



# HEALTH CARE IN DANGER

## MEETING THE CHALLENGES

PROTECT  
HEALTH CARE

IT'S A  
MATTER  
OF **LIFE**  
& **DEATH**



ICRC



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# **HEALTH CARE IN DANGER**

## **MEETING THE CHALLENGES**



M. Tahitah/CRC

"He who has health has hope;  
and he who has hope has everything."

Thomas Carlyle

## INTRODUCTION

Every day, doctors, nurses, ambulance drivers and first aiders come under attack while trying to save lives in armed conflict. They are threatened, arrested and beaten. Some are unable to work because medical supplies cannot get through or their hospital is looted or bombed; some are forced to flee for safety. Some are even killed. Their absence presents a tremendous challenge. For wounded and sick people in need of treatment it is a matter of life or death.

*Health care in danger – Meeting the challenges* is a collection of stories from the field. These are the stories of Abdul Aziz, Dr Julio Cesar, Bilal Ahmad Ahmadi, Bhesh Raj Thakuri, Dr Florent Pierre Aka Kroo, Sheikh Khamis and Ariane Bauer. They describe how violence can disrupt the delivery of health care in a matter of seconds. Their stories are all too familiar to millions of people across the globe who have suffered because health-care facilities, services and staff have been the target of violence. The consequences can be dramatic: entire communities are

left without access to health care and eventually the health system collapses. Ensuring the safe delivery of health care is therefore vital to both the direct victims of violence and those vulnerable to its long-term effects.

But these stories also offer a glimpse of hope. They illustrate effective measures taken by different people in different countries to prevent violence against health-care workers and facilities. They prove that even in times of armed conflict, access to health care can be made safer.

Four years on since the launch of the Health Care in Danger project, this publication brings together recommendations and concrete measures to ensure the safe delivery of health care, and seeks to promote their wider implementation. It also celebrates the courage, determination and compassion of the many health-care workers that strive to reaffirm a space for humanity in war every day.



D. Chavez/World Bank

## Glimpses of hope

# A HAVEN FOR HEALTH CARE

**Abdul Aziz was a project coordinator at Timbuktu hospital for the International Alliance for Medical Action (ALIMA), a non-governmental organization, when the conflict broke out in Mali in 2012.**

“ I was in Timbuktu when it started. Early one morning, a heavy firefight broke out between the army and several armed groups. The army camp was just three hundred metres from the hospital. We didn't know what to expect.

A rocket fell close to one of the hospital buildings. The explosion shattered the windows and sent ceiling fans spinning to the ground. It was chaos. Patients that had just been operated on were trying to get out. I remember two women were bleeding heavily – they'd had Caesarean sections and their wounds had reopened. Most of the staff were running out of the hospital too, panic-stricken.

We knew that health facilities had been ransacked elsewhere – ambulances had been hijacked and health personnel threatened. It was just a matter of time before we would face the same problems.

Towards the end of the day the fighting abated. I knew I had to do something to protect the hospital.

We started contacting all the armed groups. I spoke to heads of units mainly because high-ranking commanders are too far away from the field. You need to talk to those who head the units on the ground – they have the power to change things quickly. I explained that the hospital was there to take care of everyone who needed it, regardless of ethnicity, belief or politics. But if the hospital was looted or attacked, everyone would run away and a lot of the patients would die. I stressed that they could bring their own wounded too, and that we would take care of them just like everyone else. They agreed not to attack the hospital and staff, and let our ambulances through the checkpoints they controlled.

One day, a crowd gathered around our hospital. I had heard that all the other hospitals in the regions had

## RECOMMENDATION

Gaining people's trust is key to getting access to sick and wounded people and increases the safety of health-care workers. To do so, emergency services should first assess and monitor how health-care providers are seen by weapon-bearers, the authorities and other relevant groups and individuals. On the basis of this assessment, they should follow country-specific codes of conduct and regularly carry out trust-building and awareness-raising activities on the importance of safeguarding medical personnel and facilities.



been ransacked and it looked like they might loot ours too. I immediately went to meet some religious leaders and asked them to come and speak to the crowds about the importance of preserving health-care services. The people wouldn't have listened to me – but to respected imams, they did: everyone backed off.

Sometimes, armed men came to the hospital for medical treatment. If they refused to come in without their weapons, we pointed at people's terrified reactions. When they saw the sheer panic that they were causing, they understood. Many agreed to leave their weapons outside.

The hospital became a safe haven for staff and patients alike. I think that our success in safeguarding the hospital owed a lot to the diversity of our staff. We had made sure we recruited people from all the groups or tribes that were involved in the conflict. This helped on

two levels. First, we had a better chance of being seen as neutral and impartial. Second, our staff enabled us to get in contact with all the warring parties.

I have continued to apply the lessons I learnt in Mali: to stay safe, it is crucial that we understand the social, political and cultural context and are in contact with community leaders. ”

# THE ORIGINS OF THE HEALTH CARE IN DANGER PROJECT

When Henry Dunant, a Swiss businessman, came across wounded soldiers left for dead after the Battle of Solferino in June 1859, he was horrified. His belief in treating all the wounded and sick on the battlefield, without discrimination, lies at the heart of international humanitarian law and led to the founding of the International Red Cross and Red Crescent Movement over 150 years ago.

But if civilians and combatants are to be spared unnecessary suffering in armed conflict and to receive treatment – as is their right – medical workers, facilities and vehicles have to be protected.

Given the alarming rise in the number of attacks on medical workers and hospitals in the field, the International Committee of the Red Cross (ICRC) launched a 16 country-study in 2008 to better understand the problem. The study took three years. Its findings revealed the range of issues affecting the safe delivery of health care in armed conflict and other emergencies: there were direct attacks on patients, medical workers and facilities,

or inadvertent hits by explosive weapons; access to health care was being obstructed and denied; ambulances were being held up at checkpoints; hospitals were being looted; and medical workers were being kidnapped.

Most importantly, the study emphasized that violence against health-care workers is more than the sum of individual incidents; it is a complex issue with often far-reaching consequences for a country's entire health-care system. It also highlighted that solutions cannot only come from health-care workers but must also come from people working further afield, such as in law, politics, humanitarian dialogue and preventive action.

In December 2011, the 31st International Conference of the Red Cross and Red Crescent brought together around 3,700 representatives from more than 180 States party to the Geneva Conventions and the three components of the Movement (the ICRC, the International Federation of Red Cross and Red Crescent Societies and the National Societies).





Building on the information gathered in the ICRC study, Resolution 5 called upon the ICRC to begin consultations with experts from States, the International Federation, National Societies and health-care communities worldwide to formulate recommendations for making the delivery of health care safer in armed conflict and other emergencies.

The Health Care in Danger project was born. Spearheaded by the ICRC and supported by a network of committed partners, the Health Care in Danger project strives to ensure that people can get the medical attention they need, wherever and wherever they are, and that health-care workers, facilities and vehicles are safe and protected.

*“There are many preventable diseases in this conflict zone but people get seriously ill or die simply because they cannot get medical treatment. For health workers like myself, it is very hard to take.”*

Dr Francisco Ortiz, ICRC, Colombia

## THE DANGERS PREVENTING SAFE ACCESS TO HEALTH CARE

### Violence

Ambulances and hospitals are attacked, health-care workers and patients are harmed or killed.

### Obstruction

Restrictions imposed by warring parties on health-care workers can stop patients from getting medical treatment. Ambulances are deliberately prevented from reaching wounded people or held up for hours at checkpoints.

### Discrimination

Health care should be provided on the basis of medical need. But weapon bearers or other influential actors may try to stop health-care workers from treating wounded enemies, in violation of medical ethics. Health-care workers themselves may not treat patients from different ethnic groups or political entities equally and impartially.

### Lack of security

The general lack of security resulting from armed conflict can have major consequences on health-care provision: health professionals, even if not directly targeted, may flee themselves or stop going to certain areas. Instead of seeking treatment, the sick and wounded often stay at home rather than risk the roads, where attacks and muggings are rife.

## Glimpses of hope

# COLOMBIA ON A MISSION TO PROTECT HEALTH CARE

In 2002, as attacks on medical staff and patients had left large swathes of the country with limited or no medical services, the Colombian government took the matter into its own hands. It issued a decree on protecting medical services during armed conflict. All health-care providers had to use a new symbol that would help protect them during armed conflict. Dr Julio Cesar Castellanos Ramírez, Director of the San Ignacio University Hospital, is the longest-serving member of the national round table on protecting health care, which has existed for over a decade.

“ There was a considerable number of emblems that were being used by public health services, whether for armed conflict or natural disasters. This was really confusing. After so many years of conflict, we decided we needed an emblem that would not be associated with a specific humanitarian mission or with the military.

It is really important to regulate the use of the emblem to make sure it will be respected and provide

protection. To use it, health services have to get permission from the Ministry of Health. Because smuggling and trafficking are rife in Colombia, vehicles with the emblem must be used for health purposes only. The decree also stipulates that those who use the emblem must be trained in first aid. That is one way of making sure that it is about providing health care.

The new emblem is more recognizable, and has definitely improved the protection of health services.



The number of offences and attacks has decreased. In fact, the emblem protects so well that some people have started using it on their vehicles for illegal activities. One of our main challenges now is stopping the unauthorized use of the emblem.

We are making sure that the manual on the protection of health services is circulated as widely as possible. It was drafted following the 2002 decree and amended ten years later to extend the protection of medical services to cover all situations of violence – not just armed conflict. It provides practical advice, and in particular security tips, such as a checklist for health-care workers going to conflict zones, and explains their rights and responsibilities.

To make sure that they are familiar with its content, health-care workers starting in a new position are tested on their knowledge of the manual, especially in areas where the conflict is more acute. We've worked hard to get the manual out there, but more needs to be done. We're going to make it available on the web as an online course soon, and we are pushing for hospitals and universities to provide courses on the manual. ”

## RECOMMENDATION

Signs that indicate health-care activities – other than the red cross, red crescent and red crystal emblems recognized under international law – should be created and used to enhance protection for health-care workers only if the situation genuinely requires it. This is to avoid a proliferation of emblems.

If new signs are introduced to indicate health-care activities, they must be established and regulated by government. In addition, they must be clearly distinguished from the red cross, red crescent and red crystal emblems.

## THE COLOMBIAN EMBLEM TO PROTECT HEALTH-CARE WORKERS

In 2002, the Colombian government introduced its own sign to try to protect health-care workers carrying out their medical duties (*la misión médica*). It was necessary because of the number of violent attacks against health-care workers and the proliferation of emblems used in internal disturbances that did not meet the threshold of armed conflict under international humanitarian law. The purpose of the new emblem was also to guarantee that the most vulnerable people would get the medical attention they needed. The emblem has been a success, providing greater protection for health-care workers, hospitals and ambulances throughout the country.



# PROTECTING HEALTH CARE TOGETHER

Over 4 years, the Health Care in Danger project launched and supported a number of initiatives to protect health care. They aimed to gain a better grasp of the issues at stake, raise public awareness of the scale and consequences of the problem, foster dialogue, come up with practical recommendations and best practice, and promote measures that would bring about real change on the ground.

The initiatives are described below. They have been instrumental in forging partnerships and bringing together influential people from outside the Movement: health-care workers, governments, armed groups, humanitarian organizations and members of civil society. Together, they make up a “community of concern” that wants to uphold safe access to health care.

## CONSULTING PRACTITIONERS TO FIND SOLUTIONS

Through a large consultation process, and in particular through thematic workshops, the Health Care in Danger project brought together experts and other individuals concerned from across the world (see pp. 16-17) to discuss obstacles and dilemmas raised in the 16-country study into violence against health-care workers and facilities. Participants were asked to share their experiences, present ideas, propose measures and provide practical recommendations to make health care safer. The main areas of discussion are set out below.

## The role of States: Strengthening domestic legislation

States have the primary responsibility to prevent the targeting, obstruction, and/or abuse of the delivery of medical assistance. Therefore, bolstering the role of States in preventing violence against health care is key. Medical workers, facilities and vehicles must be protected. States should ensure that all possible measures are taken to protect access to health care through domestic law and its implementation.

Participants in the consultation process were encouraged to discuss experiences in their own countries, to help identify best practice and to draw up recommendations with regard to the implementation of the international rules and standards protecting the provision of health care. Together, the experts put forward measures and procedures that can be adopted by governments to ensure they are adequately prepared to deal with violence against health-care services. They also put forward some measures for building respect for medical ethics in armed conflict and other emergencies and ensuring compliance with the existing international framework protecting safe access to health care. These measures are compiled in a specialized publication entitled *Domestic Normative Frameworks for the Protection of Health Care*, which is a reference work for States engaged in ensuring safe access to and delivery of health care.





### The role of State armed forces

In armed conflict, State armed forces often have to strike a balance between the need for medical help and legitimate security concerns. The best way to achieve this balance is to implement military operational rules that protect health-care workers and uphold international law.

A Health Care in Danger workshop brought together military personnel from 20 countries to identify practical ways to mitigate the effect of their operations on health-care services. The negative impact of the following three scenarios were discussed: holding up medical vehicles or refusing to let them pass a checkpoint, carrying out military search operations in hospitals and deploying military force in or near health-care facilities. The workshop showed the willingness of the armed forces to incorporate practical measures into their rules of engagement, standard operating procedures and training.

The ideas and recommended operational practice that came out of these consultations are available in the publication: *Promoting military operational practice that ensures safe access to and delivery of health care.*

### The role of armed groups

Over 2 years, 36 non-State armed groups from around the world gave their views on access to health care and protecting medical workers, facilities and vehicles, and sick and wounded people. The consultations identified practical steps that armed groups can take to improve the safe delivery of health care.

The publication *Safeguarding Health Care: Operational Practice and Relevant International Humanitarian Law concerning Armed Groups*, describes the results of this process, focusing on armed groups as parties to a non-international armed conflict. The Health Care in Danger project also drafted a model declaration that armed groups can adopt to voice their commitment to upholding and protecting safe access to and delivery of health care.



## Glimpses of hope

# EVACUATING WAR-WOUNDED PATIENTS IN AFGHANISTAN

**In Afghanistan, the ICRC set up a War-Wounded Assistance Programme to ensure access to health care for war-wounded people – both civilian and fighters – by facilitating their evacuation from the battlefield. Bilal Ahmad Ahmadi, head of the ICRC's office in Ghazni province, shares his insights into the programme he helped launch in May 2014.**

“The international forces in Afghanistan were in charge of evacuating by helicopter the wounded of all parties to the conflict. When they left in 2013, the ICRC stepped in. This was because we are seen as neutral and impartial thanks to the work we have been carrying out for many years in Afghanistan. The problem with health-ministry ambulances is that they might be perceived as siding with the government, and so some groups might not use them to evacuate wounded or sick people.

Most of the programme's beneficiaries are weapon-bearers, since they're the ones who are most at risk of being stopped by enemy fighters on their way to the hospital.

Between May and December 2014, we took 39 patients to hospital, almost all of them from the armed forces or armed groups.

The Afghan National Security Forces supported us from the outset. The first negotiations took place at provincial level, and we later received an official approval letter from the interior ministry that we carry with us. But we haven't had to show it yet – the commanders we meet on the ground at checkpoints always know about our mandate and activities and have clear instructions to let our vehicles through.

Similarly, the armed opposition has given us security guarantees, and we've never had any problem. I remember the case of two police officers who had been injured in the fighting. We received authorization to pick them up, and on our way back we were stopped at two checkpoints by Taliban fighters who had been told we were coming. After inspecting the vehicles, they let us pass.

The programme is a success because we have a good working dialogue with both the army and the armed opposition – they understand and uphold the right of all wounded and sick people, irrespective of which party they belong to, to receive medical care – and because the ICRC has earned the reputation of being neutral and impartial after many years working with all the different communities here. ”



S. Lenelle/ICRC

## RECOMMENDATION

Lines of communication for medical evacuations need to be established among medical workers, NGOs, the military and other people concerned prior to operations and then maintained throughout. In addition, local community leaders and the authorities need to be included as evacuating wounded and sick people might not necessarily be carried out by medical workers or vehicles.



K. Holt/ICRC

# BUILDING ON THE STRENGTH OF NATIONAL RED CROSS AND RED CRESCENT SOCIETIES

National Red Cross and Red Crescent Societies are uniquely placed to understand and advance the aims of the Health Care in Danger project. Staff and volunteers not only witness violence against health care, they may be prevented from reaching patients, injured or even killed while on duty. In addition, National Societies are often part of national health-care systems, and are familiar with local cultures, conditions and institutions. They can be instrumental in bringing people together to find solutions that match local conditions.

National Societies have launched a variety of initiatives, talking to authorities, the health-care community and civil society to raise awareness of the problem and seek solutions. In the field of ambulance services and pre-

## LEARNING FROM EACH OTHER

In two workshops held in Colombia and Lebanon in 2014, 14 National Societies with experience operating ambulance and pre-hospital services in risk situations provided examples of best practice. These are compiled in a report entitled *Best Practice for Ambulance Services in Risk Situations*. Topics include basic attributes and conduct of personnel, communication and coordination in the field, preventing misuse of National Society ambulances, and dealing with personal psychological trauma.





Palestine Red Crescent Society

hospital care, for example, they have forged partnerships with other health-care providers to better coordinate their services. And some National Societies have come together on a regional basis to develop procedures and best practice for ambulance staff and volunteers working in dangerous situations (see box p. 14).

National Societies have also been encouraged to initiate or continue their efforts to apply the Safer Access Framework (see box). The goal is to make sure staff and volunteers are accepted by everyone, enabling them to have access to those most in need and to work in safety in times of conflict or serious violence.

## GAINING ACCESS TO COMMUNITIES, STEP BY STEP

The **Safer Access Framework** draws on many National Societies' extensive experience in dangerous situations to provide a structured way to operate safely. The Framework covers a number of steps that a National Society can take, in tandem with the Fundamental Principles, to reduce risk and earn the trust of both local communities and those who control access to people in need. There are some steps that should be taken during peacetime in order to facilitate safer access in more turbulent times. Because of this, the Framework is relevant to all National Societies regardless of their immediate circumstances.

# FINDING SOLUTIONS TOGETHER TO PROTECT HEALTH CARE

## A GLOBAL PROCESS

Between 2012 and 2014, the Health Care in Danger project conducted global consultations with a variety of relevant actors. Some of them have lived through conflict, or worked to assist people in need of health care, or have established prevention or response mechanisms to violence or emergencies, or developed their resilience to crisis. Building on the expertise and practice of the participants, this global process aimed at sharing and discussing the different experiences and collectively identifying concrete solutions to make access to health care and its delivery safer.



M. Tahtah/ICRC



O. Shadman/ICRC



ICRC



El Baba/Palestine Red Crescent Society

### 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, perception, coordination



C. Granier-Deferre/ICRC



T. Gassmann/ICRC



ICRC



B. Heger/ICRC

## 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



## Glimpses of hope

# IMPROVING AMBULANCE SERVICES IN NEPAL

**Although the 10-year armed conflict in Nepal ended in 2006, there is still sporadic violence that affects health-care services in general and ambulance services in particular. Political parties and various groups often resort to strikes, during which ambulances have frequently been held up and even destroyed. Ambulance services themselves have failed to uphold medical ethics, and news bulletins have featured cases of ambulance misuse. To address these issues and improve the quality of ambulance services, the Nepal Red Cross Society and the ICRC organized round tables on ambulance services that brought together representatives from the field of pre-hospital care.**

“What am I supposed to do when people threaten me? They want me to take their patients, their family members – even though sometimes their condition is not that serious. They tell me that they will set my ambulance on fire if I don’t agree,” says Bhesh Raj Thakuri, who has long experience as an ambulance driver with the Nepal Red Cross. “We drivers need more training. We need to know what we should do – there is some confusion regarding what is allowed and what isn’t,” he adds.

Round tables are the ideal forum to raise such concerns. Participants range from public-health, police and military officers to representatives from civil society and the Movement. Together they discuss what problems ambulance services face and how they can tackle them. So far, round-table meetings have been held in around 30 districts in Nepal.

“Before we started having these meetings, we used to hear of ambulances being misused or vandalized, but

nobody had fully grasped the scale of the problem,” explains Pushpa Raj Paudel, former executive director of the Nepal Red Cross. “Now, all those concerned understand the conditions under which ambulance services operate and the challenges they face.”

After identifying the problems, participants discuss how to deal with them and recommend what steps to take. As a result, some groups that have been responsible for holding up or damaging ambulances have changed their behaviour. “After these meetings, we have seen political parties take action by making it clear to their officials that ambulances should not be held up, and district health officials have handed out information on ambulance services for the first time in their district,” says ICRC medical assistant Shashi Kumar Lal Karna.

Driver Bhesh Raj Thakuri says he learned a great deal through these meetings: “There were so many rules and regulations that we didn’t know. Many of us discovered

## RECOMMENDATION

All emergency teams should understand and promote the Safer Access Framework. Even though it was originally designed for Red Cross and Red Crescent staff and volunteers, it can be used as a reference tool by all those working in conflicts and other emergencies.

that ambulances had to have blue flashing lights, instead of red ones, which are reserved for security forces. We learned more about when we should use the siren. We also discussed how the very difficult road conditions mean we have to drive very carefully and how to clean ambulances between patients properly. All of these actions improve how the community sees ambulance drivers, the services we offer and the organization we represent.”

A notable outcome of these meetings is that there is a follow-up mechanism to monitor the implementation of their recommendations. Several months after a round-table discussion, a meeting is organized to reassess the situation, discuss best practice and lessons learnt and share them later in other districts. ”



# BUILDING A COMMUNITY OF CONCERN

As part of the Health Care in Danger project, the ICRC, hand in hand with National Societies, has built a community of concern made up of health and aid organizations, governments, armed forces, civil society organizations and individuals. The community's goal is to enhance support for and compliance with laws that protect health-care workers and to ensure the safe delivery of health care. To bring all those concerned together and share studies, data and best practice, the Health Care in Danger team launched an interactive web-based platform that centralizes a wide variety of resources from a range of organizations and incorporates a calendar of the different initiatives taking place across the world: [www.healthcareindanger.ning.com](http://www.healthcareindanger.ning.com).

The Health Care in Danger project brought together the World Medical Association, the International Committee of Military Medicine, the International Council of Nurses, the International Federation of Medical Students Associations and the International Pharmaceutical

*"It's not enough to say there is a problem. The increasing lack of respect for health-care facilities and staff is a real concern. This is why we don't just want to raise awareness, we need to take action."*

Rudi Coninx, World Health Organization

Federation to agree on basic ethical principles that apply in all armed conflicts and emergencies (see box p. 21). The project also helped about twenty universities to develop teaching modules for their public-health courses on how a lack of security adversely affects health-care services.

Influential civil society and religious leaders were approached to involve them in protecting health-care services. An international workshop on the importance of gaining the support of such leaders was also organized.



M. Cruppe/ICRC



D. Chavez/World Bank

*"In times of unrest, health professionals face incredibly challenging situations. Ethics can be put under pressure, which may adversely affect our prime concern: the care of patients. This new code of ethics reflects our strong commitment to show a united front against all forms of violation of ethical principles."*

Luc Besançon, International Pharmaceutical Federation



T.E. Voeten/ICRC



N.S. Cohen/ICRC

## ETHICAL PRINCIPLES OF HEALTH CARE IN TIMES OF ARMED CONFLICT AND OTHER EMERGENCIES

As part of the Health Care in Danger project, the ICRC came together with the World Medical Association, the International Committee of Military Medicine, the International Council of Nurses and the International Pharmaceutical Federation to agree on common ethical principles for providing health care in armed conflict and other emergencies.

The resulting code of practice sets out the ethical principles that health-care workers should follow at all times when carrying out their duties. It covers both general principles – such as humanity, non-discrimination and the absolute rejection of torture – and specific principles – such as ensuring medical confidentiality, obtaining patients' express consent and acting in their best interest. It also deals with how to ensure the safe delivery of health care.

The code was adopted by the organizations and then officially launched in June 2015. It has since been adopted by the International Federation of Medical Students' Associations. All the organizations are committed to promoting and implementing the code as widely as possible. This includes ensuring that health-care personnel are not forced to act against the principles or punished for following them. The code can be downloaded here: [www.icrc.org/en/document/common-ethical-principles-health-care-conflict-and-other-emergencies](http://www.icrc.org/en/document/common-ethical-principles-health-care-conflict-and-other-emergencies).

## CONSOLIDATING AND IMPROVING FIELD PRACTICE

Drawing on decades of work in conflicts and crises, the ICRC and National Societies have developed practical measures for ensuring the safety of health-care facilities. Representatives of the ICRC and National Societies came together at two workshops with representatives from, among others, Médecins Sans Frontières (MSF), the International Hospital Federation and the Pan American Health Organization to share best practice. The resulting recommendations were published in *Ensuring the preparedness and security of health-care facilities in armed conflict and other emergencies*.

Other meetings have brought to light the difficult conditions faced by health-care workers and the ethical dilemmas that arise, such as how to do triage in mass casualty situations or deal with media requests without compromising medical ethics. Medical workers across the globe have pointed out the need for guidance on their rights and responsibilities. So, to address that need a guide was published, entitled *Responsibilities of health care personnel in conflict and other emergencies*, and later produced as an e-learning module.



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## Glimpses of hope

### “IT IS IN TIMES OF PEACE THAT WE SHOULD PREPARE FOR CRISES”

**During a decade of armed conflict in Côte d'Ivoire, health-care workers had to operate in a climate where violence was commonplace. The experiences of doctors during this period led the National Council of the Order of Physicians in Côte d'Ivoire to draft a white paper on preparing and training health-care workers on how to act in dangerous situations. Dr Florent Pierre Aka Kroo, the president of the council, looks back on this experience.**

“ In the wake of the disputed elections in 2010, violence against health-care services was rife in Côte d'Ivoire. It began with threats; then the violence escalated but the health authorities did not react. It was a real crisis: health-care providers were prevented from reaching their places of work, armed men stormed an operating theatre and brought in their own patient for emergency surgery and some doctors refused to treat patients for ethnic or political reasons. Health-care workers did not know how to react appropriately in these circumstances.

Since then, there has been sporadic violence against health-care services. We realized that doctors had to take matters into their own hands and needed a better understanding of what they could and could

not do when conflicts breaks out, and how others should treat them.

The council therefore decided to write a white paper telling the stories of doctors who disappeared or were arrested during the conflict. It provided practical recommendations, primarily for doctors but also for the authorities and weapon-bearers. It also helped illustrate health workers' rights and responsibilities. Registration with the council is mandatory, so the white paper was sent to all 6,500 doctors currently practising in Côte d'Ivoire.

In writing the white paper, we realized just how much information we had to cover – many people were not even familiar with the basic legal texts – and we learned a great deal ourselves as well.

## RECOMMENDATION

Health-care personnel should have a solid understanding of how international humanitarian law, human rights and ethical principles shape their rights and responsibilities in armed conflict and other emergencies. Training should be made available and provided to them, for instance, on upholding ethical principles of health care and facing medical dilemmas, violence management and prevention, and stress management.



We received help from other organizations. The World Medical Association agreed to share its code of conduct, which explains universal medical ethics and the duties of all health-care workers, such as providing health care to all patients without discrimination. Armed groups are less likely to target health-care workers who are seen as impartial. In addition, the ICRC contributed its legal expertise in international humanitarian law.

We set up an observatory to monitor the level of violence and to see how safe it is for doctors to practise. We ask doctors to report any cases of violence. However, we still need to find a way to get doctors to fill out the forms immediately after incidents. Statistics are key when bringing up the issue with government authorities.

We should not wait for violence to occur before getting the message out there. Rather, it is in times of peace that we should prepare for crises. In my opinion, the most important thing is to train everyone – doctors, weapon-bearers and the general public alike. The more informed they are, the less likely it is that violations will occur. But more money needs to be made available to spread the word.

The white paper is a valuable resource that should be shared with other countries in similar situations. We plan to have it translated into English and Portuguese for our counterparts working in the other fifteen countries of the Economic Community of West African States. ”



C. Von Toggenburg/ICRC

## Glimpses of hope

# “PRAYER LEADERS LIKE ME CAN PLAY A KEY ROLE IN SPREADING THE RIGHT MESSAGE”

**Imams – Muslim religious leaders – are highly respected and influential in Palestinian society. Nearly all Muslim men go to mosque on Fridays and listen to the imam’s speech, which is considered the most important part of Friday prayers. Imams are employed by the Ministry of Religious Affairs and receive guidance on their speeches from Sheikh Khamis Abdeh, the deputy to the Palestinian minister for religious affairs. The sheikh is in charge of public advocacy and Islamic guidance – an important channel for spreading humanitarian messages.**

“ The ICRC invited me to take part in an international humanitarian law course in Beirut. There, I discovered that the law of war and Islam share the principle of humanity. The Quran, Sunnah and sayings of the various Islamic schools are very clear about the respect that is due to wounded and sick people, who must be protected even if they are on the side of the enemy. Prisoners of war should be cared for even before one’s own people. All those who are not directly taking part in hostilities should be spared.

The law of war should be incorporated into university courses as well. I teach Islamic law at university and I am pushing for international humanitarian law to be incorporated into degree courses.

Once back in Ramallah, I organized a workshop on international humanitarian law for senior ministry staff, to share what I had learned in Beirut. After the workshop, the Islamic guidance department prepared a speech for Friday prayers on protecting health-care services. They sent it to all 2,000 speakers in West Bank mosques, thereby reaching some two million Muslim worshippers.

Clearly, there are no differences between the rules of Islam and the law of war, and prayer leaders like me can play an important role in spreading the message about protecting health-care services in times of conflict. ”

"In the event of the use of force and in case of armed conflict, it is not permissible to kill non-belligerents such as old men, women and children. The wounded and the sick shall have the right to medical treatment; and prisoners of war shall have the right to be fed, sheltered and clothed. It is prohibited to mutilate or dismember dead bodies. It is required to exchange prisoners of war and to arrange visits or reunions of families separated by circumstances of war."

Cairo Declaration on Human Rights in Islam, 1990, Article 3(a)

## RECOMMENDATION

It is essential to strengthen dialogue on protecting health-care services and reach out to all civil-society leaders, including religious and community leaders, taking into account their importance in society, especially in times of conflict and crisis.



# UNDERSTANDING VIOLENCE AGAINST HEALTH CARE THROUGH DATA GATHERING AND ANALYSIS

In 2012, the ICRC broadened its first incident-collection exercise from 16 to 23 countries and has since published annual reports on violent incidents against health care. This data helps the Health Care in Danger project to draw the attention of decision-makers, raise awareness on the urgent need for action and promote debate.

Although the number of countries is not globally representative, this data is still useful for identifying recurring aspects of violence against health-care services. For example, information collected by the ICRC in the 23 countries studied showed that, although the spotlight is often put on attacks on international aid workers, 90% of attacks actually targeted local health-care providers.

The Health Care in Danger project promotes a context-specific approach to dealing with violence against health-care services. In particular, it encourages governments to set up data-collection systems to improve their understanding of the nature of violence against health-care services in their own country so as to tailor their response.

“We still don’t know enough about the causes and consequences of attacks. Without this knowledge, we’ll not be able to deal with the problem effectively.”

Françoise Duroch, Médecins Sans Frontières

## VIOLENCE IN NUMBERS

In April 2015, the ICRC released *Violent Incidents Affecting the Delivery of Health Care*, a report analysing over 2,300 incidents that took place in 11 countries between 2012 and 2014. The report highlights a number of issues that require particular attention, such as the vulnerability of health-care facilities to attacks and looting and the frequent violation of ethical principles of health care, particularly those concerning confidentiality and non-discrimination of patients.

## MONITORING VIOLENCE IN FRANCE

In France, in an effort to prevent violence in medical facilities, the government established a national observatory of violence against health care (*Observatoire national des violences en milieu de santé*) in 2005. Health-care workers from both the public and private sectors are encouraged to report any incidents of violence through a shared platform that gathers local, regional and national data.

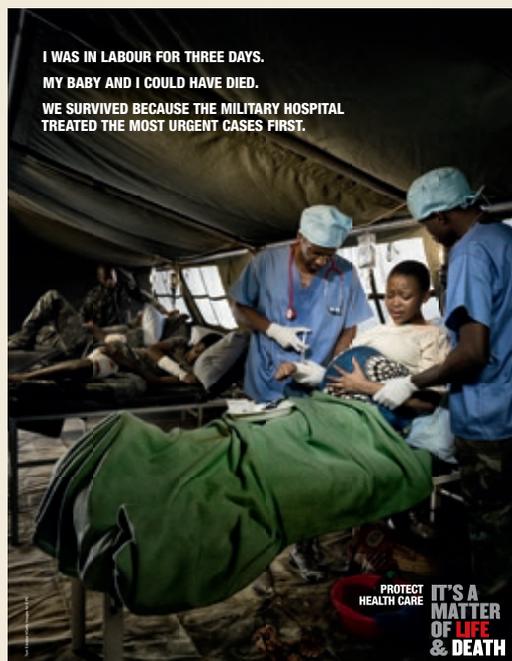
The observatory manages the data and publishes an annual statistical report on violence – most of which are attacks, insults and threats – that take place in hospitals and clinics. It also analyses trends, gives a list of solutions provided by hospitals and other health facilities across the country and monitors the impact of steps taken to prevent violent incidents.



“A study done in Iraq, showed that over 2,000 senior doctors were killed and 250 kidnapped after 2003 and that out of a total of 34,000 over 12,000 had left the country. Those numbers have probably increased since. The main point is that the country was left with junior doctors, who are not prepared or trained to treat war-wounded patients.”

Marco Baldan, ICRC chief surgeon

# PUBLIC AWARENESS AND DIPLOMATIC EFFORTS



The Life&Death campaign was launched in 2011, with the aim of raising awareness among the general public about the consequences of violence against health-care workers. It also aims to promote national and international initiatives for safer access to and delivery of health care. Several other organizations have joined the call and started their own campaigns, such as Médecins Sans Frontières with its Medical Care Under Fire campaign. The Safeguarding Health in Conflict Coalition, for its part, counts Human Rights Watch, Physicians for Human Rights and the Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health among its many members.

Some States have also paved the way for diplomatic engagement. Norway, for example, used its status as chair of the Foreign Policy and Global Health Initiative to put the effects of violence against health care at the top of the diplomatic agenda, and submitted a resolution on the issue at the United Nations General Assembly. This initiative laid the groundwork for three further resolutions on the protection of health care adopted in December 2014. Those texts were an important step, as governments recognized the serious nature of violence against health-care workers and facilities and committed themselves to fostering a constructive dialogue on possible solutions.

## INTERNATIONAL ACTION

The 69th session of the United Nations General Assembly represented an important milestone for the protection of health care. The General Assembly adopted four resolutions\* calling on States to protect the delivery of health care, reinforce the resilience of national health systems and take appropriate measures to prevent and end violence against health care. This paved the way for stronger international commitment to ensuring safer access to and delivery of health care.

One resolution, in particular, was the result of diplomatic efforts by the Foreign Policy and Global Health Initiative. This was established in 2007 and brought together Norway, Brazil, France, Indonesia, Senegal, South Africa and Thailand.

In all four resolutions the emphasis was on the issue of violence against health care, acknowledging the seriousness of the problem and its immediate and long-term impact, particularly in terms of:

- exacerbating loss of life and human suffering;
- eroding the ability of health systems to deliver essential life-saving services;
- hindering health development.

\* Resolution A/RES/69/120, Resolution A/RES/69/132, Resolution A/RES/69/133, Resolution A/RES/69/135



A. Beaumont/ICRC

## Glimpses of hope

# MAKING HOSPITALS SAFER

**Ariane Bauer, who heads the ICRC's operations in Kaga Bandoro, explains what can be done to minimize damage to health-care facilities in the event of attack, curb disruptive entries by weapon-bearers and lessen the fears of staff and patients.**

“ Kaga Bandoro hospital, in the conflict-ridden Central African Republic, is the referral centre for health-care services in the district and serves around 134,000 people. Because there was no physical barrier controlling access to the hospital, armed men would enter the hospital unhindered. Understandably, this made staff and patients feel threatened.

So, the ICRC launched a project to improve the hospital's security. Local people were hired to build a perimeter wall around the hospital, which was then accessible only through a gate. The hospital was also clearly marked with the appropriate signs and emblems.

At the same time, we carried out awareness-raising sessions for weapon-bearers on the need and the obligation to protect health-care services. This paid

off when the commander of an armed group contacted us to discuss transferring one of his wounded men to the hospital.

The commander understood that if he arrived as armed groups usually do – in large numbers in pick-up trucks – it would generate panic, and he was keen to avoid that. He made sure that medical personnel knew the wounded man was coming and told his troops to leave their weapons outside. We stayed on the premises to reassure staff and patients.

We also installed an alarm system, so that hospital guards and staff could notify us or the local security patrol if anyone tried to break in during the night. This has reassured staff to work night shifts again, which had been suspended because it was too dangerous.

## RECOMMENDATION

The various factors affecting the safety of health-care facilities should be considered together. That includes the capacity for the health-care system and infrastructure to absorb shock, the potential impact of disruptions to the supply chain and the well-being of staff and patients.

In addition, we provide extra support to hospital staff when the security situation worsens by coordinating the orderly arrival and admission of patients – often wounded weapon bearers. In this way we minimize the stress experienced by hospital staff and other patients.

Finally, to ease tensions between people from different ethnic groups, the ICRC and volunteers from the Central African Red Cross Society carry out awareness-raising sessions for patients and visiting family members. ”



# KEEPING UP THE MOMENTUM

To bring about better protection of health care and even more tangible results on the ground, the concerted, global effort driven by the Health Care in Danger project must continue.

In the coming years, the project will focus on keeping up the international momentum, working with individuals, groups and governments to implement the recommendations stemming from the workshops, and exploring local, national and international solutions to emerging issues related to violence against health care.

## #ProtectHealthCare

The Health Care in Danger project has brought to light seven areas where the move from commitment to meaningful action needs to be made a priority by all concerned.

Only then can we tackle the challenges that violence poses to the safe delivery of health care.

### ADAPTING DOMESTIC LEGISLATION

The role of States in reaffirming international humanitarian law and holding parties to armed conflict accountable for attacks on health-care staff and facilities cannot be stressed too highly. The Health Care in Danger team will continue to work in close collaboration with partners and support Governments to review and, where necessary, revise their domestic legislation to protect patients and medical staff, facilities and vehicles.

### COLLECTING DATA

States are encouraged to develop a better understanding of the nature of violence against health care on their own territory. Countries such as France, with its national observatory of violence against health care (*Observatoire national des violences en milieu de santé*), and Côte d'Ivoire, which launched an initiative supported by a similar database, are leading the way.

### SHARING BEST PRACTICE

Data collection will enable analysis of and research into the motives behind attacks against medical workers and health-care facilities in armed conflict. This information can then feed into strategies to prevent or at least reduce the rate of attacks. States, together with health-care organizations, are encouraged to discuss challenges and share best practice to develop stronger policies and identify practical measures at the national, regional and international level.



H. Habboush/Syrian Arab Red Crescent

**VIOLENCE AGAINST HEALTH CARE MUST END**

**IT'S A MATTER OF LIFE & DEATH**

**FURTHERING DIPLOMATIC INITIATIVES**

A concerted effort to promote the issue in diplomatic circles is vitally important. This should foster a global environment conducive to implementing the recommendations from the expert workshops at the local level. The 32nd International Conference of the Red Cross and Red Crescent in December 2015 will take stock of the progress made and encourage the actors concerned to implement the recommendations at both the international and national levels. It could represent, in this sense, a major milestone for the protection of health care.

**WEAPON BEARERS AND SAFER HEALTH CARE**

Armed forces and non-State armed groups must continue to work towards incorporating health-care-related recommendations into their doctrine, training and operations. To this end, the Health Care in Danger project offers a model declaration that armed groups can adopt to declare their intention to support and protect safe access to health care. Multilateral and regional military organizations and the United Nations Department of Peacekeeping Operations should also include regulations on protecting health-care services and workers in their policies. Moreover, the Project team is working on integrating scenarios drawn from the Health Care in Danger project into virtual reality training for military and police personnel in Australia and Myanmar.

**INTERNATIONAL RED CROSS AND RED CRESCENT MOVEMENT**

National Societies, the International Federation and the ICRC should continue to work together on this issue, engaging individuals and organizations at all levels – authorities, the health-care community and civil society in general – to act to protect safe access to health care. Groups from different backgrounds, committees and roundtable discussions will bring to light the most pressing issues, develop action plans, and promote and oversee the implementation of solutions. The Movement should take advantage of existing mechanisms, such as national committees on international humanitarian law and other national forums, and help to set up local associations to share experiences, highlight progress and promote existing and new partnerships.

**FROM A COMMUNITY OF CONCERN TO COMMUNITIES OF PRACTICE**

The Health Care in Danger community of concern is a loose association of various governments, groups and individuals that work towards a common purpose: enabling safe access to health care. The community must maintain its commitment, bring in new partners, work with local organizations and communities, and engage with the private health sector. The Health Care in Danger project will continue to support the exchanging of experience and knowledge, particularly at national and regional level, between members of the community. The aim is to ensure the widest possible implementation of solutions to protect health care, so that the community of concern will flourish into communities of good practice.



## FURTHER RESOURCES

All publications and additional material are available in various languages at [www.healthcareindanger.org](http://www.healthcareindanger.org).

### Main publications and reports

- *Health Care in Danger: Making the case*
- *Health Care in Danger: A harsh reality*
- *Ambulance and pre-hospital services in risk situations*
- *Best practice for ambulance services in risk situations*
- *Health Care in Danger: Responsibilities of health-care personnel in armed conflict and other emergencies*
- *Promoting military operational practice that ensures safe access to and delivery of health care*
- *Ensuring the preparedness and security of health-care facilities in armed conflict and other emergencies*
- *Domestic normative frameworks for the protection of health care*
- *Safeguarding health care: Operational practices and relevant international humanitarian law concerning armed groups*
- *Study on access to health care during armed conflict and other emergencies: Examining violence against health care from a gender perspective*
- *Violent incidents affecting health care* (2013, 2014 and 2015 reports)
- *Health Care in Danger: A sixteen-country study*

### Reviews and magazines

- *International Review of the Red Cross*, "Violence against health care" (Parts I and II), Vol. 95, No. 889 and 890
- Newsletters from the Health Care in Danger project: February, August and December 2014, June and November 2015
- *International Humanitarian Law Magazine*, Issue 1, 2013, Australian Red Cross
- *Coping with Crisis*, Issue 2, 2014, Psychosocial Centre, International Federation of Red Cross and Red Crescent Societies

### E-learning tools

*Health Care in Danger: The legal framework*

This module, designed for the general public, provides a basic introduction to government obligations and health-care workers' responsibilities in armed conflict and other emergencies.

*The rights and responsibilities of health-care workers*

This module focuses on ethical principles, rights, responsibilities and dilemmas for health-care workers.

### Other resources

- *Ethical decision-making for doctors in the armed forces: a tool kit*, British Medical Association
- *Between rhetoric and reality: The ongoing struggle to access health care in Afghanistan*, Médecins Sans Frontières
- *Ethical principles of health care in times of conflict and other emergencies*, ICRC

## GET INVOLVED

Join our campaign to protect health care:

[www.healthcareindanger.org](http://www.healthcareindanger.org)

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@HCIDproject

YouTube channel:

[www.youtube.com/playlist?list=PL976DC37B1EF9FD69](http://www.youtube.com/playlist?list=PL976DC37B1EF9FD69)

Join our platform:

<http://healthcareindanger.ning.com>

## **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