PROTECTING HEALTH CARE

KEY RECOMMENDATIONS

PROTECT HEALTH CARE IT'S A MATTER OF LIFE & DEATH

ICRC

REPORT

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PREFACE

Attacks, threats and other violent obstructions of the work of health-care personnel, facilities and medical transport often occur when armed conflict or other violence is raging. Frequently, these obstructions result in the disruption of health-care services, just when these services are needed most. The short-term consequences are obvious: patients are deprived of much-needed care and medical staff are prevented from rendering assistance. The long-term consequences, while difficult to assess, are equally if not more serious. Hard-won gains in reducing child mortality, improving maternal health and fighting diseases such as polio can be erased in mere minutes.

These high stakes explain why violence affecting health-care services has become an issue of growing global concern. And why it is all the more important to find ways to improve the protection of health-care services during armed conflict or other emergencies.

To this end, the International Committee of the Red Cross (ICRC) held experts' consultations around the world between 2012 and 2014 with a wide range of organizations and institutions, including States, professional health-care organizations and civil society. The aim was to develop recommendations and measures for making the delivery of health care safer in armed conflict or other emergencies.

A condensed list of the recommendations resulting from this global process is presented below. The recommendations provide practical guidance for devising policies and strategies and implementing measures to make accessing and delivering health care safer in armed conflict or other emergencies. When adapted to fit local contexts, the recommended measures can also help make health-care systems more resilient. Ultimately, they can substantially improve compliance with international humanitarian law (IHL) and related human rights law and bolster respect for the life-saving work of health-care personnel.

ABOUT THIS GUIDE

This guide is for anyone concerned about or involved in ensuring that health care is delivered impartially and effectively during armed conflicts or other emergencies. As such, government authorities and policymakers, State armed and security forces, armed groups, National Red Cross or Red Crescent Societies (National Societies), health-care workers, aid agencies and civil-society organizations will find the content of this guide relevant to their work. It provides recommendations for devising policies and strategies and for developing and implementing practical measures to prevent violence against patients, health-care workers and facilities, and medical transport.

Many factors need to be considered when addressing violence against the delivery of health care: applicable laws and regulations; military doctrine and practice on the subject; compliance with the professional and ethical principles of health care; whether health-care providers – including humanitarian organizations – have access to patients and communities, and whether their activities are accepted; the physical safety and mental well-being of health-care workers; and the security of health-care facilities and infrastructure. This guide contains recommendations on each of these factors. The recommendations are intentionally not specific to any situation or location. Readers can therefore select, adapt and apply the recommendations that best fit their situation. There are also some examples illustrating how the recommendations can be translated into concrete action, programmes, laws etc.

The recommendations are organized by topic:

1. Developing domestic legislation;
2. Promoting the rights and responsibilities of health-care personnel;
3. Improving the operational response of National Red Cross and Red Crescent Societies;
4. Ensuring the preparedness and safety of health-care facilities in armed conflict or other emergencies;
5. Improving the operational practice of ambulance and pre-hospital services;
6. Promoting military practices that make accessing and delivering health care safer;
7. Engaging armed groups to safeguard health-care services;
8. Promoting the involvement of religious and community leaders to ensure acceptance and access.

Although this guide is comprehensive, it is not meant to be exhaustive, and not all measures cited in the examples will be applicable everywhere. Rather, the examples are meant to enable readers to draw on the experiences and practices of others in a wide range of contexts.

The guide can and should be used together with a range of other Health Care in Danger tools and information sources (see Appendix I), which are available through the Health Care in Danger website: www.healthcareindanger.org/resource-centre.

HEALTH CARE IN DANGER

Health Care in Danger is a global initiative that was launched by the International Red Cross and Red Crescent Movement (Movement) in response to violence committed against patients, health-care personnel and facilities, and medical transport in armed conflict or other emergencies.

Violence against health care is not new. However, given the alarming frequency of attacks and threats against health-care providers and the violent obstruction of their activities, the ICRC launched a study on the matter in 2008. It looked into incidents of violence against patients, health-care workers and facilities, and medical transport in 16 countries. The goal was to better understand the threats the health-care community faced during armed conflict or other emergencies and what made it vulnerable to those threats. With a better grasp of the problem, preventive measures could perhaps be found.

The study report, *Health Care in Danger: A Sixteen-Country Study*[1] was published in July 2011. It highlighted the multi-faceted nature of the violence and the need for a collective response to effectively prevent it and mitigate its effects.[2] In December 2011, the report was presented to the 31st International Conference of the Red Cross and Red Crescent (International Conference). There, representatives from 180 States, the ICRC, the International Federation of Red Cross and Red Crescent Societies (the Federation) and National Societies used the report's findings as a basis for Resolution 5, "Health Care in Danger: Respecting and protecting health care". The resolution called upon the Movement to identify ways of strengthening the protection of health care.

Violence against health-care workers and facilities is preventable. By mobilizing a growing "community of concern" – a loose association of States, the Movement, professional health-care organizations and others – the Health Care in Danger initiative is

- raising awareness about the multi-faceted nature of this violence and the serious consequences it has in humanitarian terms;
- highlighting the need for comprehensive and interconnected solutions;
- promoting the development of recommendations and the implementation of measures to ensure that health-care workers and facilities and medical transport stay safe; and
- calling upon a wide range of persons from different sectors to work together to foster respect for the delivery of health care and protect patients and health-care providers at all times.

In bringing together States, the Movement, weapon bearers, the health-care community, humanitarian agencies and anyone else concerned with this issue, the Health Care in Danger initiative emphasizes that everyone has a role in preventing such violence.

[1] PDF available in English at www.icrc.org/eng/assets/files/reports/report-hcid-16-country-study-2011-08-10.pdf.

[2] "The means to address this problem do not lie within the health-care community; they lie first and foremost in the domain of law and politics, in humanitarian dialogue and in the adoption of appropriate procedures by State armed forces."

SAFEGUARDING HEALTH CARE: CONTEXT AND RATIONALE

A growing humanitarian plea

Violence leading to interruptions in health-care services has been observed with alarming frequency around the world.[3] Health-care providers have been attacked, patients discriminated against, ambulances held up at checkpoints, hospitals bombed, medical supplies looted and entire communities cut off from critical services.

Between January 2012 and December 2014, the ICRC documented nearly 2,400 violent incidents such as these in just 11 countries. In over 90% of cases local health-care providers were affected, seriously threatening the effectiveness and sustainability of the national health-care systems. In September 2015 the World Health Organization (WHO) reported that 654 medical personnel had been killed since the beginning of the conflict in Syria, and that almost 60% of hospitals were either partially functional or completely out of service.[4] On 16 February, less than one year since the hostilities began in Yemen, the United Nations Emergency Relief Coordinator, Stephen O'Brien, announced[5] to the Security Council that nearly 600 health facilities – about 25% of the facilities nationwide – had closed. Previously, 220 of those facilities had offered treatment for acute malnutrition.

This violence is generating increasing concern, and it is not limited to armed conflict. During the Ebola outbreak in western Africa, there were a number of attacks against health-care personnel and volunteers. Problems with acceptance by communities in some cases also hindered health teams' work and their access to patients. Major professional health organizations, such as the World Medical Association and the International Council of Nurses have also warned that health-care workers – particularly those providing emergency services – experience violence even in peaceful countries. A comprehensive approach that blends prevention with measures to mitigate violence is therefore required in times of armed conflict, in other emergencies and in peacetime.

Seeking solutions

The humanitarian principle that all wounded and sick people should receive adequate and timely treatment without discrimination is firmly established in IHL, which sets out the obligation to safeguard health-care services. This principle also lies at the heart of the Movement. Concerned by the erosion of respect for this principle, and in line with the mandate it received from the 31st International Conference, the ICRC facilitated global consultations with a variety of organizations affected by this issue. The aim was to formulate "practical recommendations for making the delivery of health care safer in times of armed conflict or other emergencies."[6]

A series of workshops was held around the world, attended by representatives of a wide range of institutions, organizations and groups. Each workshop focused on a different topic related to ensuring that people can safely access and deliver health care. Participants had different geographic and professional backgrounds: hospital managers, doctors, nurses, pharmacists, ambulance drivers, first aiders, first responders, scholars, religious leaders, Movement staff and volunteers, military officers, government officials, etc. They were convened on the basis of their expertise and experience. Some had lived through conflict; others had advocated for people needing health care; still others had contributed to developing measures for preventing or responding to violence against health care in armed conflict or other emergencies, or had worked to improve health-care systems' resilience to crisis. These global consultations

[3] Check the Health Care in Danger website at www.healthcareindanger.org for regular updates on incidents and attacks against health-care workers and facilities and medical transport in armed conflict or other emergencies.

[4] See www.who.int/hac/crises/syr/sitreps/syria_health_sector_cluster_news_september2015.pdf?ua=1; and www.emro.who.int/images/stories/WHO_SitRep_September2015.pdf

[5] See http://reliefweb.int/report/yemen/under-secretary-general-humanitarian-affairs-and-emergency-relief-coordinator-stephen-4

[6] Resolution 5 on Health Care in Danger available at www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm

offered participants a forum for sharing and discussing different practices and working together to identify concrete solutions to make accessing and delivering health care safer.

In preparation for the workshops:

- The ICRC Advisory Service on IHL carried out research on 39 countries from all regions of the world, looking specifically at their domestic normative frameworks for protecting the delivery of health care.
- The ICRC also conducted bilateral, confidential consultations with military personnel in 29 countries and with two multilateral military and defence organizations.

In parallel, the ICRC began holding structured discussions with 36 armed groups from 10 countries. Speaking with these groups is important, given their role in contemporary armed conflicts and in ensuring the safe delivery of health care. In addition, ICRC specialists examined the internal and public documents (such as codes of conduct, manuals, declarations and agreements) of 73 armed groups from various regions of the world.

An equally important consultation process was conducted with the World Medical Association, the International Council of Nurses, the International Committee of Military Medicine and the International Pharmaceutical Federation. The aim was to identify a common denominator of ethical principles of health care applicable in times of armed conflict or other emergencies (See Appendix 2). The common core of ethics was launched in June 2015 in Geneva during a conference with the representatives of all four organizations and the ICRC. Since its launch, the common core has been endorsed by other organizations within the health-care community, most notably the International Federation of Medical Students' Associations and the World Confederation for Physical Therapy.

In 2014, the Swedish Red Cross commissioned a field study to examine violence against the delivery of health care from a gender perspective and identify gender-specific recommendations.[7]

In 2015 the Norwegian Red Cross, following up on a set of recommendations, published a report on best practices for ambulance services in high-risk situations. It was based on input from 12 National Societies operating ambulance services in the Americas, North Africa and the Middle East.

The recommendations identified during the process described above are presented topic-by-topic in a condensed form below. They were also published in a series of specialized reports which give more detailed guidance on legal, policy and practical measures for safeguarding health care.[8]

[7] The study report can be found at: www.icrc.org/en/document/understanding-violence-against-health-care-gender-perspective

[8] Appendix 1 contains a detailed list of the specialized reports.

1. RESPONSIBILITIES AND RIGHTS OF HEALTH-CARE PERSONNEL

London, April 2012
Cairo, December 2012

180 participants
23 countries represented

Main audience: State representatives, medical, health and humanitarian organizations

Final recommendations – keywords: ethical principles of health care, training, relations with the media, violence management, stress management

2. NATIONAL SOCIETIES' RESPONSE TO HEALTH CARE IN DANGER

Oslo, December 2012
Tehran, February 2013

76 participants
26 countries represented

Main audiences: National Red Cross and Red Crescent Societies, States

Final recommendations – keywords: Safer Access Framework, security of staff and volunteers, training, first aid, acceptance, perception, emblems, national legislation

3. MOBILIZING CIVIL SOCIETY AND RELIGIOUS LEADERS

Dakar, April 2013

26 participants
6 countries represented

Main audience: civil society and religious organizations, international and national non-governmental organizations, health organizations

Final recommendations – keywords: coordination, leadership, dissemination, emblems, access, perception, acceptance

4. AMBULANCE AND PRE-HOSPITAL SERVICES

Toluca, May 2013

71 participants
25 countries represented

Main audience: National Societies, ambulance, emergency health care and first-aid providers

Final recommendations - keywords: security, safety, personal protection equipment, access to population, perception, training, insurance, emblems, volunteers, coordination

5. SAFETY OF HEALTH FACILITIES

Ottawa, September 2013
Pretoria, April 2014

48 participants
14 countries represented

Main audience: States and technical departments of Health Ministries, non-governmental organizations, international governmental organizations, professional federations and coalitions

Final recommendations – keywords: contingency planning, risk assessment, coordination, staff and patients' well-being, passive security, relocation, essential services, equipment, supplies and storage, mapping of health-care facilities

6. MILITARY PRACTICE

Sydney, December 2013

27 participants
20 countries represented

Main audience: States, armed forces, intergovernmental military alliances and international peace and security organizations, international organization representing military health workers

Final recommendations – keywords: military operations in the proximity of health-care facilities, search operations and arrest, checkpoints, territorial control, military necessity, humanitarian needs, coordination, ethical principles, training

7. NATIONAL LEGISLATION AND PENAL REPRESSION

Brussels, January 2014

77 participants
25 countries represented

Main audience: States

Final recommendations – keywords: IHL, domestic legislation, emblems, sanctions, training, dissemination, ethical principles of health care

8. ACCESS TO HEALTH CARE AND ARMED GROUPS

April 2013-October 2014

36 armed groups consulted
10 countries on 4 continents

Main audience: armed groups, other audiences interested in a dialogue with armed groups for the protection of health care

Final recommendations – keywords: access, training, IHL, operational practices, Model Unilateral Declaration, first aid, coordination, mapping of health-care facilities, security, ethical principles

1 DEVELOPING DOMESTIC LEGISLATION

The recommendations in this section are to help States put in place measures to strengthen domestic legislation protecting access to health care and ensuring its safe delivery, and thus comply with their obligations under international law. These recommendations focus on improving legal protection for patients and health-care workers, ensuring the proper use of emblems, developing legal protection for medical ethics and confidentiality, and dealing effectively with violations of the rules.

1.1 Legal framework protecting the wounded and sick, health-care personnel and facilities, and medical transport

States must take appropriate measures so that their domestic legislation reflects the international obligations they have undertaken with regard to safeguarding access to, and delivery of, health care, taking due consideration of national specificities.

In **Afghanistan**, a number of preventive measures have been adopted to protect the wounded and sick and the delivery of health care. The Police Law requires the police to protect public and private health-care facilities and medical transport. Private hospitals are entitled by law to take the security measures necessary to guarantee the safety of patients and medical staff. At present, however, there are no mechanisms for monitoring the implementation of these legal obligations in the country.

In **China**, specific measures have been taken to protect Red Cross staff. Anyone using violence or threats to impede the work of Red Cross personnel providing disaster relief or responding to an emergency is subject to the same criminal punishment as for hindering the work of government officials.

So that States can respond more effectively, they should **collect data on interferences with and/or violence against the delivery of health care** in their countries. Government authorities should manage and protect the data-collection system, guided by clear criteria for classifying data into context-specific categories. The data collection system should include everyone concerned, be independent and transparent, and serve for analysis only.

Measures for safeguarding access to health care should include education, training and spreading knowledge of existing legislation. **Armed and security forces, civil servants, health-care personnel and the general public should all know about this legislation**. Programmes should be run that raise awareness of the importance of complying with the obligation to treat health-care personnel and facilities and medical transport with special restraint.

The auxiliary role of National Societies

National Societies serve as humanitarian auxiliaries to public authorities. In keeping with this role and their mandates, National Societies have signed national agreements enabling them to organize the delivery of health care in their countries. They therefore play an important role in guaranteeing that people can access and deliver health care safely during armed conflict or other emergencies. This role was reaffirmed in Resolution 5, adopted at the International Conference in 2011, and strengthened in Resolution 4, adopted in December 2015 (see Appendix 4).

More specifically, National Societies can play a significant role in raising awareness of and providing training on the regulations for the use of the emblems and on IHL more generally. The Statutes of the Movement state that the National Societies shall "disseminate and assist their governments in disseminating international humanitarian law" and, more specifically, "cooperate with their governments to ensure respect for international humanitarian law and to protect the distinctive emblems recognized by the Geneva Conventions and their Additional Protocols".

That is the case in many countries, such as **Belgium**. It is the Belgian Red Cross's duty under its Statutes to spread knowledge of the Fundamental Principles of the Movement and of IHL. In **Serbia**, the Red Cross Law makes it the National Society's duty to ensure respect for IHL, work to prevent violations and educate the public about IHL-related topics.

Every State should have a plan for coordinating during armed conflict or other emergencies, and domestic legislation should clearly define the roles and responsibilities of everyone involved in the emergency response.

In **Peru**, the Disaster Response Law defines the roles of each emergency-response group and establishes mechanisms for working together so that medical assistance in emergency situations can be channelled to those who need it most.

In **Senegal**, there is a plan for coordinating emergency services – referred to as Plan ORSEC – that government authorities can implement under certain conditions. It identifies the different State institutions that respond in emergencies and provides for a coordination mechanism and a crisis cell for following up on health-care delivery in emergencies. This plan is coordinated by the Ministry of Internal Affairs. Senegalese law also allows State services to be requisitioned when there is imminent danger.

Similarly, in **Sri Lanka**, the Disaster Management Act set up the National Council for Disaster Management, which covers both natural and man-made disasters such as armed conflict. The council has the authority to designate which organizations (including any ministries or other governmental bodies) will be tasked with implementing either the National Disaster Management Plan or the National Emergency Operation Plan.

In **Argentina**, the Federal System of Emergencies established a national response mechanism to assist the efforts of provincial and municipal governments when their capacities are exceeded. The commander-in-chief of the armed forces is responsible for coordinating operations when the Ministry of Defence or another State authority authorizes the use of the armed forces, including their medical services.

Under domestic law, people should be required in all circumstances to rescue or provide assistance to people needing urgent medical care, and failure to do so should be subject to criminal punishment.

In **Colombia**, people are required to provide care, an obligation that is derived from a constitutional "duty of social solidarity". Failure to do so can be punished by imprisonment under the Criminal Code. Similarly, several other countries with civil-law systems have made it people's duty to provide live-saving assistance in road accidents and emergencies.

Specific legislative and practical measures should be adopted to address the particular health-care needs of certain individuals and groups (e.g. women, girls, boys, the elderly and people with disabilities). In particular, these measures should address the specific needs of victims of sexual and gender-based violence, in order to put the principle of non-discrimination into practice.

1.2 Emblems

Emblems serve as a visible indication of the protection conferred on health-care personnel and facilities and medical transport in armed conflict or other emergencies. As such, they help ensure that the wounded and sick can get access to the health care they need. **States should adopt specific legislation to reinforce the prestige and significance of the red cross, red crescent, and/or red crystal emblems.** States should identify the entities that are entitled to use the emblems and designate a national authority to regulate their use.

A number of States, such as **Chad**, **France**, **Luxembourg**, **Madagascar**, the **Philippines**, **Portugal** and **Sierra Leone**, have enacted domestic legislation to regulate the use of the red cross, red crescent and red crystal emblems and to raise awareness about their proper use.

In 2002, **Colombia** created an additional emblem for medical services.

Its use is subject to authorization by the Ministry of Health and Social Protection. It was created partly in response to numerous violent incidents affecting the delivery of health care and the proliferation of emblems used in internal disturbances that did not reach the threshold of armed conflict under IHL. The emblem's purpose is to generate respect and protection for the personnel, facilities and transport involved in providing medical care in armed conflict or other emergencies. That respect and protection will help ensure that health care is provided to those who need it most in armed conflict, natural disasters and other emergencies. It is also intended to guarantee, protect and facilitate the provision of health care by civilian health-care personnel, civilian private and public health-care facilities and medical transport.

Any **misuse of the emblems must be severely punished** through criminal, administrative and disciplinary means. Perfidious use of the emblems is a war crime. **States should monitor misuse of the emblem** and encourage it to be reported to the appropriate authorities. **The armed forces should also be trained to prevent misuse of the emblem.**

Serbia's criminal code includes war crimes committed against civilians and wounded and sick people, cruel treatment of wounded and sick people and prisoners of war, and misuse of internationally recognized emblems. Health-care facilities can be fined for (i) violating data protection rules and (ii) not submitting accurate data on the situation to the pertinent State bodies, in epidemics and other disasters. People in charge of health-care facilities can also be fined. Furthermore, the Law on the Use and Protection of the Emblem and the Name of the Red Cross imposes fines for unauthorized use of the red cross emblem.

In **Senegal**, it is a crime to misuse the red cross emblem or other distinctive emblems. Offenders may be sentenced to a fine and/or up to five years of imprisonment under the Law Relating to the Use and the Protection of the Red Cross and Red Crescent Emblem. The length of the sentence is doubled if the violation is committed during armed conflict. Senegal is also considering a number of provisional measures, such as having the person responsible for the violation shoulder the cost of seizing objects bearing the distinctive emblem.

Unnecessary proliferation of emblems should be avoided. Before adopting new signs to indicate health-care activities, States should ensure that their use would enhance protection of the delivery of health care in a specific situation. If so, the authorities should make a clear distinction between the new sign and the red cross, red crescent and red crystal emblems recognized under international law. States should regulate the signs and educate the public about their purpose.

Some well-known symbols

The emblems of the International Red Cross and Red Crescent Movement

The Star of Life, known throughout the world as a symbol of emergency medical services

A widely used symbol for first aid

1.3 Confidentiality and ethical principles of health care

States should ensure that domestic laws do not prevent health-care personnel from carrying out their activities according to the ethical duties of their profession.

Independence and impartiality in providing care are universal ethical principles of health care, and as such should be adequately protected under domestic legislation. **Government authorities should take measures to ensure that health-care personnel can exercise their profession without undue pressure** – particularly pressure to determine treatment order using criteria other than medical need – and without fear of facing criminal prosecution for providing impartial care in line with their ethical duties.

Confidentiality must remain the abiding principle and general rule for all health-care professionals at all times. Exceptions must be few and strictly circumscribed in domestic legislation.

In **Mexico**, the Federal Code of Criminal Procedure establishes that people who are bound by medical confidentiality, such as health professionals and civil servants, cannot be compelled to testify on confidential information. Federal courts have determined in civil matters that the professional duty of confidentiality is linked to the right to privacy. People bound by the duty of medical confidentiality cannot therefore disclose information made accessible to them in the course of their duties. Specifically, surgeons and specialists cannot testify as to the health of their patients. Public prosecutors and judges are required to refuse the admission of evidence that violates the duty of confidentiality. Medical records should always be handled with discretion and treated as confidential, in accordance with scientific and ethical principles. They may be disclosed to third parties only by order of judicial, administrative or health authorities, or the National Medical Arbitration Commission or a State arbitration commission.

Protecting the duty of medical confidentiality serves the interests of the wounded and sick and of health-care personnel. Therefore, **domestic legislation should protect medical confidentiality** not only as a privilege and ethical duty of health-care personnel, but also as a patient right. For better consistency and increased protection, patients' rights and protection for health-care personnel should, where possible, be contained in the same legislation.

In **Belgium**, the law of 22 August 2002 on the rights of the patient is an example of how medical ethics can be incorporated into legislation on other patient rights, such as patient consent, protection of privacy, the right to information and the right to access medical records.

Disclosure of personal health-care information without consent or legal obligation is a violation of a professional duty and should be punishable by administrative or disciplinary action.

In **Nigeria**, disclosure of confidential medical information constitutes a criminal offence under Article 221 of the Nigerian Penal Code. It is punishable by imprisonment of between two months and one year and by a fine of 10,000 to 200,000 nairas.

Health-care personnel should receive special training on fulfilling their ethical duties. State authorities and national associations of health-care providers could provide guidance to their members through publications, such as handbooks or practical guidelines. Measures to regulate interactions between health-care providers and the media could also be taken to strengthen protection of confidentiality.

Law enforcement officers must know and respect the rights and responsibilities of health-care personnel.

1.4 Sanctions

Sanctions serve as an important deterrent to violations of rules protecting the provision of health care. States can incorporate punishments for such violations into their domestic legal frameworks in various ways. Doing so complies with their obligation to take effective measures in the criminal justice system and elsewhere to put a stop to and prevent the violations.

Sanctions in domestic legislation may be criminal, disciplinary or administrative. They should be graduated and combinable to ensure that the penalty is commensurate with the seriousness of the violation, taking into account aggravating and mitigating circumstances.

Perpetrators should face administrative or disciplinary action as well as criminal penalties, depending on their title or role. Violence against the delivery of health care that amounts to a grave breach of the Geneva Conventions must be penalized as such under the relevant regulations. Such regulations need to be incorporated into domestic law and must cover both individual and command responsibility.

Domestic legislation should go beyond the Geneva Conventions in terms of criminal prosecution, the situations that are covered and the conduct that is criminalized. Laws should penalize all undue interference with the provision of health care – including threats against health-care workers.

In **Kenya**, the Geneva Conventions Act criminalizes grave breaches of the Geneva Conventions. In addition, Section 8 of the International Crimes Act gives the High Court jurisdiction over war crimes committed in Kenya or elsewhere if either the perpetrator or the victim is a Kenyan citizen or if the perpetrator is currently in the country. The Kenyan Defence Forces Act also provides for disciplinary measures for some of the offences under the Act; these include dismissal from the armed forces, reprimands, fines and prison sentences.

The military manuals of **Belarus** and **Russia** also set out disciplinary measures for violations of IHL.

In **Austria**, a number of provisions for the protection of civilians and humanitarian personnel were also added to the criminal code following the adoption of Resolution 5 at the International Conference in 2011. The amendments entered into force on 1 January 2015.

State authorities should do everything in their power to enforce existing legal sanctions so that they act as a deterrent. They should strengthen oversight to ensure compliance with the rules in place. And they should ensure that the judicial system is independent and honest, administrative procedures are transparent and that the criminal procedures are abided by.

2 PROMOTING THE RIGHTS AND RESPONSIBILITIES OF HEALTH-CARE PERSONNEL

The recommendations in this section focus on measures for promoting and raising awareness of the rights and responsibilities of health-care personnel and ensuring that they are respected by all.

2.1 Understanding rights and responsibilities

Measures should be put in place to ensure that health-care personnel have a broad understanding of IHL, human rights laws and the ethical principles of health care. This knowledge can help health-care workers defend their rights and those of their patients during armed conflict or other emergencies. It can also help them choose to assume their professional responsibilities when faced with difficult dilemmas. These responsibilities include treating the wounded and sick humanely, not abandoning anyone in need, refusing to take part in hostilities, and providing impartial care.

In 2013, **Côte d'Ivoire's** medical association (the *Ordre National des Médecins*) adopted a white paper summarizing health-care workers' roles and responsibilities when confronting violence in crises or armed conflict. The paper is the result of a joint study carried out by the medical association and the ICRC. The first part addresses acts of violence faced by physicians in peacetime, and the second part deals with violence in armed conflict or other emergencies.

The health-care community can help create an environment conducive to respecting ethical principles of health care and making the delivery of health care safer. The white paper aims to build on that by preparing and training health-care personnel to act appropriately in dangerous situations. They must respect the principles of medical ethics regardless of the circumstances.

Health-care personnel and facilities and medical transport are entitled to protection during armed conflict so long as they do not commit harmful acts deviating from their humanitarian and medical duties.

Mechanisms should be put in place so that health-care personnel can remind authorities of their duty to search for and collect the wounded and sick and ensure they are treated without discrimination. They can demand assistance from authorities in carrying out their work, and should have access to victims.

Health-care workers must never be asked to violate the law or ethical principles of health care, or to disclose information about patients beyond that required by law. **They must not to be punished for fulfilling their responsibilities or disobeying an illegal or unethical order**. They should receive psychological support and health insurance and be covered under the social security system. They may carry light individual weapons to defend themselves and the wounded and sick in their care.

While on the job, health-care workers should combine humanity and a sense of professional duty with common sense, bearing in mind the **three pillars of ethical principles of health care**: **confidentiality**, **respect for every individual's autonomy and dignity, and genuine and valid consent for any medical procedure**.

When health-care workers are confronted with an ethical dilemma regarding their patients in armed conflict or other emergencies, they should ask themselves the following questions: Have I prioritized the interests of the wounded and sick? Are my actions consistent with humanitarian law, human rights law and domestic law? Will my actions do more good than harm? Am I taking any risks by acting or not acting? Am I providing the most appropriate care, given the constraints?

The **World Medical Association** (WMA) is an international organization of physicians that was founded in 1947 and has 106 national member associations. It seeks to ensure the independence of physicians and to promote the highest standards of ethical behaviour and care by physicians at all times. In pursuit of this objective, the WMA has adopted several declarations, resolutions and global policy statements providing ethical guidance for physicians, national medical associations and governments on a range of ethical issues. These include medical professionalism, the rights of the patient, care of the wounded and sick in armed conflict, research on human subjects and public health.

- *The Declaration of Geneva* (1948, amended in 2006), like the International Code of Medical Ethics (1949, amended in 2006), sets out physicians' obligation to act in patients' best interest and to provide health care in a fully independent, impartial and non-discriminatory manner and to respect patients' right to confidentiality.
- *The Declaration of Lisbon* (1985) on patients' rights specifically enshrines the right to medical confidentiality.
- The *Manual of Medical Ethics* (2005) explains the principal features of medical ethics and provides guidance for physicians in applying them to relations with patients, society and colleagues.
- *The WMA Regulations in Times of Armed Conflict and Other Situations of Violence* (1956) provide a code of conduct with the duties that physicians must discharge in those circumstances.

The International Committee of Military Medicine (ICMM) is an international and intergovernmental organization created in 1921. Its mission is to maintain and strengthen the bonds of cooperation and knowledge between the medical services of its member States' armed forces. The ICMM also fosters – within its means and the scope of its operations – respect for and application of IHL. It organizes and sponsors courses on IHL in armed conflict aimed at members of armed forces' medical services.

Since 2011, the ICMM has been holding an annual workshop on military medical ethics through its Centre of Reference for Education on IHL and Ethics. The event brings together around 40 people from various geographic and religious backgrounds who are experts on topics related to the military, international law and ethics. They discuss specific dilemmas that medical services face in the field in order to identify best practices and common guidelines for military medical ethics.

The WMA and ICMM, together with the International Council of Nurses and the International Pharmaceutical Federation**,** drew up the Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies (see Appendix 2). It is the first document of its kind in that it provides a common core of ethics for health-care professionals. Since its launch in June 2015, it has also signed by the International Federation of Medical Students' Associations and the World Confederation for Physical Therapy. It therefore applies to the more than 35 million professionals worldwide represented by the six signatory health-care organizations.

2.2 Responsibilities towards patients

Health-care personnel are responsible for gathering data about patients in their care while still respecting the principles of patient confidentiality and consent. **Accurate health records should be kept** at every stage of treatment. **They should be handled in a way that serves patients' best interests** and stored in a manner that ensures confidentiality. **Access to health records should be restricted** to patients themselves and, when necessary, other health-care providers.

Confidentiality is crucial if people are to continue seeking health care from professionals. Domestic law should recognize and protect the confidentiality of health records. Rare exceptions – for example in cases of communicable diseases – should be clearly regulated.

Health-care personnel have a responsibility towards patients who could have specific health-care needs, including women, boys, girls, the elderly and people with disabilities. Victims of sexual violence in particular have specific needs that should be addressed by people with the authority and experience to investigate and document each case.

Health-care personnel are responsible for looking after the dying and dead and treating them with dignity and respect. One reason for this is to alleviate the suffering of relatives. Health-care workers should therefore legally confirm any death, shield the dying and dead from curious onlookers, ensure that authorities dispose of bodies properly, and uphold families' right to know what happened to their relatives. Any messages communicated by someone who is dying, or found on someone who has died should be transmitted or stored. Unidentified bodies should be disposed of in a way that facilitates future identification.

At times, health-care personnel may witness violations of IHL or international human rights law. If possible, such **violations should be reported to the proper authorities if this does not put the victims or health-care workers at greater risk**. **Data or information about violations should be collected in accordance with ethical principles of health care**. Information should not be shared if it poses a risk to the health-care personnel doing the reporting or to others. In extremely difficult circumstances, the collection of data and information should be aborted.

2.3 Trust and acceptance

It is fundamental for health-care personnel to assess how the local community – especially weapon bearers, authorities and important individuals and groups in that community – **perceives them and their work**. **They should use codes of conduct appropriate to the context**. They must know that they are trusted and respected, so they can gain access to the wounded and sick without impediment. Awareness-raising sessions can emphasize the importance of keeping health-care personnel and facilities and medical transport safe, and explain professional ethical principles, such as impartiality. That knowledge will help people understand the reasons behind medical decisions. In addition, local volunteers can be asked to monitor the community's acceptance and understanding.

To enhance their credibility and respect for them, health-care personnel should use the emblems, whether for identification or protection, in accordance with the law. Emblems should also be displayed on health-care facilities and medical transport and be visible from afar.

The following categories of health-care personnel may use the emblem for protection:

- military medical or religious personnel and objects;
- civilian medical and National Society personnel and objects, whether they are authorized as civilian medical personnel or as auxiliaries to the medical services of State armed forces;
- other providers specifically authorized by competent authorities to provide medical care in times of armed conflict;
- the ICRC;
- the Federation.

Only health-care personnel from the Movement are permitted to use the emblem for indicative purposes in armed conflict. In peacetime, the emblem may be used indicatively by National Societies, the ICRC, the Federation, authorized ambulances providing free treatment, etc.

Given that the various entities providing ambulance services, from firefighters to National Societies, used different signs, they should all agree on rules governing their use.

Misuse of emblems can create confusion and undermine respect. Health-care personnel should work with National Societies to advocate for stronger domestic legislation in this regard.

2.4 Communication, coordination and preparedness

During armed conflict or other emergencies, it is crucial that health-care providers coordinate and communicate on a regular basis about medical referrals, security issues, ambulance services, etc. **Reliable communication methods should be available at all times**.

In some situations, interacting with the local media or using social media can be helpful in disseminating key messages to the community and local authorities. Taking into account the risks involved, **a strict media policy guaranteeing patients' privacy at all times should be developed to guide and regulate any use of public means of communication**.

In addition to medical training, health-care workers should be provided training on communications, their rights and responsibilities and those of their patients, ethical principles of health care, security and stress management, problem-solving, decision-making and reporting. Communications training is of particular importance for ambulance personnel, who are often the first point of contact with local authorities, armed and security forces, armed groups and local communities.

3 IMPROVING THE OPERATIONAL RESPONSE OF NATIONAL RED CROSS AND RED CRESCENT SOCIETIES

These recommendations aim to ensure that National Societies are prepared in armed conflict or other emergencies to provide health-care services to everyone who needs them. Representatives of National Societies from around the world have suggested: taking measures to improve security and increase acceptance by and access to communities; being trained, well prepared and appropriately equipped; collecting data, analysis and research; providing peer-to-peer support and sharing good practice; and engaging in advocacy, dialogue and training with the broader health-care community, authorities and civil society.

3.1 Improving security and increasing acceptance by and access to communities

One of the most effective ways for Movement staff and volunteers to improve their security, their acceptance by communities and their access to those in need is by applying the Safer Access Framework (SAF).[9] The SAF is a set of actions and measures designed to prepare National Societies to face the challenges of operating in sensitive and insecure contexts, to reduce and mitigate any security risks, and to earn the trust and acceptance of local communities.

In sensitive and insecure contexts, most National Societies provide some sort of emergency health services. To do so, they must combine solid technical skills with actions that increase their access to people in need while minimizing the risk to beneficiaries, staff and volunteers. An example would be combining emergency first-aid training with the actions and measures contained in the Safer Access Framework.

The **Lebanese Red Cross** does this very effectively. It runs an effective ambulance service in a very divisive and challenging context by combining technical training with training on applying the Fundamental Principles and by taking relevant measures informed by the Safer Access Framework.

The **Egyptian Red Crescent Society** has made significant progress on connecting these factors together. It spent three years building an emergency-response programme that trained nearly 100 teams of emergency first aiders and first responders, gave them personal protective equipment, and now manages them as they respond daily to the challenging events within their country.

The **Mexican Red Cross** has applied the Safer Access Framework across all programmes and geographical sectors, allowing it to continue providing effective ambulance and other services despite working in an environment characterized by organized violence.

The **Indonesian Red Cross Society** (PMI) has developed standard operating procedures for its staff and volunteers who provide health-care services. The procedures draw on elements of the Safer Access Framework and recommendations from Health Care in Danger experts' workshops.

For more examples, go to the interactive map on the Safer Access website at saferaccess.icrc.org.

Investing in relationship-building and networking is a key to strengthening peoples' knowledge of the organization and trust in its people. Positive relationships with religious and community leaders, authorities and weapon bearers can make accessing health care easier and safer in armed conflict or other emergencies.

[9] For more information on the Safer Access Framework, go to saferaccess.icrc.org.

The **Nepal Red Cross Society** holds what it calls "perception round-tables". Whenever it experiences difficulties within a community, its access is impeded or its security is compromised, the National Society, often in conjunction with the ICRC, invites community representatives and key individuals and organizations to a round-table discussion, where problems and concerns can be aired and responded to. These events are also an opportunity for the National Society to increase participants' awareness of its mandate, activities and methods, and particularly its need to work in accordance with the Fundamental Principles. Sometimes the problem is just a misperception that can be cleared up immediately. In other cases the National Society may need to take action to address the concerns. In that case, it will go back to the round-table participants to inform them what actions have been taken and continue the trust-building dialogue. The National Society makes every effort to keep communication channels open.

All National Society staff and volunteers must have a solid understanding of how the Fundamental Principles,[10] **IHL**, **human rights law and the ethical principles of health care shape their rights and responsibilities, those of the people they are trying to assist and those of the warring parties**. When Fundamental Principles guide thought processes, communication, decision-making and practice, they are highly effective at making access to health care safer. Conforming to a context-specific code of conduct can also help, as can following standard operating procedures, under certain circumstances.

National Societies must also strengthen communication and coordination mechanisms between legal and operational departments to ensure that legal initiatives reflect the reality in the field.

3.2 The red cross and red crescent emblems

The red cross and red crescent emblems are an important means of identification. However, **they must be displayed according to the rules governing their use**, since misuse by others can erode the distinctive identity of the National Society and lead to distrust or even violence towards staff and volunteers. **National Societies should start by carrying out awareness-raising and trust-building activities to generate respect for the emblem**. **A tracking system should be established to record instances of misuse** and perhaps a procedure to address them.

National Societies are well placed to advocate for the adoption and/or implementation of a domestic red cross or red crescent emblem law and punishments for emblem misuse. National Societies should set up an internal system for assisting public authorities in their duty to record and address misuse and ensure that the laws and regulations are understood and complied with at all times.

National Societies should explore additional ways of easily identifying their staff and volunteers, such as by uniform colour or marks of recognition.

National Societies should ensure that where emblems other than the red cross, red crescent and red crystal are in use (e.g. Misión Médica in Colombia mentioned above), they are regulated by the government and promoted widely, and that health-care personnel understand their proper use.

3.3 Training, resources and support

Emergency response teams that are competent, well trained and properly equipped are better able to care for victims and stay out of danger**. National Societies should conduct training adapted to their situation on a range of tasks**, from negotiating passage through checkpoints to supporting and managing distraught relatives. **They should build first responders' capacity to assess risk and develop contingency plans and standard operating procedures** tailored to likely scenarios. **They should also ensure that their staff, volunteers, means of transport and equipment clearly and consistently display the emblem and/or logo**. Finally, National Societies should create mechanisms and set up forums for sharing good practices and lessons learned across the Movement and with the health-care community.

[10] The seven Fundamental Principles are an expression of the Movement's values and practices. They were developed to guide the work and decisions of all staff and volunteers in all situations at all times. They are: humanity, impartiality, neutrality, independence, voluntary service, unity and universality.
Learn more at: www.ifrc.org/who-we-are/vision-and-mission/the-seven-fundamental-principles/.

National Societies should determine whether or not to use personal protective equipment. If they do use it, they must carefully track and store their stocks and provide training for its use that is adapted to the situation.

Means of transport must be well maintained and outfitted for the situation, including, where possible and appropriate, installing proper communications equipment and/or GPS or tracking systems. Ambulance services operated by National Societies should develop safety standards and abide by them.

The **Kenya Red Cross Society** has developed a national trauma framework that outlines how to provide care to trauma patients and how to mitigate secondary attacks. Its mass-casualty protocol covers ambulance safety and explains how to spread that knowledge to the military. It also has a system to ensure that all staff and volunteers who have been involved in mass-casualty incidents get psychosocial support.

The **Syrian Arab Red Crescent** has combined Health Care in Danger recommendations with Safer Access Framework measures to improve security and safety for its staff and volunteers. These measures include: developing standard operating procedures; improving external and internal communication; using personal protective equipment; introducing new technologies such as GIS; coordinating with other partners on the ground; and conducting educational campaigns to explain its mission and foster respect for the emblem.

Health Care in Danger has been a catalyst for National Societies to share their experiences and expertise with each other. **Magen David Adom** of Israel has worked with the **Kenya Red Cross** Society to set up a paramedic ambulance service and develop a mass-casualty protocol covering ambulance safety. The **Bangladesh Red Crescent Society** and the **Egyptian Red Crescent Society** exchanged experiences, particularly on emergency training.

National Societies should have a programme to help staff and volunteers deal with stress that includes debriefing sessions, peer support mechanisms and psychosocial support**. Staff and volunteers should be covered by a comprehensive insurance policy**, ideally backed by the State.

Communities can play an important role as first aiders. This is particularly useful when National Societies' emergency teams do not have access to those in need of life-saving medical assistance. **National Societies should, on their own or with the help of other organizations, strengthen people's capacity to provide basic health care and first aid to those who might be isolated during armed conflicts or other emergencies**.

3.4 Data collection, analysis and research

National Societies should routinely collect and analyse data on the current situation and any potential threats. They should **regularly review and the outcomes of debriefings and lessons learned and integrate them into their processes** in order to improve their methods, planning, problem-solving and advocacy efforts. If some cases, it may be beneficial to work with other health-care providers and/or authorities to do this.

Some National Societies have mechanisms for collecting data on incidents of violence against their health-care staff and volunteers. Others have conducted research on specific issues. For example, the **Swedish Red Cross** looked at Health Care in Danger from a gender perspective and the **Canadian Red Cross** co-authored an academic paper on safety and security in a changing environment.

3.5 Awareness-raising, advocacy and dialogue with the health-care community, authorities and civil society

It is important to establish connections within the Movement and with a range of key individuals and organizations to foster respect for the obligation to safeguard health-care services and share expertise and policies and practices on the matter. **National Societies should seek to strengthen cooperation with the health-care community**, including national medical associations and health-care personnel, in particular at the national level.

By virtue of their auxiliary role, **National Societies should develop strategies for raising awareness among decision makers** using the recommendations resulting from the Health Care in Danger experts' consultations. They could address issues such as victims' rights; the rights and responsibilities of health-care workers; measures to protect health-care personnel, ambulances, facilities and patients; strengthening domestic legislation; and monitoring violations. **National Societies are also well placed to remind States of their duty** to instruct civil servants, the armed and security forces, the health-care community and the general public on these issues.

National Societies can play a very important role in working with civil society, religious and community leaders, the media and other influential people and organizations. They could promote interaction with academic circles; encourage universities and training centres to include the most important Health Care in Danger recommendations and messages into the university curricula of, say, medical, nursing and law students.

Recognizing the importance of implementing concerted and cross-sectoral actions to effectively respond to the problem of violence against health care, **a number of National Societies**, such as those of **Afghanistan**, **Australia**, **Canada**, **Colombia**, **Indonesia** and **Iran**, have succeed in mobilizing key individuals and organizations, including the authorities, and have held round-tables, workshops and meetings at national, regional and local levels.

The **Egyptian Red Crescent Society** and the **Swedish Red Cross** have also effectively reached out to the professional health-care community in their countries to raise awareness about the problem and plan common initiatives. Along the same lines, the **Spanish Red Cross**, the **Spanish Medical Association** and the **German Red Cross** have translated various Health Care in Danger materials and resources into their languages and used them when engaging with the broader health-care community in their countries.

4 ENSURING THE PREPAREDNESS AND SAFETY OF HEALTH-CARE FACILITIES IN ARMED CONFLICT OR OTHER EMERGENCIES

The recommendations in this section place a strong emphasis on preparedness. They are meant to assist governments and hospital managers in coping with situations that could jeopardize the organization and provision of assistance to the sick and wounded. The recommended measures include drawing up contingency plans, training staff, taking steps to protect patients, maintaining good community relations, taking security measures to ensure that health-care facilities and their supplies remain safe and, last but not least, devising temporary relocation plans.

4.1 Protecting health-care facilities

It is vital to **set up a safety and security framework tailored to the situation**. This must be done, where possible, in cooperation with the parties to a conflict, the authorities and other humanitarian organizations. To this end, essential capacity must be identified and a crisis scenario's possible impact on human resources must be assessed.

A contingency plan should be drawn up, together with a checklist of the supplies and services which are needed in order to guarantee self-sufficiency for about ten days. It is crucial **to build up a good working relationship with several suppliers**, as reliance on a single source is too risky. Agreements with national authorities on exemptions from standard procedures can significantly facilitate the import of medical supplies.

Sufficient resources should be allocated to formulating plans and holding drills enabling the entire staff to prepare for emergencies. Arrangements should be made with other health-care providers to supply any backup resources that might be required. The facility's contingency plans should fit in with existing regional or national plans.

While passive and active security measures can **mitigate damage to a health-care centre** in the event of attack or armed entry, they must not spoil the local community's perception of the facility.

The person in charge of the health-care centre must **ensure that fire and other risks are monitored and that all members of staff are familiar with evacuation plans**. The use of plastic film on windows and protective walls outside critical areas reduces damage from explosions. It is also essential to arrange for an alternative water supply along with several types of power, including those from sustainable sources.

Measures to protect critical areas and manage the flow of people can minimize the risk of intrusion, **although care must be taken not to impede access for patients, their relatives or health-care personnel**.

To better control access and entries, perimeter walls with control points should be erected around the entire health-care facility. Initial security screening and medical triage should be clearly separated. Guards should be employed only for security duties and at control points, not for triage. People in charge of health-care facilities should **ensure that due consideration is given to cultural mores regarding gender** in reception and screening areas. They should ensure that there are enough entrances and adequate lighting, that there are separate areas for screening means of transport and that capacity is sufficient to deal with mass-casualty situations.

In the event of large numbers of casualties, community health-care workers could be called upon to make preliminary assessments of patients as they arrive. Patients who are not in a critical condition could be referred to other health-care facilities, if it is safe for them to travel.

An early warning system, preferably using closed circuit television, **is indispensable.**

Critical utilities should be located in a safe place to reduce their vulnerability to attack and **secure backup information management systems should be put in place in case normal communication channels break down**.

Senior managers should identify key contacts and save their details in order to facilitate communication and a coordinated response in emergencies.

It is important to have a complete picture of an ongoing crisis and not become isolated. Maps showing all key health-care providers in the area should be shared whenever possible, provided that this does not pose a risk to providers, patients or services. The information supplied should include GPS coordinates, a description of the services provided and how to reach them.

Other vital measures include:

- storing goods in secure areas, where they are protected from hazards and looting;
- using oxygen concentrators rather than cylinders;
- incinerating waste and isolating dangerous material.

Preventive measures should be considered when constructing new facilities. These may include:

- a careful choice of location;
- the use of fire-resistant building materials;
- the construction of sufficiently high boundary walls;
- the strategic placement of critical facilities and windows.

In **South Sudan**, at the end of 2014, passive security within the Wau teaching hospital's grounds was significantly improved by a few simple measures, such as equipping the main entrance of the hospital with lights, providing guards with electric torches, designing a "talking wall" with self-explanatory logos designed to promote the protection of medical facilities and staff and putting up signs banning the carrying of weapons within the hospital's grounds. Furthermore, in order to enhance the impact of these measures, awareness-raising sessions on respecting the hospital's safety were held for weapon bearers from the region.

4.2 Protecting people

Providing health care services during an armed conflict or other emergencies entails additional risks. **Health-care personnel should therefore be prepared to face challenging conditions and ever-changing demands**. **Staff roles and responsibilities** should be clarified to ensure the requisite flexibility during emergencies. **Health-care personnel should be offered training in emergency preparedness and stress management**. This training could include fire drills, risk assessment and management, protection issues, negotiation, communication, managing people's expectations, self-defence, psychological support, first aid and self-care. Guidance and training should also be provided on appropriate staff behaviour inside and outside the facility to defuse aggression.

The safe delivery of health care may be hampered both in armed conflict and in peacetime because health-care personnel face lack of respect, insults, threats and physical violence. The quality and the provision of health-care services may therefore suffer as a result of high staff turnover or of health-care personnel being forced to flee. In an effort to address this pressing issue, the **Norwegian Red Cross** published the *Training Manual on Interpersonal Violence Prevention and Stress Management in Health Care Facilities*. The manual draws on existing resources to try to reinforce personal safety skills and raise health-care workers' awareness of the active role they can play in preventing or de-escalating tension in health-care facilities. The long-term objective of the manual is to reduce the incidence of violence and thus to avoid the stigma and trauma associated with it.

It is vital to forestall, whenever possible, any ethical dilemmas that might arise during emergencies. It is also important to create support systems and incentives for all personnel. Furthermore, it is crucial to **establish a transparent recruitment process**. Staff composition should ideally reflect a local community's ethnicity, religion and culture.

Health-care facilities need to protect their patients while paying due heed to the risks that may be associated with some of them. If possible, grouping patients according their affiliation should be avoided and those who pose a high security risk should be discharged as soon as it is feasible to do so.

Health-care managers should also **consider the needs of patients' relatives**. Their consent should be sought before major surgical procedures, such as amputations, are performed and they should, if necessary, be provided with psychosocial support. While it may sometimes be advisable to limit the number of visitors, waiting rooms should be available for patients' relatives.

4.3 Local outreach

Maintaining regular communication channels and good relations with the local community increases a facility's safety and acceptance by building a sense of ownership. Those in charge of a hospital or clinic should regularly try to ascertain what the local community thinks of it and whether these precautionary measures are seen as barriers.

Engaging with the media may improve the safety of a hospital or clinic; **informing the general public and relevant actors about its services can increase the acceptance of health care owing to an awareness that it is delivered impartially**. A proactive media strategy, including guidelines on responsible behaviour on social media, should be developed, and regular contact should be established with the press in order to reduce tension and misunderstandings in the event of an emergency or crisis occurring. However, **the need for information-sharing must always be weighed against ethical considerations, confidentiality and the facility's safety**.

4.4 Temporary relocation

If security risks become intolerable, a temporary relocation of health-care services may be the only solution. **Any temporary relocation should be carefully planned and a strategy should be worked out to guide management during the preparatory phase, as well as during the transfer of services, patients and staff**. It is useful to consult local providers, authorities, community leaders, staff, patients and non-governmental organizations when setting up a temporary health-care facility. Before choosing a new location, a security and site analysis should be conducted and the following factors should be considered: community acceptance, accessibility to staff and the population, the availability of quality health-care services and the presence of potential partners.

While the aim must always be to achieve the highest possible level of health care, the capacity of a relocated facility should be carefully assessed and patients, their relatives and the community at large should be informed of its capacity.

5 IMPROVING THE OPERATIONAL PRACTICE OF AMBULANCE AND PRE-HOSPITAL SERVICES

The role of first responders and first aiders (including ambulance drivers) puts them on the front line. The recommendations for pre-hospital services focus on training, support, coping mechanisms and coordinating services as a means of preparing first responders and first aiders for the stress and risks of the job and enhancing their capacity to deal with them.

5.1 Preparedness and training

Ambulance teams must be adequately prepared for their work on the front line. Their training should encompass at least: road and field safety, the ethical principles of health care, psychosocial support, communication and negotiating skills, and cultural sensitivity. They should regularly attend refresher courses for their own safety and in order to maintain their ability to perform their duties throughout an armed conflict or other emergency. The Emergency Vehicle Operator Course should be compulsory.

5.2 Support and coping in a crisis

Volunteers and employees of ambulance and pre-hospital services should all have health insurance. Governments and volunteer organizations should jointly draft a framework agreement covering volunteers. National laws should recognize their role and allow them to draw benefits in the event of injury, sickness or disability resulting from their work, and should entitle their families to survivors' benefits after their death. Volunteering should be perceived as a collective responsibility, not as something done at one's own risk.

Emergency teams, including drivers, should be psychologically prepared for a mission. Whenever possible, they should receive pre-mission instruction in **stress management techniques** and post-mission **psychological support** combining formal and informal peer-to-peer, community and professional support. The **psychological preparation of first responders and first aiders should include**:

- comprehensive screening before deployment;
- identification of coping mechanisms;
- training that simulates realities in the field;
- training in security management systems;
- information about the situation in the area of deployment.

They should be given sufficient food, as well as adequate accommodation and equipment. An emergency plan for rescuing injured first responders and first aiders should be drawn up. At the same time, they should be properly supervised and be able to rely on support. Supervisors and managers should therefore guide teams and evaluate their workforce before and after a mission. These evaluations must be confidential in order to ensure that people are not afraid to seek help. Breaks should be introduced between difficult missions.

Helping those who help others

The **Reference Centre for Psychosocial Support** (PS Centre) was established in 1993 to back up National Societies' efforts to promote the psychosocial well-being of the wounded and sick, staff and volunteers. The Centre, which is hosted by the **Danish Red Cross** and located in Copenhagen, Denmark, puts together manuals and toolkits and organizes training courses for helpers. It also advises National Societies and assists them with psychosocial support measures, especially in areas where staff and volunteers have to contend with a complex, unsafe environment. For more information, see the website: http://pscentre.org.

The ICRC and some National Societies run joint mental health and psychosocial counselling programmes for community helpers. This is true, for example, in **Côte d'Ivoire**, **Egypt**, **Mexico**, **Gaza**, **Syria** and **Ukraine**.

5.3 Perception and respect

Ambulance services must enjoy respect in order to operate safely in dangerous situations. **Emergency services should therefore undertake awareness-raising and trust-building activities**. When first responders and first aiders provide good-quality services and conduct themselves appropriately in delivering those services, it improves community acceptance and facilitates access. **All emergency services should be provided in an impartial manner**. **Neutrality should be encouraged**, although it must be recognized that not all health-care providers can be neutral at all times. The *Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief* should be distributed to emergency health-care providers[11].

National Societies' emergency staff and volunteers must adhere to the seven Fundamental Principles. They should also bring them to the attention of key individuals and organizations in the areas where they operate.

It is wise to persuade governments to promote a culture of respect for emergency health-care providers by disseminating information on the rights and responsibilities of health-care personnel, and by encouraging universities and training institutions to offer courses on the ethical principles of health care in armed conflicts or other emergencies. Awareness-raising campaigns should inform the general public about the constraints on emergency health-care providers' actions and the limits to the care they can provide.

While additional protective measures can reduce an ambulance's exposure to risks or limit the effects of violent incidents, they might also raise suspicion or attract unwanted attention. Armed escorts for civilian ambulances should be avoided. The use of personal protective equipment and a GPS system to track ambulances might even be dangerous in some situations and therefore requires very careful consideration.

The **Norwegian Red Cross** took the lead in facilitating the sharing of operational best practices among 12 National Societies from the Americas and from the Middle-East North Africa region. As a follow-up to the experts' consultations held in Mexico in 2013 on ambulance and pre-hospital services in high-risk situations, two workshops were organized in 2014 – one hosted by the **Colombian Red Cross** in Cartagena and the other hosted by the **Lebanese Red Cross** in Beirut. Staff and volunteers with extensive operational experience in the ambulance and pre-hospital sectors discussed the challenges they faced and the best practices they had developed in response to those challenges. The report published in 2015 consolidates this input. The Norwegian Red Cross has recognized the need to encourage more exchanges of experience and to implement procedures for ambulance and pre-hospital services. It is currently drumming up support to establish a working group (a community of action) on this particular issue.

5.4 Protective emblems and other signs

The use of a sign or of the red cross or red crescent emblem is not always sufficient to protect emergency services. Misuse of ambulances greatly undermines the respect and trust of the public. In order to protect the significance of the emblem, **National Societies should work with governments** to secure the adoption of domestic legislation providing for effective measures to address and correct inadvertent or deliberate misuse.

[11] See www.icrc.org/eng/resources/documents/publication/p1067.htm

Other ambulance-service providers, e.g. firefighters and hospitals, use signs other than the red cross or red crescent. It is vital to agree on common rules in this respect.

5.5 Coordination

Since a number of different services manage and provide emergency care, they need to understand each other's roles and coordinate their activities, if they are to use resources efficiently and manage risk effectively. **Domestic legislation should clearly define their various roles and responsibilities and regulate the coordinated action of pre-hospital and emergency health-care providers and the armed forces**. If it is difficult to lobby for the adoption of a legal framework, stakeholders should make their own working arrangements and coordinate activities such as training programmes and simulations. When appropriate, they should share information on security incidents.

Contingency plans should be drawn up in cooperation with the hospital system. **Emergency health-care teams should have action plans and alternative means of transport** in order to deal with situations where ambulance capacity is exhausted.

Communication systems must be operational during armed conflicts or other emergencies and they must have stand-alone backups.

As National Societies serve as auxiliaries of the public authorities for humanitarian activities, they should establish clear notification procedures to ensure that the safety of staff and volunteers is adequately safeguarded when they are on duty.

6 PROMOTING MILITARY PRACTICES THAT MAKE ACCESSING AND DELIVERING HEALTH CARE SAFER

These recommendations focus on helping State armed forces develop practical measures to minimize disruptions to health-care services while addressing legitimate security concerns. They cover both the planning and the conduct of three types of military operation: ground evacuations, search operations in health-care facilities, and military operations near health-care facilities. These situations were identified as most likely to impede patients' access to health care and have a negative impact on its safe delivery, based on the experiences shared during the global consultation process and data on incidents gathered by ICRC delegations. To be effective, these recommendations should be incorporated into orders, rules of engagement, training and standard operating procedures and other relevant documents.

Whenever concrete measures are adopted, a reporting system should be put in place and someone should be designated to follow up on their implementation and make improvements.

The **Armed Forces of Liberia** (AFL) recently incorporated Health Care in Danger recommendations into their military training manual with the help of the ICRC. In addition to an entire chapter on the Health Care in Danger issue, the manual includes guidelines for soldiers on how to conduct military operations while preserving people's access to health-care services. The guidelines include detailed procedures on the precautions to take during attacks, ground evacuations, search operations in health-care facilities, and other situations where medical personnel, facilities, ambulances, ships and aircraft are protected by IHL. The manual also emphasizes training for armed forces to ensure that they respect the obligation to safeguard health-care personnel and the wounded and sick.

6.1 Checkpoints

The wounded and sick should always be evacuated as quickly as possible. Because they delay medical transport, checkpoints can put patients' lives in danger. **During ground evacuations, a balance must be struck between security requirements and safe and speedy passage of medical transport**.

Prior to military operations, armed forces should set standard operating procedures or give operational orders for checkpoints and give priority to medical transport. Whenever possible, they should **coordinate with health-care providers and others conducting medical evacuations**—including opposing forces. If there is a coordination platform for emergency services, armed forces should consider joining, or creating one of their own.

Armed forces should also determine and regulate how health-care providers should notify the military of planned and emergency transport, e.g. through a predetermined radio frequency. A schedule for routine medical movements could also be set. Furthermore, an armed forces liaison officer should provide updates on road conditions.

A clearly identifiable fast-track lane should be established so that medical means of transport do not have to queue. If that is not possible, they should be given priority at checkpoints. The checkpoints should communicate effectively to facilitate the passage of medical transport.

Armed forces should ensure that checkpoints are sufficiently staffed. The personnel should be trained to limit the duration of identification checks on official health-care personnel and medical transport to a strict minimum, and to give official and unofficial medical transport priority.

Passage during a medical evacuation should never be denied, aside from exceptional circumstances clearly indicated in the standard operating procedures or operational orders, provided that the person also has the authority to do so. In such cases, official and unofficial health-care providers should be informed of alternative routes.

During curfews, exceptions for medical evacuations should be formally established.

6.2 Searches in health-care facilities

Searches and interrogations in health-care facilities may be disruptive, and should take place only when absolutely necessary. **Armed forces should balance any expected military advantage with the impact of a search in humanitarian terms**, and consider alternatives.

Armed forces should **use standard operating procedures or operational orders to specify the circumstances and authority level needed before the decision can be made to conduct a search or remove a person from a health-care facility**. This will help guarantee that legal obligations on providing medical care are met, and that medical opinions are taken into account. Armed forces should develop a checklist of guidelines to follow during search operations. Such a checklist could touch on patient privacy, biometric data collection, protocols on personal protective equipment, and interaction between armed forces (including military medical personnel) and civilian health-care personnel and patients.

Penal or disciplinary measures should be introduced into military law to ensure that commanding personnel do not issue orders to conduct searches in a way that unduly impedes access to and delivery of health care.

Armed forces should coordinate with health-care providers and the authorities to facilitate operations and minimize misunderstanding. Participating in an emergency coordination platform for first responders would be one way. Armed forces should also consider working with military medical staff, civilian health-care personnel, and legal and cultural advisers to **prevent affronts to religious, gender or cultural sensibilities.** Search units should include medical officers and female officers.

If infectious diseases or other potential hazards are present in health-care facilities in areas under the control of armed forces, those armed forces should share that information and provide guidance on any necessary precautions.

6.3 Attacks on or near health-care facilities

Attacks on a military target near a health-care facility or on a facility that has lost its protection must be exceptional and a last resort.

Before attacking a military objective in the vicinity of a health-care facility or a health-care facility that has lost its protection, **armed forces should weigh the potential effects on the delivery of health care and explore ways to avoid damaging** the facility, disrupting essential utilities, and harming health-care personnel, patients and other civilians. Armed forces should consider the proximity of health-care facilities to military objectives and the effect on the capacity to deliver services if a facility were to suffer damage. Information about back-up medical systems and resupply routes should be gathered and updated.

> The **Military Forces of Colombia** recently added a casualty evacuation chain to their planning and operational processes. It covers not only their own casualties, but also those of the adversary and the civilian population. With support from the ICRC, they incorporated lessons from medical-services workshops into their courses on IHL and human rights for units on a training rotation. Key Health Care in Danger messages are also systematically included in after-action review exercises and debriefings, thanks to cooperation between the Colombian Ministry of Defence and the ICRC.

It is essential for armed forces to map the locations of health-care facilities and the essential services on which they depend in their areas of responsibility and the immediate vicinity of those areas. This information should be continuously updated and entered into the list of non-strike or sensitive areas. Armed forces should ensure

coordination with health-care providers and relevant NGOs in these areas and they should take all possible measures to ensure the re-establishment of medical services.

Standard operating procedures and operational orders should **set out the process for authorizing a request to strike a military objective near a health-care facility or strike a facility that has lost its protection**. Armed forces should ensure that commanders involved in the decision to attack are accountable under military law.

Before deciding to attack, armed forces should **conduct a threat assessment** and give due consideration to alternative measures. These could include: cordoning off the area to contain the threat, getting the other fighting parties to agree to leave the facility or surrender (using third parties such as local authorities or influential people or organizations if necessary), or agreeing with the other fighting parties to evacuate patients and health-care personnel.

If an attack is deemed necessary, armed forces should contact health-care providers and the authorities to get a full understanding of the role the facility plays in the health-care system. Similarly, they should check whether and what back-up medical systems are available, and whether there are resupply routes. Military medical personnel and legal and cultural advisers should be involved in the planning and conduct of the attack.

Armed forces should ensure that their personnel are trained on following standard operating procedures and operational orders designed to ensure minimal disruption to health-care facilities.

Sufficient warning should be given to everyone inside the health-care facility prior to an attack.

Armed forces should develop a deliberate and immediate targeting process that is based on IHL (the law of armed conflict) and incorporates terrain analysis, weapons effects and means of delivery. Battle damage should be assessed constantly to keep the level of disruption in proportion to military necessity. **Attacks must be suspended whenever the anticipated collateral damage outweighs the expected military gain,** or when the conditions that caused the facility to lose its protection no longer apply (e.g. the combatants and/or fighters have fled). **After attacks, all appropriate measures should be undertaken to rapidly restore health-care services**. Finally, a report to send up the chain of command should be drafted, assessing the impact of the attack on health-care delivery and describing the remedial measures taken.

7 ENGAGING ARMED GROUPS TO SAFEGUARD HEALTH-CARE SERVICES

These recommendations are meant to help armed groups identify which practical measures they could adapt to fit their situation, in order to better safeguard health care and make it more accessible to the populations under their control.

Armed groups can voice their commitment to safeguarding health care by, say, incorporating these recommendations into their manuals or codes of conduct or issuing a unilateral declaration. A model declaration is provided in Appendix 3.

7.1 Ensuring access to health care for those in need

Armed groups must treat health-care personnel with special restraint and facilitate their work, from allowing medical supplies to be delivered to helping with emergency evacuations.

Direct communication with health-care providers can minimize misunderstanding. Whenever possible, **oral or written arrangements should be made between armed groups and health-care workers to ensure workers have access to the wounded and sick**. Such arrangements should, at the very least, cover IHL rules, each party's responsibilities and problem-solving options.

Members of armed groups should safeguard patients and health-care personnel by taking steps to protect them from security and environmental threats. These steps could include developing contingency plans, devising evacuation routes and designating shelters where the sick and wounded can be treated if need be.

Armed groups should be able to systematically develop their own capacity to provide at least emergency health care for the wounded and sick.

7.2 Safeguarding health-care personnel

At times, armed groups have pressured health-care-facility staff to abandon their posts to care for the groups' wounded fighters, leaving civilians without access to care. To prevent this, **armed groups should appoint a focal point to identify health-care personnel who are permitted to provide care outside their duty station**, and only contact them in times of need.

When calling on the services of health-care workers who are not among their members, armed groups should define the terms of the arrangement and establish channels of communication. Armed groups should make every reasonable effort to safeguard the workers and facilitate their work when they come to care for the wounded and sick. These measures could include: minimizing workers' exposure to sensitive information, ceasing operations to guarantee safe passage, finding secure roads and shelters, arranging for medical evacuations, preparing patients' medical history before the workers arrive, and where possible, putting all the medical supplies and patients in one location.

All members of armed groups, including their health-care workers, **should receive training to ensure they understand and acknowledge the ethical principles of health care and the obligations of health-care personnel under international and national law**. **Armed groups should make a clear distinction between their health-care personnel and members of the group dedicated to combat functions**.

Health-care personnel must never be punished for performing their duties in accordance with the ethical principles of health care. Their medical decisions must be respected – they must not be compelled to give priority to any given patient other than for medical reasons. **Armed groups should establish a way for health-care personnel to report violations of the ethical principles of health care without fear of retaliation**.

Some armed groups have already addressed the protection of health care in their internal documents. During the global consultation process, the ICRC examined over 70 internal and public manuals or codes of conduct from armed groups. Some excerpts of these documents are presented here:

- "Medical personnel must be respected and protected. They must be provided with [the] assistance they need in order to practice their profession, and they must not be forced to carry out acts that are in conflict with their code of conduct. They must not be prevented from exercising their profession, regardless of who might be the beneficiary."
- "DO NOT target medical personnel, facilities, transports or equipment. They may be searched if you need to verify they are genuine, but REMEMBER that medical personnel are allowed by law to carry small arms to protect their patients."

7.3 Safeguarding health-care facilities

All members of armed groups should recognize and respect the emblems and other signs identifying health-care facilities.

Health-care facilities should be mapped to prevent them from being damaged in military operations. **Fighters should only be permitted to enter health-care facilities in exceptional circumstances,** and if they do, they must strictly follow the facility's regulations, including complying with "no weapons" signs. Armed groups' internal rules should forbid carrying weapons or fighting within the perimeter of health-care facilities.

To avoid entering health-care facilities, members of armed groups should contact health-care personnel to come and evacuate wounded or sick people.

Specific procedures must be followed before the decision can be made to attack a facility that has lost its protection under IHL. First, armed groups should attempt to resolve the issue without the use of force—perhaps by negotiating with the other side through a neutral intermediary or under a truce flag. If an attack is deemed necessary, it may only be directed at a military objective, and must follow other IHL rules. **Fighters must do all they can to limit the consequences in humanitarian terms and to protect civilians, wounded and sick people, health-care personnel and facilities**. They must gather the necessary intelligence to determine how many fighters and civilians there are in the facility, and how to differentiate between them. Armed groups should also issue warnings to the civilian population – telling them to leave the area and evacuate patients – and immediately suspend any attack causing excessive harm to civilians.

Excerpts from armed groups' internal manuals or codes of conduct:

- "Health-care structures are never considered military objectives and should be respected. If a military operation endangers the life of a single civilian, it should be aborted."
- "In combat zones, vehicles and facilities that display the red cross symbol must be respected. Our forces are forbidden from using this symbol to deceive the enemy."

7.4 Not pillaging

Armed groups must never commandeer equipment, supplies or facilities that health-care personnel need for their medical activities.

They should have their own stock of medical supplies and keep it secure. They can plan ahead by allocating part of their budget to medical supplies, giving first-aid kits and emergency cash for supplies to their health-care personnel, and learning about local natural remedies.

If armed groups need to buy medical supplies from a health centre, they must abide by the facility's rules, buy only as much medication as they require, and never threaten or attack health-care personnel.

7.5 Safeguarding medical transport

Armed groups should create fast-track procedures for identifying and verifying medical transport and passing them through checkpoints. Medical supplies should never be removed from medical transport.

Members of armed groups should be instructed to inform medical transport about the best and fastest way to get to a health-care facility, and to communicate with other checkpoints to facilitate safe passage. Safe passage should only exceptionally be denied to medical transport and only due to absolute military necessity.

7.6 Respecting emblems

Members of armed groups must recognize and respect the protective emblems.

Emblems are to be displayed only by authorized users and only under the prescribed conditions. Misuse of emblems undermines their protective purpose; instances of misuse should be documented and shared with a neutral intermediary.

Internal regulations should specify that past misuse of medical transport does not justify violent acts against them. Medical means of transport remain entitled to protection unless they are used to commit hostile acts deviating from their humanitarian duties and only after a warning – with a time limit where appropriate – has been given and ignored.

7.7 Safeguarding wounded and sick adversaries

Armed groups must collect and care for the wounded and sick and abide by the obligation to treat them with special restraint, no matter what their affiliation or actions on the battlefield. Armed groups should protect wounded and sick adversaries from further harm and allow them to get timely access to health care, even when they are being arrested.

Armed groups should have training courses dedicated to the treatment of wounded and sick people. They should give operational orders reminding fighters of how they are expected to behave towards the wounded and sick. Informing adversaries of an armed group's ethical policy could encourage reciprocal behaviour. Acts of revenge and abuse should be forbidden in all circumstances. Restraint should be shown towards all those who temporarily stop taking part in hostilities to collect and care for the wounded and sick.

Excerpts from armed groups' internal manuals or codes of conduct:

- "It is prohibited to kill or injure an adversary who has surrendered or is *hors de combat*."
- "Give immediate medical treatment/first aid to anyone who needs it. There is a duty to search for, collect and aid the injured and wounded from both sides of the battlefield."

8 PROMOTING THE INVOLVEMENT OF RELIGIOUS AND COMMUNITY LEADERS TO ENSURE ACCEPTANCE AND ACCESS

These recommendations are mainly for religious and community leaders, who can serve as critical allies in protecting health-care personnel and facilities and medical transport. They can use their position to raise awareness of this issue in their communities, guide perceptions and link the obligation to safeguard health care to relevant religious rules and traditions.

Religious leaders and the campaign against hospital overcrowding in Gaza

In the **Gaza Strip**, hospital emergency departments are routinely overcrowded. Many patients present with conditions that could be treated in primary-health-care centres, and they are almost always accompanied by multiple family members. It is a serious problem under normal circumstances, and even more so during conflicts or other large-scale emergencies, when emergency departments can quickly become chaotic. The overcrowding seriously hinders doctors and other medical staff's ability to triage patients effectively and ensure they get timely and effective care.

The ICRC – as part of its public and community-focused campaign to help the Palestinian Ministry of Health reduce overcrowding and improve emergency departments' services – worked with the Ministry of Waqf (Gaza's Ministry of Islamic Affairs), to involve imams in promoting the campaign throughout the Strip. Imams who delivered Friday sermons in the North, South and Gaza City areas took part in three workshops organized by the ICRC and the Ministry of Health. Participants worked together to decide on the best way to promote the campaign. They left with key messages and speaking points to deliver during their sermons.

Engaging with Muslim leaders also led to the campaign being promoted on regular radio spots (3-4 times a day) for one week on the Al Quraan Al Kareem station. The station is run by the Ministry of Waqf and has hundreds of thousands of Gazan listeners. Campaign materials were distributed throughout the Strip, 1,000 posters were hung in mosques; and 50,000 leaflets with the campaign's main messages were handed out. The messages were on the back of the prayer timetables, which are distributed once a month by the Ministry of Waqf.

While the impact of the campaign will be measured over the long term, engagement such as this is one way to involve religious circles in concrete campaigns. It is part of the ICRC's ongoing and broader cooperation with the Ministry of Waqf in Gaza on key humanitarian issues.

Religious and community leaders can help their communities understand the crucial role that local and international health-care workers play and the importance their work. Religious scholars could, for instance, emphasize universal values and use sacred texts as a basis for the obligation to protect health-care personnel and facilities and medical transport.

Religious scholars, community leaders and health-care providers can use existing forums, such as conferences and workshops, to raise awareness of the importance of safeguarding health care and to mobilize their communities and others. They can also help enrich IHL awareness-raising events by drawing connections to religious precepts.

Religious and community leaders can work with the health-care community to locate and publicize the locations of health-care facilities. **They can also coordinate their communications to mitigate risk and keep health-care personnel safe.** For these reasons, it is important for health-care personnel to maintain dialogue and regular contact with religious leaders at all times – especially in armed conflict or other emergencies.

CONCLUDING REMARKS

The formulation of the recommendations presented in this publication already represents an important milestone for the protection of health care. But what can make a real difference on the ground is their adoption and translation into practical measures.

It is worth mentioning that some of the recommendations have already been endorsed at several global forums:

- In October 2014, the African Union Commission adopted a set of twenty recommendations that African Union Member States, the Commission itself, the ICRC and other international organizations could take to better protect national health-care systems and increase their resilience to armed conflict or other emergencies.
- In December 2014, the 69th session of the United Nations General Assembly adopted four resolutions calling on States to: (1) protect the delivery of health care, (2) reinforce the resilience of national health systems, and (3) take appropriate measures to prevent and punish violence against the delivery of health care. These resolutions are paving the way for greater involvement and stronger commitment from the international community on this issue.
- In December 2015, the States party to the Geneva Conventions gathered at the 32nd International Conference and adopted Resolution 4, "Health Care in Danger: Continuing to protect the delivery of health care together". This resolution sets out a clear road map for protecting the delivery of health care in armed conflict or other emergencies, drawing on the Health Care in Danger recommendations. In particular, it emphasizes the need to take measures tailored to each country's situation (see Appendix 4). The resolution has been strengthened by the numerous pledges made by a wide range of participants, including States, National Societies, and conference observers such as professional health-care organizations and intergovernmental organizations.[12]

The Movement and a number of States and professional health-care associations have also begun implementing these recommendations, as illustrated by the numerous examples in this guide, in other Health Care in Danger publications[13] and by the pledges made at the last International Conference.

These efforts must continue. Bringing everyone concerned together – governments, National Societies, the health-care community, weapon bearers, academia, civil society, religious and community leaders – is fundamental. Together, they can all devise and implement measures relevant to their contexts to improve the protection of health care and achieve more tangible results.

The Movement remains deeply committed to helping everyone involved in the delivery of health care to implement these recommendations and develop practical measures for use at regional, national and local levels.

[12] To view all the Health Care in Danger pledges, please consult the database on the conference website, at http://rcrcconference.org/international-conference/pledges/current-conference-pledges/.

[13] See, among others, *Health Care in Danger: Meeting the Challenges*, available at https://shop.icrc.org/les-soins-de-sante-en-danger-relever-les-defis-2205.html.

APPENDIX 1: RESOURCES

You can find these resources in several languages at http://healthcareindanger.org/resource-centre

Thematic publications

These publications provide in-depth analysis on a topic related to violence against health-care workers and facilities and medical transport. They provide recommendations and practical measures for making accessing and delivering health care safer.

- *Best Practice for Ambulance Services in Risk Situations*, Norwegian Red Cross, August 2015
- *Ensuring the Preparedness and Security of Health-care Facilities in Armed Conflict and Other Emergencies*, ICRC, July 2015
- *Safeguarding the Provision of Health Care: Operational Practices and Relevant International Humanitarian Law concerning Armed Groups*, ICRC, June 2015
- *Examining Violence against Health Care from a Gender Perspective*, Swedish Red Cross, March 2015
- *Domestic Normative Frameworks for the Protection of Health Care*, ICRC, January 2015
- *Promoting Military Operational Practice that Ensures Safe Access to and Delivery of Health Care*, ICRC, August 2014
- *Ambulance and Pre-hospital Services in Risk Situations*, Norwegian Red Cross, ICRC and Mexican Red Cross, November 2013
- *Health Care in Danger: The Responsibilities of Health-care Personnel in Armed Conflict and Other Emergencies*, ICRC April 2013

Booklets, reports and journals

Must-reads for anyone wishing to learn more about violence against health-care workers and facilities and medical transport; the Health Care in Danger project; and the initiatives around the world to make accessing and delivering health care safer.

- *Health Care in Danger: Meeting the Challenges*, ICRC, November 2015
- *Health Care in Danger: Making the Case*, ICRC, August 2011
- *Health Care in Danger: A Harsh Reality*, ICRC, September 2011
- *Violent Incidents Affecting Health Care*, ICRC, 2013, 2014 and 2015 reports
- *Health Care in Danger: A Sixteen-Country Study*, ICRC, July 2011
- *International Review of the Red Cross*, "Violence against health care" issues (Parts I and II), Vol. 95, Nos. 889 and 890, spring and summer 2013
- Health Care in Danger newsletters: February, August and December 2014 and June and November 2015
- Australian Red Cross, *International Humanitarian Law Magazine*, Issue 1, 2013
- International Federation of Red Cross and Red Crescent Societies, Psychosocial Centre, *Coping with Crisis*, Issue 2, 2014

E-learning tools

- Health Care in Danger: The legal framework

This course for the general public provides a basic introduction to the obligations of governments and the responsibilities of health-care workers in armed conflict or other emergencies.

- Health Care in Danger: The rights and responsibilities of health-care personnel working in armed conflict and other emergencies

This course focuses on ethical principles and dilemmas and the rights and responsibilities of health-care workers.

Other resources

- *Ethical Decision-Making for Doctors in the Armed Forces: A Tool Kit*, British Medical Association
- *Ethical principles of health care in times of armed conflict and other emergencies*, ICRC
- *Training Manual on Interpersonal Violence Prevention and Stress Management in Health Care Facilities*, Norwegian Red Cross
- *Toolkit for Doctors Working in Situations of Violence*, World Medical Association, October 2015

APPENDIX 2:
ETHICAL PRINCIPLES OF HEALTH CARE IN TIMES OF ARMED CONFLICT AND OTHER EMERGENCIES

Within the framework of the HCiD project, the World Medical Association (WMA), the International Committee of Military Medicine (ICMM), the International Council of Nurses (ICN) and the International Pharmaceutical Federation (FIP) were consulted by the ICRC with the aim of these organizations agreeing on a common denominator of ethical principles of health care applicable in times of armed conflict and other emergencies. The following document, which is the result of these consultations, is without prejudice to existing policy documents adopted by these organizations.

Civilian and military health-care organizations share the common goal of improving the safety of their personnel and other health assets and the delivery of impartial and efficient health care in armed conflicts and other emergencies,

Referring to the principles of humanity, whereby human suffering shall be prevented and alleviated wherever it may be found and impartiality, whereby health care shall be provided with no discrimination;

Bearing in mind the standards of international humanitarian law, in particular the 1949 Geneva Conventions and their 1977 Additional Protocols, and of international human rights law, specifically the Universal Declaration of Human Rights (1948) and the International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights (1966);

Considering the principles of professional ethics adopted by health-care professional associations, including the WMA Regulations in Times of Armed Conflict and Other Situations of Violence;

Endorse the following ethical principles of health care:

General principles

1. Ethical principles of health care do not change in times of armed conflict and other emergencies and are the same as the ethical principles of health care in times of peace.
2. Health-care personnel shall at all times act in accordance with relevant international and national law, ethical principles of health care and their conscience. In providing the best available care, they shall take into consideration the equitable use of resources.
3. The primary task of health-care personnel is to preserve human physical and mental health and to alleviate suffering. They shall provide the necessary care with humanity, while respecting the dignity of the person concerned, with no discrimination of any kind, whether in times of peace or of armed conflict or other emergencies.
4. Privileges and facilities afforded to health-care personnel in times of armed conflict and other emergencies are never to be used for purposes other than for health-care needs.
5. No matter what arguments may be put forward, health-care personnel never accept acts of torture or any other form of cruel, inhuman or degrading treatment under any circumstances, including armed conflict or other emergencies. They must never be present at and may never take part in such acts.

Relations with patients

6. Health-care personnel act in the best interest of their patients and whenever possible with their explicit consent. If, in performing their professional duties, they have conflicting loyalties, their primary obligation, in terms of their ethical principles, is to their patients.

7. In armed conflict or other emergencies, health-care personnel are required to render immediate attention and requisite care to the best of their ability. No distinction is made between patients, except in respect of decisions based upon clinical need and available resources.
8. Health-care personnel respect patients' right to confidentiality. It is ethical for health-care personnel to disclose confidential information only with the patient's consent or when there is a real and imminent threat of harm to the patient or to others.
9. Health-care personnel make their best efforts to ensure respect for the privacy of the wounded, sick and deceased, including avoiding the use of health care for the wounded and sick, whether civilian or military, for publicity or political purposes.

Protection of health-care personnel

10. Health-care personnel, as well as health-care facilities and medical transports, whether military or civilian, must be respected by all. They are protected while performing their duties and the safest possible working environment shall be provided to them.
11. Safe access by health-care personnel to patients, health-care facilities and equipment shall not be unduly impeded, nor shall patients' access to health-care facilities and health-care personnel be unduly impeded.
12. In fulfilling their duties and where they have the legal right, health-care personnel are identified by internationally recognized symbols such as the Red Cross, Red Crescent or Red Crystal as a visible manifestation of their protection under applicable international law.
13. Health-care personnel shall never be punished for executing their duties in compliance with legal and ethical norms.

Final

14. By endorsing these ethical principles of health care, the signatory organizations commit themselves to work for the promotion and implementation thereof wherever possible, including by appropriate dissemination amongst their members.

APPENDIX 3:
UNILATERAL DECLARATION ON THE RESPECT AND PROTECTION OF THE WOUNDED AND SICK AND ON ACCESS TO HEALTH CARE

Explanation

In armed conflict, armed groups have legal obligations under international humanitarian law (IHL) to protect the wounded and sick as well as health-care personnel, facilities and transport. To express their commitment to abide by their obligations, armed groups may choose to issue a unilateral declaration.

The model unilateral declaration on the respect and protection of the wounded and sick and on access to health care contains a preamble, general principles, and specific principles regarding the obligations to respect and protect:

- the wounded and sick,
- medical transport,
- health-care facilities,
- health-care personnel.

It also provides a number of practical measures that armed groups may take in order to familiarize their members with the terms of the unilateral declaration and ensure that they comply with them.

Unilateral declarations have been made by a variety of armed groups in recent decades. Some armed groups take the initiative themselves and declare their commitment through spoken or written public statements (e.g. in newspapers or on their website or Facebook page). At other times, the ICRC or another humanitarian organization initiates, negotiates and/or receives the declarations.

Armed groups can use this model unilateral declaration to:

- express their commitment to abide by their legal obligations to respect and protect health care;
- assume responsibility for ensuring that their members comply with the law; and
- inform all the groups' members of the terms of the unilateral declaration and of IHL more broadly.

Individuals and entities that engage with armed groups regarding the protection of health care can use the model unilateral declaration:

- to strengthen their dialogue with armed groups through the negotiation process preceding such declarations; and
- once the declaration has been made, to continue engaging with armed groups regarding compliance with the terms of the declaration and with IHL more broadly.

The International Committee of the Red Cross (ICRC) stands ready to provide guidance and support to armed groups interested in making a unilateral declaration. The text below is a model and starting point.

Unilateral declarations are exclusively humanitarian in character. They do not affect the legal status of the armed groups concerned, nor do they undermine or replace their legal obligations.

Text of a model declaration

We acknowledge the need for all wounded and sick persons, i.e. those who require health care and refrain from any act of hostility, to have access to health care, and we are deeply concerned about the devastating impact of hindering such access.

We recognize that the provision of health care must be guided by the principles of humanity and impartiality.

We are convinced that we can play an important and positive role in improving the safe delivery of, and access to, health care and are resolved to do so.

We recognize that this declaration is no substitute for existing legal rules, including Article 3 common to the Geneva Conventions, customary international humanitarian law and, where applicable, Additional Protocol II to the Geneva Conventions.

In view of the above:

1. We hereby commit to the following general principles:

a. respecting and protecting the wounded and sick, and actively supporting and facilitating their access to health care;
b. respecting and protecting health-care personnel, facilities and medical transports, whether civilian or military, regardless of their affiliation;
c. respecting the impartial, humanitarian character of health care;
d. ensuring that health-care personnel, facilities and medical transports remain exclusively engaged in medical tasks;
e. refraining from denying or disrupting health care as a military tactic;
f. respecting the distinctive emblems of the red cross, red crescent and red crystal, and not using the distinctive emblems improperly;
g. disseminating IHL and the terms of this declaration and ensuring that our members abide by them;
h. abiding by our obligations and commitments regardless of the behaviour of the adversary.

2. We commit to respecting and protecting the wounded and sick. This includes:

a. not attacking, harming or killing the wounded and sick;
b. treating the wounded and sick humanely in all circumstances, even if they have engaged in prior military operations on behalf of any party to the conflict;
c. searching for, collecting and caring for the wounded and sick without delay and without distinction, to the fullest extent practicable, whenever the security situation permits;
d. allowing civilians and impartial humanitarian organizations to assist in this task;
e. not preventing medical care, in particular medical supplies, from reaching the wounded and sick;
f. taking all feasible measures to ensure that the wounded and sick are respected by others.

3. We commit to respecting and protecting medical transports. This includes:

a. not attacking medical transports, even if they are not identified as such;
b. allowing and facilitating the medical evacuation of the wounded and sick, including across front lines, to a location where they can receive adequate care;
c. allowing unimpeded and fast passage to all vehicles dedicated to health care, even if they are not identified as such;
d. not using medical transports for military purposes, such as transporting healthy fighters and weapons;
e. taking all feasible measures to ensure that vehicles used for health care are respected by others.

4. We commit to respecting and protecting health-care facilities. This includes:

a. not attacking health-care facilities exclusively performing medical functions, even if they are not identified as such;
b. not attacking infrastructure essential for health-care delivery as long as it is not used for military purposes;
c. not using health-care facilities for military purposes, such as establishing military posts or storing arms and ammunition;
d. taking all feasible precautions, while planning and conducting military operations, to avoid incidentally damaging or destroying health-care facilities;

e. taking all feasible precautions to spare health-care facilities from the effects of attack, including avoiding military operations near such facilities;
f. not interfering with the work carried out in health-care facilities, a commitment that includes not taking supplies or material from health-care facilities and refraining from armed entry that disrupts the functioning of health-care facilities;
g. facilitating the work carried out in health-care facilities.

5. We commit to respecting and protecting health-care personnel. This includes:

a. not attacking, threatening or pressuring any health-care personnel providing impartial health care, even if they are not identified as such;
b. respecting health-care personnel's obligation to treat all wounded and sick, without distinction on any grounds other than medical ones, including the wounded and sick associated with the adversary;
c. not interfering with the work of health-care personnel;
d. providing health-care personnel with all possible assistance in the accomplishment of their medical tasks;
e. being aware of and promoting the ethical principles of health care and the obligations of health-care personnel under international and national law, and not punishing health-care personnel acting in accordance with their obligations;
f. not compelling health-care personnel to carry out acts contrary to the ethical principles of health care;
g. ensuring that our health-care personnel abide by the terms of this declaration and the ethical principles of health care.

6. We commit to informing the members of our group of the terms of this declaration and of IHL and ensuring they respect them. This includes:

a. integrating the rules contained in this declaration in our doctrine, education and training;
b. ensuring these rules are clearly translated into orders and directives;
c. setting up an internal system to monitor compliance with this declaration and with the corresponding rules of IHL;
d. applying sanctions, which are respectful of the individual's fundamental rights, to anyone in the group who does not abide by the rules contained in this declaration, and taking concrete measures to repair the damage done;
e. widely and publicly disseminating the terms of this declaration, including, to the extent possible, to supporters of the group and to people living on any territory that may be controlled by the group.

APPENDIX 4:
RESOLUTION No. 4
Health Care in Danger: Continuing to protect the delivery of health care together

The 32nd International Conference of the Red Cross and Red Crescent (International Conference),

deeply concerned about attacks, threats and obstructions affecting the wounded and sick, health-care personnel and facilities, and medical transports as well as the misuse of health-care facilities, medical transports or the distinctive emblems and other impediments to the delivery of health care in times of armed conflict or other emergencies, and deploring the fact that such acts lead to serious humanitarian consequences, including loss of life and widespread suffering, and to the weakening of the capacity of health systems on a national and regional level to provide health care to affected populations,

recalling Resolution 5 of the 31st International Conference entitled "Health care in danger: Respecting and protecting health care," including its call upon the International Committee of the Red Cross (ICRC) in operative paragraph 14 "to initiate consultations with experts from States, the International Federation, National Societies and other actors in the health-care sector, with a view to formulating practical recommendations for making the delivery of health care safer" in armed conflicts or other emergencies, in accordance with the applicable legal frameworks, "and to report to the 32nd International Conference in 2015 on the progress made,"

welcoming the expert consultations held between 2012 and 2014 and taking note with appreciation of the practical recommendations resulting therefrom, as well as the progress report submitted by the ICRC pursuant to operative paragraph 14 of Resolution 5 of the 31st International Conference,

expressing its appreciation for the specific role played by States, National Red Cross and Red Crescent Societies (National Societies) and health-care professional associations in hosting expert consultations,

welcoming the ongoing efforts made by States, the International Red Cross and Red Crescent Movement (Movement) and other actors in the health-care sector to improve the protection of the delivery of health care, in accordance with the applicable international and domestic legal frameworks, and efforts to implement relevant practical recommendations as well as to follow good practices in this regard,

bearing in mind that international humanitarian law applies only to situations of armed conflict and recognizing that international humanitarian law and applicable international human rights law provide a framework for protecting health care,

stressing that this Resolution does not give rise to new obligations under international law,

also stressing that this Resolution does not expand or modify the mandates, roles and responsibilities of the components of the Movement as prescribed in the Statutes of the Movement,

recalling the obligations to respect and protect the wounded and sick, health-care personnel and facilities, as well as medical transports, and to take all reasonable measures to ensure safe and prompt access to health care for the wounded and sick, in times of armed conflict or other emergencies, in accordance with the applicable legal frameworks,

calling for all States and all stakeholders to respect the integrity of medical and health-care personnel in carrying out their duties in line with their respective professional codes of ethics and scope of practice,

bearing in mind the specific health-care needs of certain categories of the wounded and sick, including children, women, persons with disabilities and the elderly,

stressing that identification of health-care personnel, facilities, and medical transports as such may enhance their protection, and in this regard recalling international legal obligations pertaining to the use and the protection of the distinctive emblems under the 1949 Geneva Conventions, and where applicable, their Additional Protocols,

recalling the Statutes of the Movement, in particular the mission of the components of the Movement as stated in the preamble of these Statutes, which guide the work of the Movement to make the delivery of health care safer in armed conflict or other emergencies,

stressing, in particular, the importance of the Fundamental Principles of the Movement and recalling that "States shall at all times respect the adherence by all components of the Movement to the Fundamental Principles," as laid down in the Statutes of the Movement,

emphasizing, in this context, the principle of humanity, whereby human suffering shall be prevented and alleviated wherever it may be found, and the principle of impartiality, whereby no discrimination on grounds of nationality, race, religious beliefs, class, political opinions or gender shall be made between individuals whose suffering is to be relieved, being guided solely by their needs and giving priority to the most urgent cases of distress,

recalling the importance of health-care personnel having sufficient practical knowledge of their rights and responsibilities, in accordance with the applicable legal frameworks and with their professional codes of ethics and scope of practice, and stressing that health-care personnel should be able to offer their services without obstruction, threat or physical attack,

stressing the need for continued and, where relevant and appropriate, strengthened cooperation between States, the Movement, international and national health-care professional associations and other health-care providers, international and regional organizations, civil society, religious and community leaders, affected communities and other relevant stakeholders to raise awareness, promote preparedness to address and address violence against the wounded and sick, health-care personnel and facilities, and medical transports, especially at a national level, bearing in mind existing roles, mandates and capacities,

1. *urges* full respect by all parties to armed conflicts for their obligations under international humanitarian law and by States for their obligations under international human rights law, as applicable and relevant for the protection of the wounded and sick and health-care personnel, facilities, and medical transports exclusively engaged in medical duties;

2. *recalls*, in this regard, the prohibitions against attacking the wounded and sick, health-care personnel and facilities, and medical transports, against arbitrarily denying or limiting access for the wounded and sick to health-care services, and against harassing, threatening or punishing health-care personnel for carrying out their duties, in accordance with the applicable legal frameworks;

3. *notes* that attacking, threatening or otherwise preventing health-care personnel from fulfilling their medical duties undermines their physical safety and the integrity of their professional codes of ethics;

4. *expresses* its deep concern about attacks against health-care personnel and facilities, and reaffirms the commitment of all components of the Movement to the protection of health-care personnel, facilities and medical transports as afforded by international humanitarian law, and calls upon States, as are required, to conduct full, prompt and independent investigations with a view to reinforcing preventive measures, ensuring accountability and addressing the grievances of victims;

5. *calls upon* States, where relevant and appropriate, to adopt and effectively implement the required domestic measures, including legislative, regulatory and practical ones, to ensure respect for their international legal obligations pertaining to the protection of the wounded and sick and health-care personnel, facilities, and medical transports, and the protection and use of the distinctive emblems by authorized medical personnel, facilities and transports;

6. *calls upon* States to ensure that their armed forces and security forces, within their respective competencies under domestic law, make or, where relevant, continue their efforts to integrate practical measures for the protection of the wounded and sick and health-care services into the planning and conduct of their operations;

7. *calls upon* States, where relevant, also to contribute to the integration of such practical measures by armed forces and security forces in the operational practices and procedures of regional or international organizations;

8. *calls upon* States, in cooperation with the Movement, the health-care community and other relevant stakeholders, as appropriate, to enhance their understanding of the nature of violence affecting the delivery of health-care services with a view to developing and effectively implementing domestic legal, regulatory and practical measures for preventing and addressing such violence, where relevant, and to this end, encourages States and the Movement, in cooperation with the health-care community and other relevant stakeholders, to regularly share challenges and good practices in this regard;

9. *calls upon* States and the Movement, in cooperation with the health-care community and academia, as appropriate, to continue making use of or otherwise support existing training tools or, where relevant, developing new tools to enhance the understanding by health-care personnel of their rights and responsibilities resulting from applicable law and their professional codes of ethics, as well as understanding of national and local customs and traditions, in accordance with the applicable legal frameworks, and of dilemmas in the discharge of their legal and ethical responsibilities and stresses that this may contribute to behaviour that could increase their acceptance with local communities and thereby to their safety and security;

10. *calls upon* States and the Movement, in cooperation with the health-care community and academia, as appropriate, to intensify or otherwise support efforts to make instruction on the rights and responsibilities of health-care personnel part of the curricula of relevant university faculties, including but not limited to medical faculties, and of training institutions for health-care personnel;

11. *calls upon* National Societies, the ICRC and the International Federation of Red Cross and Red Crescent Societies to continue supporting and strengthening the capacity of local health-care facilities and personnel around the world and to continue providing training and instruction for health-care staff and volunteers by developing appropriate tools on the rights and obligations of health-care personnel and on protection for and the safety of health-care delivery, to the extent possible;

12. *calls upon* States and the Movement, where relevant, and in cooperation with affected local communities and their leaders, to enhance the secure functioning of health-care facilities through preparatory and practical measures;

13. *calls upon* States and National Societies, where relevant, to engage or continue to engage with each other, with a view to strengthening domestic law, regulations and practice regarding the auxiliary role of National Societies to the public authorities in the humanitarian field for the safer delivery of health care, including the effective coordination of their respective health-care services, and calls upon National Societies, in the fulfilment of that auxiliary role, to promote and support the implementation of States' international legal obligations and dissemination efforts in this regard;

14. *calls upon* National Societies to intensify their commitment and efforts to increase their acceptance, safety and security in order to access persons in communities where they deliver health-care services, including by providing training or other support to their staff and volunteers to ensure that they operate in accordance with the Fundamental Principles of the Movement, by applying existing operational approaches and approaches designed to enhance the organizational development of National Societies, such as the Safer Access Framework, and by continuing to work, where relevant, on specific procedures, protocols and capacities to enhance risk management and the overall security of their ambulance and emergency health-care services, and encourages other National Societies, the ICRC and the International Federation, as appropriate, to support them in these efforts.

MISSION

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.

ICRC

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