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OF THE RED CROSS AND RED CRESCENT**

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**Health care in danger:
Continuing to protect the delivery of health care together**

Background report

**Document prepared by the International Committee of the Red Cross
in consultation with the International Federation of Red Cross and Red Crescent
Societies**

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EXECUTIVE SUMMARY

Violence against health care in armed conflict or other emergencies continues to be a serious humanitarian concern, with devastating short and long-term consequences for affected communities, health-care facilities and thousands of health-care staff and volunteers who seek to provide assistance.

The latest ICRC report on violent incidents against health care, released in April 2015, analysed information collected on 2,398 incidents in 11 countries from January 2012 to December 2014. The report concludes that, in total, at least 4,275 people were victims of violence against health care, 1,633 of whom were patients. Over 50% of the attacks targeted or took place inside or near health-care facilities and at least 598 health-care personnel lost their lives or were wounded during an attack. In addition, over 700 medical transports were directly or indirectly affected. In most incidents, local health-care workers were most seriously affected.¹

The issue was identified as a priority for action by the International Red Cross and Red Crescent Movement at the 2009 Council of Delegates and further cemented at the 31st International Conference of the Red Cross and Red Crescent through the adoption of Resolution 5 entitled “Health care in danger: Protecting and respecting health care,” which called upon States, the International Committee of the Red Cross (ICRC), National Red Cross and Red Crescent Societies and the International Federation of Red Cross and Red Crescent Societies to undertake a series of actions in accordance with their respective roles, mandates and capacities to better address this issue. It also called upon the ICRC 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, and to report to the 32nd International Conference in 2015 on the progress made.

The implementation of the Health Care in Danger Project has generated very positive momentum. A variety of stakeholders, including States, the Movement and the health-care community, have engaged at both the operational and diplomatic levels to implement measures and advocate for practical solutions. The Project has demonstrated the unique power of the Movement to bring together stakeholders from the world community who have the authority and influence to effect positive change.

The efforts to date are to be commended. However, greater efforts, particularly by States at the national level, are needed if attacks, threats and obstructions against health-care workers, facilities and medical transports are **not** to become the norm. The advocacy and awareness raising that has been a dominant feature over the past four years should now translate into practical measures informed by a substantial body of recommendations emanating from global consultations conducted on relevant thematic issues.

Measures reflecting the following themes are called for:

- Strengthening domestic normative frameworks
- Practical measures for armed forces and security forces
- Enhancing understanding and sharing challenges and good practices
- Training for health-care workers in their rights and obligations pursuant to applicable law and their professional codes of ethics
- Measures to enhance the physical protection of health-care facilities
- Strengthening the auxiliary role of National Societies specifically relating to safer delivery of health care

¹ www.icrc.org/eng/resources/documents/publication/p4237-violent-incidents.htm

- Facilitating safer delivery of health care by Red Cross and Red Crescent staff and volunteers.

All Conference participants are encouraged to demonstrate their commitment to implementing practical measures on these or other relevant themes by submitting individual or joint voluntary pledges.

1. Introduction

Violence against health care in armed conflict or other emergencies is a serious humanitarian concern with devastating short- and long-term consequences:

- Patients are killed, wounded, beaten, discriminated against and arrested.
- Health-care personnel are killed, threatened, physically assaulted and subjected to arrest and also to coercion and forced treatment in violation of the ethical principles of their profession.
- Health-care facilities are subject to attack, armed entry, takeover or looting.
- Obstructions to and attacks against medical transports occur to and from health-care facilities, at checkpoints and in public spaces.²

Violence, actual or threatened, against health-care personnel and facilities and medical transports can paralyze the delivery of emergency or life-saving health care precisely when it is needed most. The consequences for local communities, particularly when hospitals or first-aid posts are forced to close, or when health-care personnel are no longer able to provide care, are often dire and can also have long-term consequences at the national and regional level. In addition to the affected communities, thousands of health-care staff and volunteers, including from National Red Cross and Red Crescent Societies (National Societies), are directly affected by such violence each year.

The issue is central to the mission of the International Red Cross and Red Crescent Movement (Movement) and to its history of protecting and assisting wounded and sick people. It was identified as a priority for Movement action at the 2009 Council of Delegates, and at the 31st International Conference in 2011 with the adoption of Resolution 5 entitled “Health care in danger: Protecting and respecting health care,”³ which called upon States, the ICRC, National Societies and the International Federation to undertake a series of initiatives in accordance with their respective roles, mandates and capacities to improve the situation. Nine States and 26 National Societies submitted voluntary pledges to take action in their countries. In addition, the Resolution called upon the ICRC 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, and to report to the 32nd International Conference in 2015 on the progress made.⁴ The Movement further reaffirmed the importance of the issue at the 2013 Council of Delegates.

In 2011, the ICRC – in partnership with other Movement components – launched the Health Care in Danger (HCiD) Project. This entailed working with States, the health-care community and other actors, with a focus on four priority issues: (i) attacks on health-care services and patients; (ii) unlawful obstruction to the delivery of health services; (iii) discrimination in the treatment of patients; and (iv) armed entry by weapon-bearers into health-care facilities. The Project has included an operational response track and an expert consultation and diplomatic track, and both tracks have been supported by a communication campaign.

² www.icrc.org/eng/resources/documents/publication/p4237-violent-incidents.htm

³ See Resolution 5 of the 31st International Conference, “Health care in danger: Respecting and protecting health care” www.icrc.org/eng/assets/files/publications/icrc-002-1130.pdf

⁴ *Ibid.* para. 14.

Global consultations with relevant actors from different professional fields have generated practical recommendations specific to key thematic issues. Partnerships with international stakeholders have been consolidated and have led to independent initiatives, either alone or collectively, by a range of health-care organizations. At the global diplomatic level, the United Nations General Assembly (UNGA) adopted four resolutions which include language of relevance for the protection of health-care personnel in armed conflict or other emergencies.⁵

Notwithstanding these commendable efforts, threats to the delivery of health care in armed conflict or other emergencies continue to be a serious humanitarian problem and more needs to be done to address the issue, particularly by States, which have a primary role in this regard. The draft resolution to be submitted to the 32nd International Conference identifies recommendations from the global consultations whereby continued engagement, particularly on the national level, is encouraged, bearing in mind the contextual relevance of these recommendations and in accordance with respective roles, mandates and capacities to address them. The ultimate objective is to strengthen the protection afforded to the sick and the wounded and – by striving for better protection for health-care personnel, facilities and medical transports – to improve their access to, and the delivery of, impartial health care, in accordance with existing applicable international legal regimes.

2. Analysis / Progress

Progress on the implementation of Resolution 5 is provided under the following headings:

- I. Global consultations and recommendations
- II. Awareness raising and calls for action in international fora and through partnerships
- III. Translating calls for action into concrete measures
- IV. Communications

2.1 Global consultations and recommendations

The ICRC, in cooperation with States, National Societies and non-governmental organizations (NGOs), held 12 global consultations on nine thematic areas from 2012 to 2014 (see appendix 1 for full list of consultations), and sought to identify challenges and practical recommendations relevant to each area, as outlined below.

Responsibilities and rights of health-care personnel

State authorities and health-care personnel from the Movement, NGOs, and health-care associations participated in two workshops: in London co-hosted by the ICRC and the British Red Cross, and in Cairo co-hosted by the ICRC and the Egyptian Red Crescent. Participants highlighted the challenge of not being able to offer their services without attack, threat or obstruction in line with the existing applicable legal framework and with their professional codes of ethics. They called for practical training tools to help health-care personnel deal with these challenges. Consequently, the guide *Health care in danger: the responsibilities of health-care personnel in armed conflicts and other emergencies*⁶ was produced, which has been widely promoted in various national and international fora, including through health-care associations. Accompanying this publication, two e-learning modules have been developed: one entitled “Health Care in Danger: the legal framework”⁷ and the other “The rights and responsibilities of health-care personnel working in armed conflict and other emergencies.”⁸

Ethical principles of health care in armed conflict and other emergencies

⁵ Resolution A/RES/69/120: www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/120
 Resolution A/RES/69/132: www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/132
 Resolution A/RES/69/133: www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/133
 Resolution A/RES/69/135: www.un.org/ga/search/view_doc.asp?symbol=A/69/L.40

⁶ Available at: www.icrc.org/eng/resources/documents/publication/p4104.htm in Arabic, English, French and Spanish

⁷ www.icrcproject.org/elearning/health-care-in-danger2

⁸ www.icrcproject.org/elearning/health-care-in-danger

A two-day workshop, convened by the ICRC in Geneva, gathered representatives from the International Committee of Military Medicine (ICMM), the World Medical Association (WMA), the British and Canadian Medical Associations, McMaster University, Médecins Sans Frontières (MSF) and the ICRC. Its main purpose was to reflect on existing ethical principles and the specific challenges in their implementation in armed conflicts or other emergencies.

National Societies' role in protecting health care

Representatives of 25 National Societies participated in two workshops: in Oslo, co-hosted by the Norwegian Red Cross and the ICRC, and in Tehran co-hosted by the Red Crescent Society of the Islamic Republic of Iran and the ICRC. Participants spoke of the challenges that their staff and volunteers face in their roles as emergency responders, medical workers, ambulance drivers, paramedics and first aiders when trying to provide critical treatment or rendering their services to those in need, in accordance with the Fundamental Principles of the Movement. These included ensuring the safety and security of their staff and volunteers; the capacity to respond effectively, particularly in the event of a 'follow-up attack'⁹; lack of respect for the red cross and red crescent emblems; constraints in being able to deliver health-care services to the wounded and sick in some areas of their country; and having appropriate coordination mechanisms with authorities and other health-care providers. The resultant recommendations call for measures to enhance the security and safety of their staff and volunteers, including undertaking emblem-awareness activities; engaging with the health-care community; highlighting the importance of this issue in their regular dialogue with authorities and armed forces; undertaking data collection and research; and working peer to peer with other National Societies to share experiences and build good practice.

Military operational practice that ensures safe access to and delivery of health care

Military experts from 20 countries met in Sydney to discuss how to better protect people providing or receiving health care in armed conflict or other emergencies, in a workshop hosted by the ICRC and the Australian government. Based on the results of prior bilateral consultations with State armed forces in 25 countries, participants focused on identifying practical measures in relation to three focus areas:

- measures to minimize delays on ground transportation of the sick and wounded when controlling ground movements, in particular through roadblocks or checkpoints;
- measures to avoid or at least minimize the negative effects on the effective running of health-care facilities and on the safety of staff and patients when conducting search operations; and
- measures to avoid or at least minimize the incidental damage that may be caused when attacking military objectives in the vicinity of health-care facilities.

Experts made recommendations on how to ensure the effective integration of these measures into the planning and the conduct of operations. The report from the workshop was published in 2014¹⁰ and the recommendations have been presented in workshops to military personnel from over 60 countries, including at the San Remo International Institute of Humanitarian Law, the NATO National Defense College in Rome, and the Senior Workshop on International Rules governing Military Operations (SWIRMO) in China. In addition, the report has been promoted in the context of confidential bilateral discussions throughout 2014 with a number of States involved in armed conflict as part of the ICRC's bilateral and confidential dialogue with States party to a conflict. The ICRC is now integrating the report into its regular training for armed forces and, more recently, has begun developing a virtual reality training tool based on information included in the report. Certain armed forces have already made headway in integrating recommendations into their doctrine, training and practice. NATO is looking to amend and/or develop measures in its training modules on the following topics: checkpoints –

⁹ This term describes a situation where the same location is targeted several times to injure or kill the first responders that rush to assist and evacuate those wounded by the initial attack.

¹⁰ www.icrc.org/en/document/health-care-danger-new-tool-state-armed-forces

dealing with health-care vehicles, to be integrated into checkpoint training and exercises; search operations – specific training on the protected status of health-care facilities; and precautions in attacks – consideration of protected persons and objects in offensive and defensive operations.

Ambulance and pre-hospital care

The critical role that first responders (including ambulance drivers) play in providing treatment to those in urgent need of medical care was reiterated in a workshop co-hosted by the Mexican Red Cross and the ICRC in Toluca, Mexico. The participants, drawn from the Movement, international health-care organizations and authorities, highlighted the following challenges: ensuring continuity of service; misuse of ambulances; attacks on ambulances and health-care personnel; and obstruction of ambulances. Recommendations made in the publication *Ambulance and pre-hospital services in risk situations*¹¹ produced by the Norwegian Red Cross include strengthening national laws to further protect ambulance services, and improving coordination with the authorities, the military and other stakeholders. The report also called for psychological support, training for first responders (including ambulance drivers) and, where appropriate, the provision of personal protective equipment, and training in its use, for staff and volunteers.

Security of health-care facilities

Two workshops were held on this issue: in Ottawa hosted by the Canadian Red Cross and the ICRC, and in Pretoria hosted by the South African Department of International Relations and Cooperation and the ICRC. Participants included hospital managers, representatives of the World Health Organization (WHO), the International Hospital Federation, the WMA and MSF, and personnel from the Movement. As outlined in the publication *Ensuring the preparedness and security of health-care facilities in armed conflict and other emergencies*,¹² discussions were organized around four focus areas: ensuring the functioning of health-care facilities; managing stress under pressure; physical security of health-care infrastructure; and creating temporary safe solutions. Recommendations included: preventive measures to increase the safety of health-care facilities; community acceptance; provision of impartial treatment; emergency preparedness; and psychosocial support for medical staff working under stress.

Domestic normative frameworks for the protection of the provision of health care

In early 2014, some 50 experts from Africa, Asia, the Middle East and the Americas, including civil servants, members of national IHL committees, members of parliament, independent experts and other professionals, met in Brussels to discuss how to reinforce domestic legislation to better protect people providing or receiving health care. The workshop was hosted by the ICRC, the Belgian Interministerial Commission for Humanitarian Law and the Belgian Red Cross. Participants concluded that existing international rules adequately ensure the protection of the provision of health care; what is crucially needed is strong domestic legal frameworks to implement these rules effectively. Four areas were identified where measures could be taken: improving legal protection for patients and health-care personnel and facilities; ensuring proper use of the distinctive emblems; providing legal protection for safeguarding medical ethics and confidentiality; and effective sanctioning of violations of the rules protecting the provision of health care. In each of these four areas, practical measures were identified, including legislative measures, dissemination and training, as well as measures to ensure better coordination between the stakeholders concerned. These are set out in the publication *Domestic Normative Frameworks for the Protection of Health Care* and its accompanying Guidance Tool.¹³

The role of civil society and opinion leaders

¹¹ www.icrc.org/eng/resources/documents/publication/p4173.htm

¹² www.icrc.org/eng/resources/documents/publication/p4239.htm

¹³ www.icrc.org/eng/resources/documents/publication/p4215.htm

This consultation aimed to involve various sections of civil society in devising practical recommendations for the HClD Project. During a two-day workshop in Dakar in 2013 co-hosted by the ICRC and the Senegalese Red Cross, aspects of the relationship between IHL and the relevant rules of Islamic law (fiqh) were discussed, and humanitarian organizations' practical experiences of promoting protection for the health-care mission in times of armed conflict or other emergencies were highlighted. Two types of recommendations emerged: those aimed at developing, strengthening and promoting the legal framework (IHL/relevant Islamic rules) to bring about greater respect for health-care personnel, facilities and medical transports; and those concerning the practical aspects of the protection of the delivery of health care and the role that religious leaders might play in this regard. Further consultations were conducted with civil society, including Islamic scholars, throughout the course of the Project.

Armed groups

After a two-year consultation process with 36 armed groups, the ICRC has gathered a number of recommendations directed at armed groups party to non-international armed conflict. The recommendations concern operational practices and measures that they can implement to strengthen their capacity to respect and protect health care. The recommendations are presented through 10 case studies in the publication *Safeguarding the provision of health care: Operational practices and relevant international humanitarian law concerning armed groups*.¹⁴

2.2 Awareness raising and calls for action in international fora and through partnerships

International fora

Priority has been given to promoting the recommendations from the global consultations among States and other relevant stakeholders through bilateral and multilateral consultations.

States have initiated resolutions and fora that speak to the central tenets of the HClD Project. At the 65th World Health Assembly in May 2012, a resolution (WHA 65.20) was adopted that called on the WHO to develop methods for systematic collection and dissemination of data on attacks against or lack of respect for patients and/or health-care personnel, facilities and medical transports in humanitarian emergencies.¹⁵ In follow-up to this Resolution, the WHO is developing a data-collection system to register violent incidents affecting the delivery of health care and linking its own initiative on safe hospitals (mainly in the context of natural disasters) with work on the security of health-care facilities.

In 2014, the UNGA adopted Resolution 69/132, entitled "Global health and foreign policy,"¹⁶ which was initiated by the cross-regional group of States that make up the Foreign Policy and Global Health Initiative and co-sponsored by more than 60 countries.¹⁷ The Resolution, *inter alia*, strongly condemns all attacks on medical and health personnel, their means of transport and equipment, as well as hospitals and other medical facilities, and deplores the long-term consequences of such attacks for the population and health-care systems of the countries concerned. It invites the WHO and other relevant international organizations to develop their capacity to assist Member States, notably through technical cooperation upon request, and urges Member States to develop effective preventive measures to enhance and promote the safety and protection of medical and health personnel, as well as respect for their respective professional codes of ethics, including through means of identification, educational measures, national legal frameworks and physical protection; and to develop data collection on obstruction, threats and physical attacks on health workers. The ICRC was consulted and contributed its views during the preparatory stages of this Resolution. As noted above, the 69th

¹⁴ www.icrc.org/en/document/engaging-dialogue-non-state-armed-groups-protect-health-care

¹⁵ http://apps.who.int/gb/or/e/e_wha65r1.html

¹⁶ Resolution A/RES/69/132: www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/132

¹⁷ The Foreign Policy and Global Health Initiative is aimed at increasing health's importance in foreign policy and is backed by a group of seven countries: Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand.

session of the UNGA also adopted three other resolutions containing language relevant to the protection of the delivery of health care in armed conflicts or other emergencies.¹⁸

On the margins of the 69th UNGA, the ICRC organized a debate that raised further awareness of the issues covered by the HCiD Project, highlighting the importance of a protective environment for national health-care systems and enjoining States to enact measures to strengthen the resilience of these systems to armed conflicts or other emergencies. The ICRC presented a position paper¹⁹ containing key recommendations for States on protecting their health-care systems and making them more resilient.

The African Union (AU) Commission and the ICRC co-organized a conference in Ethiopia in October 2014 to promote the practical measures proposed during the global consultations and to enhance cooperation with the health-care community in Africa. It was attended by 80 representatives of member States of the AU, key global institutions and health-care providers in Africa, and members of the non-African diplomatic corps and other humanitarian partners. At this Conference, members of the AU Permanent Representatives' Committee endorsed 20 recommendations, including: adopting and reinforcing domestic laws designed to protect patients and health-care personnel, facilities and means of transport; raising awareness of these laws among weapon-bearers and the wider public; improving coordination among those providing emergency medical care; and enhancing respect for the emblems protected under IHL and vigorous prosecution in the event of any misuse of these emblems.²⁰

An international seminar was organized by the Colombian Ministry of Health and Social Protection in Bogotá in July 2014, with support from the Colombian Red Cross, the ICRC and the Norwegian Red Cross. International organizations, public health authorities and National Societies from 12 Latin American countries exchanged experiences and good practices as regards mitigating the effects of security problems faced by health services. As a follow-up to this seminar, the Chilean Ministry of Health hosted a workshop in Santiago in November 2014 whose main objective was to establish a working group to come up with proposals and solutions addressing the global phenomenon of violence against health care at the local level. More recently, the Red Crescent Society of the Islamic Republic of Iran and the ICRC co-hosted a roundtable in Tehran with the purpose of responding to humanitarian challenges for the safe delivery of health care. Participants from the Iranian ministries of health, defence and foreign affairs, the Iranian Medical Council, Tehran University of Medical Sciences, and the Norwegian and Afghan National Societies shared knowledge, ideas and experiences.²¹

Partnerships

Developing and nurturing partnerships and building a community of concern with a broad range of stakeholders, as promoted by Resolution 5 of the 31st International Conference, is central to the progress made. Foremost in this undertaking has been the partnership between the ICRC, National Societies and the International Federation. Of particular note is the HCiD Movement Reference Group (MRG), which comprises 27 National Societies and the International Federation.²² Convened by the ICRC, it has provided guidance on the Project's direction and played a seminal role in mobilizing other National Societies, contributing to the global consultations, organizing and hosting regional events, and carrying out activities in the members' own countries, as outlined in section 2.3.

¹⁸ Resolution A/RES/69/120: www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/120

Resolution A/RES/69/132: www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/132

Resolution A/RES/69/133: www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/133

Resolution A/RES/69/135: www.un.org/ga/search/view_doc.asp?symbol=A/69/L.40

¹⁹ www.icrc.org/en/download/file/1194/icrc-hcid-position-paper-2014-09-24-english.pdf

²⁰ www.icrc.org/en/document/african-union-seminar-protection-health-services

²¹ <http://rcs.ir/en/?p=3625>

²² National Societies in Afghanistan, Australia, Canada, Colombia, Egypt, Germany, Indonesia, Iran, Israel, Kazakhstan, Kenya, Lebanon, Libya, Mexico, Nepal, Nigeria, Norway, occupied Palestinian territory, Pakistan, Philippines, Senegal, Somalia, South Sudan, Sudan, Sweden, Uganda, United Kingdom and United States.

By way of examples, two MRG members – the Nepalese and Afghan National Societies – co-hosted an HCiD workshop at the International Federation’s 9th Asia Pacific Regional Conference, held in Beijing in late 2014, where participants shared their challenges and responses. The impact of violence on health-care workers was also a central topic at the 20th Inter-American Conference of the Red Cross in March 2015 in Houston, Texas, during a workshop hosted by MRG members the Colombian Red Cross and the American Red Cross. Over 70 participants analysed the humanitarian impact of violence in the Americas, the challenges facing health-care workers, and measures that National Societies in the Americas are taking to protect them. Participants stressed the need for more action on this issue. Building on the global consultation held in Mexico, the Norwegian Red Cross, also a member of the MRG, facilitated two regional workshops²³ to discuss procedures and best practices for Red Cross/Red Crescent ambulance and pre-hospital care personnel. The resultant publication *Best Practice for Ambulance Services in Risk Situations*²⁴ sets out practical recommendations and best practices and calls for a forum to be established where experiences, best practice and tools relevant for ambulance and pre-hospital services can be shared.

The active engagement of the broader health-care community has been instrumental in furthering the HCiD Project’s goals. Some examples include:

- MSF, the ICN, the ICMM, the International Pharmaceutical Federation (FIP) and the WMA are key partners for the Project. In early 2013 MSF launched its own Project called Medical Care Under Fire, which looks at violence affecting its operations in several countries. MSF and the HCiD team collaborate on synergies between their respective Projects.
- In 2014, the International Hospital Federation (IHF), the ICN and the World Confederation for Physical Therapy signed cooperation agreements with the ICRC. The International Federation of Medical Students’ Associations began working with the WMA, the ICN and the ICRC to develop a strategy for limiting the risks faced by health-care workers.
- The WMA’s 65th General Assembly in October 2014 adopted a declaration on the protection of health-care workers.²⁵ Attendees also discussed the Millennium Development Goals and concluded that no progress could be made in relation to health without securing the safety of patients and health-care providers.
- The Safeguarding Health in Conflict Coalition was established to advocate for the safety and security of health-care workers, facilities, patients and ambulances. It comprises NGOs, associations of health professionals and the Center for Public Health and Human Rights at the John Hopkins Bloomberg School of Public Health.²⁶
- In June 2015, at an event hosted at ICRC headquarters in Geneva, the WMA, the ICMM, the ICN and the FIP launched the *Ethical principles of health care in times of armed conflict and other emergencies*.²⁷ These principles provide a common ethical code for these major international health organizations, which between them represent more than 30 million people from both the military and civilian realms. Discussions are underway with other health-care professional organizations to endorse the ethical principles.

2.3 Translating calls for action into concrete measures

The recommendations that have emanated from the global consultations, as outlined in section 2.1, are intended to guide measures that can be implemented at a national level. The intention is not that each stakeholder implement all these recommendations but rather that States, the

²³ For National Societies in Latin America in Cartagena in September 2014 hosted by the Colombian Red Cross, and for National Societies in North Africa and Middle East in Beirut in December 2014 hosted by the Lebanese Red Cross.

²⁴ www.rodekors.no/Global/HK%20-%20Hovedkontoret/Internasjonal/Dokumenter/Helse/Ambulance_best_practice_report_English.pdf

²⁵ www.wma.net/en/30publications/10policies/p3/

²⁶ For more information, see: www.safeguardinghealth.org/sites/shcc/files/safeguarding-health-in-conflict-overview.pdf

²⁷ www.icrc.org/en/event/ethical-principles-health-care-times-armed-conflict-and-other-emergencies

Movement, the health-care community and other stakeholders consider what is needed given the specific challenges they face, in accordance with their respective roles, mandates and capacities. Many of these recommendations are being translated into operational responses, as outlined in the following section.²⁸

This Project has provided an opportunity for **National Societies** to engage with a broad range of stakeholders on an issue that goes to the very heart of their *raison d'être*. Over 70 National Societies have responded in many ways, ranging from measures to train and strengthen the capacity of their own staff and volunteers, to advocacy, training and dialogue with the broader health-care community, authorities and civil society. The following provides an overview of these activities:

Training and strengthening the capacity of National Society staff and volunteers. The focus of this work has been implementing measures to enhance the acceptance, security and safety, and access of National Society staff and volunteers by applying the Safer Access Framework²⁹ and undertaking training and capacity building in first aid and emergency response. Particular focus has been placed on the regulations and operational procedures of health-care providers, such as those related to the use of personal protective equipment, how to mitigate 'follow-up' attacks and the provision of insurance and psychosocial support for staff and volunteers. Many National Societies have integrated the central themes of HCiD into induction, deployment, IHL and other training conducted with their staff and volunteers.

Linked to strengthening capacity is the work done on **peer-to-peer support and sharing good practices**. The Project has been a catalyst for National Societies to share their experiences and expertise with each other. In many instances this is done on a bilateral basis; for example, Magen David Adom in Israel worked with the Kenya Red Cross to set up a paramedic ambulance service and to develop a Mass Casualty Incident Protocol that covers the safety of ambulances, and the Bangladesh Red Crescent joined forces with the Egyptian Red Crescent to exchange experiences, particularly with respect to emergency training. The Norwegian Red Cross has supported certain National Societies in developing their operational responses to contribute to better protection of health-care delivery, and has facilitated horizontal cooperation between National Societies in the Americas region. The previously mentioned regional workshops on best practices for ambulance services, spearheaded by the Norwegian Red Cross, are also a good example of this peer-to-peer support and sharing of good practice at the regional level. With the support of the ICRC delegations, National Societies are developing their own Safer Access case studies, detailing their experiences, which are then shared online with other National Societies.

Sharing the outcomes of the global consultations, identifying concrete measures to contribute to better protection of health-care delivery, and awareness raising and training have been central to National Societies' **engagement with the authorities and the broader health-care community**. National Societies, often in concert with the ICRC and national health-care associations, have organized roundtables with government officials and members of the health-care community to raise awareness of the issue and to discuss possible responses in their specific context.³⁰ Many have integrated HCiD into their training sessions with the military,

²⁸ Please note that this report does not allow for a full account of these responses; therefore to get a fuller picture please see the ICRC publication *Health Care in Danger: Meeting the Challenges*, available at www.icrc.org/en/document/health-care-danger-meeting-challenge and the *Report on the outcomes of the 31st International Conference*, available at rcrconference.org/international-conference/documents

²⁹ The Safer Access Framework proposes a structured approach to meeting the challenges of operating in sensitive and insecure contexts, drawing on the extensive experience and good practice of many National Societies. It contains a set of preparedness actions and acceptance measures, grounded in the Fundamental Principles of the Movement and other Movement policies that a National Society can adopt when responding in sensitive and insecure contexts. For more information see: www.icrc.org/en/what-we-do/cooperating-national-societies/safer-access-all-national-societies

³⁰ National Societies in the following countries have organized or co-organized such events: Afghanistan, Australia, Canada, Colombia, Egypt, Iraq, Iran, Senegal, Sudan, Sweden, United Arab Emirates and United States. Please note that this list may not be exhaustive.

NGOs and health-care and law students, and the Project has been a catalyst for National Societies and State armed forces to jointly conduct new training and awareness-raising initiatives focused on HCD. In some instances, National Societies have translated HCD resources into their local languages to support these efforts. For example, the German Red Cross has translated into German the publications on the responsibilities of health-care personnel, and on ambulance and pre-hospital care, and has used these when engaging with the German Medical Association and other health-care organizations. Drawing on the materials produced by the ICRC as part of the global communications campaign, the Colombian Red Cross and the ICRC produced a locally relevant video that highlighted the importance of respect for health-care providers. It was disseminated widely through local television and radio outlets. Some National Societies have effectively used national IHL committees and other national fora to engage with their governments on issues relevant to HCD, particularly with respect to domestic legislation, protection of the emblems and the development of protocols and guidelines to ensure effective procedures for coordinating the delivery of health care. Through bilateral dialogue, some National Societies have conducted humanitarian diplomacy concerning safe passage of medical transports and the impact of violence against patients, health-care workers and health-care facilities.

National Societies have also taken a leading role on **awareness raising and advocacy** vis-à-vis NGOs, the media, academia, secondary and tertiary students, community and religious leaders and the broader civil society through roundtables, conferences, workshops, traditional and social media, publications and visual campaigns. By way of example, in 2013 the Australian Red Cross produced an edition of its widely disseminated IHL magazine that focused solely on HCD.³¹ Many National Societies have skilfully used the media – through articles, videos and interviews – to draw attention to attacks on health-care workers and the need for concerted action to make the delivery of health care safer in armed conflict or other emergencies. Others have conducted training programmes to educate and raise awareness about the issue: in some instances they have utilized the e-learning modules referred to in section 2.1; in other instances they have developed new training materials. For example, the American Red Cross has developed a new course entitled “Born on the Battlefield” that gives its staff, volunteers and the general public an opportunity to learn about the protections afforded health-care workers under IHL. National Societies have been proactive in seeking out opportunities to put HCD on the agenda of major events being held in their countries, thus bringing the issue to the attention of a broad audience. Others have focused their efforts on engaging with specific groups, such as community and religious leaders, journalists and young people.

Research and data collection. Some National Societies have implemented mechanisms to collect data on incidents against their health-care staff and volunteers. Others have conducted research on specific issues, such as the Swedish Red Cross looking at HCD from a gender perspective³² and the Canadian Red Cross co-authoring an academic paper on safety and security in a changing environment.³³

Informed by the recommendations from the global consultations and drawing on the expertise of different ICRC departments (e.g. Protection, Water and Habitat, Health, Legal, Communications, Dialogue with State armed forces and other arms carriers), **ICRC delegations** have developed multidisciplinary strategies to address HCD issues specific to their contexts. Delegation staff also underscore the need to protect the wounded and sick, health-care services and medical transports not only during IHL briefings and first-aid training sessions for government forces and armed groups but also by addressing specific cases with

³¹ www.redcross.org.au/ihl-magazine.aspx

³² www.redcross.se/Documents/Rapporter/Report%20-%20Study%20on%20HCDG%20SRC_TRYCK.pdf

³³ www.ncbi.nlm.nih.gov/pubmed/25247880

the authorities concerned, as part of their ongoing efforts to enhance the protection of civilian populations.

In late 2014, the **ICRC Directorate extended the Project until the end of 2017**. This decision reflected the strong resolve of Movement components and the community of concern to build on the momentum generated by all those involved in the Project. The ICRC's efforts in coming years will focus on engaging with States to increase their involvement in addressing threats to health-care services in their national contexts, and on developing further partnerships and communities of practice to facilitate the sharing of challenges and good practices. Keeping the issue alive as an important humanitarian concern internationally will also be a priority.

Reflecting the commitments made at the global level, many **health-care associations** are engaging with this issue at a national level, often in concert with the ICRC and National Societies. National medical and health-care associations have participated in roundtables convened by National Societies and/or the ICRC to discuss contextually relevant challenges and responses – for example in Australia, Colombia, Egypt, Iran, Nepal and United Arab Emirates, to name a few. In Côte d'Ivoire, in response to violence against health-care personnel, the National Council of the Order of Physicians drafted a white paper entitled *Rights and responsibilities of doctors faced with acts of violence in times of crisis and armed conflict*. It is a set of practical recommendations primarily for doctors, but also for the authorities and weapon-bearers, and includes guidelines, along with the WMA's code of conduct, specifying the duties of every doctor.³⁴

In April 2015, representatives of major health organizations³⁵ met with National Societies from the Movement Reference Group and highlighted the importance of health-care organizations and National Societies working together at the national level to identify challenges and implement recommendations from the global consultations. Participants responded positively to a proposed way forward whereby communities of practice would be established around specific issues in order to facilitate cooperation and peer-to-peer learning.

States' efforts have focused on: legislative measures to both regulate the use of the red cross, red crescent and red crystal emblems and to sanction attacks and other forms of interference with the delivery of health care; training and awareness raising with armed forces and security forces; and support for the HClD Project. With respect to **legislative measures**, a number of States have taken measures in their domestic legislation (since 2011) to regulate the use of the red cross, red crescent and red crystal emblems and to raise awareness about the proper use of the emblems. Examples include Belgium, Chad, France, Madagascar, Mexico, the Philippines, Portugal and Sierra Leone. Some States have adopted measures in their domestic legislation to protect the delivery of health care. In 2012, Colombia's Ministry of Health and Social Protection adopted the *Manual for the Medical Mission* through Resolution 4481, which was the result of a joint effort on the part of the ICRC, the Colombian Red Cross, the Ministry of Interior, the Ministry of Justice and Law and other government institutions. The Manual aims to strengthen respect and protection for the medical mission and sets out, among other things: the rights and responsibilities of health-care personnel; the acts that constitute violations affecting the medical mission; the establishment and use of the emblem of the medical mission; and recommendations for the safety of health-care personnel.³⁶ Also in 2012, the Yemeni government signed a declaration to protect the delivery of health care. Since then, workshops have gathered hospitals and authorities to work jointly on the issue. In 2014, Austria inserted a number of provisions for the protection of civilians and humanitarian personnel into the Austrian Criminal Code.

³⁴ www.icrc.org/eng/resources/documents/article/health-care-in-danger/2014-02/hcid-cote-d-ivoire-white-paper.htm

³⁵ World Confederation for Physical Therapy, WMA, IHF, Junior Doctors Network, MSF, FIP, Safeguarding Health in Conflict Coalition, World Federation for Medical Education, ICCM and WHO.

³⁶ www.idsn.gov.co/images/documentos/normatividad2013/res4481_2012mm.pdf

Some States have initiated new **training and awareness-raising activities with their armed and security forces** with regard to protection for the wounded and sick and health-care services. In Belgium in 2013, the Research Centre for Military Law and the Law of War and the Belgian Red Cross organized a study day for 60 representatives of the Belgian Armed Forces, with HCiD featuring on the agenda. Similarly, in 2013, the Swedish Armed Forces and the Swedish Red Cross co-organized a one-day meeting for National Societies and armed forces from Nordic countries with a specific focus on the use of the emblems and the status of military medical personnel. Further to Colombia's Resolution 4481, as mentioned above, training on the protection of the delivery of health care is regularly held for the armed and security forces, and also the judiciary and civil society.

Many States have **supported the aims of the HCiD Project** in diplomatic fora and by co-organizing and/or participating in the global consultations and regional and national conferences (as outlined in section 2.2).

2.4 Communications

In August 2011, the ICRC launched the "Life&Death" campaign – a worldwide communication initiative. The campaign aims to harness the power of public opinion to help mobilize influential stakeholders and to support the efforts of the Movement and its partners to promote the implementation of the recommendations that have emanated from the global consultations. Communicating through a variety of channels, such as the media, the internet, conferences and other events, the campaign has fostered engagement among Movement staff and volunteers, health-care communities, health-oriented NGOs and other members of civil society.³⁷

3. Conclusion and beyond the 32nd International Conference

Resolution 5 of the 31st International Conference was the impetus for the HCiD Project and the significant achievements outlined above. Collectively, these efforts have laid a strong foundation on which to build future work; they are to be commended. However, further work is needed to achieve the shared fundamental objective of making the delivery of health care safer in armed conflict or other emergencies.

The draft resolution being presented to the 32nd International Conference posits a way forward and builds on the achievements of the past four years. It signals three important ambitions: the need to keep this humanitarian issue alive internationally; the critical importance for States, Movement components and the health-care community to implement measures at the national level that reflect their contextual challenges and realities, in accordance with their respective roles, mandates and capacities; and the benefits of bringing together a variety of stakeholders to share good practices. Underpinning these ambitions is the continued relevance and importance of developing and nurturing partnerships to leverage these efforts.

The practical recommendations from the global consultations provide a blueprint for the measures that could be taken to achieve these ambitions. The operative paragraphs of the draft resolution highlight those recommendations where continued engagement, particularly at the national level, is encouraged.

Effective legal implementation

The importance of strengthening domestic normative frameworks was repeatedly emphasized during global and regional consultations. Reflecting these deliberations, States that have not yet done so are encouraged to adopt domestic implementing measures, in particular regulatory

³⁷ To view the tools that have been developed, including publications, visual materials, and web-based tools, see www.icrc.org/eng/what-we-do/safeguarding-health-care/index.jsp

and legislative ones, to ensure that they respect their international legal obligations pertaining to the protection of the wounded and sick and health-care services. This includes their obligations concerning the protection and use of the distinctive emblems by authorized medical personnel, facilities and transports, respect for the respective professional codes of ethics of health-care personnel, and adequate preparedness for addressing violence against health-care services.

Practical measures for armed forces and security forces

Given their direct influence on the safe delivery of health care, State armed forces have an important role to play. Drawing on the recommendations from the bilateral consultations and the workshop bringing together military experts in 2013, States are encouraged to make or, where relevant, to continue efforts to integrate practical measures for the protection of the wounded and sick and health-care services into their military doctrine, training and operations at the national, regional and international levels as well as, to the extent that it falls within their competence, into the planning and conduct of operations by security forces. These could include measures to: mitigate the effects of checkpoint controls on the evacuation of the wounded and sick; mitigate the effects of search operations on the continued delivery of health care to the wounded and sick in health-care facilities; and avoid or minimize the impact on health-care delivery when the use of force directly or indirectly affects health-care facilities.

Enhancing understanding, sharing challenges and good practices

A recurring recommendation from the global workshops was the need to gain a better understanding of the nature and the root causes of violence against health care on a national level as a basis for developing practical action to address the problem. To that end, States, in cooperation with the Movement, the health-care community and other relevant stakeholders, are encouraged to regularly share challenges and good practices through existing appropriate national forums or, where these do not exist, in forums involving all relevant stakeholders that may be created for this purpose.

Practical training for health-care personnel

Ensuring that health-care personnel receive practical training on their rights and responsibilities derived from applicable law and their professional codes of ethics has been a cross-cutting issue highlighted in almost every global consultation. By utilizing existing training tools or developing new ones, there is a clear role for States, the Movement, the health-care community and academia to intensify their efforts to include instruction on this issue in the curricula of universities and other training institutions.

Ensuring preparedness and physical protection of health-care facilities

Implementing measures to enhance the security of health-care facilities helps ensure that patients are protected and receive a high quality of care, and that health-care personnel are respected and feel safe in their workplace. States and the Movement, where relevant, and in cooperation with local communities and their leaders, may support the implementation of preparatory and practical measures to enhance the secure functioning of health-care facilities, including measures related to the supply, management and safe storage of essential supplies; managing access and controlling the entry of persons who could disrupt the continued functioning of health-care facilities; and/or where feasible and appropriate, physical protection of the structures of health-care facilities.

Strengthening domestic law, regulations and practice regarding the auxiliary role of National Societies in the context of health-care delivery

In the global consultations, National Societies emphasized the need for a strong legal basis for regulating their auxiliary role to the public authorities in the humanitarian field as part of achieving safer health-care delivery, and for the public authorities to have a clear understanding of that role. Furthermore, National Societies highlighted the need to translate the regulatory framework into effective operational coordination with the authorities, so that

they can effectively respond to the needs of the sick and the wounded. To that end, States and National Societies are encouraged to engage or continue to engage with each other, with a view to developing a sound domestic legal framework regulating their auxiliary role to the public authorities in the humanitarian field, and with a view to ensuring effective procedures for coordination in the delivery of health care. In fulfilling that auxiliary role, National Societies also have a role to promote and support the implementation of States' international legal obligations and dissemination efforts relating to the protection of the wounded and sick and health-care services.

Facilitating safer access for Red Cross and Red Crescent staff and volunteers

National Societies repeatedly highlighted the importance of increasing their acceptance and thus their access to the wounded and sick in the communities where they deliver health-care services. They also acknowledged the need to intensify their commitment and efforts in this regard by taking measures to ensure that all staff and volunteers operate in strict compliance with the Fundamental Principles, by using existing operational approaches such as the Safer Access Framework, and by continuing to work on specific procedures and protocols for risk management.

Pledges and reporting on progress

All Conference participants are encouraged to demonstrate their commitment to better protecting the delivery of health care by submitting individual or joint voluntary pledges to adopt relevant practical measures as outlined above.

Progress on these and other initiatives will be reported to the 33rd International Conference in 2019.

GLOBAL CONSULTATIONS

Appendix 1

Issues for global consultations	Location and dates	Organizers
Responsibilities and rights of health-care personnel	London (April 2012) Cairo (December 2012)	British Red Cross, ICRC, the British Medical Association and the World Medical Association Egyptian Red Crescent and the ICRC
National Societies' response to HCD	Oslo (December 2012) Teheran (February 2013)	ICRC and the Norwegian Red Cross ICRC and the Red Crescent Society of the Islamic Republic of Iran
Civil society: Mobilizing opinion and religious leaders	Dakar (April 2013)	ICRC
Ambulances and pre-hospital services in risk situations	Toluca, Mexico (May 2013)	ICRC and the Mexico Red Cross
The physical safety of health facilities	Ottawa (September 2013) Pretoria (April 2014)	ICRC and the Canadian Red Cross ICRC and the Government of South Africa
Military practice: From training to operational orders	Sydney (December 2013)	ICRC and the Government of Australia
National legislation and penal repression	Brussels (January 2014)	ICRC and the Belgium Red Cross
Armed groups	Dialogue in various countries in 2013 & 2014	ICRC
Ethical principles of health care in armed conflict and other emergencies	Workshop/consultation with partners (2014)	ICRC, Geneva