Rehabilitation in conflict – webinar 2 transcript

Edited transcript
This transcript has been edited for clarity, readability, and accessibility. Timestamps have been removed, speaker names have been added, repeated phrases and transcription errors have been cleaned up, and content has been grouped into clear paragraphs to support translation tools and screen readers.

Erica Blakely (Chair)

My name is Erica Blakely. I am an occupational therapist from Australia, and I am delighted to chair this session today in my role as Chair of the World Rehab Alliance's Emergencies Workstream.

Today we have a hugely impressive panel of experts to discuss their experiences and perspectives on providing rehabilitation in conflict. Our panellists are either living and working in conflict-affected areas or regularly working in these environments, and they have highly relevant, current tips and advice to share with colleagues doing similar work.

I will introduce our panellists first, and then we will begin the discussion.

First, we have **Fatima Nasser Eddine**, representing **Humanity & Inclusion**. Fatima is a Lebanese physical therapist with a master's degree in public health and physical education. She has worked in the humanitarian field for more than 13 years, primarily in emergency contexts across Lebanon, Syria, Iraq, Yemen, Jordan, the Central African Republic, the Democratic Republic of Congo, and Haiti. She currently works as a rehabilitation specialist for the Palestine mission.

Next, we have **Verena Kreiliger Young**, representing the **International Committee of the Red Cross (ICRC)**. She is currently based in Amman, Jordan, but trained in Switzerland and completed postgraduate studies in New Zealand, where she now resides. She has more than six years' experience with the ICRC, including over two years in her current role with the hospital team, and has worked extensively across the Eastern Mediterranean region and other conflict-affected areas where the ICRC operates. She brings expertise across the full continuum of care, from early rehabilitation to reintegration, and her experience spans both the humanitarian sector and New Zealand's governmental healthcare system.

We also have **Feras Swairjo**. Feras is a physiotherapy activity manager with **Médecins Sans Frontières (MSF)** and has 11 years of experience working in rehabilitation in emergency and conflict areas. He is currently based in Gaza and has worked across multiple conflicts, providing rehabilitation for patients with severe injuries including burns, amputations, and complex trauma, always in close collaboration with multidisciplinary teams. He has contributed to early rehabilitation for amputees during his work with MSF in Ukraine and focuses on clinical supervision, capacity building, and practical rehabilitation approaches in resource-limited, high-pressure environments. He is particularly interested in early rehabilitation in emergencies and in sharing field-based strategies to prevent long-term disability and improve functional outcomes.

Next, we have **Dr Charles Khalife**. Dr Khalife is a Doctor of Physiotherapy with a master's degree and over 15 years of experience in clinical rehabilitation, programme coordination, and humanitarian medical response. He is currently Head of the Department of Physical Therapy at the Lebanese German University and has served as head of the Rehabilitation Centre at Hôpital Kortbawi. He also works as a physiotherapist at LAU Saint John's Hospital and is actively involved in emergency response as part of the search and rescue team at the Lebanese Civil Defence. He also serves as the official representative of **Pompiers Sans Frontières**, a French NGO. Beyond his clinical and volunteer work, he is passionate about education and mentorship, guiding physiotherapy students and young professionals in developing their skills and professional growth. He specialises in

coordinating multidisciplinary teams and designing training programmes that integrate academic knowledge with practical experience.

Finally, but certainly not least, we have **Amani Alserr**, representing **WHO in Gaza**. Amani is a physiotherapy and rehabilitation officer with the WHO Office for the Occupied Palestinian Territory and serves as Gaza Rehabilitation Task Force Coordinator. She is working hard to strengthen rehabilitation services in emergency contexts and is passionate about improving access to care for people with injuries and disabilities, while integrating data-driven approaches to enhance the quality, coordination, and impact of rehabilitation services.

As you can all see, this is a very impressive panel with highly relevant experience, and I am delighted to begin our discussion.

So firstly, I am going to go to Dr Charles.

Dr Charles, Lebanon is one of the many countries in the region currently affected by conflict. Can you describe some of the main challenges when delivering rehabilitation services in these areas?

Dr Charles Khalife

Good evening, everyone.

I will give a brief overview of our work in Lebanon with the Lebanese Order of Physiotherapists. Two years ago, during the war in 2024, the Lebanese Order of Physiotherapists created a crisis cell. Through this crisis cell, we brought together many volunteer Lebanese physiotherapists from across the country.

Lebanon is not a large country, and many of us know one another. But during the 2024 war, and again now, some regions have been much more affected than others. That creates a major challenge because the healthcare system becomes fragmented.

For example, the situation in the south is quite different from what we see in the north, Keserwan, or Beirut. This fragmentation causes serious problems for hospitals, private clinics, and rehabilitation centres.

A second major problem is infrastructure damage. If we need to help displaced people, there is a big challenge because we cannot easily move around the whole country. So, the small LOPT teams we created are volunteer teams in different regions. These volunteer physiotherapists help prioritise and support displaced people.

For example, a patient may have previously gone to a clinic in the south, but now that clinic no longer exists, or the physiotherapist there may also have been displaced. When that patient moves to another region, we try to support them through our volunteer groups there.

Another major challenge is the high patient demand. The number of injured people has increased, and we are also seeing more people with chronic disabilities whose needs continue during the crisis.

For example, after the recent attack in Beirut, we had many injured people. We called for volunteers to help with early rehabilitation and wound support, not only rehabilitation.

We are also dealing with economic problems. Many people cannot afford to pay for sessions. Volunteers can help with some sessions, but they cannot do this every day because they also have their normal patients and jobs.

Security is another major challenge. The problem is not limited to one region. It affects the whole country, and that makes access and continuity exceedingly difficult.

So, we help as much as we can. We continue to operate the crisis cell, but we still need more support. We have shortages of materials and a shortage of centres. Some rehabilitation is now being done in shelters, which may be camps or schools.

We go to these shelters and provide physiotherapy sessions there. We also work in more of a consultancy role. If someone has, for example, a hip injury, we may help arrange a bed, crutches, or splints.

These are the main problems we are facing, and we are trying to work across the whole country to address them.

I would also like to add one point. At the beginning of the 2024 war, when we created the crisis cell, we did it with President Saydeh Sassine and Dr Mike Landry. We also collaborated with colleagues from HI, ICRC, Interburns, and others to train physiotherapists across all regions of Lebanon.

Early rehabilitation was not something familiar in Lebanon before this. We have exceptionally good physiotherapists and a strong healthcare system, but this specific approach to early rehabilitation in crisis response was not something we had fully developed.

So, over the course of around a year to a year and a half, we delivered many specific training sessions to increase the number of physiotherapists within the LOPT who could work across Lebanon and support the greatest possible number of displaced people.

Erica Blakely (Chair)

That is really interesting, Charles, because that is quite a rapid change in approach in a brief period of time. It is impressive that you have been able to establish early rehabilitation in a setting where that was not already part of standard practice.

Would any of the other panellists like to add anything to the discussion about the challenges of delivering rehabilitation services in these environments?

Verena, go ahead.

Verena Kreiliger Young (ICRC)

Thank you very much, Charles.

I think what you said highlights a crucial point. Most of our physiotherapy education is not geared towards conflict, and in conflict we see quite different, often more serious, and more specific injuries.

So, I really commend the work in Lebanon. You recognised that pressure was building and that you needed to prepare your workforce. That is a lesson all of us can learn from, because situations change quickly and the demands in conflict are extremely specific, especially in the current context.

It is a good example of how, although none of us ever want to be in these situations, they can sometimes act as a catalyst for system strengthening. So again, congratulations to the LOPT and your colleagues.

Erica Blakely (Chair)

Thank you, Verena.

Amani, Feras, or Fatima, would you like to add anything?

Amani Alserr (WHO, Gaza)

I would like to add one point related to the challenges.

In Gaza specifically, we have a massive number of spinal cord injuries, traumatic brain injuries, and newly amputated cases. Due to extremely limited bed capacity and the daily mass casualty caseload, we are losing quality and specialised rehabilitation for those patients, especially the most complex spinal cord injury cases, such as ASIA A and ASIA B injuries.

Unfortunately, this is leading to an increase in permanent disabilities, and that is one of the major warning signs across all our activities in Gaza.

The second point is specific to the Gaza context. There are severe restrictions on assistive products entering Gaza because they are considered dual-use items. This has a direct impact on reintegration. People feel isolated and cannot rejoin their communities or resume daily activities, especially patients with conditions such as hemiplegia or paraplegia.

Erica Blakely (Chair)

Thanks, Amani. Feras, over to you.

Feras Swairjo (MSF)

I think one important lesson from these difficulties is that physiotherapists should be prepared for mass casualties.

It is better to have a plan and provide training for all health workers so they can be involved in the triage system during mass casualty events.

In Gaza, we prepared for this in advance. We trained our team, including physiotherapists and occupational therapists, to be part of the triage system during mass casualties.

We saw this happen in practice at the Gaza clinic in Gaza City, when a shelling happened about twenty metres away from the clinic. Within two minutes, we converted the clinic into a triage area using a colour-coded system, and all the physiotherapists were involved.

It was a primary response, not a fully developed advance system, but at least the team was able to do something at the first step: first aid, separating patients, and setting up the colour-coded zones.

That was extremely helpful in getting injured people transferred quickly by ambulance to the nearest hospitals, and it saved many lives.

From this experience, I strongly recommend that wherever mass casualties are possible, people should prepare for it. Physiotherapists are intelligent, capable professionals and they can take on this role.

Erica Blakely (Chair)

Thank you, Feras. I agree. I think rehabilitation professionals have too often been kept at arm’s length from mass casualty triage, when in fact we are very capable of contributing to that initial sorting process. It is an important way to support the wider health response.

Fatima, you had your hand up?

Fatima Nasser Eddine (Humanity & Inclusion)

Yes. I just want to add one point.

Sometimes the overall scenario is not what determines the intervention. In Lebanon, yes, there was induction training and capacity building. In other countries, such as Syria and other conflict settings, what is often missing is the inpatient rehabilitation component.

When there is large-scale destruction of health facilities, small facilities begin functioning as hospitals. But rehabilitation still becomes the third-tier service, or the service left until last.

People assume rehabilitation can happen later, in shelters or community settings, but in inpatient hospitals, in departments, and in primary healthcare centres that have effectively become hospitals, rehabilitation should already be there.

The same applies to field hospitals. Too often, rehabilitation becomes the last thing considered.

My recommendation in any conflict setting is to continue advocating for rehabilitation professionals to be part of emergency medical teams. On paper, rehabilitation is often included in EMTs, but especially in the Middle East, rehabilitation is still often missing from that structure.

There are many reasons for this, including economic challenges and limited access to assistive technology, but that is also an area for advocacy. Assistive technology must be seen as part of the response.

At the same time, rehabilitation professionals themselves and their professional associations need to advocate for inclusion from the first day of a response.

Even in very developed countries, once conflict begins, rehabilitation is often not seen as a priority. The scenario tends to focus on shelters, displacement, and large hospitals. But small primary health centres often become hospitals, and rehabilitation services need to be included there too, in the most inclusive way possible.

That is my point. Thank you.

Erica Blakely (Chair)

Absolutely. I completely agree.

I think we could do an entire additional session just on how to make that integration happen. It is such a missed opportunity when health systems do not include rehabilitation at the earliest stage of care, because they may not realise what they are missing and how rehabilitation can support the functioning of the entire system.

I am going to move on to our next question.

Feras, this one is for you. Working in conflict can be extremely stressful, especially when you are from the affected area yourself. How do you take care of yourself, and do you have any tips for colleagues who may be in similar situations?

Feras Swairjo (MSF)

To be honest, this is a reality.

People are working under intense stress, especially when they are also living in the same conflict conditions. Working and living in the same context causes a double level of distress.

I would answer this in two parts: how to take care of yourself when you go back home, and how to take care of yourself during work.

The organisation can also help reduce some of these pressures through coordination and support.

Starting with living conditions: many workers, including physiotherapists, occupational therapists, and other health workers, go back not to a normal home but to a shelter. It is not like a bunker. It is simply shelter above the ground, and it may be close to danger, putting family members and colleagues at risk.

The organisation provides shelters for staff and their families in special places. This is coordinated according to the conflict situation, and it does reduce stress because at least people feel safer when they return to their families.

There is also dedicated support from our mental health and psychosocial support colleagues. They organise activities, encourage staff to play with their children, and try to create moments of enjoyment. We are encouraged to gather for meals, especially dinner, because most of us return to the shelter late.

We have dinner together, talk about our fears, and try to calm each other. Living and working together creates some positive support, especially when combined with small social activities like games, football, and time with the children. These things really help reduce stress.

The organisation also provides transport between the shelter and the hospital or clinic, and that movement is coordinated and flagged. Feeling safer going to and from work also makes a significant difference.

The work environment is even more stressful than the shelter because you are face to face with severe injuries every day.

From the management side, we try to reduce this by not putting too much pressure on staff. If someone feels they cannot continue in one role, we move them to another place with less pressure. We also rotate the staff.

Rotation is extremely helpful. It supports good performance and helps people tolerate the pressure. We try to rotate staff daily. For example, a physiotherapist may work in triage one day, then the next day alongside nurses in the dressing room, and then another day in the rehabilitation hall or department.

This way, they are not always exposed to the same kinds of complex or severe cases every day. That helps reduce stress.

We also encourage staff to take several breaks, not to work seven or eight hours continuously. Even taking five minutes after each patient to breathe, or step outside, helps.

We tell staff not to be shy about saying when they are tired. If you feel too much pressure, say so. You can stop, and another colleague can help. You can also go and speak with the mental health team.

These steps help maintain people’s performance even in a high-stress environment.

We also encourage staff to stay in contact with their families. They may step outside, call their wife or children, and see whether they need anything. If they find something useful, they can take it back to the shelter.

At the end of the day, we also gather to discuss difficult cases. We talk about the case itself, how we feel, and what the treatment plan should be. When there are so many cases, it is easy to lose focus and concentration. Discussing things together helps us support one another and find better plans for patients.

We may also change the setting where someone works. Today someone may work in the hospital, and tomorrow in the outpatient clinic. We know this can affect continuity of care, and ideally, we want staff to be patient coaches, but in a mass casualty situation the scale is so large that we must adapt.

We also need to accept that we cannot help everyone. That is a fact. We remind each other of that. We do our best, but we must accept that sometimes we will lose someone, or that we cannot help everyone at the same time.

So, the message is: do your best and be proud of the small things you can do. They are valuable. They are needed in these moments.

That is how we try to reduce the stress.

Erica Blakely (Chair)

Thank you, Feras. It sounds like you have a very thoughtful system and process in place, even in such difficult circumstances.

I am interested to know whether, before this current conflict or escalation in Gaza, it was already common for staff to engage with mental health support services. Or is this something newer that people have had to get used to?

Feras Swairjo (MSF)

Mental health support has always been an important part of our organisation. It is a core element.

We have one team supporting colleagues and another supporting patients. This system existed before the war, but not on the same scale we have now.

Since the war began, the activity has increased a lot. The mental health teams are now involved much more regularly, even within patient sessions.

For example, when a patient is in pain, the team may help with pain management. They may distract the patient, use storytelling, especially with children, and support the session emotionally.

As physiotherapists, we often call them in to support us during decision-making, and they are fully engaged.

Erica Blakely (Chair)

That is interesting.

I am conscious of time, so I will ask whether any of the other panellists have brief advice or tips they would like to share on taking care of yourselves in these environments.

No? That is fine.

Thank you again, Feras. We may come back to this topic later if there are more audience questions. For now, we will move to the next question.

Fatima, the question for you is: what other skills do rehabilitation professionals need to work effectively in conflict? This is a question that comes up a lot in discussions around rehabilitation in emergencies, so I would be extremely interested to hear your perspective.

Fatima Nasser Eddine (Humanity & Inclusion)

To answer this, I want to place the discussion clearly within the emergency context.

All rehabilitation professionals receive core skills during their education. But in a conflict scenario, those skills change. Beyond clinical expertise, a rehabilitation professional needs to combine technical, practical, and interpersonal skills.

If we think about the environment itself, the difference is huge between a rehabilitation centre in a calm setting and a rehabilitation unit established in an active conflict zone. In Gaza, for example, the options available are often the best possible under extremely difficult circumstances.

We have already spoken about early rehabilitation. But what does that really mean? It means the physiotherapist or rehabilitation professional must be ready and have the knowledge to recognise that if they do not intervene now, the person may be left with a long-term disability.

At the same time, working in these conditions also requires strong safety and security awareness. Professionals need to be able to assess safety in the environment as part of their work.

Some clinical skills also need to be more advanced—for example, bandaging or stump management. In a traditional rehabilitation setting, outside conflict, you may have access to all the right equipment and conditions. In emergency settings, which is often not the case.

That means every professional also needs to understand infection prevention and control measures. They may be working outside, or in settings where conditions are poor, but they still need to protect themselves and their patients.

Because resources and equipment are limited, professionals also need to be able to adapt and solve problems. Rehabilitation in conflict cannot be provided by a physiotherapist alone. It must involve the patient, the caregiver, and other professionals.

That means the work must be multidisciplinary. It may involve occupational therapists, speech therapists, and especially strong integration with mental health and psychosocial support.

Professionals need to be highly adaptable, because they may see cases they have never seen before, work in conditions they have never worked in before, and face access challenges far greater than in other contexts.

I also want to mention something beyond the technical side. We are not only physical therapists or rehabilitation professionals. We are also human beings.

Conflict does not cause only loss of function. It may also involve loss of family, loss of life, and loss of memories.

So, the rehabilitation professional needs empathy, resilience, and strong ethical and emotional adaptability. They need to communicate well and understand that their role is to help the patient move back toward participation in life.

So, my main message is this: in conflict, strong clinical skills are essential, especially in early rehabilitation, but professionals also need flexibility, resilience, ethical awareness, emotional strength, and the ability to work under pressure.

They must be able to imagine the scenario and be ready for whatever conditions they may need to work in.

Erica Blakely (Chair)

Thank you, Fatima.

What you have described really applies across all rehabilitation professions working in conflict environments. Physiotherapists may sometimes be the largest group, but the same kinds of skills apply to occupational therapists, prosthetists and orthotists, and rehabilitation physicians as well.

If we focus specifically on occupational therapy and prosthetics and orthotics—and I am throwing you in at the deep end a little here—could you share some observations on how occupational therapy practice has changed since the onset of conflict? Are occupational therapists seeing different patients or prioritising treatment differently now that they are working in a very acute emergency setting?

Fatima Nasser Eddine (Humanity & Inclusion)

Yes. Occupational therapy becomes part of the comprehensive approach. It becomes part of the initial assessment.

For example, when we assess patients, we stop focusing only on clinical forms and trauma scores. We also look at functional scores. As soon as you do that, it naturally brings occupational therapists into the process.

I am not saying physiotherapists do not work on function, or that occupational therapists only do that work. But in conflict settings, because we have so many kinds of cases, we really need a multidisciplinary case management approach.

Some people have loss of function that is permanent, while others may recover. Occupational therapists have a particularly strong role in adaptation, motor skills, and accessibility.

In the Gaza response, for example, occupational therapists have brought significant value through their work on adaptation and accessibility.

Previously, accessibility was often only seen in terms of buildings or construction, and there was not enough recognition of what occupational therapists or other functional rehabilitation professionals could contribute. That is changing.

I can give an example from another context. In Haiti, we had a small project on functional empowerment. It was not the same kind of conflict setting, but it was still a crisis setting, and we were collaborating with people affected by the crisis who had lost functional ability—not necessarily because of injury, but because they had lost the ability to do everyday things.

In that project, we discussed what would be most useful from a functional perspective. We created group sessions that included occupational therapists, physiotherapists, and psychologists. Our goal was to support social participation and daily life activities through practical exercises.

What we found was that sometimes we focus only on the large components of rehabilitation, when smaller functional interventions can make a big difference.

So, for me, that is a good example of comprehensive rehabilitation. Each profession has a role, but none can work alone.

That is one of the big differences in conflict. In a calm, well-resourced rehabilitation centre, people may go directly to one professional or another. In conflict, we have learned that working together around a single functional objective is much more effective.

That is something we see clearly in the field.

Erica Blakely (Chair)

Thank you so much. That was a brilliant example.

We will move on now and welcome Amani back.

Amani, we would like to hear from you about the most familiar challenges you have encountered while working in conflict, and how you have been working around these to deliver rehabilitation services.

Amani Alserr (WHO, Gaza)

Thank you, Erica, and thank you to Charles for the first contribution, which really reflected many of the usual challenges we see.

These include continuous displacement, severe shortages of assistive products and supplies, and limited transportation for patients travelling between home and clinic. These are common challenges in conflict areas.

I would like to highlight three more.

The first is the harsh and catastrophic conditions in which people are living. Most people are now living in tents and in extremely difficult conditions.

Because bed capacity is extremely limited in specialised rehabilitation hospitals, and in mass casualty hospitals, many patients must be discharged early.

To respond to this in Gaza, we established what we call long-stay units or step-down units. These are intermediate places for patients before they return to the community and to very harsh living conditions.

The idea is to provide at least one place where patients can receive wound care, psychosocial support, and physiotherapy as part of a comprehensive service package, so that they are not suddenly left behind and can receive a proper home programme before returning to the community.

This has really helped reduce the development of disability, especially in people with major complex injuries, amputations, spinal cord injuries, and traumatic brain injuries.

The second point I want to talk about is the assisted product tracker system, of which I am immensely proud.

This is a unified system established across the Gaza Strip. We brought together all organisations working in the rehabilitation sector to enter data on assisted products so that we could avoid duplication for patients across Gaza.

As everyone knows, access to assistive products in Gaza is extremely restricted, and many of these items are considered dual-use.

At that point in the session, the connection became unstable, so Erica invited Feras to explain the system from his perspective.

Feras Swairjo (MSF)

The idea for the tracker was initiated by WHO because they are the main importer of assistive devices into Gaza.

Because of the conflict, we are facing a major shortage of assistive devices. Sometimes we try to manufacture things locally from whatever materials we can find.

The purpose of the tracker is to record where devices have been distributed. Some patients, understandably, may go to one organisation for crutches and then try to get another pair from a different organisation, just in case they lose the first set and want a spare.

So, the idea was to use the patient's ID number in a centralised tracker, filled in by all organisations through a direct link, coordinated by WHO.

For example, when a patient comes to an MSF clinic and receives axillary crutches, we enter only the ID number, the device received, the date, and the organisation that provided it.

If that patient then goes to another facility and asks for the same item again, the team there can check the tracker before making another donation.

This helps us understand what the patient has already received, what they still need, and which organisation provided it. That gives us a better overview of patient needs and helps us manage limited stock more rationally.

Some patients may need, in addition to assistive devices, other materials such as hygiene supplies. One organisation can provide one part, and another can provide the rest.

This system gives us a much better picture of needs, and it helps organisations use their stocks more efficiently.

We are now in the second stage of developing the tracker, which includes building a dashboard so organisations can see statistics and visual graphs—for example, how many items were distributed last month and what kinds of items they were.

This has made distribution much more controlled and much better than it was before.

Erica Blakely (Chair)

Thank you, Feras. That was an extremely helpful overview.

I also want to acknowledge the work of Amani, Claire O'Reilly, and the entire rehabilitation task force in Gaza, both for developing the tracker and for working so cohesively to implement it.

Amani, I am going to keep moving for the sake of time, but I hope you will be able to come back in again later.

Now I would like to turn to Verena from the ICRC.

Verena, could you tell us a little about humanitarian principles and why they are so important in conflict? We have seen more discussion about whether humanitarian principles are being upheld, and I think it would be useful for this group to hear more about them.

Verena Kreiliger Young (ICRC)

Thank you very much, Erica.

International humanitarian law was developed after the Second World War to protect civilians and others who are not, or are no longer, taking part in conflict. This includes humanitarian workers and those of us providing rehabilitation services in conflict settings.

There are three basic principles. Pete touched on them last week, but I will summarise them again.

The first principle is **humanity**. Humanity forbids the infliction of suffering, injury, or destruction that is not necessary to achieve a legitimate purpose in conflict.

The second is **military necessity**, which means that only the degree of force required to achieve a legitimate military purpose is permitted.

The third is **distinction**. Parties to a conflict must always distinguish between civilians and combatants to spare civilian populations and civilian property. Attacks may be directed only against military objectives.

These principles are especially important because they make it possible for us to do our work. They are the basis that allows humanitarian actors to operate, provide rehabilitation, and reduce suffering, especially among vulnerable populations.

As we know, these principles are not always respected. We recently heard that over the last three years, more than 1,000 humanitarian workers have been killed.

So clearly, these principles that underpin our work are not always being adhered to.

Recently, the ICRC President said: "I urgently call on all parties to spare civilians and civilian objects in military operations. It is their obligation under international humanitarian law. Indiscriminate warfare is indefensible and incompatible with law. States must respect and ensure respect for the rules of war in both what they are saying and what they are doing. The world cannot succumb to a political culture of prioritisation of death over life."

I know that can sound quite heavy in legal terms, but the final sentence is what drives many of us in this work—whether we are outside conflict zones or directly within them.

I also want to acknowledge that many of our workforce are themselves personally affected.

This is therefore a particularly prominent issue for all of us because it determines whether we can do our work at all.

We have heard about the struggles in Gaza, especially the reduced entry of equipment and severe shortages. But we should not give up hope that these things can improve, or that, as humanity, we can still stand up and say what kind of world we want.

I think this webinar, bringing people together as professionals, is one example of light in a very dark time.

So, thank you to everyone who has joined us—those from the region, and those from around the world.

Erica Blakely (Chair)

Thank you, Verena. It is a complicated issue, but in some ways also quite simple when you go back to the principles themselves.

This is a suitable time to bring in a question from participants.

We have had a couple of questions asking how the global community, and the wider humanitarian community, can support colleagues working in conflict-affected areas. How can we use the goodwill we see in sessions like this to advocate for and strengthen rehabilitation in the region?

Verena, I will start with you and then open it to others.

Verena Kreiliger Young (ICRC)

There are several layers to this.

First, at an individual level, people can donate to organisations that are trying to provide care but are facing major financial restrictions. Many of us are dealing with reduced funding, so that practical support matters.

Second, there is moral support—standing together as a profession and being clear about what we want to defend and support.

Third, we can provide opportunities and resources to colleagues in conflict settings. Amani mentioned data-driven rehabilitation earlier, and that is something remarkably close to my heart. People outside the conflict can help by supporting evidence generation, research opportunities, and data-informed rehabilitation. That gives us stronger evidence for what we are doing and what is needed.

I will hand over there.

Fatima Nasser Eddine (Humanity & Inclusion)

I would add that rehabilitation needs to be recognised as part of health interventions in general. Too often, rehabilitation is not considered central to health protection, even though it plays a key role in preventing long-term disability.

On data, HI has done a lot of advocacy to include disability-related questions in data collection. Not only to identify people with disabilities, but also because without proper data we cannot advocate effectively.

There is increasing recognition globally of the considerable number of people living with disabilities, but in conflict settings we still often do not have the data to show the scale of need properly. Sometimes the actual proportion is far higher than what people assume.

Humanitarian actors and the wider community need to think more carefully about assessment and response across the whole spectrum of need, because these figures are not accidental. They are partly a reflection of missing rehabilitation services.

I also want to use the opportunity to advocate for inclusive approaches across all sectors, particularly for people with disabilities, so that needs do not continue to rise without adequate response.

Amani Alserr (WHO, Gaza)

Thank you, Erica, and thank you Verena, especially for raising the point about data-driven rehabilitation.

I would like to share one example. The ICRC is currently supporting the Ministry of Health in collecting detailed data on amputation cases, spinal cord injuries, and traumatic brain injuries.

This includes detailed assessments such as the type of amputation and the need for artificial limbs. This is allowing us to develop evidence-based planning and more pragmatic, strategic thinking for the exceptionally substantial number of amputation cases in Gaza—around 6,500 people.

This is exactly why I strongly support evidence-based, pragmatic, and strategic planning in conflict zones. It is essential for building a more sustainable health system and delivering more effective support.

Erica Blakely (Chair)

Thank you, Amani.

I think one thing the global community can do is make sure that if colleagues in conflict settings are putting effort into data collection and analysis, we take that evidence forward, amplify it, and use it to advocate to the people who need to hear it.

Dr Charles, I noticed you sat up very quickly when we were talking about how the global community can help. Did you want to add anything?

Dr Charles Khalife

Yes. In Lebanon, I can send a message to physiotherapists who want to volunteer in the crisis cell or in affected regions. They can contact me or the LOPT, and we can involve them.

When we run specific training sessions, we can include them as well.

And for people globally who want to help, I would add to what Verena said about financial support. It can also help to support organisations such as the Lebanese Civil Defence and the Lebanese Red Cross in their operations, including their work alongside emergency medical teams.

That would be immensely helpful to us in this conflict and in other emergencies.

Erica Blakely (Chair)

Thank you. Dr Charles, could I ask you to put that information in the chat? We have had a question about joining the LOPT.

And if anyone has information about occupational therapy societies or other organisations that professionals from other disciplines could join, please share that too.

Feras, did you want to add anything on global support?

Feras Swairjo (MSF)

Yes. Advocacy can help. Advocacy about shortages and needs can create pressure through the media and other channels, and that can support people working on the ground.

Erica Blakely (Chair)

Great, thank you.

We are running short on time, so I am going to ask everyone to keep the next answers noticeably short.

Feras, in a couple of minutes, can you explain how your team prioritises caseloads in the face of overwhelming demand?

Feras Swairjo (MSF)

Prioritising is difficult, but it does happen in a mass casualty environment.

What we do is place a physiotherapist in the first consultation room. That physiotherapist directs patients to the service that best fits their needs.

If a patient has multiple trauma or a more complex case, they are sent to the group of physiotherapists responsible for prolonged treatment plans.

If the case is simpler—someone who needs advice or a home programme—there is another group who manage those patients with shorter treatment plans and longer home programmes.

Those simpler cases might receive small items such as therabands or elastic bandages, and they are shown what to do at home. They are then asked to return after three weeks or one month, because their case is less urgent.

The more complex group can then focus on patients with multiple injuries who need several sessions per week.

Critical cases are directed to inpatient departments where hospitalisation is required.

Hospitals are often over 100% capacity, with patients even in corridors, but at least we try to provide services inside the hospital for those who need them most.

We also shorten the assessment and documentation process to save time. We created special forms for emergencies—short assessment forms for burns and trauma cases—which gives us more time with patients.

This has been effective, but I must be honest: the quality is not as good as we would want.

When the context becomes calmer, we can spend more time with patients and provide more techniques and interventions in each session.

Erica Blakely (Chair)

Thank you. That really highlights the core challenge in an emergency: overwhelming demand and not enough resources to meet it.

That was extremely useful insight—not only into prioritising patients, but also prioritising treatment, which is often the missing piece.

I will now come to Verena.

Verena, could you talk about considerations when organising a rehabilitation team or service during conflict? And if possible, could you also comment on ideal shift lengths for team members?

Verena Kreiliger Young (ICRC)

Of course.

When setting up a rehabilitation service in a conflict area, it is important—whether you are from inside or outside the country—to work within the law of the land. It is not appropriate for non-professionals to

take on professional roles. Even in emergencies, we must remain clear about that, because the highest priority is still to do no harm.

So, we need a workforce that is trained and capable of working with the kinds of cases they are seeing. That means not only clinical competence, but also competence in how to work in conflict settings.

We have heard powerful examples today from colleagues in Gaza and Lebanon about the pressure they are under.

Another important principle is not to work in isolation. There is too much work for any one group, and we want to avoid duplication.

That means liaising, linking, and communicating with other organisations, providers, ministries of health, and WHO. WHO has done exceptionally good work through rehabilitation coordination structures, especially in Gaza, and I want to commend Amani and the team there for that.

We also need to be accountable. We are accountable not only to our employers and the law, but also to our beneficiaries and patients.

Part of that accountability is maintaining a minimum level of data collection, so we can remain responsible to those we serve and to those funding the work.

Another important consideration is staff safety. When you establish a service, choose a place that is as safe as possible for the staff and as accessible as possible for the patients. In some places, checkpoints or unsafe areas may prevent patients from reaching you, so location matters.

And then, as Feras said, we need to support staff as a team. Staff need to look after one another, not only the patients.

One useful practice is to have a short morning group meeting to think through the kinds of scenarios that may come up.

Last year, there were periods when catastrophic mass casualty incidents happened daily, and we did not know when they would happen. So, preparing the team, and deciding who would go where, was especially important.

I also strongly support rotating staff positions so that individuals are not exposed to the same kind of stress every day.

Erica Blakely (Chair)

Thank you very much. That was very practical, and I think your point about not working in isolation applies to everything we do in these environments.

I am sorry that we are rushing a little now, but I do want to make sure some remaining questions are covered.

So, I am coming back to Fatima.

We heard from Pete last week that displacement is a major issue in most conflicts, including those affecting the region now. Do you have any advice on how we can provide effective services for people who are displaced?

Fatima Nasser Eddine (Humanity & Inclusion)

Yes. The first point is that when we speak about displacement, we are not speaking only about injury. We are speaking about all people who may have functional limitations and are forced to be displaced.

We have already talked a lot about early rehabilitation and prioritisation. Yes, we prioritise injury, but we also need to prioritise fairly. People may be displaced because of non-communicable disease, older age, congenital conditions, or many other reasons. All these people may need rehabilitation support.

Displacement adds more barriers to service access.

So, improving service efficiency starts with improving access and making the service itself inclusive.

We cannot use a stand-alone approach in displacement settings. We need an integrated approach where basic needs are treated as an essential part of the response.

In rehabilitation, we often talk about establishing field hospitals or small units, but if we cannot reach people where they are living, then we do not fully understand their needs and cannot refer them properly.

That is why needs assessments must include rehabilitation as part of the overall assessment of basic needs.

Then we need to prioritise fairly and identify the most vulnerable people—not only from an injury perspective, but also from chronic disease and disability perspectives.

We are not the only actors involved, so we need to improve coordination between actors to make sure displacement does not add even more barriers for people who already have difficulties, especially people with disabilities.

I want to highlight that many people with disabilities are left behind during evacuation and cannot access safety measures.

Displacement also breaks continuity of care. Once people are displaced, they may lose access to medication, services, and rehabilitation. For example, a child with cerebral palsy may lose their whole treatment plan because of displacement.

That is why continuity of care is so important.

One recommendation is to make sure rehabilitation is available everywhere, through community-based and inclusive approaches, supported by networks and trained professionals.

In summary, the response must be inclusive, accessible, and integrated.

We need to understand displacement from a person-centred perspective—not only as a rehabilitation issue, but as an issue affecting the whole person and all their needs.

Displacement in conflict does not simply mean moving from one house to another. It means changing your condition, your lifestyle, sometimes losing function, losing your assistive device, and arriving in a place that may not be accessible.

If we look at Gaza, or many other conflicts, health systems themselves have also been damaged by conflict.

So, when we build rehabilitation services, we need to ask not only whether the service exists, but whether it is truly inclusive and whether people in need can reach it.

Erica Blakely (Chair)

Thank you, Fatima.

There is clearly a whole body of work still to be done around displacement and how best to support people who are displaced.

We are getting close to the end of our time, though I know some participants may have had to leave.

If it is all right with the panellists, I would like to continue with the final questions for the recording.

Amani, I would like to ask you about fragmentation. Charles and Feras have both mentioned the fragmentation of health and rehabilitation services.

These services are often delivered by a range of actors, and we have representatives of several of those groups on the panel today.

We are hoping you can share some of the practical approaches you have developed or observed in Gaza to address that fragmentation.

Would you like me to share your slide?

Amani Alserr (WHO, Gaza)

Thank you.

Very quickly, because of time:

One of the most usual challenges in conflict is losing a clear map of the key actors and the services they provide.

So, WHO and the health cluster gathered detailed data on all key players and rehabilitation services across the Gaza Strip.

On the map, we have four colours. Each colour represents a level of rehabilitation service: level 1 community-based, level 2 primary healthcare, level 3 tertiary hospital care, and level 4 specialised rehabilitation.

When you click on any point, it shows the location, the focal point, and all the details for that facility.

We delivered extensive training for rehabilitation actors across Gaza so they could use this mapping in a clear and interactive way as a referral system for patients.

This was especially important, because in one focus group I found that about 70% of cases did not begin their first rehabilitation session until three months after injury. That delay clearly showed the effect of fragmentation and missing service mapping.

So, we took the lead in building this interactive mapping system with comprehensive data across Gaza.

We also conducted detailed analysis of how services were distributed across all governorates to ensure equitable and efficient rehabilitation coverage based on the target population in each area.

The goal was to ensure that no one would be left behind, even in the farthest areas, and that everyone would know where services existed and at what level.

The last point I want to mention is the preparedness mobility aid kit.

This is an emergency kit placed in emergency rooms and mass casualty hospitals so that when patients are discharged, they immediately have access to the right mobility aid from day one.

This can help them with essential daily tasks, such as going to the toilet and managing daily life more safely.

One final lesson from Gaza is that although conflict settings often focus on trauma cases, we must not forget non-trauma and chronic cases.

For example, in Gaza we have also seen Guillain-Barré syndrome outbreaks. That reminded us that rehabilitation must remain focused on trauma, chronic disease, and other acute conditions as well.

For me, this is a reminder to all of us as humanitarian workers to work transparently and consistently to provide high-quality services for everyone.

Erica Blakely (Chair)

Thank you, Amani—and thank you as well, we loved hearing your daughter in the background.

Erica Blakely (Chair)

That would be great. It is an extremely useful tool for understanding the rehabilitation picture in Gaza and a strong example of how some fragmentation can be reduced.

We are almost at the end of our discussion, but I want to return briefly to Dr Charles.

Dr Charles, could you comment on the role of national professional societies in supporting rehabilitation in conflict zones?

Dr Charles Khalife

I will keep it short.

National professional societies play a key role in coordinating rehabilitation services. They can train volunteers, support local and international initiatives, and in some cases provide logistical support and equipment.

They also act as a bridge between international NGOs and local communities. That is important because local professional groups often have the trust of the population and of displaced people.

This work is extremely sensitive, and that trust matters.

Professional societies can help connect international actors with local communities and, in some cases, also help bring in international funding.

Erica Blakely (Chair)

Thank you.

And building on that, many of our participants today are interested in how they can access professional support or mentorship at this point in time.

Do any of you have suggestions about how mentorship arrangements could be put in place? I will start with you again, Dr Charles.

Dr Charles Khalife

Yes. I saw one question from someone wanting mentorship from professionals.

I shared my contact details so this can be discussed with the LOPT.

Our volunteers on the ground are Lebanese physiotherapists who are part of the Order, so we cannot have non-Lebanese physiotherapists join directly in the same way.

However, we can share our experience with other nationalities and support them through discussion and mentorship, even if that is not on the ground with us.

Verena Kreiliger Young (ICRC)

This may not be something for the immediate moment, but I would really like to call on educational institutions to include preparedness for disaster and conflict as part of their curricula.

That would be helpful for all of us because we never know where the next conflict or disaster will happen.

Erica Blakely (Chair)

Yes, I completely agree.

We are all realising that this cannot remain an optional extra. Whether the next emergency is conflict or another kind of disaster, we need to be ready.

Fatima, please go ahead.

Fatima Nasser Eddine (Humanity & Inclusion)

To build on that point, last year in Haiti one of our main activities was working with universities to include awareness of rehabilitation and rehabilitation in emergencies within medical and health curricula.

Unfortunately, when a country is in conflict, universities often become weaker over time, and the pool of rehabilitation professionals becomes more limited.

Even when qualified professionals exist, they may not have enough knowledge about rehabilitation services because the service itself is not always visible or well established.

So, we developed a substantial workplan with universities across different governorates to introduce at least an awareness component of rehabilitation and comprehensive rehabilitation in the main medical and health curricula.

This included medicine, nursing, paediatrics, burn management, and psychosocial aspects.

This was one of the key activities in a volatile environment, because rehabilitation was not well understood and was often not recognised.

So alongside including emergency models within rehabilitation curricula, it is also important to raise awareness of rehabilitation across all multidisciplinary health sectors.

Erica Blakely (Chair)

Thank you.

I am going to wrap us up there because we are a little over time and I know it is getting into the evening.

Before we close, I want to acknowledge each of our panellists—the time you have given today, the energy you put into preparing for this discussion, and the work you are doing all the time, every day.

I also want to acknowledge all of you joining online who are delivering rehabilitation services in these challenging environments.

The humanitarian rehabilitation community is with you. We think of you often, and we are in awe of what you continue to achieve despite all the challenges.

Please take care, stay safe, and we will see you all next week.

I believe the details for next week’s session, which I understand is on spinal cord injuries, are in the chat.

Please do join us.

This is the second of ten webinars in the series, so there is much more to come, and we look forward to having you with us again.

Thank you, and good night.

End of edited transcript
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