

EMBARGO
UNTIL 10 AUGUST 2011



HEALTH CARE IN DANGER

MAKING THE CASE

**VIOLENCE AGAINST
HEALTH CARE MUST END**

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



ICRC

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Front cover: Atef Safadi

An ambulance fills with tear gas shot into it during a demonstration.

A VITAL CONCERN OF THE INTERNATIONAL RED CROSS AND RED CRESCENT MOVEMENT

During the afternoon of 7 January 2009, personnel from the International Committee of the Red Cross (ICRC) and the Palestine Red Crescent Society made a shocking discovery in a house in the Zaytun neighbourhood of Gaza City: four young children crouched beside the lifeless bodies of their mothers. The house had been shelled four days earlier, yet the ambulance teams had not been permitted to reach the victims. By the time they arrived, twelve corpses lay on the floor of the room and the children were too weak to stand. Soldiers at a nearby checkpoint had offered no assistance to the injured and ordered the ambulances to turn back once they reached the devastating scene. The ambulance crews disobeyed and rescued the survivors.

Less than one month later, in northern Sri Lanka, the Puthukkudiyiruppu hospital in the Vanni region was shelled, killing and wounding many of the 500 patients seeking treatment in the last functioning hospital of the war-torn north. The hospital compound sustained two direct hits and had to be evacuated. The patients were transferred to a community centre that had no potable water.

In September of the same year, soldiers entered the Ghazi Mohammed Khan Hospital in the Wardak province of Afghanistan late one night, searching for a wounded enemy combatant. Unsuccessful in their search, they rounded up the staff and ordered them to report the presence of "enemy fighters" seeking treatment. When the staff refused, citing medical ethics, the soldiers threatened them at gunpoint, saying they would be killed if they did not comply. Several members of the staff quit their jobs after this incident, too afraid to return to work.

And in December 2009, a man blew himself up at a university graduation ceremony in the Somali capital, Mogadishu, killing medical students who had studied hard to help pull their country from suffering and despair wrought by two decades of civil war. This was only the second batch of medical graduates to emerge in the last twenty years, depriving the Somali people of desperately needed doctors.

These four incidents from four different conflicts in 2009 represent the tip of the iceberg: attacks on health-care facilities, health-care personnel and medical vehicles, and impediments to the wounded and the sick reaching health-care services have become common in conflicts and upheavals all over the world. And they provoke far-reaching secondary consequences as health-care professionals flee their posts, hospitals close, and vaccination campaigns come to a halt. These knock-on effects leave entire communities without access to adequate services. Violence, both actual and threatened, against patients and health-care workers and facilities is one of the most crucial yet overlooked humanitarian issues of today.



forbidden as long as they retain a neutral function and treat all patients equally, irrespective of political, religious or ethnic affiliation. Protective symbols such as the red cross, red crescent and red crystal were introduced to clearly identify medical installations, vehicles and personnel as protected entities. These provisions, enshrined in the four Geneva Conventions of 1949 and their Additional Protocols and in customary international law, match the right to receive health care with an obligation on all parties to a conflict to search for and collect the wounded after battle, and to facilitate access to health-care facilities. Human rights law protects health care at all times, including during internal disturbances. These laws are binding on all States and parties to conflicts around the world. But they are not always respected.

In 2008, the ICRC launched a study to look at how violence affects the delivery of health care in 16 countries where it is operational. Reports of incidents were collected from a variety of sources, including health organizations, Red Cross and Red Crescent staff, and the media. These were analysed to identify the most serious forms of violence, which are presented in the following pages. But while the statistics paint a bleak picture of the widespread nature of the attacks on patients, health-care workers and facilities, and on medical vehicles, they fall short of capturing the full scope of the problem, particularly in areas inaccessible to aid organizations and reporters, such as many regions of Pakistan and Afghanistan. Furthermore, the statistics do not reflect the indirect and multiplier effects of these attacks as health-care facilities close and staff leave. Thus, this publication first looks at the general disruption to health care that occurs during conflict and civil strife, before looking more closely at specific types of violence.

Reaffirming Dunant's dream

Providing assistance to the wounded, regardless of the side on which they fought, is the idea that gave birth to the International Red Cross and Red Crescent Movement over 150 years ago on the blood-stained battlefield of Solferino, Italy. Henry Dunant, a Swiss businessman, witnessed the carnage of June 1859 and – horrified at the suffering – mobilized the local townsfolk to help the injured with no consideration as to whether they were from the Austrian or the French side. "Tutti fratelli" – they are all brothers – was the refrain as the 40,000 soldiers who lay wounded or dying were offered common decency as human beings: some water to quench their thirst, a clean bandage to dress a wound, a last word home so that a mother, wife or daughter would know what became of her son, husband or father.

From these humble beginnings emerged international law to assert the right of combatants and civilians alike – to be spared further suffering during armed conflict and to receive assistance. To assure this in practice, health-care facilities and personnel, and medical vehicles, had to be protected: attacks upon them are

THE COMPOUNDED COST OF VIOLENCE

Violence disrupts health-care services at the moment when they are needed most.

Armed conflict and internal disturbances – such as violent protests and riots – cause injuries among those directly participating and those who get caught in the way. Serious injuries require medical attention, yet it is precisely at these moments of greatest need that health-care services are most vulnerable to disruption, interference and attack. Violence, both actual and threatened, affects the delivery of health care in several ways.

First, active fighting in the vicinity of health-care facilities prevents access to them by the wounded and the sick, health-care staff, and vehicles carrying essential medicines and medical equipment to resupply these facilities. Fighting can also disrupt the flow of water and electricity, as well as fuel supplies for back-up generators. For instance, heavy fighting in the Ivorian capital, Abidjan, in March 2011, prevented ambulances from collecting the wounded, and the medical, humanitarian organization Médecins Sans Frontières (MSF) from resupplying Abobo Sud Hospital, the only functioning hospital in the northern half of the city. Dozens of wounded arrived at the hospital each day by whatever means they could, and medical stocks soon began to run low. The head of the MSF team, Dr Salha Issoufou, worried that “if this continues for a few more days, the hospital will run out of anaesthesia, sterile compresses, and surgical gloves.”



Abidjan's Abobo Sud Hospital, normally a 12-bed facility, held over 130 patients during the 2011 post-election violence.

Peter DiCampo/VII Mentor Program



André Liohm/ICRC

The main clinic in Misrata, Libya had to be evacuated when it was taken over to be used as a military base.

Second, violence can set off the displacement of civilians, including health-care personnel and their families, to safer areas. Iraq's health ministry reported that 18,000 of its 34,000 doctors fled the country between 2003 and 2006. Libya has also been affected by the exodus of health-care professionals since unrest began in early 2011 because a large percentage of the medical workforce, particularly nurses, were migrant workers. When foreign governments ordered their nationals to evacuate the country in February, many vital medical facilities, such as hospitals in Benghazi and Misrata, were left critically understaffed. The shortage of personnel not only affects those wounded in the fighting, but also Libyans suffering from chronic illnesses that require regular care.

Third, violence hampers the implementation of important preventive health-care programmes (such as vaccination campaigns), which might have implications long into the future. The fight to eradicate polio, for example, has faced setbacks in countries like Afghanistan, Pakistan and the Democratic Republic of the Congo, where the safety of vaccination teams is difficult to assure. Furthermore, conflict causes the displacement of people to areas that are often beyond the reach of regular health-care systems, just at the moment when they are most vulnerable to disease.

These disruptions to health care caused by violence are less visible and more difficult to measure than overt attacks against health-care personnel and facilities. But they are just as deadly for all the wounded and sick who never manage to reach the help they require.

SECURING ACCESS IN THE FIGHT TO ERADICATE POLIO

For over twenty years, major efforts have been under way to eradicate the devastating disease of poliomyelitis. Enormous progress has been made in reducing the transmission and number of cases worldwide, but violence in a few key countries is a major obstacle to its total elimination. In two of the four countries with endemic polio – Pakistan and Afghanistan – vaccination coverage is hampered by fighting and/or a lack of security guarantees that would enable vaccination teams to reach all areas of polio transmission. Military offensives also cause population displacements that can spread the disease from infected to uninfected areas: the province of Punjab in Pakistan, which had been polio-free for two years, experienced an outbreak in 2008 following the influx of people fleeing violence in the province of Khyber Pakhtunkhwa and in the Federally Administered Tribal Areas. Hundreds of thousands of children remain beyond reach in parts of Afghanistan and Pakistan.

In 2007, the Afghan health ministry and the World Health Organization asked the ICRC to use its unique contacts with the armed opposition in Afghanistan to negotiate safe passage for polio vaccinators. Although some areas remain inaccessible, the opposition's agreement to this plan enabled the country-wide vaccination campaigns to resume and coverage has dramatically increased.

“One of the first victims of war is the health-care system itself.”

Marco Baldan, the ICRC's chief war surgeon



A doctor surveys the rubble left in the Adnan Khairallah Hospital in Baghdad after it was hit by a missile.

Karim Sahib/AFP Photo

VIOLENCE AGAINST HEALTH-CARE FACILITIES

Violence includes bombing, shelling, looting, forced entry, shooting into, encircling or other forceful interference with the running of health-care facilities (such as depriving them of electricity and water).

Health-care facilities include hospitals, laboratories, clinics, first-aid posts, blood transfusion centres, and the medical and pharmaceutical stores of these facilities.

Attacks on health-care facilities during armed violence and internal disturbances tend to fall into four main categories. The first is the deliberate targeting of such places to gain military advantage by depriving opponents and those perceived to support them of medical assistance for injuries sustained. Some attacks might also be intended to terrorize a local population by targeting a protected facility. Occasionally, attacks have been mounted to rescue wounded comrades detained while being treated in hospital: the attack on Jinnah Hospital in Lahore, Pakistan, in June 2010 aimed to free a wounded militant captured after a mosque bombing that killed over 80 worshippers. Three gunmen dressed as police officers entered the hospital and opened fire indiscriminately, killing medical personnel, visitors and security guards.

The second category of attack is also deliberate, but this time for political, religious or ethnic reasons rather than for military advantage *per se*. Such assaults against health-care facilities include the burning down of an Uzbek-run clinic in Kyrgyzstan during ethnic violence in June 2010; the cordoning off and military takeover of Salmaniya referral hospital in Bahrain in early 2011 after it was perceived to support the cause of anti-government protesters; and the explosion at a hospital in Karachi in February 2010 that targeted survivors of an earlier sectarian attack on a bus carrying members of a minority Shiite sect.

The third type of attack is unintentional bombardment or shelling – “collateral damage” from a missile or mortar aimed at a military target. This occurs most frequently when military operations are carried out in densely populated, urban areas. Those firing the weapons are supposed to take all feasible precautions to distinguish between legitimate and illegitimate targets, but conflicts in Libya, Sri Lanka, Somalia, the occupied Palestinian territory, Lebanon, Yemen and Rwanda have all seen serious damage to health-care facilities that was claimed to be in error. The risk to health-care facilities rises with their proximity to military installations. Although it is hard to believe, the twelve shells that landed on Medina Hospital in Mogadishu on 12 April 2011 were not intended for the clearly marked hospital, but targeted officials of

the Somali Transitional Federal Government (TFG) attending a high-level military event not far away. Miraculously, eleven of the shells did not explode, but the one that did injured two guards and sowed panic among patients and staff. Some shells did reach their target, though, killing at least three people at the TFG’s military headquarters.

The fourth and perhaps most common form of violence committed against health-care facilities is the looting of drugs and medical equipment. Occasionally, the motive might be to obtain medical supplies for injured combatants too afraid to enter a facility, but purely criminal motives are more common. Baghdad in 2003 saw the pillage of medical facilities and destruction of infrastructure and supplies on an enormous scale, which brought the whole medical system in Baghdad to virtual collapse. Hospitals were forced to close and the wounded and dying left unattended.

The misuse of health-care facilities

Health-care facilities retain their protected status as long as they are exclusively devoted to the care of the wounded and the sick and are not used to advance military goals. Unfortunately, there have been many occasions when the neutrality of a health-care facility has been compromised through its use to store weapons or launch attacks. For instance, hospitals have been used as cover in inter-Palestinian violence, putting patients and hospital staff in great danger of being caught in the crossfire. Reports from Libya suggest that the Ajdabiyah Hospital was used as cover for snipers. The presence of armed combatants inside a medical facility for other than medical reasons also compromises its protected status. In August 2009, a group of armed insurgents entered a clinic in the province of Paktika in Afghanistan, seeking treatment for their wounded commander. They exchanged gunfire with army personnel outside until a helicopter gunship fired rockets into the clinic, killing all but one of the insurgents and burning the male ward to the ground.

THE ICRC HOSPITAL IN KIGALI: AN ISLAND OF HUMANITY IN A SEA OF INHUMANITY

An extraordinary example of success in ensuring respect for the sanctity of a hospital, its personnel and patients, occurred in the Rwandan capital, Kigali, during the 1994 genocide. As the organized slaughter of the Tutsi minority and those deemed to support them continued relentlessly for three months, the ICRC and MSF teams saved ten thousand lives in a compound protected only by the Red Cross flag. They ventured onto the streets to collect the wounded, with only their badge, their courage and the strength of their arguments to prevent the wounded from being torn from the back of ambulances. The hospital was threatened several times, and was damaged by rocket fire more than once, but was never forcibly entered by those scouring the city for more victims. It even inspired some killers to stop: before fleeing the city when they knew they were defeated, some militiamen brought a Tutsi nurse they had held for the last three months to the hospital to release her. “We have decided not to kill her despite the fact that she is a Tutsi,” they said to the head of the ICRC’s delegation, Philippe Gaillard. “As a nurse she will be more useful in your hospital than dead.”



Patients had to be moved to the basement of this hospital after the building was partly destroyed.

Dmitry Kostyukov/AFP Photo

WHAT THE LAW SAYS:

- Health-care facilities shall be respected and protected at all times and shall not be the object of attack.
- Protective emblems such as the red cross, red crescent and red crystal identifying medical units shall be respected in all circumstances.
- Small arms are permitted in health-care facilities for the purpose of self-defence or defence of the wounded and the sick (against bandits, for example). The presence of all other weapons compromises the neutral status of a facility.
- Health-care facilities lose their protection if they are used to commit “acts harmful to the enemy.”
- “Acts harmful to the enemy” include the use of health-care facilities to shelter able-bodied combatants, to store arms or ammunition, as military observation posts or as a shield for military action.

VIOLENCE AGAINST THE WOUNDED AND THE SICK

Violence includes killing, injuring, harassing and intimidating patients or those trying to access health care; blocking or interfering with timely access to care; the deliberate failure to provide or denial of assistance; discrimination in access to, and quality of, care; and interruption of medical care.

The wounded and the sick include all persons whether military or civilian who are in need of medical assistance and who refrain from any act of hostility. This includes maternity cases, newborn babies and the infirm.

One of the worst recorded cases of assault on the wounded and the sick occurred in November 1991 in the Croatian town of Vukovar. The same day that the ICRC secured agreement on the neutral status of the hospital, 300 patients and their relatives were forced onto buses: the bodies of 200 were later found in a mass grave and 51 individuals are still missing today. The execution of patients in ambulances or health-care facilities has also occurred in Sierra Leone, Colombia, Lebanon, the Democratic Republic of the Congo and the occupied Palestinian territory, and in gang-related violence in Mexico. It is also alleged to have occurred in Libya. In September and October 2000, tit-for-tat executions of patients in ICRC ambulances in Colombia, first by paramilitaries and then by rebels, led to the ICRC suspending its role in the evacuation and transfer of patients until it received guarantees that its ambulances and patients would be respected.

More common than these deplorable attacks are the impediments placed in the way of wounded and sick people having rapid access to health care. Sometimes access is deliberately blocked, but most impediments take the form of road closures and checkpoint delays for security reasons. No matter how valid the security concerns, lengthy delays at checkpoints while vehicles

“They entered through the parking lot, ordered us at gunpoint to lie on the ground, then shot dead the patient on the stretcher and left again as if nothing had happened.”

Red Cross volunteer describing the execution of a patient on Red Cross premises

are searched and passengers questioned can cost lives. And bypassing the queue can be perilous: stories abound in Iraq and Afghanistan of vehicles being shot at as they tried to circumvent the queue. Roads are sometimes closed for hours on end during sweeping operations for explosive devices or following security incidents, with sometimes dire consequences. A girl injured by an explosion in Chahar Dara district of Kunduz province in Afghanistan died soon after arriving at hospital on 3 February 2010: she had been carried on foot for an hour because the military had closed the road.



Gunmen pulled over this ambulance to kill a police commander who was being transported to hospital.

Under international humanitarian law, no one may be left wilfully without medical assistance and care.





Wounded civilians are evacuated by ferry from Puttumatalan to Trincomalee in Sri Lanka.

Sometimes the military and law enforcement agencies want to arrest or detain a patient for questioning, which is a perfectly legitimate demand. But the detaining authorities have an obligation to ensure the continuity of medical care for the patient, something that is difficult in contexts where detention facilities lack proper health-care services. In Afghanistan and Pakistan, the local authorities have been receptive to the ICRC's requests to prioritize treatment over interrogation, permitting the wounded to see a doctor before being questioned. But other contexts are more challenging: four of MSF's patients were removed from its Katanga health-care centre in south Kivu in the Democratic Republic of the Congo by soldiers in March 2010, despite protests by the MSF surgeons that their medical condition advised against it.

In some contexts, the wounded and the sick face discrimination in access to, and quality of, health care. Although prohibited by international humanitarian law and human rights law, as well as contrary to medical ethics, health-care personnel have refused to treat, or given inferior treatment to patients on the basis of their ethnicity, religion or political affiliation. This occurred

during ethnic violence in Kyrgyzstan and Rwanda, during periods of political tension such as in Zimbabwe and Lebanon, and in countries where minorities are oppressed, such as the Muslim Rohingyas in Myanmar. In recent unrest in Bahrain, Syria and Yemen, protesters have been too afraid to use medical facilities for fear that their wounds will identify them and provoke harsh reprisals.

One final violation of the rights of the wounded and the sick that frequently occurs in armed conflict – but is difficult to document – is the failure of combatants to search for, assist, and evacuate the wounded. The incident in Gaza described above, where checkpoint soldiers ignored the cries of the wounded, the dying and their distraught children, is not an isolated case. In conflicts all over the world, combatants overlook their responsibility to care for civilians caught in the crossfire. Invariably, it is relatives and neighbours who bring civilian casualties to hospital, not men and women wearing uniforms or bearing weapons. And these relatives and neighbours are as vulnerable as any patient to attacks and discrimination on the way to and in health-care facilities.

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WHAT THE LAW SAYS:

The four Geneva Conventions of 1949 and their Additional Protocols of 1977 contain the following rules:

- The wounded and the sick, as well as the infirm, and expectant mothers, shall be the object of particular protection and respect.
- The wounded and the sick must be protected against ill-treatment and pillage.
- No one may be left wilfully without medical assistance and care.
- Whenever circumstances permit, and particularly after fighting, each party to a conflict must, without delay, take all possible measures to search for, collect and evacuate the wounded and the sick without adverse distinction between them.
- The special role of the ICRC is recognized in facilitating the establishment of neutralized zones to protect the wounded, the sick and civilians from the effects of war.
- Parties to a conflict have the first obligation to care for the wounded and the sick. Any care provided by the local population, humanitarian organizations or other third parties does not relieve the parties of their obligations.

Human rights law, in accordance with the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and several other conventions, affirms that:

- Everyone has the right to life. States must refrain from deliberately withholding or delaying health care to the wounded and the sick in life-threatening circumstances.
- Whenever the use of force is unavoidable, law enforcement officials must ensure medical assistance to those affected as early as possible.
- Everyone has a right to the highest attainable standard of physical and mental health. States must provide at least essential primary health care.
- Everyone has a right of access to essential health-care facilities and services on a non-discriminatory basis. States must refrain from arbitrarily denying or limiting such access, for instance, against political opponents.
- States must take active measures to enable and assist individuals to enjoy their right to health.

TREATING EVERYONE, WITHOUT DISCRIMINATION

In two of the world's most dangerous places, Somalia and Pakistan, the personnel in ICRC-supported hospitals make no distinction among patients according to the side on which they fought. In the tense atmosphere of Pakistan, it took one year of negotiations and several setbacks to ensure the neutral status of the hospital in Peshawar. In Somalia's Medina and Keysaney Hospitals, the personnel do not ask patients questions about their clan or political allegiance. In October 2009, pamphlets showing pictures of grenades and handguns were thrown into the compound of Medina Hospital, warning the staff to stop treating "the enemy." But the hospital director, Mohammed Yusuf, said that the threat would not change the way they worked. "People need to understand that health-care workers are neutral and provide treatment to everyone, even the ones writing the leaflets and their relatives."



After being attacked, Mohammed Yusuf, director of the Medina Hospital in Mogadishu, is now guarded 24 hours a day.



A doctor cries for four of his colleagues – a doctor, an ambulance driver and two nurses – who were killed by an air strike on the road between Ajdabiyah and Brega in Libya.

VIOLENCE AGAINST HEALTH-CARE PERSONNEL

Violence includes killing, injuring, kidnapping, harassment, threats, intimidation, and robbery; and arresting people for performing their medical duties.

Health-care personnel include doctors, nurses, paramedical staff including first-aiders, and support staff assigned to medical functions; the administrative staff of health-care facilities; and ambulance personnel.

Health-care personnel face many challenges working in situations of armed conflict and other violence, having to adapt standards of care to the resources available and dealing with large influxes of patients requiring immediate life-saving attention. Beyond these professional challenges often lie grave dangers associated with the nature of their work.

Iraq has been the site of some of the worst attacks against health-care professionals. In 2008, the Iraqi health ministry estimated that over 625 medical personnel had been killed since 2003. Many doctors were deliberately targeted in a spate of killings in 2007 that claimed the lives of physicians like Ibrahim Mohammed Ajil, head of a Baghdad psychiatric hospital, who was shot dead on his way home by men on a motorcycle. Hundreds more doctors have received death threats or been kidnapped – sometimes for ransom, but sometimes for political or religious reasons. Over half the country's doctors have fled abroad; many of those who stay are forced to live in the hospitals where they work, to avoid the risky journey home each day.

Violence against health-care personnel is also common in Afghanistan, where they are exposed to threats, harassment and attacks. Dozens of health-care staff have been abducted, sometimes for ransom payments and other times for their skills, for treating wounded fighters who fear arrest if seeking treatment in a government clinic. During the long war in Sri Lanka, doctors and other health-care personnel were threatened and killed for "treating the enemy." In December 2008, half of the doctors working in Vavuniya received anonymous death threats in a letter posted from Colombo, which said that a Tamil doctor would die in revenge for the death of a Sinhalese doctor in Batticaloa.

Although local health-care personnel bear the brunt of the threats and assaults, the staff of foreign aid organizations have on occasion been specifically targeted. In December 1996, six expatriate staff members working in the ICRC field hospital in Novye Atagi, Chechnya, were assassinated, at point-blank range while in bed, in a premeditated attack on the hospital premises. A seventh delegate was shot and left for dead but survived. The assassins had silencers on their guns and clearly aimed to kill all the expatriate staff members,

but stopped when the alarm was raised. Four nurses, a hospital administrator and a construction technician were among the dead. The ICRC suspended operations throughout Chechnya and handed over responsibility for the hospital to the Chechen health ministry.

Perhaps the most dangerous job in the field of health-care during armed conflict is that of the first-aiders and medics who go to the front line to provide immediate life-saving assistance to the injured and evacuate them to safety. They risk being directly targeted, caught in the crossfire of an unfinished battle, or injured by unexploded ordnance scattered around the area. Between 2004 and 2009, 57 volunteers from the International Red Cross and Red Crescent Movement were killed or wounded in the line of duty. Such incidents are not limited to situations of armed conflict: in 2010, fear among health-care workers in Mexico led them to strike to demand a halt to violence. Health-care personnel in many parts of the country are increasingly reluctant to treat victims of gunshot wounds suspected of belonging to criminal gangs for fear of being caught in the midst of further violence.



Health-care personnel who give life-saving assistance to the injured are often at risk themselves.

On occasion, health-care personnel have also been arrested for carrying out their professional responsibilities to treat all in need regardless of who they are and what they have done. Three doctors who had been working in northern Sri Lanka were detained in mid-2009; Red Crescent volunteers in Yemen were detained on suspicion that they sympathized with protesters during the unrest in early 2011; and in Bahrain, 47 doctors and nurses who treated protesters have been detained in sweeping arrests of health workers that followed the crackdown on protesters and face trial in a military court on a range of other accusations.

Even during peacetime, health-care personnel in many countries face unacceptable threats from patients and their relatives related to the quality of health care delivered. One study carried out in six Lebanese hospitals in 2009 found that 80 percent of the emergency room staff had been verbally abused and 25 percent physically assaulted over the past 12 months. More than two-thirds of the perpetrators were relatives or friends of patients. This tendency is exacerbated during the heat of war: emergency rooms and operating theatres were invaded by gun-toting fighters in Somalia and Iraq, demanding that their friend, relative or comrade be treated immediately.

“I have no doubt that one missile was aimed at us. I do not know for certain whether it was meant to kill us or warn us to keep away, but it was definitely aimed in our direction.”

Palestinian Red Crescent ambulance driver Khaled Abu Saada

WHAT THE LAW SAYS:

- Health-care personnel, whether military or civilian, may not be attacked or harmed.
- Health-care personnel shall not be hindered in the performance of their exclusively medical tasks.
- Parties to a conflict shall not harass or punish health-care personnel for performing activities compatible with medical ethics, nor shall they compel them to perform activities contrary to medical ethics or to refrain from performing acts required by medical ethics.
- Medical personnel may not be required to give priority to any person except on medical grounds. Medical personnel decide, in accordance with medical ethics, which patient receives priority.
- The protection of medical personnel ceases when they commit, outside their humanitarian function, acts harmful to the enemy.

SAFER ACCESS FOR HEALTH-CARE WORKERS IN COLOMBIA

The remote village of Santa Cruz in south-eastern Colombia is littered with landmines and other explosive remnants of war. The only health-care worker in this village risks her life and limbs every time she ventures from the health-care centre to conduct a home visit or make a round of vaccinations with her cool box. “Everyone walks at their own risk here,” she says with a smile that hides her unease. She is well aware of the repercussions for herself and for the whole community were she to put her foot in the wrong place. To improve her safety and that of thousands like her all around Colombia, the ICRC’s weapons contamination team trains health-care workers in techniques to help them avoid driving over or stepping on explosive devices. They learn what to look out for and what to do when hit by, or in the midst of, these deadly objects. The ICRC also talks to all sides in the conflict about the consequences of these weapons for civilians.





VIOLENCE AGAINST MEDICAL VEHICLES

Violence includes attacks upon, theft of and interference with medical vehicles.

Medical vehicles include ambulances, medical ships or aircraft, whether civilian or military; and vehicles transporting medical supplies or equipment.

The final example of violence affecting the delivery of health care concerns attacks against medical vehicles. There is, of course, considerable overlap in the law protecting health-care facilities, health-care personnel and medical vehicles, and similarities in the types of attack directed against them. Nevertheless, the sheer number of attacks on medical vehicles, and their more frequent misuse to trick the enemy, warrants their discussion as a separate subject.

Circulating in the midst of conflict to collect and assist the wounded, ambulances sometimes come under fire, both accidental and deliberate. The Libyan Red Crescent reported that over one four-day period in May 2011, three of its ambulances were hit in three separate incidents, resulting in the death of a nurse and injuries to a patient and three volunteers. Another volunteer was killed in Zlitan. Such a toll is reminiscent

of the conflict in Lebanon in 2006, when on one day, 11 August, two ambulances came under attack in separate incidents. One Lebanese Red Cross ambulance that was attacked from the air while transporting supplies from Tyr to Tibnine caught fire, injuring the paramedics aboard; another was shot at in the Marjayoun region when coming to aid victims of an air attack. A Lebanese Red Cross paramedic was shot dead in the second incident.

Attacks on ambulances have also occurred in the occupied Palestinian territory, Colombia, Mexico, Yemen, Iraq and Libya, and in Nepal during the conflict from 1996 to 2006. Some of the deliberate attacks and many of the impediments and delays imposed upon ambulances in Libya, the occupied Palestinian territory, Afghanistan and Nepal were due to mistrust of the ambulance service that stemmed from its misuse in the past. Not all misuse is intended to cause harm: in Nepal, ambulance drivers complain of politicians using ambulances as a private taxi service or of others riding in them to avoid being inconvenienced by roadblocks during general strikes that paralyse the country. But some armed groups engage in perfidy – the deliberate misuse of the medical mission to fool the enemy. In Afghanistan, the armed opposition sent ambulances packed with explosives across security

cordons. The ICRC publicly denounced this grave violation of international humanitarian law following the 7 April 2011 “ambulance” attack on a police training centre in Kandahar that killed twelve people. A Taliban spokesman pledged to conduct an inquiry in response and said that such attacks would not happen again. In Libya, the ICRC is also receiving allegations of the misuse of the red cross and red crescent emblems to support military operations and the use of ambulances to transport arms and armed combatants.

The abuse of trust that occurs through the misuse of the protective emblems, and of protected facilities and vehicles, can spiral into a vicious circle that undermines the whole purpose of creating neutral entities in conflict. When ambulances are misused, whether to trick the enemy or for some other purpose, they fall under suspicion and are, at best, subjected to the same delays and impediments as other vehicles or, at worst, become the object of attack. In both instances, they lose the advantage meant to preserve life in conflict, to the detriment of the wounded and the sick who require urgent medical attention.

AMBULANCES IN MEXICO: CAUGHT IN THE CROSSFIRE

Over the last few years, drug-related gang violence has claimed thousands of lives across Mexico. As violence increases, so does the demand for ambulance services. The Mexican Red Cross operates around 80 percent of all the emergency ambulances in the country and sometimes finds itself caught in the crossfire between rival gangs or between the police and gangs, when trying to evacuate the victims. “There has never been direct aggression against the Mexican Red Cross,” said the Sinaloa branch coordinator, Valentin Castilla Astrada. “The groups see us as an organization that wants to help, not as being for one side or another.” Nevertheless, the ambulance crews live in constant fear of being caught in the middle. “We never know when something is going to happen to us,” said the deputy coordinator of the Ciudad Juarez branch of the Mexican Red Cross. “We are really afraid. Before, we just had to worry about the sick or someone injured in an accident. We worked in security. But now everything has changed. When a car approaches the scene we are scared that something will happen.” The ICRC is helping the Mexican Red Cross to review its current procedures and practices and introduce new ways to assure the safety of these dedicated ambulance crews.

“By violating the neutrality of health-care services, such acts of deception endanger medical personnel engaged in caring for the injured and sick in hospitals, clinics and rural health posts.”

From the ICRC statement condemning the use of an ambulance in the 7 April 2011 attack in Afghanistan

WHAT THE LAW SAYS:

- Medical vehicles shall be respected and protected at all times and shall not be the object of attack.
- Medical units may not be used to launch attacks or to shield fighters or other military objectives from attack.
- Medical vehicles cease to be protected when they are used, outside their humanitarian function, to commit acts harmful to the enemy.
- Examples of “acts harmful to the enemy” include the transport of healthy troops, arms or munitions, as well as the collection or transmission of military intelligence.
- Examples of acts not harmful to the enemy include the carrying of light arms by medical personnel for use in self-defence or arms that have just been taken from the wounded.
- Isolated incidents implicating medical personnel, facilities or vehicles in “acts harmful to the enemy” do not entitle armed actors to attack them indiscriminately. A warning and reasonable time limit must be given before an attack is launched. An attack must also respect the principles of distinction and proportionality.



Amnon Gutman/ICRC

WHAT THE ICRC DOES

The ICRC mounts emergency responses to outbreaks of conflict around the world: this includes a range of medical activities, from collecting the wounded to war surgery. It also undertakes many initiatives behind the scenes – both immediate during conflict and longer-term during peacetime – to create an environment of respect for the work of the International Red Cross and Red Crescent Movement and for international humanitarian law.

LEGAL INITIATIVES

> The ICRC spreads knowledge of international humanitarian law among military personnel, government officials, non-State opposition groups, influential members of civil society, and the medical establishment. It encourages States to incorporate international humanitarian law into domestic legislation and enforce respect for it. This includes laws to restrict use of the red cross and red crescent emblems. It also spreads knowledge of the rules protecting health-care facilities and of the obligations of weapon-bearers and medical personnel to avoid compromising the neutrality of these facilities.

> The ICRC appeals to all parties to a conflict to prevent obstruction of health care and respect and facilitate the work of health-care personnel and volunteers.

> The ICRC engages in dialogue with all parties to a conflict regardless of whether they are considered “legitimate” or not by the opposing side. It brings allegations of violations of international humanitarian law to the parties concerned and engages in confidential dialogue on measures to prevent such violations in the future.

PRACTICAL INITIATIVES

> The ICRC negotiates ceasefires or safe passage with parties to a conflict to organize the collection of the wounded and dead, access to health care, or preventive health programmes such as vaccination campaigns. It also negotiates a “fast track” for ambulances through checkpoints in some contexts, such as the occupied Palestinian territory.

> It reinforces the physical integrity of health-care facilities through the placement of sandbags, building of bunkers and application of bomb-blast film to windows.

> The ICRC marks health-care facilities with a red cross or red crescent emblem (flags, roof painting) and equips health-care centres with signs barring weapons inside. In some contexts, like Somalia, it establishes a system for the collection and retrieval of weapons at the hospital entrance. It also equips health-care personnel with aprons to signify their protected status.

> The ICRC takes the GPS (Global Positioning System) coordinates of health-care facilities and provides these to all parties to a conflict.

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> It conducts first-aid training for various groups exposed to violence to enable them to stabilize patients before their arrival in a health-care facility. The ICRC may also take this opportunity to discuss directly with combatants the importance of respecting international humanitarian law.

> In places where violence against health-care workers and facilities is a frequent occurrence, the ICRC runs information campaigns such as a radio series with the BBC Trust Fund in Afghanistan and a poster campaign in the occupied Palestinian territory.

> The ICRC accompanies the sick and the wounded to hospital if they fear discrimination.

> It mounts mobile health-care services in areas that are difficult of access: such as the flying surgical team in Darfur that operated from 2005 to 2009 or the mobile clinics transported by canoe to remote areas in Colombia.

> The ICRC conducts “safer access” campaigns with the National Societies of countries facing conflict and other violence to increase awareness of ways to minimize the danger when accessing potentially dangerous areas. Work is also done on improving local knowledge and public perception of the National Society’s role and function.

> The ICRC addresses specific problems, such as impediments to ambulances, with all those concerned. For instance, to improve the reputation of, and increase respect for, ambulance services in Nepal, the ICRC holds periodic meetings with ambulance services, the National Society, and State and non-State actors to iron out misunderstandings and to reiterate the roles and responsibilities of ambulance drivers, political parties, and the people manning checkpoints.



Thomas Pizer/ICRC



Pancho Duda/ICRC



Boris Heger/ICRC



Juan Carlos Sierra/Semana News

WHAT NEEDS TO BE DONE

Violence, both real and threatened, against health-care workers, facilities and beneficiaries must be recognized as one of the most serious and widespread humanitarian concerns of today. As this booklet has shown, there is an urgent need to secure the safety of the wounded and the sick, and of health-care personnel, health-care facilities and medical vehicles during armed conflict and other violence. More must be done to ensure that the wounded and the sick have timely access to health care and that the facilities and personnel to treat them are available, adequately supplied with medicines and medical equipment, and secure. Safeguarding health care cannot be addressed by the health-care community alone. Primary responsibility for it lies with politicians and combatants.

To increase awareness of this issue and generate action to improve it, the ICRC is seeking support for the following initiatives:

1. Building a community of concern

The ICRC aims to mobilize support for this issue from within the International Red Cross and Red Crescent Movement and among the health-care community, medical aid organizations, military forces, and governments around the world. Working together to enhance respect for the law, this community should cultivate a culture of responsibility among all concerned to safeguard health care.

2. Regular and methodical information gathering

In order to better understand and react to attacks on patients, health-care workers and facilities, and medical vehicles, reports of incidents should be more systematically collected and centralized with the data of other organizations.

3. Consolidating and improving field practices

The ICRC has undertaken many initiatives to improve access to and safeguard health care in the various contexts in which it is working. Experiences and best practice need to be shared more widely within the International Red Cross and Red Crescent Movement and broader health-care community to encourage more and better initiatives on this front.

4. Ensuring physical protection

Hospitals and other health-care facilities in countries affected by armed conflict or other violence will be assisted in organizing the physical protection of the premises and in developing procedures for notifying others of their location and of the movements of their vehicles.

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

The ICRC will encourage greater involvement of Red Cross and Red Crescent staff and volunteers in collecting data on, and responding to, threats to patients, health-care staff, volunteers, health-care facilities and medical vehicles.

6. Engaging with States

All States that have not yet introduced domestic legislation to safeguard health care in situations of armed conflict and internal strife will be encouraged to do so. This includes enacting and enforcing legislation on limiting use of the red cross and red crescent emblems.

7. Engaging with national armed forces

All national armed forces that have not yet incorporated provisions into their standard operating procedures with respect to safeguarding health care will be encouraged to do so. These standard operating procedures must address, among other issues, management of checkpoints to facilitate the passage of medical vehicles and entry into health-care facilities.

8. Engaging with non-State armed groups

Armed groups operating outside the purview of the State will be engaged in dialogue on laws and practices pertaining to safeguarding health care.

9. Engaging with professional health-care institutions and health ministries

Increase dialogue with health ministries and health associations to generate solidarity on this issue and improve reporting on, and responses to, violence against health-care workers, facilities and beneficiaries.

10. Encouraging interest in academic circles

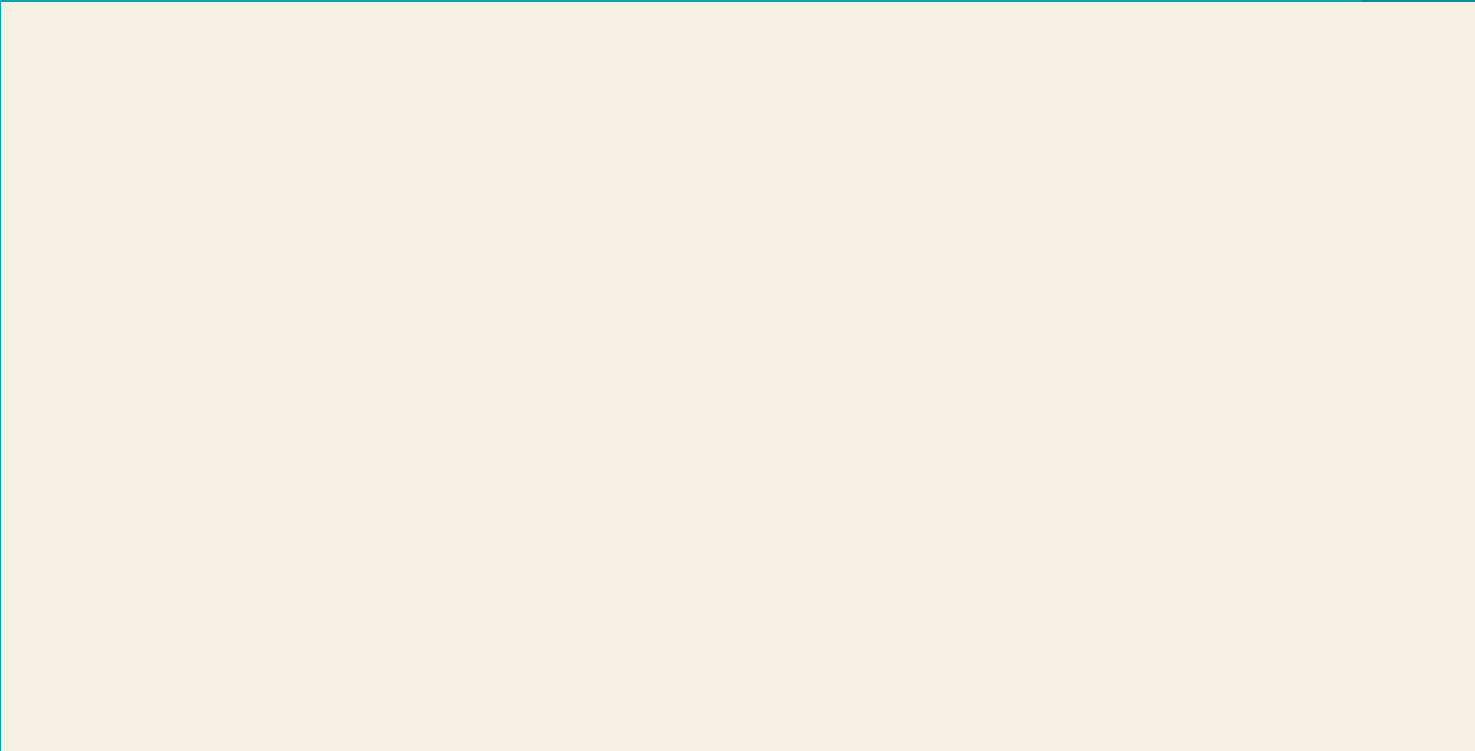
Assist universities, other educational institutions and think tanks to incorporate modules on the implications of, and means to address, violence against patients and health-care workers and facilities into courses in public health, political science, law and security studies.



MISSION

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

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