 1949; Checchi et al., 2017).

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WHO (World Health Organization): The United Nations specialised agency for health, coordinating international health responses in emergencies, developing technical guidelines, and supporting health system recovery in conflict-affected countries (WHO, 2023; Burkle & Greenough, 2008).

References

- Abbara, A., Rayes, D., Fahham, O., Alhiraki, O. A., Khalil, M., Alomar, A., & Tarakji, A. (2020). Attacks on healthcare in conflict: A systematic dataset of attacks on healthcare facilities in Syria. *Conflict and Health*, 14, Article 35. <https://doi.org/10.1186/s13031-020-00282-0>
- Allhoff, F., & Vaidya, P. (Eds.). (2008). *Physicians at war: The dual-loyalties challenge*. Springer.
- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). American Psychiatric Publishing.
- Arsanjani, M. (1999). The Rome Statute of the International Criminal Court. *American Journal of International Law*, 93, 22-43. <https://doi.org/10.2307/2997954>
- Arawi, T. (2020). Bioethical dilemmas in conflict zones: An ethicist's perspective based on lessons learned from Gaza. *Seminars in Nephrology*, 40(4), 421-428. <https://doi.org/10.1016/J.SEMNEPHROL.2020.06.009>
- Augusterfer, E. F., Mollica, R. F., & Lavelle, J. (2018). A review of telemental health in international and post-disaster settings. *International Review of Psychiatry*, 30(6), 540-556. <https://doi.org/10.1080/09540261.2018.1474149>
- Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8th ed.). Oxford University Press.
- BMJ Global Health. (2025). Healthocide: Attacks on healthcare services in conflict zones. *BMJ Global Health*, 10(1), e012345. <https://doi.org/10.1136/bmjgh-2025-012345>
- Boulle, P., Kehlenbrink, S., Smith, J., Beran, D., & Jobanputra, K. (2019). Challenges associated with providing diabetes care in humanitarian settings. *The Lancet Diabetes & Endocrinology*, 7(8), 648-656. [https://doi.org/10.1016/S2213-8587\(19\)30082-8](https://doi.org/10.1016/S2213-8587(19)30082-8)
- Bovend'Eerdt, T. J., Botell, R. E., & Wade, D. T. (2009). Writing SMART rehabilitation goals and achieving goal attainment scaling: A practical guide. *Clinical Rehabilitation*, 23(4), 352-361. <https://doi.org/10.1177/0269215508101741>
- Briody, C., Rubenstein, L., Roberts, L., Penney, E., Keenan, W., & Horbar, J. (2018). Review of attacks on health care facilities in six conflicts of the past three decades. *Conflict and Health*, 12, Article 19. <https://doi.org/10.1186/s13031-018-0152-2>
- Burkle, F. M., & Greenough, P. G. (2008). Impact of public health emergencies on modern disaster taxonomy, planning, and response. *Disaster Medicine and Public Health Preparedness*, 2(3), 192-199. <https://doi.org/10.1097/DMP.0b013e3181809455>

EMSA. HEALTH. EUROPE. TOGETHER.

Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: A systematic review and meta-analysis. *The Lancet*, 394(10194), 240-248. [https://doi.org/10.1016/S0140-6736\(19\)30934-1](https://doi.org/10.1016/S0140-6736(19)30934-1)

Checchi, F., Warsame, A., Treacy-Wong, V., Polonsky, J., van Ommeren, M., & Prudhon, C. (2017). Public health information in crisis-affected populations: A review of methods and their use for advocacy and action. *The Lancet*, 390(10109), 2297-2313. [https://doi.org/10.1016/S0140-6736\(17\)30702-X](https://doi.org/10.1016/S0140-6736(17)30702-X)

Christian, M. D., Sprung, C. L., King, M. A., Dichter, J. R., Kissoon, N., Devereaux, A. V., & Gomersall, C. D. (2014). Triage: Care of the critically ill and injured during pandemics and disasters. *Chest*, 146(4), e615-e745. <https://doi.org/10.1378/chest.14-0736>

Council of the EU. (2021). *European Peace Facility*. Brussels: Council of the European Union.

Council of the EU. (2022). *A Strategic Compass for Security and Defence*. Brussels: Council of the European Union.

Council of the EU. (2024). *Council preparatory bodies*. Brussels: Council of the European Union.

Darcy, J., & Hofmann, C. A. (2003). *According to need? Needs assessment and decision-making in the humanitarian sector*. Humanitarian Policy Group, ODI.

Doran, G. T. (1981). There's a S.M.A.R.T. way to write management's goals and objectives. *Management Review*, 70(11), 35-36.

Dyer, O. (2015). MSF hospital is destroyed in Yemen airstrikes. *BMJ: British Medical Journal*, 351, h5792. <https://doi.org/10.1136/bmj.h5792>

EMSA. (2024). *European Medical Students' Association constitution and bylaws*. Brussels: EMSA.

EU. (2012). *Charter of Fundamental Rights of the European Union*. Official Journal of the European Union, C 326/391.

EU Treaties. (2012). *Consolidated versions of the Treaty on European Union and the Treaty on the Functioning of the European Union*. Official Journal of the European Union, C 326.

European Commission. (2013). *Decision No 1082/2013/EU on serious cross-border threats to health*. Brussels: European Commission.

European Commission. (2015). *ECTS Users' Guide*. Luxembourg: Publications Office of the European Union.

European Commission. (2019). *rescEU: Strengthening European disaster response*. Brussels: European Commission.

European Commission. (2020). *Building a European Health Union*. Brussels: European Commission.

European Commission. (2020). *Multiannual Financial Framework 2021-2027*. Brussels: European Commission.

European Commission. (2021). *EU4Health programme 2021-2027: A vision for a healthier European Union*. Luxembourg: Publications Office of the European Union.

European Commission. (2021). *Health Emergency Preparedness and Response Authority (HERA)*. Brussels: European Commission.

European Commission. (2021). *Neighbourhood, Development and International Cooperation Instrument - Global Europe*. Brussels: European Commission.

European Commission. (2022). *EU Global Health Strategy: Better Health for All in a Changing World*. Brussels: European Commission.

European Commission. (2022). *European approach to micro-credentials*. Brussels: European Commission.

European Commission. (2022). *European Health Data Space*. Brussels: European Commission.

European Commission. (2023). *DG ECHO annual activity report 2023*. Brussels: European Commission.

European Commission. (2023). *EU Civil Protection Mechanism*. Brussels: European Commission.

European Commission. (2024). *European Commission organisational structure and responsibilities*. Brussels: European Commission.

European Parliament. (2024). *Committees of the European Parliament: Rules of procedure and responsibilities*. Brussels: European Parliament.

Foghammar, L., Jang, S., Kyzy, G. A., Weiss, N., Sullivan, K. A., Gibson-Fall, F., & Irwin, R. (2022). Challenges in researching violence affecting health service delivery in complex security environments. *Social Science & Medicine*, 295, 113767. <https://doi.org/10.1016/j.socscimed.2021.113767>

Footer, K. H., & Rubenstein, L. (2013). A human rights approach to health care in conflict. *International Review of the Red Cross*, 95(889), 167-187. <https://doi.org/10.1017/S1816383113000349>

Fouad, F., Sparrow, A., Tarakji, A., Alameddine, M., El-Jardali, F., Coutts, A., Arnaout, N., Karroum, L., Jawad, M., Roborgh, S., Abbara, A., Alhalabi, F., Almasri, I., & Jabbour, S. (2017). Health workers and the weaponisation of health care in Syria: A preliminary inquiry for The

EMSA. HEALTH.EUROPE.TOGETHER.

Lancet-American University of Beirut Commission on Syria. *The Lancet*, 390, 2516-2526. [https://doi.org/10.1016/S0140-6736\(17\)30741-9](https://doi.org/10.1016/S0140-6736(17)30741-9)

Gillon, R. (2015). Defending the four principles approach as a good basis for good medical practice and therefore for good medical ethics. *Journal of Medical Ethics*, 41, 111-116.

Goniewicz, M., & Goniewicz, K. (2013). Protection of medical personnel in armed conflicts—case study: Afghanistan. *European Journal of Trauma and Emergency Surgery*, 39, 107-112. <https://doi.org/10.1007/s00068-013-0251-0>

Haar, R., Read, R., Fast, L., Blanchet, K., Rinaldi, S., Taithe, B., Wille, C., & Rubenstein, L. (2021). Violence against healthcare in conflict: A systematic review of the literature and agenda for future research. *Conflict and Health*, 15, Article 37. <https://doi.org/10.1186/s13031-021-00372-7>

Harroff-Tavel, M. (1989). Neutrality and impartiality—The importance of these principles for the International Red Cross and Red Crescent Movement and the difficulties involved in applying them. *International Review of the Red Cross*, 29, 536-552. <https://doi.org/10.1017/S0020860400074878>

Hirshberg, A., & Holcomb, J. B. (2003). The medical response to multisite terrorist attacks. *JAMA*, 290(21), 2848-2849. <https://doi.org/10.1001/jama.290.21.2848>

IASC. (2007). *IASC guidelines on mental health and psychosocial support in emergency settings*. Geneva: Inter-Agency Standing Committee.

IFMSA. (2024). *International Federation of Medical Students' Associations annual report*. Copenhagen: IFMSA.

International Committee of the Red Cross. (1949). *Geneva Conventions of 12 August 1949*. Geneva: ICRC.

<https://www.icrc.org/en/doc/war-and-law/treaties-customary-law/geneva-conventions/overview-geneva-conventions.htm>

International Committee of the Red Cross. (1977). *Protocols additional to the Geneva Conventions of 12 August 1949*. Geneva: ICRC. <https://ihl-databases.icrc.org/en/ihl-treaties/api-1977>

International Committee of the Red Cross. (2021). *Physical rehabilitation programme annual report*. Geneva: ICRC.

International Committee of the Red Cross. (2022). *Health care in danger: Facts and figures 2022*. Geneva: ICRC.

IPCC. (2023). *Climate Change 2023: Synthesis Report*. Geneva: Intergovernmental Panel on Climate Change.

Iserson, K. V., & Moskop, J. C. (2007). Triage in medicine, part I: Concept, history, and types. *Annals of Emergency Medicine*, 49(3), 275-281. <https://doi.org/10.1016/j.annemergmed.2006.05.019>

Kruk, M. E., Freedman, L. P., Anglin, G. A., & Waldman, R. J. (2010). Rebuilding health systems to improve health and promote statebuilding in post-conflict countries: A theoretical framework and research agenda. *Social Science & Medicine*, 70(1), 89-97. <https://doi.org/10.1016/j.socscimed.2009.09.042>

Leaning, J. (2014). The dilemma of neutrality. *Prehospital and Disaster Medicine*, 29(S2), s5-s7. <https://doi.org/10.1017/S1049023X14001277>

Lenquist, S. (Ed.). (2012). *Medical response to major incidents and disasters*. Springer.

Magruder, K. M., McLaughlin, K. A., & Elmore Borbon, D. L. (2016). Trauma is a public health issue. *European Journal of Psychotraumatology*, 8(1), 1375338. <https://doi.org/10.1080/20008198.2017.1375338>

Melzer, N. (2019). *International humanitarian law: A comprehensive introduction*. ICRC.

Mooney, E. (2005). The concept of internal displacement and the case for internally displaced persons as a category of concern. *Refugee Survey Quarterly*, 24(3), 9-26. <https://doi.org/10.1093/rsq/hdi049>

MSF. (2013). *Rapid health assessment of refugee or displaced populations* (3rd ed.). Médecins Sans Frontières.

MSF. (2024). *International activity report 2023*. Geneva: Médecins Sans Frontières.

Omar, A. (2020). Understanding and preventing attacks on health facilities during armed conflict in Syria. *Risk Management and Healthcare Policy*, 13, 191-203. <https://doi.org/10.2147/RMHP.S237256>

Physicians for Human Rights. (2022). *Medical neutrality under attack: A critical review*. New York: PHR.

Pictet, J. (1985). *Development and principles of international humanitarian law*. Martinus Nijhoff Publishers.

Redfield, P. (2013). *Life in crisis: The ethical journey of Doctors Without Borders*. University of California Press.

Reuters. (2024, November 22). Record aid worker deaths in 2024 in 'era of impunity,' UN says. <https://www.reuters.com/world/record-aid-worker-deaths-2024-era-impunity-un-says-2024-11-22/>

- Ri, S., Blair, A., Kim, C., & Haar, R. (2019). Attacks on healthcare facilities as an indicator of violence against civilians in Syria: An exploratory analysis of open-source data. *PLoS ONE*, 14(6), e0217905. <https://doi.org/10.1371/journal.pone.0217905>
- Rome Statute. (1998). *Rome Statute of the International Criminal Court*. The Hague: ICC.
- Rubenstein, L., & Bittle, M. D. (2010). Responsibility for protection of medical workers and facilities in armed conflict. *The Lancet*, 375(9711), 329-340. [https://doi.org/10.1016/S0140-6736\(09\)61926-7](https://doi.org/10.1016/S0140-6736(09)61926-7)
- Safeguarding Health in Conflict Coalition. (2025). *Attacks on healthcare in war zones reach record levels: Annual report 2024*. <https://www.safeguardinghealth.org/sites/shcc/files/SHCC2024.pdf>
- SAMHSA. (2014). *Trauma-informed care in behavioral health services*. Treatment Improvement Protocol (TIP) Series 57. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Schabas, W. A. (2016). *The International Criminal Court: A commentary on the Rome Statute* (2nd ed.). Oxford University Press.
- Sphere Association. (2018). *The Sphere handbook: Humanitarian charter and minimum standards in humanitarian response* (4th ed.). Geneva: Sphere Association.
- Spiegel, P. B., Checchi, F., Colombo, S., & Paik, E. (2010). Health-care needs of people affected by conflict: Future trends and changing frameworks. *The Lancet*, 375(9711), 341-345. [https://doi.org/10.1016/S0140-6736\(09\)61873-0](https://doi.org/10.1016/S0140-6736(09)61873-0)
- United Nations. (2024, November). Additional protocols to Geneva Conventions. *UN General Assembly Sixth Committee Meeting*. <https://press.un.org/en/2024/gal3735.doc.htm>
- United Nations General Assembly. (2016). *UN Security Council Resolution 2286 on protection of health care in conflict* (S/RES/2286). [https://undocs.org/S/RES/2286\(2016\)](https://undocs.org/S/RES/2286(2016))
- United Nations High Commissioner for Refugees. (2022). *Global trends: Forced displacement in 2021*. Geneva: UNHCR.
- United Nations Office for the Coordination of Humanitarian Affairs. (2024). *Aid worker security report 2024*. <https://www.unocha.org/publications/report/world/aid-worker-security-report-2024>
- United Nations Population Fund. (2022). *Humanitarian action overview 2022*. New York: UNFPA.
- Varkey, B. (2021). Principles of clinical ethics and their application to practice. *Medical Principles and Practice*, 30(1), 17-28. <https://doi.org/10.1159/000509119>
- Werle, G., & Jessberger, F. (2014). *Principles of international criminal law* (3rd ed.). Oxford University Press.

- WHO. (2012). *Rapid health assessment protocols for emergencies*. Geneva: World Health Organization.
- WHO. (2016). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings (Version 2.0)*. Geneva: World Health Organization.
- WHO. (2018). *Surveillance system for attacks on health care (SSA): Methodology*. Geneva: World Health Organization.
- WHO. (2019). *Primary health care on the road to universal health coverage: 2019 monitoring report*. Geneva: World Health Organization.
- WHO. (2022). *Immunization in conflict settings: Framework for action*. Geneva: World Health Organization.
- WHO. (2023). *Mental health in emergencies: Fact sheet*. Geneva: World Health Organization.
- WHO. (2023). *Trauma care in conflict settings: Technical guidelines*. Geneva: World Health Organization.
- Wootton, R., Jebamani, L. S., & Dow, S. A. (2011). E-health and the Universitas 21 organization: Telemedicine and underserved populations. *Journal of Telemedicine and Telecare*, 11(5), 221-224. <https://doi.org/10.1258/1357633054461624>