Australian Red Cross
THE POWER OF HUMANITY

international humanitarian law magazine

Issue 1, 2013

health care in danger

CRISIS CARE COMMITMENT

Inside this issue

Yemen, 2011. Ambulances take huge risks during armed conflicts to reach and transport the wounded, and can fall victim to stray bullets.

Photo: COSMOS/C. Martin Chico

Editorial

Welcome to the first edition of the international humanitarian law (IHL) magazine for 2013 which focuses on the theme of health care in danger.

From its inception, at the battle of Solferino, a primary aim of IHL has been to protect not just those who are sick and wounded on the battlefield but also those whose role is to care for the sick and wounded – in particular, military medical personnel and the staff of voluntary aid organisations, such as staff and volunteers of the International Red Cross and Red Crescent Movement (the Movement).

In 2011 the Movement launched a four year campaign entitled Health Care in Danger (HCiD). The campaign came about following a study which looked at the effect of violence on the delivery of health services. The study, which covered 16 countries, painted a concerning picture for those in the business of providing medical services in war-torn countries. Attacks on health care workers and health care facilities have been identified as a clear concern of the Movement. The HCiD campaign aims to raise awareness about this crucial issue and mobilise a community of concern.

Australian Red Cross is pleased to be involved in promoting this campaign through a number of events and activities, including this magazine. In this edition of the magazine we bring you a range of perspectives – including those from the military, the Australian Government's Aid Program (AusAID) and Médecins Sans Frontières (MSF) – about why this campaign is so important. Australian Red Cross international delegates Dr Jenny Stedmon and Ruth Jebb tell us first-hand of situations where violence has detrimentally affected the provision of health care. Similarly, Solomon Islands Red Cross staff member Oligao Niniu shares his reflections on health care in danger in the Pacific. Dr Peter Hill and his colleagues analyse the impacts of the distortion of a health system by violence, and the International Committee of the Red Cross (ICRC) shares its reflections on the campaign. We also look at the history of attacks on health care, and how this issue is a concern in 'other situations of violence'.

We would like to sincerely thank all the contributors for their time and expertise, and also note our appreciation for AusAID's support of the campaign and magazine.

We hope you will enjoy this edition of the IHL magazine.

Robert Tickner
Chief Executive Officer
Australian Red Cross

the ICRC-led Health Care in Danger project:

from awareness and mobilisation to tangible impact

Pierre Gentile is the ICRC's Head of the Health Care in Danger (HCiD) project. Olga Miltcheva is a Communication Officer with ICRC and the HCiD Campaign Coordinator.

Aleppo, Syria, 2013. A wounded man is tended to. Photo: ICRC/R. Garcia Vilanova

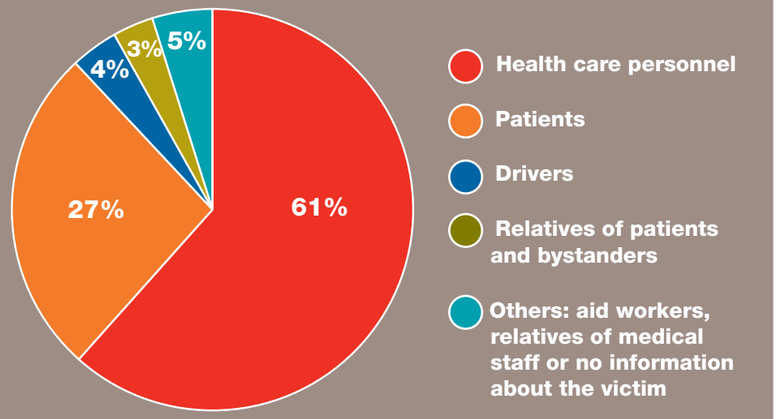
Violence against health care is not an obscure topic. Mainstream television stations provide shocking visual proof on a weekly basis, ranging from a blood-soaked patient in a bombed Syrian hospital to a pale-faced humanitarian worker kidnapped in East Africa, a looted health care centre in Congo or a beaten up doctor in a crime-ridden district. The International Committee of the Red Cross (ICRC) gathered information in 22 countries about more than 900 incidents of this kind in 2012 alone – from first-hand accounts or other trustworthy sources. Despite such overwhelming evidence, the link between all these cases is seldom made, neither in the public arena nor even in the humanitarian context where this would be a matter of immediate concern.

The HCiD project is an ICRC-led initiative of the International Red Cross and Red Crescent Movement (the Movement) that aims to make access to health care safer. It began by recognising violence against health care as a major humanitarian issue.

From single incidents to a humanitarian issue

Regardless of where they take place or when, acts of violence against patients or medical staff have the same consequence: a huge number of wounded and sick people are deprived of health care.

The global media features more frequently the direct attacks against health care workers, particularly those affecting the international staff of aid organisations. The information gathered by the ICRC hints at a different trend. In 75 per cent of the incidents, local health care providers were affected. Attacks are, however, only one aspect of the matter. The violence in question takes



In 2012, ICRC gathered information of 1,007 victims of violent incidents against health care services. The direct casualties are most often health care personnel, both medical professionals and first-aiders. In around 35 per cent of the cases they were threatened, but the patterns of violence can be very different, ranging from a robbery to a murder.

other forms as well: discriminating against patients for political, racial or ethnic reasons, or simply obstructing health care delivery.

It is also not at all unusual for medical personnel to be subjected to threats. This happens much more often than the kidnappings or killings that are reported, and the consequences can be just as serious. When health care workers are threatened, they might decide not to visit particular areas. Large numbers of them might even decide to leave the country or the region, which was the case in Iraq. The result is that entire communities will be left without health care.

As a consequence of violence, actual or threatened, the entire health care system will be rapidly weakened – international support notwithstanding. This is exactly what happened in 2010 in Libya, which had well-trained medical personnel and modern health care facilities before the conflict.

Mobilising a community of concern

The Movement is an ideal advocate for this issue. Our staff and volunteers not only witness acts of violence against health care; they are themselves sometimes prevented from reaching wounded and sick people, and some are injured or killed while on duty. Today, the protective power of the red cross and red crescent emblems cannot be taken for granted. In 2011, during the last International Conference of the Red Cross and Red Crescent, ICRC was mandated to lead the HCiD project and many Red Cross Red Crescent National Societies formally pledged to ensure safer access to health care.

However, we are only one of many organisations for whom violence against health care is a matter of concern. Private and public health care providers, and local and international organisations are also affected by it. The scope of the HCiD project extends far beyond the safety of our colleagues. In addition to securing our own operational response, we are also mobilising various other actors to work on the issue in a complementary way.

Authorities, National Societies, Médecins Sans Frontières, the World Medical Association, a number of universities and many others are already contributing to the same objective. We call such actively involved organisations and individuals a ‘community of concern’.

Towards practical solutions

Since April 2012, members of this ‘community of concern’ have met at several HCiD workshops to discuss measures for making access to health care safer. In London and in Cairo, regional and international experts examined the role and the responsibilities of the health care community. In Teheran and in Oslo, National Societies recommended stronger advocacy by the Movement as well as a range of measures for enhancing humanitarian access and increasing respect for the emblem.

The workshops planned for 2013-2014 will have a more practical orientation. They will examine measures for ensuring the safety of health care infrastructure and ambulance services, and domestic legislation for protecting health care workers and patients. At one workshop, for instance, military experts will discuss how weapons bearers can more effectively ensure rapid passage for medical vehicles, or improve their procedures for conducting searches in clinics.

It is hoped that these workshops will have a broad range of results: building greater awareness of the issue, developing useful technical guidelines for reinforcing hospitals in armed conflict, training modules for health care workers, at least 40 National Societies developing plans of action, and so on.

Ways of dealing with this complex humanitarian issue will vary from one context to another. For instance, in Colombia, a government decree promoting the protective use of a national emblem by all medical workers has been successful, but the same measure might be completely unsuited to another context. Sharing field practices internationally will help to formulate the most effective solutions; it will also be useful in dialogue with authorities.

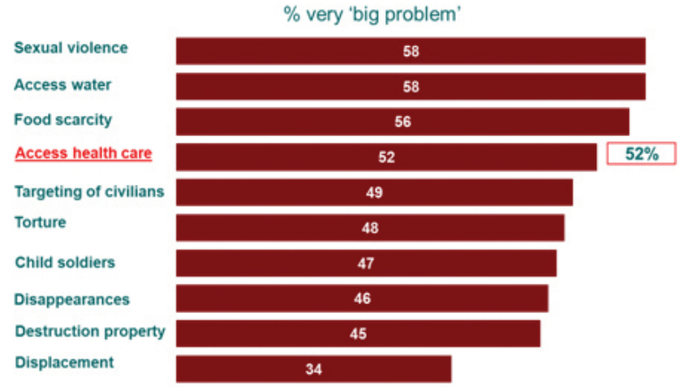
Developing practical recommendations is only the beginning. The current state of affairs cannot be changed without the support of states. As an example, in Yemen, a declaration signed by the government last December was a first step of a process aiming to secure access to health care in the country.

This is also the case at the international level. Putting the issue on the diplomatic agenda and providing the necessary support will be vitally important for implementing the recommendations made by experts at the workshops.

lack of safe access to health care:
global public opinion favours government engagement

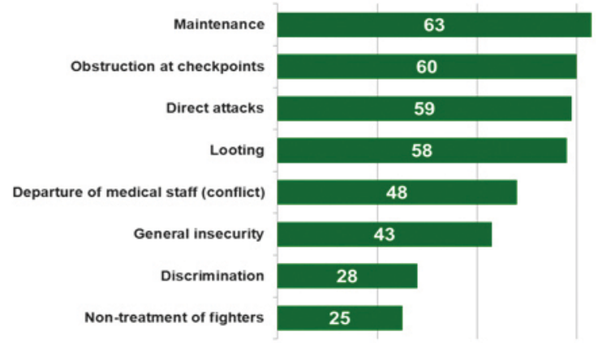
In 2012, the research agency IPSOS conducted an online opinion poll on violence against health care in armed conflict and other emergencies. The objective was to assess how the public understands, perceives, and engages with the issue. The survey interviewed over 14,000 participants in 18 countries, both in advanced economies such as the United Kingdom and Australia, and in emerging powers such as China and India. All countries were selected with regard to their regional or international political influence.

How much of a problem, if at all, do you think the following humanitarian issues are in armed conflict and other emergencies?



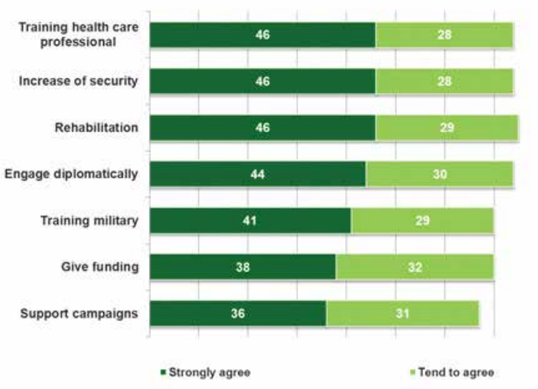
The access to health care is ranked as the fourth most important humanitarian problem in armed violence. The results of the opinion poll also indicated that knowledge can influence perception. Most of the respondents that stated they “know about the issue” also considered it a “very big problem”.

To what extent, if at all, do you think the following reasons contribute to this humanitarian issue?



The public opinion in all 18 countries considers that the top three factors contributing to the insecurity of health care are the lack of maintenance of medical structures due to the conflict (63%), the obstructions at checkpoints (60%) and the direct attacks against health care workers and patients (59%). One of the most ignored aspects of the issue is discrimination in the provision of health care (28%).

To what extent do you agree or disagree that your government should do the following things to improve access to health care in countries affected by armed violence?



More than 70% of the respondents believe that their governments should take at least one action to improve safe access to health care in armed violence. Public opinion is particularly supportive of diplomatic engagement on the international level (74%) and ensuring rehabilitation and increasing security of health care structures in areas affected by violence (75%).

the unwritten history of health care in danger

Helen Stamp is an International Humanitarian Law Officer with Australian Red Cross.

In *A Memory of Solferino*, Henry Dunant – the founder of the International Red Cross Red Crescent Movement – spoke of his admiration for the many doctors and medical students who assisted the wounded in the aftermath of the battle of Solferino. He writes, "[s]urely, if those who make the slaughter can claim a place on the roll of honour, those who cure, and cure often at the risk of their lives, are entitled to their due of esteem and gratitude".

Providing medical care to the wounded and sick in armed conflict, and the protections afforded to those who provide this care, have consistently remained important principles in the development of IHL, from the provisions of the First Geneva Convention, to the revised 1949 Geneva Conventions and the Additional Protocols of 1977 and 2005.

Although the protections for medical workers and health care facilities are clearly included in IHL, recent research indicates a growing number of violations of these protections in armed conflicts around the world. In 2011, the ICRC released 'Health Care in Danger: a sixteen country study', which analysed information from 16 countries over the course of two and a half years. During this period there were 655 incidents of violence, or threats of violence, against health care services which resulted in the deaths or injury of over 1,800 people.

Have such violations always occurred in situations of armed conflict, or is this a new development in the dynamics of modern warfare? This is an important question to consider in order to identify the causal factors for these attacks and to assist in developing mechanisms to prevent or reduce the rate of these incidents.

In researching the history of attacks against medical workers and health care facilities in armed conflict an interesting anomaly is discovered. Given the serious nature of this issue, it would be logical to expect that any violations would be carefully investigated and documented each time they occur. Whilst anecdotal evidence from those in the field who have been subject to this type of attack, or who have witnessed such an attack, is available there is a startling lack of systematic recording and research on incidents until very recently.

This cannot be because such violations have only just started – there is evidence that violations have occurred in armed conflict throughout the twentieth century. Examples include: the sinking of the Canadian hospital ship HMHS Llandovery Castle in June 1918; reports from the Greek Red Cross in July 1944 of the bombing and machine gun fire on ambulances in Greece; the death of 42 health care workers in the Nicaraguan conflict from 1983 to 1985[1]; 341 attacks on medical personnel and patients from 1995 to 1998 in the Columbian armed conflict[2]; and the torture and summary execution of staff and patients from the Vukorar Hospital during the conflict in the former Yugoslavia[3].

Incidents of security forces obstructing access to health care, harassing medical personnel and assaulting patients have been reported in Bahrain, Syria and Libya[4]. Violations tend to be reported across a wide variety of formats and publications, rather than in any systematic manner. As such, the true extent of abuses and why they have increased in number is difficult to accurately determine.

In 2010 research conducted by Rubenstein and Bittle highlighted the infrequent nature of reports of violence against health care facilities and personnel, and a lack of detail in the reports that were made[5]. In 2012 Rubenstein noted that there is "no international mechanism for systematic monitoring" of these attacks and that, to effectively respond to this increasing problem, a "sound evidence base" was needed[6]. Rubenstein did note, however, that concern in the international community regarding this form of IHL violation has increased since 2011, with the ICRC HCiD study pioneering the collection of evidence of these attacks[7].

The importance of formally collating and recording details of attacks was illustrated in Rubenstein and Bittle's research as they were able to identify three trends in the incidents that were occurring: attacks which were part of generalised violence directed towards civilians, attacks to specifically gain a military advantage, and attacks that occurred in reprisal for the provision of medical services to wounded enemy combatants. This analysis can be used to develop strategies to counteract the growing number of these incidents.

The history of attacks against medical personnel and health care facilities in times of war is unlikely to ever be very clear, given the sporadic nature of the reporting of these, until recent times.

The increasing rate of incidents and the need for ongoing, international systematic reporting and monitoring of these attacks is clear. Monitoring will provide the evidence base required for analysis and research into the motives and psychology behind attacks against medical workers and health care facilities in armed conflict. This information can then be used to develop strategies to effectively prevent, or at least reduce, the rate of attacks occurring so that proper protection for those who care for the wounded in times of war can be restored.

1. Garfield, Richard et al 1987, 'Health- related outcomes of War in Nicaragua'. American Journal of Public Health, vol.77,no.5, pp.615-618

2. De Currea-Lugo, Victor, 2001 'Protecting the health sector in Colombia: A step to make the conflict less cruel', International Review of the Red Cross. vol. 83. no.844, p.1111

3. Andreopoulos, George J, 1997 'War Crimes in the Balkans: Medicine under Siege in the Former Yugoslavia 1991-1995. A Report by Physicians for Human Rights (1996)' Book Review. Human Rights Quarterly 19. 3, pp.692-693

4. Rubenstein, L, January 2012, 'Protection of Health Care in Armed and Civil Conflict: Opportunities for breakthroughs,'A report of the CSIS Global Health Policy Center. p.1

5. Rubenstein, L& Bittle, M, January 2010 'Responsibility for protection of medical workers and facilities in armed conflict,' The Lancet, vol 375. pp 329-331

6. *supra* at note 4 at p.2 and p.4

7. *Ibid* at p. 3

Above: Danish military ambulance, 1878. The 1864 Geneva Convention established a unique distinctive emblem (a red cross on a white background) for ambulances, hospitals and medical personnel. Photo: ICRC

Top left: Saigon, 1969. An ICRC doctor visits an orphanage. During the Vietnam War the ICRC was only able to work in South Vietnam, despite repeated appeals to the North Vietnamese Government. Photo: ICRC

the distortion of conflict: health services in severely disrupted environments

Peter Hill (corresponding author) is an Associate Professor in the School of Population Health at the University of Queensland.

This paper is an abridged version of a paper prepared by Peter Hill, Enrico Pavignani, Markus Michael, Maurizio Murru and Mark E Beesley.

Sa'ada, Yemen, 2007. Patients waiting in front of the tent of the primary health care centre project organised by the ICRC and Yemeni Red Crescent Society. Photo: ICRC/P. Duda

The impact of conflict on health professionals is, at last, being openly examined. But in addition to the direct impact on individual lives, conflict also impacts on health systems as a whole. The distortions that it causes last well beyond the cessation of violence and become structured into the systems themselves. In many cases, these health systems are already fragile and the problems they face are often compounded, but are rarely new. Yet, even for those vulnerable systems conflict may provide opportunities for change and, in fact, is an imperative for change.

Recent research by the University of Queensland has examined health services in severely disrupted environments: Afghanistan, Central African Republic, the Democratic Republic of the Congo (DRC), Haiti, Palestine and Somalia. The findings of this research point to the diffuse and pervasive penetration of violence, affecting each of the six building blocks that make up a health system.

Health services

While the pre-existing coverage of health services is often poor, services contract even further away from active conflict – as in Afghanistan – and tend to concentrate development resources in the limited number of secure provinces, inevitably privileging their development over the long term. The mal-distribution of staff exacerbates existing disparities, with those who have portable skills often taking advantage of these to migrate.

The health services gaps, however, do not necessarily remain a vacuum. They are filled by health workers with limited, incomplete or expedited training, retired staff, traditional practitioners, volunteers and quacks. The services that will then be available to the community will depend on which staff remain, the availability of drugs, accessible supply lines and adaptability to the dynamics of conflict. Preventive programs become more difficult to sustain; immunisation and child health services may be curtailed due to the risks of congregating, or threats to staff during outreach activities.

Human resources

The health sector itself is increasingly a focus for violence, for a variety of complex reasons. In conflicts where the state is being challenged, it may be targeted through its social services; destroying health infrastructure undermines links to government. The loss of human resources through death and injury, relocation and migration contributes to the distortion of the health workforce, exacerbating already problematic rural-urban mal-distribution. Training is often patchy and of poor quality, with qualifications whose standards are difficult to confirm, and the resultant workforce is frequently bloated and under skilled.

Financing

In conflict, local financing for health is frequently reduced, with security consuming a disproportionate part of the budget – military health services the one potential exception. State funding frequently contracts to (irregularly) cover salaries alone, with limited allocations for drugs and outreach activities. Out-of-pocket expenditure rapidly becomes integral to health service provision: departmental health services in Haiti are heavily dependent on user-fees; in Afghanistan, patients prefer to spend their money in the private for-profit sector; with state financing for health in the DRC among the lowest in the world, district administrations, often with no other sources of financial support, rely on user fees to support the Health Zone with a cut sent on to the Provincial Health Directorate.

Drugs, vaccines and technology

Conflict and its aftermath are characterised by a conspicuous commodification of health, with drugs, vaccines and technology providing an economic rationale for sustaining private provision of selected services in the absence of the state. Porous borders in Somalia have allowed increased importation of drugs from a range of sources, including informal and at times illegal elements. The limited regulation means that poor quality drugs, or fraudulent drugs, many with European brand-names, have easy access. Without prescribing controls, self treatment results in inadequate therapy and the lack of Western medicines in some conflict locations means that traditional medicines are frequently substituted.

Health information

The Health Information System is frequently vulnerable prior to conflict, but further compromised through loss or relocation of the staff responsible for recording, reporting or analysing information. There is disrupted communication, reporting and supervision, and key staff may migrate or be reallocated to higher 'priorities' as capacity contracts. The aggregate data often conceals greater inequities between provinces within countries. Health information is a political commodity – used with often laudable intentions. But the politics of health information make it contentious: challenges to the estimates of deaths – particularly civilian deaths – in recent conflicts have pitted claim against counter claim, methodology against methodology.

Leadership and governance

Legitimate authority in conflict situations is often contested or lost and the opportunity for local ownership of health systems change is already under challenge. Even where the state is recognised its 'reach' may be truncated by its limited capacity. In all the case studies, health services are compromised by the limitations of the state: recurrent civil disturbance and insecurity has left the Haitian state with control of only 15 per cent of its own health facilities; and Afghanistan's fragile control of contracted health services, with substantial international support, provides access for over 85 per cent of the population, but only 25 per cent of service utilisation.

Health systems in conflict

For health systems, the acute, the immediate, the unpredictable, and the chaotic need to be managed with the long term in view. Afghanistan rightly decided to add a ninth Millennium Development Goal to the existing eight: that peace is a pre-requisite for development. Without peace and security, the state cannot rebuild, and health systems cannot be comprehensively re-established and extended. With peace, the post-conflict phase offers a critical opportunity to address the health systems' distortions of violence.

Children are weighed and vaccinated at a primary health community centre in Iraq. During the wave of sectarian violence, health facilities were difficult to reach. Photo: ICRC/O. Moeckli

AusAID a critical issue: protecting health care workers, patients and health facilities

Catherine Walker is AusAID's Humanitarian Coordinator.

Violence against health care workers, facilities and patients is a serious humanitarian issue in the world today, and one that is not sufficiently recognised. It is hard to believe that health care workers are frequently the target of attacks in many conflicts throughout the world, with the shelling of hospitals, attacks on ambulances and threats to medical personnel for treating certain patients. That those most skilled and committed to saving lives should have their lives in danger is abhorrent.

The Australian Government believes that preserving access to health care is essential in conflict zones. It reflects compassion and the wish to provide life-saving support to those in need. It also reflects our humanity and respect for international law.

The fundamental purpose of the Australian Aid Program is to help people overcome poverty, and to a large extent this is achieved by investing in health care in developing countries. Good health is a fundamental human right and has been recognised in internationally agreed goals. Australia has committed to a number of global health commitments including the United Nation's Millennium Development Goals, four of which relate directly to improving people's health in developing countries. Australia can, and does, make a difference to the health of the poorest and most vulnerable people. However, Australia's aid efforts are hampered in conflict-affected contexts, where vulnerabilities are exacerbated.

Violence and a lack of security can have detrimental impacts on delivering aid. Conflict and insecurity prevent development; they slow progress, erode hard-won development gains and are extremely costly. They can also prevent health services and humanitarian assistance from reaching vulnerable populations most in need, and can impede needs assessment, implementation, and monitoring and evaluation of programs.

Ensuring that health workers have access in conflict areas is essential to protecting and saving lives. Australia's Foreign Minister, Senator Bob Carr, put forward a plan at the United Nations Security Council on January 17, 2013 to protect medical workers and ensure safe access to hospitals for families caught up in Syria's civil war – in accordance with IHL. The Australian Government's plan involves securing a commitment from all parties in the Syrian conflict to not target medical personnel, to not block access to doctors, hospitals or emergency care, and to not attack medical facilities. This is a problem occurring in many conflicts around the world.

At the 31st International Conference of the Red Cross and Red Crescent in Geneva in 2011, Australia also pledged its support for the resolution on 'Health Care in Danger: Respecting and Protecting Health Care', and pledged support to strengthen international humanitarian laws. The Australian Government is very supportive of the ICRC HCiD project and AusAID has committed to providing $1.5 million to the project in 2013. More broadly, the Australian Government has also accepted the ICRC's invitation to be a key partner of the HCiD project and to host a workshop of military experts as part of the project, to be held in Sydney in December 2013. The aim of the workshop is to define practical ways to better protect health care personnel, facilities and patients from the consequences of military operations in armed conflict and other emergencies.

The ICRC project will develop strategies, with a range of partners, to enhance access to crisis-affected communities, improve the safety of affected communities and enhance the safety of health care workers. However, there are challenges in moving forward with this project. The way ahead needs to include all key stakeholders. The focus of the project has three interconnected streams: humanitarian, political and military. Civil and military partners have shared independent skills to contribute to the fundamental challenge of saving lives. Government, civil society and military actors firstly need to recognise a shared role and then broaden understandings of the part each might play.

An acceptance of, and adherence to, international humanitarian principles and IHL is also essential. Advocacy for these laws is important and the Australian Aid Program (through AusAID) supports the ICRC and Australian Red Cross to do this. There needs to be a clear understanding of the complexities involved, including the conflict, the culture and the range of options that might be advanced. We all need to play our respective parts in addressing this issue and learn from each other. As insecurity and conflict impede development and kill people – increasingly including health care workers – we need to work seriously and collaboratively to address this. It is important that we do more than talk. Humanitarian access and the safety of those workers, in particular health care workers, are critical to our shared successes in saving lives.

AusAID will continue to support humanitarian and global health related resolutions advocating for protection of humanitarian personnel working in insecure environments and provide support for global health initiatives to reach the most vulnerable populations.

I commend Australian Red Cross on the initiative to focus this edition of the *IHL magazine* on the theme of health care in danger. This issue will assist to build a deeper appreciation of the urgent need to protect health care workers and their patients in conflict, and other situations of violence.

Above: Somalia, Mogadishu, 2006. Keysaney hospital emergency entrance. Managed by the Somali Red Crescent and supported by the ICRC, the hospital started operating in 1992 in the buildings of a former prison. Photo: ICRC/ Benoit Schaeffeer.

Top left: A Palestinian Red Crescent Society ambulance is blocked at a checkpoint in Hebron. Photo: ICRC

perspectives from the field

Mongo, Chad, 2012. Training of volunteer hygiene promotion workers during the Cholera outbreak. Photo courtesy Ruth Jebb.

The goal of ICRC health activities:

To give people affected by armed conflict and other situations of violence access to basic health care, in order to reduce mortality, morbidity, suffering and disabilities.

Ruth Jebb is an International Health Delegate with the International Red Cross and Red Crescent Movement.

I was being driven home from the Feeding Centre in one of our clearly marked ICRC land cruisers, unaware that we were being followed. It turned out three armed persons had been following the land cruiser. What I later discovered was that the minute I entered my residence, the armed persons approached the driver and demanded the keys to the land cruiser. They were all armed with AK-47s. He managed to narrowly avoid any harm, but as a result security was heightened and ICRC staff were unable to move around in land cruisers.

The stories I will share with you occurred in 2008 in Darfur, Sudan where I was coordinating and managing a Feeding Centre for malnourished children. At the time, there were 2,500 malnourished children enrolled in the feeding program.

The compounding effect of this single event on my ability to carry out the work I was there to do, was significant. All activities, including those conducted at the Primary Health Clinic, Feeding Centre and all outreach clinics were temporarily suspended for three days, until the motivation behind the attack could be established.

What this meant was that moderately and severely malnourished children did not receive the essential nutritional supplements and medical treatment they required to survive. For some children this was the only food they were receiving. Children that were already on the brink of life and death were further compromised and as a result some died.

Following security clearance, it was decided that all ICRC activities had to be conducted using local transport methods, such as donkey and horse carts, impacting significantly on our ability to respond to emergencies, and transport supplies and patients to the hospital. Sometimes you had to wait an hour for the transport, limiting the medical work you could carry out in one day.

Because of the increase in violence and unpredictable armed movements in the camp after dark, security could not be guaranteed by all the governing parties. This limited our ability to provide adequate health and nutritional services to the internally displaced population over a 24-hour period.

As a result, the Feeding Centre program was limited to eight hours per day. Malnourished children were seen and treated for a short eight hour period during the day, and then sent home in the hope that they would not deteriorate overnight. Many children required 24-hour intensive nutritional and medical treatment, but due to the security risks associated with running a 24-hour program, the most severely affected had to be flown one hour out of camp in order to access appropriate care.

There were obvious limitations in sending children away from the camp for specialist treatment. Mothers were often unable to accompany their unwell children (as they had other children to care for, or may have been the primary breadwinner for their family); and many of these children died, which added the challenge of dealing with the death and burial of a child away from their family and community.

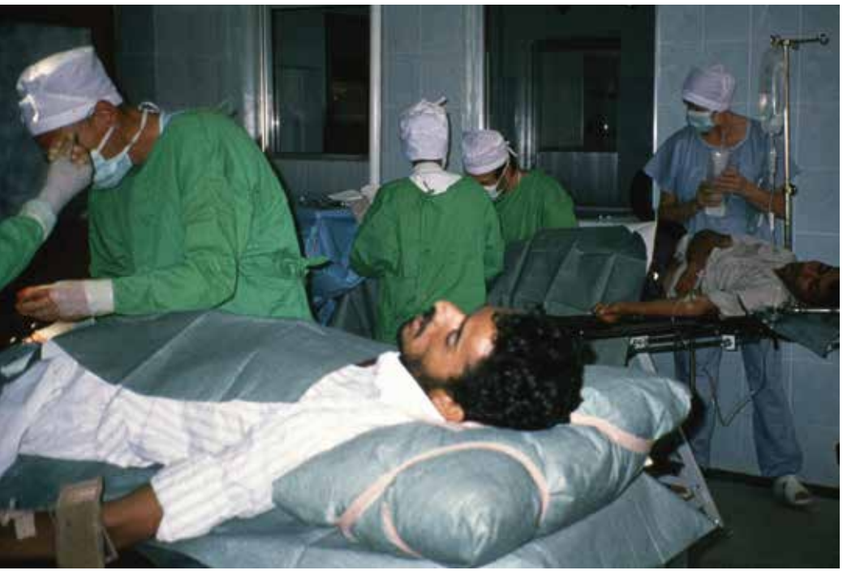
As a health care worker, though I have not been the victim of violence in the field, the threat of violence has directly impacted not only on my personal sense of safety and security, but also on my ability to meet the ICRC health goal to “give people affected by armed conflict and other situations of violence access to basic health care”.

The compounded costs associated with violence against health care workers, facilities and beneficiaries are health care staff leaving their posts, clinics running out of supplies, and suspension of essential health services. These effects dramatically limit access to health care for entire communities, meaning that the sick and wounded do not get the treatment they need, which is often the difference between life and death.

The ICRC HCiD project is one step forward for finding tangible solutions to address one of the biggest humanitarian issues facing us today – ensuring health care workers such as myself can effectively deliver timely health care to those in need.

Gerida IDP Camp, Darfur, 2009. Severely malnourished child at IFRC Feeding Centre. Photo courtesy Ruth Jebb.

perspectives from the field



Surgical teams working in Taiz, Yemen, 1994. Photo courtesy Jenny Stedmon.

Dr Jenny Stedmon is a Consultant Anaesthetist and Deputy Head of Department at Fremantle Hospital. She is on the Western Australian Medical Assistance Team (AUSMAT) for disaster medical response, the Indigenous Health Committee for the Australian and New Zealand College of Anaesthetists, and is an ICRC delegate.

An early influence in my career was hearing a talk by a young anaesthetist who had worked for ORBIS (a non-profit organisation fighting blindness in developing countries), giving anaesthetics for large numbers of eye operations on board an aeroplane. Shortly after this, in 1990, I found myself flying out to the Thai-Cambodian border to work at a Red Cross hospital called Khao-I-Dang for the ICRC. On the plane, I sat next to an experienced New Zealand nurse who had worked with the ICRC for many years and was going to spend a year there, as opposed to my three months. Her name was Sheryl Thayer.

Sheryl and I not only worked together on my first placement for the ICRC, but we became friends and holidayed together after my work was finished. In December 1996, Sheryl was one of six Red Cross health delegates assassinated by gunmen in the Red Cross hospital located at Novi Atagi, Chechnya. This was not only personally shocking, but it seemed to herald an unprecedented pattern of kidnappings, assaults, attacks and murders on health care and aid workers, ranging from those involved in primary health care projects through to ambulance drivers and support staff.

The significance of the emblems (red cross, crescent or crystal) seemed to offer less protection than previously and it was from this observation, and early studies to document and monitor these transgressions, that the current HCiD campaign has arisen. International concern is not only related to attacks on health workers of all kinds, but to the lack of access to areas where the most help is needed, and to denying humanitarian support and supplies to facilities and patients most in need.

Since my first mission I have been to three more countries all affected, usually in a long-term way, by war. I worked in Taiz in the Yemen, on the Kenya-Sudanese border at Lokichokio Hospital, and in East Timor. There have been a variety of hospital facilities available, ranging from Red Cross-led long term hospitals, to utilising mobile field equipment in the form of a Finn Hospital which comes packed in boxes designed to allow operating on a particular number of patients. The wide variety of patient injuries and illnesses differed in each place, and related not only to the weaponry used in the war, but to the availability of local health facilities and personnel.

My experience has led me to become a passionate supporter of the principles underlying the International Red Cross Red Crescent Movement and, recently, to become more aware of IHL. At first the legal aspects of IHL can be daunting, but when the purpose of the laws relating to the conduct of war, and treatment of prisoners of war and civilians are examined, they constitute a fundamentally humanitarian view. The HCiD campaign seeks to ensure that those aspects of IHL and the Geneva Conventions, relating to health care and humanitarian aid, are internationally recognised and adopted. I would encourage everyone to engage with this cause, attend local events relating to both HCiD and IHL, and above all read and talk about the issues.

The only specialised surgical centre in northern Afghanistan, is an MSF facility in the province of Kunduz. It is equipped with an emergency room, two operating theatres and an intensive care unit, and 70 beds across four wards. Photo: MSF/ Michael Goldfarb.

Françoise Duroch is the Medical Care Under Fire Project Manager with the Médecins Sans Frontières (MSF) International Office. Caroline Abu Sa'da is the Head of the Research Unit with MSF Switzerland.

Since its foundation, MSF has faced different forms of violence against its patients, staff, health facilities and medical vehicles, as well as against national health systems in general. The current situation in Syria is a forceful reminder of how health systems can become the target of attacks and how medical practice can be perverted for political and martial purposes. This violence deprives entire populations of vital assistance and is a means for the parties to the conflict to exert, both symbolically and practically, their power over people's lives.

Although attacks against patients and medical facilities can be a sign of intensification of hostilities, or they can be a part of other types of violence, as witnessed by MSF in our programs, they can also (as in the case of the Democratic Republic of Congo, Pakistan, Bahrain or Syria for example) be adopted as political or military strategies from the outset, indicating either a deterioration or complete rejection of the agreed norms and standards of warfare. Likewise, the corruption of the medical act, for example to disguise a covert military operation, similarly demonstrates a total lack of respect for the medical mission and therefore the neutrality and protection it should be afforded.

Act of care, act of war?

MSF has often condemned situations where a health facility passes on the whereabouts of its former patients, where confidential medical records are stolen or where health staff are abducted or killed. It is a sad reflection when a surgeon working for MSF in Syria reports that he was advised to tell people he was a journalist rather than a health professional.

How can those dynamics be countered or simply limited, other than by stressing the principles of reciprocity that aim to obtain acknowledgement that a place where care is administered benefits everyone and its preservation is in the clearly understood mutual interest of all parties?

Moreover, throughout the history of the organisation, violence has been uncontrolled or chronic with various types of consequences. These include a general prevention of access to and provision of care - either because the access of patients to facilities are blocked (such as at checkpoints) or the facilities are inoperative due to a lack of skilled health personnel, and a shrinking of organisations' working spaces.

The internalisation and tolerance of forms of violence experienced repeatedly by MSF teams and patients, who must sometimes endure harassment, threats and even blackmail on a daily basis, should also be noted. As such, a significant number of incidents are only partially reported. Although it is easy to understand the adoption of mechanisms to adapt to situations of tension, we should be wary of these forms of violence being perceived as a normal part of conflict and justifying their repetition.

Reaffirming the organisation's ethical principles will assist with their effective application. For example, triage policies guided by classic medical emergency factors, as well as assistance to all parties to the conflict and their respective communities, are core ethical values. These values must be reflected in practice and not just in rhetoric.

Confrontation and negotiation

While the manipulation of medical services and violence against health personnel must not be tolerated, it should never justify the establishment of a political agenda intended to put an end to it. For MSF, it is a question of focusing on preserving the medical working space, on patients' needs for adequate care under the best possible conditions, on opening as broad a space for discussion as possible and on involving all stakeholders participating directly or indirectly in the delivery of aid or controlling the area. Consequently, MSF plans to concentrate its action on establishing the medical consequences of attacks on patients and on health personnel and facilities, insofar as they result in serious short- and medium-term repercussions on health systems and disastrous impacts on both individuals and public health more generally.

health care in danger: the Solomon Islands story

Solomon Islands Red Cross Dissemination Officer Oligao Niniu speaks about health care in danger in the Pacific.

Manaoba Island, Solomon Islands. A Red Cross volunteer visits the north tip of Malaita. Photo: IFRC/R. Few

The Solomon Islands Red Cross (SIRC) recently ran some awareness raising activities in the community on the theme of health care in danger. Can you tell us about that?

The sessions have been part of our IHL dissemination program and we have found the health care in danger theme has been a great vehicle through which to approach IHL training. The students are introduced to IHL, the humanitarian auxiliary nature of SIRC and the notion that in times of violence the health care system must be respected.

Each session has been designed to be as interactive as possible and the students have asked lots of questions. We have used some of the ICRC HCiD campaign films as part of our presentations and they send a very powerful message that health care workers and facilities need greater respect. At the end of each session we have distributed IHL and HCiD campaign leaflets to the students, to give them something to take home and importantly to share with others who did not attend the session.

Why did you choose the health care in danger theme for these awareness raising sessions?

We wanted to get across to the students an IHL message, but also to make it relevant to their life experience. By using the health care in danger theme, students can relate specifically to something which has affected our country – during the Guadalcanal ethnic tension period and 2006 riots – but also that is, sadly, very much a feature of the recent violence of our time, in countries like Syria and Libya. In short, young people need to understand IHL not as a subject in a book, but rather as something which is meaningful to them and that affects their lives. A lot of interest has been shown by the students.

As you mention, the Solomon Islands has been affected by ethnic tensions and riots. Do you have any reflections to share with regard to the protection of the medical mission and medical workers during these times?

During the time of the ethnic tension on Guadalcanal, I was a form seven student and lived in Honiara. I never knew that IHL and Red Cross existed to protect those who are not, or no longer, taking direct part in conflict and other situations of violence. But I did know that medical workers and Red Cross workers took great risks to provide their life-saving services beyond the frontiers.

There were incidents of Red Cross workers being blocked at the road blocks. I also recall some incidents which had significant effects for the National Referral Hospital staff. On one occasion, nurses and doctors of the National Referral Hospital in Honiara were threatened by an unidentified armed man, and on another, two wounded militants were killed while in the hands of the nurses and doctors in the hospital.

Generally, however, the red cross emblem was well respected on both sides of the conflict and also by the affected populations which Red Cross helped both on Guadalcanal and Malaita. The neutrality and impartiality which the staff and Red Cross volunteers demonstrated made their most needed humanitarian mission (which included medical services) possible, and allowed them access to those in need on Guadalcanal. I have a great deal of admiration for their work.

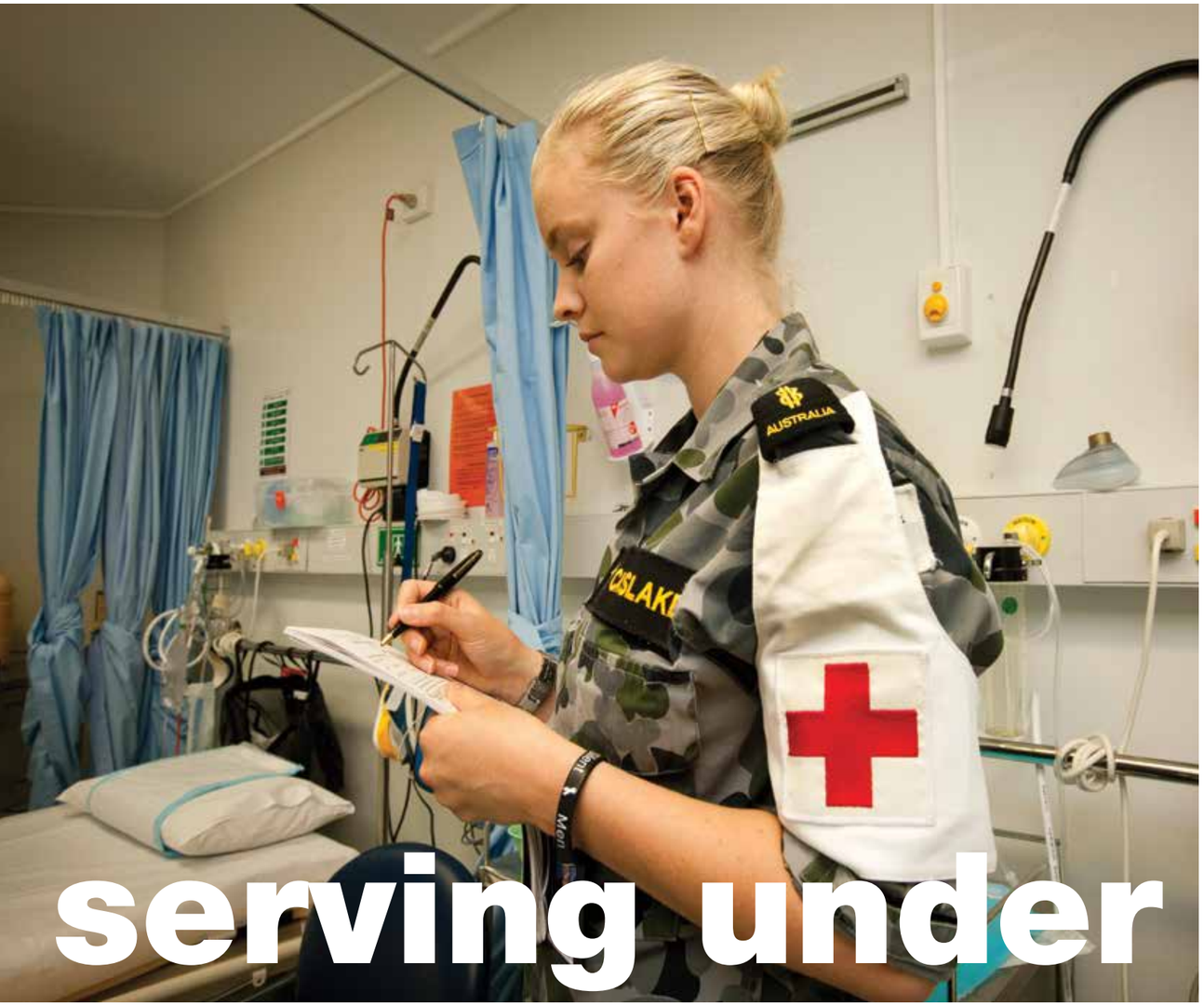
What lessons do you think SIRC learnt from the challenges it faced in terms of access to health care during the ethnic tensions?

SIRC accessibility to the population in need of assistance on Guadalcanal came with huge sacrifice and dedication from its staff and volunteers, who were tireless advocates for the Red Cross Fundamental Principles – particularly independence, impartiality and neutrality – through their actions. Their mission was to save lives and this required ensuring they had the support of all parties to the conflict in order to protect the health and dignity of the population affected by the ethnic tensions.

The humanitarian auxiliary nature of Red Cross, and the Fundamental Principles and ways of working of the organisation, have to be understood to be respected – by all parties to any conflict and by the general population. This reminds us that, in peacetime, education about these principles to the general population, in particular the young people who are very active and dominate the Solomon Islands population, is of paramount importance.

Why do you think advocating for the protection of the medical mission is so important now in the Solomon Islands?

It is the right time to strongly advocate on behalf of the health care system in the Solomon Islands. We need to stop the violence against health care and to avoid the spillover costs, which have been witnessed during the Guadalcanal ethnic tension.



serving under the red cross: reflections from a career in military medical management

HMAS Stirling, Western Australia, 2011. Australian Defence Force medical facility. Photo: Australian Red Cross.

W D Bullock is a retired British Army Major.

The unfortunate truth is that we do not have to look too far in order to identify that the provision of medical assistance to those in need, in times of conflict, is a dangerous undertaking. This is exacerbated by abuse and ignorance of the protection afforded to military medical personal by the recognised emblems of the Geneva Conventions of 1949 and their Additional Protocols.

The advent of technology has allowed attacks on military health care workers, equipment and facilities to become more prominent in our lives. I will take a brief look into medics in danger from a British military perspective, based upon historical evidence and personal diaries in order to explore this subject further.

The Victoria Cross (VC) is the highest Commonwealth award for bravery which can be given to a person. Interestingly, the Royal Army Medical Corps has the highest count of VCs amongst any organisation, two of which are Double VCs. The recipients of the double VCs – Captain Noel Godfrey Chavasse and Surgeon Captain Sir Arthur Martin Leake – both won for actions conducted in retrieving casualties, under heavy enemy fire and whilst wearing red cross emblems during WWI.

Medics operating in positions of danger, whilst displaying or operating under protected emblems, are not new to the battlefield. Throughout my own British Army career, within Expeditionary Health Operations Management, I have been witness to a number of such incidents.

1999 bore witness to numerous reports of systematic attacks on Kosovan health care workers. British Army health staff found themselves in a similar situation. Staff from the British Army Field Hospital, deployed south of Pristina in Kosovo, were involved in 'capacity building' post-military operations. They were involved in the re-establishment of the Pristina General Hospital, through coaching and supporting returning health staff, renovating and establishing capabilities, and filling staff shortages whilst recruitment took place. Approximately five days after the facility had re-opened, with a steady patient flow and an extraordinarily busy Emergency Department (ED) manned by military and civilian staff, a gunman brandishing an AK47 Automatic Assault Rifle burst into the hospital reception and ED area and began to open fire causing numerous casualties. Military health staff were required to intervene to protect their patients and themselves.

During preparations for the US and British-led invasion of Iraq in 2003, there was much deliberation regarding the arming of military ambulances and evacuation helicopters with 'standoff' weapon systems (a weapon system designed for offensive actions as opposed to defensive actions). Following lengthy debate regarding the levels of understanding and application of IHL, the decision was made that medical transports would not receive any extra weaponry support.

Following the initial post-invasion lull in hostile activities, the offensive response by insurgent groups included attacks upon ambulances and health staff, despite visual displays of the red cross and crescent emblems. As attacks increased, so too did the level of ferocity and the style of weapon systems being used. Insurgent tactical procedures included firing Rocket Propelled Grenades at lightly armoured ambulance vehicles, using the red cross as a target. In order to protect vehicles and staff in the course of their medical duties, armoured ambulances were fitted with 'standoff' offensive weapon systems and escorted by other military hardware.

There are many similar reports of attacks on evacuation transports in Afghanistan, which have now resulted in the requirement for an Aeromedical Evacuation platform in Afghanistan to be escorted by two offensive 'gun ship' platforms on all missions.

More recently, I spent some time in Afghanistan during which I witnessed an incident whereby a local Afghan violently abused clinical staff at a local hospital and then hijacked the local ambulance to take his child to the local military base for treatment.

Disturbingly, there are also many other reports of attacks against Red Cross health care facilities and workers, as well as abuses of the protected emblems including, but certainly not limited to, Israeli forces attacking an ambulance with rockets and the Serbian forces using helicopters with the red cross emblem to conduct raids in Kososvo.

Unfortunately, in light of continuing violence and conflict across many areas of the globe, I believe that both direct and indirect attacks on protected health care facilities and staff will continue to be a feature of conflict. Continued education about the true meaning of the protected emblems and of Red Cross neutrality remains the key to reducing attacks.

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health care in danger

in ‘other situations of violence’

Kelisiana Thynne has worked as a Legal Advisor with the ICRC in Afghanistan and the Pacific. Eve Massingham is an International Humanitarian Law Officer with Australian Red Cross.

An ambulance fills with tear gas shot into it during a demonstration. Photo: ICRC/A. Safadi

As the contributions in this magazine make clear, a lack of respect for health care personnel and facilities, and a lack of access to such health care in times of armed conflict, is a concern that should be of vital importance to the international community. It is also a problem for those situations of violence falling short of the threshold of armed conflict, known in IHL as ‘other situations of violence’. The nature of these situations is perhaps best understood through considering three types of violence that characterise ‘other situations of violence’: state repression (including civil unrest and low level insurgency against the state), gang related violence (often drug related), and tribal violence.

The civil unrest and brutal suppression of that unrest sweeping through northern Africa and the Middle East, the intense armed violence gripping urban parts of several Central American states (more than 35,000 deaths were blamed on drug gangs in the 2006-2010 period) and the clan or tribal violence we see in parts of Africa, the Middle East and Asia, demonstrate not a new type of armed violence (indeed such forms of violence have long been part of human history), but a comparative increase in situations of armed violence which do not reach the threshold of an armed conflict and are therefore not regulated internationally by the universally agreed laws of war. The ICRC has said that these instances have confirmed that ‘other situations of violence’ will generate high numbers of victims and could become one of the most significant forms of armed confrontations and humanitarian disasters in the coming decade.

There are many humanitarian problems associated with such violence – many of them directly related to health care. In situations of state repression, road blocks often prevent access to health care. In the initial stages of the violence, protestors might be too hemmed in by the crowds for those who have been injured to seek medical care and for medical assistance to reach them. As the violence intensifies, lack of respect for impartial humanitarian assistance increases. In Bahrain in 2011, doctors assisting protestors were attacked, sentenced for sedition or prevented from working. In Syria, people are finding it very difficult to access health care because of the violence in and around towns, and because services are limited and medicines are not available. In drug gang run environments, access to health care and humanitarian assistance is difficult because the normal state services often cannot function in the ‘farvela’ (urban slums or shanty towns) environment. Moreover, there is often lack of respect for state institutions like hospitals. In tribal violence situations, there is often a complete mistrust of humanitarian assistance. It is assumed that no one can be impartial in such situations. Codes of honour might also prevent someone from seeking medical assistance. Moreover, the violence also means that state health services are understaffed or non-existent so that injuries caused by the conflict, as well as inherent diseases and health problems existing, or caused and exacerbated by the violence, cannot be treated.

Whilst the rules are not always respected – hence the need for the ICRC’s HCiD campaign – if these situations were to occur in an armed conflict, the rules of IHLwould be very clear. IHL requires that civilian medical personnel must be afforded all available help in areas where civilian health care is disrupted by fighting. They must have access to any place where their medical services are essential.

There is a fine line between regulating armed conflict and regulating ‘other situations of violence’ and it is often hard to determine when violence reaches the level of armed conflict. However, even if violence never reaches the threshold of an armed conflict, we need to be able to regulate some aspects of this violence in order to allow humanitarian assistance and health care to access those who are affected by the violence. The consequences in human terms of ‘other situations of violence’ are often as dramatic or intense as those in traditional armed conflicts, in terms of injuries, long-term displacement and chronic problems.

There have been a number of proposals over the years to attempt to develop some international legal framework or guidance for the application of humanitarian principles in these situations (as domestic regulation and law enforcement has almost always broken down). None of these proposals have attracted sufficient state interest to develop further. Some existing legal frameworks may have application; states must respect certain universally acknowledged humanitarian principles, and the human rights instruments to which they are party. However, these frameworks have clearly proved insufficient to protect the medical mission and, as such, greater consideration should be given by states to the development of international standards under the IHL model to regulate behaviour during ‘other situations of violence’.

Australian Red Cross
THE POWER OF HUMANITY

International Humanitarian Law (IHL) Program

Australian Red Cross is part of the International Red Cross and Red Crescent Movement, the largest humanitarian network in the world.

IHL is something Red Cross thinks everyone should be aware of. We run an IHL Program providing training and education highlighting IHL issues to key target groups identified as having a role to play in situations of armed conflict.

The IHL Program focuses on the following target groups:

- Australian Defence Force
- Australian Federal Police
- Non-government organisations
- Commonwealth Government agencies
- Key professions (law, medicine, journalism)
- Tertiary and secondary education sectors
- Wider community

The IHL Program specifically offers training programs to sectors of the Australian Defence Force such as military medics and military police, in addition to being invited to participate in Australian Defence Force training exercises. More broadly, we run education seminars for members of the general community who have an interest in humanitarian issues and whose work is affected by the application of IHL.

Red Cross has a mandate to promote an understanding of, and respect for, the law in times of armed conflict – international humanitarian law (IHL).

For more information on the IHL Program visit:
www.redcross.org.au/ihl

An IHL Officer from Australian Red Cross talks to Australian Defence Force personnel at HMAS Stirling,WA. Photo: Australian Red Cross

CRISIS CARE COMMITMENT

fundamental principles

Photo credit: The ICRC co-organised with the Egyptian Red Crescent Society a three-day workshop in Cairo, gathering together 40 local and international experts. The purpose of this workshop is to discuss how the security situation of health care providers can be improved during armed conflicts and other emergencies. Photo: ERC/ M. Saad

In all activities our volunteers and staff are guided by the Fundamental Principles of the Red Cross and Red Crescent Movement.

Humanity

The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and ensure respect for the human being. It promotes mutual understanding, friendship, co-operation and lasting peace amongst all people.

Impartiality

It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality

In order to continue to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence

The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary Service

It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity

There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality

The International Red Cross and Red Crescent Movement, in which all Societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

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THE POWER OF HUMANITY

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