HEALTH CARE IN DANGER

THE RESPONSIBILITIES OF HEALTH-CARE PERSONNEL WORKING IN ARMED CONFLICTS AND OTHER EMERGENCIES

VIOLENCE AGAINST HEALTH CARE MUST END

IT'S A MATTER OF LIFE & DEATH

ICRC

REFERENCE

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PREFACE

The mandate of the International Committee of the Red Cross (ICRC)[1] is to assist and protect victims of armed conflict and internal strife, and to "take any humanitarian initiative which comes within its role as a specifically neutral and independent institution."[2] No activity is more representative of this mandate than the provision or promotion of health care for the wounded and sick – sometimes, in the most difficult circumstances.

The suffering and loss of dignity caused by being wounded or falling sick in armed conflicts and other emergencies can and must be minimized by effective and impartial health care. The ICRC has considerable experience in assuring the full range of health care for the wounded and sick in such situations, from first aid and hospital care to rehabilitation. The personnel who have accumulated this experience have not only delivered health care, but have also learnt that its delivery during armed conflicts and other emergencies creates new dilemmas and responsibilities. It should be noted that the accompanying rights of health-care personnel are not entirely fixed: they can, depending on the circumstances, vary.

Health-care personnel should have a sound grasp of their responsibilities and their rights; they should also understand how these may change according to whether or not

1 Statutes of the International Red Cross and Red Crescent Movement, Art. 5 (2) (d).

2 While taking such a humanitarian initiative, it "may consider any question requiring examination by such an institution." See Statutes of the International Red Cross and Red Crescent Movement, Art. 5 (3).

the situation in question constitutes an armed conflict. This understanding should empower any dialogue with the authorities concerned and armed actors.

In 1982, the ICRC published *A Manual on the Rights and Duties of Medical Personnel Working in Armed Conflic*t by Dr Alma Baccino-Astrada.[3] This valuable work has served as a source of reference for health-care personnel working in armed conflicts throughout the world. However, traditional armed conflicts, involving two military adversaries, are now rare. Contemporary armed conflicts and other emergencies, such as urban violence and widespread rioting, all by their nature involve armed actors *and* civilians, especially when "insurgents" hide themselves amongst the population. The wounded and sick – whether military or civilian – may find it difficult to gain access to the health-care facilities on which they normally depend. In these contexts, there is a risk that the right of the wounded and sick to effective and impartial health care may be violated for political or "security" reasons; for example, doctors and nurses may be ordered not to treat wounded fighters from one party to a conflict. Currently, the armed actors in a number of armed conflicts and other emergencies do not respect this right, even though it is derived from the essential notion of humanity, which is the basis of international humanitarian law (humanitarian law) and international human rights law (human rights law). In parallel, health-care personnel have to take into account a number of complex ethical considerations. Clearly, an up-to-date guide for health-care personnel working in armed conflicts and other emergencies is needed. The ICRC hopes that this guide will, to a great extent, fulfil this need, encourage health-care personnel to recognize their role in upholding humanitarian law and human rights law and contribute to the discussion about health-care ethics in armed conflicts and other emergencies.

3 A. Baccino-Astrada, *A Manual on the Rights and Duties of Medical Personnel Working in Armed Conflict*, ICRC, Geneva, 1982.

Although this guide is aimed at health-care personnel working in armed conflicts and other emergencies, the real issue, ultimately, is the violence, both real and threatened, against health-care personnel and facilities. This cannot be addressed adequately by health-care personnel. It is in the hands of authorities and other armed actors: they bear the responsibility for ensuring that the wounded and sick are searched for, collected, protected and cared for. And that responsibility extends to ensuring the security of every aspect of health care.

Yves Daccord
Director-General, ICRC

ABOUT THIS GUIDE

This guide is intended to help health-care personnel adapt their working methods to the exigencies of armed conflicts and other emergencies. The provision of health care in these circumstances can give rise to many unforeseeable dilemmas. The guide cannot provide answers to such dilemmas; it should, however, provoke reflection, ease the making of decisions, fuel discussion and, ideally, provide guidance for practice in the most difficult circumstances.

It may be difficult to discuss the subjects dealt with in the guide during an armed conflict or other emergency. Health-care personnel should consider their responsibilities in armed conflict or other emergencies *in advance*; that is, before they take on the responsibility of caring for the wounded and sick. It is essential that time and consideration be given to these issues beforehand. For all health-care personnel, this should be part of their training and practice.

Doctors, nurses, paramedics, physiotherapists, dentists, hospital administrators, porters, ambulance drivers, and humanitarian aid workers: these are only some of the people at whom the guide is aimed. This inclusive approach reflects the broad definition of "medical personnel" in humanitarian law.[4] It must be noted that this definition includes both military and civilian health-care personnel.

4 Art. 8 (c) of Protocol I of 8 June 1977 additional to the four Geneva Conventions (Additional Protocol I) states: "'Medical personnel' means those persons assigned, by a Party to the conflict, exclusively to the medical purposes enumerated under [sub-paragraph] (e) or to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either permanent or temporary."

Much of the guide is also applicable to first-aiders.

The guide pertains to the delivery of effective and impartial health care to people who are wounded or sick as a result of having taken part in, or who have been directly affected by, armed conflicts or other emergencies; it does *not* cover the many complex issues related to the health of people detained in these circumstances.

No guide for health-care personnel working in armed conflicts or other emergencies would be complete without a consideration of the responsibility to look after oneself. This is common sense: if a health-care worker is wounded, sick, or physically and emotionally exhausted, he or she will be in no position to deliver health care.

DEFINITIONS

For the purposes of this guide, the following definitions will be used:

ARMED CONFLICT

An international armed conflict may be said to exist whenever there is resort to armed force between two or more States; non-international armed conflicts are protracted armed confrontations occurring between governmental armed forces and the forces of one or more armed groups, or between such groups arising on the territory of a State party to the Geneva Conventions of 1949.

OTHER EMERGENCIES

The term 'other emergencies' is used in a particular way in this guide. It refers to situations that fall short of the threshold for armed conflict, during which security measures or incidents related to security can result in serious consequences for people in need of effective and impartial health care: death, aggravation of injuries, worsening of illnesses or diseases, obstruction of preventive health-care programmes, and so on. These measures or incidents might take a number of forms: violence against people in need of health care; violence against health-care personnel and facilities or medical vehicles; entry into health-care facilities by armed forces or security forces with the intent or effect of interrupting the delivery of health-care services; arbitrary denials of or delays in the passage of medical vehicles at checkpoints; or simply the general insecurity prevailing in an area affected by a situation of emergency. In these circumstances, and depending on the urgency of humanitarian

needs, health-care personnel – including but not limited to staff or volunteers from the International Red Cross and Red Crescent Movement – may be called upon to prevent and alleviate human suffering.

AUTHORITY

Any State or non-State body responsible under domestic or international law for the behaviour of armed actors and/or for the well-being of the population.

ARMED ACTORS

People bearing weapons on behalf of an authority: for instance, military personnel, law enforcement officers, security forces, or organized armed groups.

HEALTH CARE

Prevention, diagnosis, treatment or control of diseases, injuries or disabilities, as well as measures ensuring the health of mothers and young children. The term also encompasses activities that ensure, or provide support for, access for the wounded and sick to these health-care services; that is, activities such as searching for, collecting or transporting the wounded and sick, or the administration of health-care facilities.[5]

5 This definition is consistent with both humanitarian law and human rights law. Art. 8 (e) of Additional Protocol I defines medical purposes as "the search for, collection, transportation, diagnosis or treatment – including first-aid treatment – of the wounded, sick and shipwrecked, or (…) the prevention of disease." (For an almost identical list, see also Art. 24 of the First Geneva Convention.) The term 'wounded and sick,' in Art. 8 (a) of Additional Protocol I, includes those "who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain

HEALTH-CARE PERSONNEL

All those working in the area of health care. This includes:

- people with professional health-care qualifications, e.g. doctors, nurses, paramedics, physiotherapists, pharmacists;
- people working in hospitals, clinics and first-aid posts, ambulance drivers, administrators of hospitals, or personnel working in the community in their professional capacity;
- staff and volunteers of the International Red Cross and Red Crescent Movement involved in delivering health care;
- 'medical' personnel of armed forces;
- personnel of health-oriented international and non-governmental organizations;
- first-aiders.

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from any act of hostility" as well as others who are not wounded or sick in the ordinary meaning of these terms, i.e. "maternity cases, new-born babies and other persons who may be in need of immediate medical assistance or care, such as the infirm or expectant mothers, and who refrain from any act of hostility." Moreover, under humanitarian law, persons who, strictly speaking, do not perform medical activities – such as administrators of hospitals or drivers of ambulances – are also considered to be 'medical personnel' (see Art. 8 (c) of Additional Protocol I).

With regard to human rights law: the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the right "of everyone to the enjoyment of the highest attainable standard of physical and mental health" (see Art. 12 of the ICESCR). In order to discharge their obligations under the ICESCR, States Parties are required to take those steps necessary for, *inter alia,* the prevention, treatment and control of diseases (Art. 12 (2) (c)); the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child (Art. 12 (2) (a)); and the creation of conditions that would assure medical service and medical attention to everyone in the event of sickness (Art. 12 (2) (d)). This would encompass activities like searching for, collecting, and transporting the wounded and sick, which are designed to ensure access to health-care facilities, medical goods, and medical services. Ensuring the right of access to health-care facilities, medical goods and medical services on a non-discriminatory basis has been established – by the Committee on Economic, Social and Cultural Rights in its General Comment No. 14 of 2000 – as a non-derogable minimum core obligation for States party to the ICESCR.

individuals (who may or may not be representatives of the State) acting as a collective entity. The term 'other emergencies' does not cover interpersonal violence between, for example, couples or in institutional settings such as schools, workplaces, prisons and nursing homes.

AUTHORITY

Any State or non-State body responsible under domestic or international law for the behaviour of armed actors and/or for the well-being of the population.

ARMED ACTORS

People bearing weapons on behalf of an authority: for instance, military personnel, law enforcement officers, security forces, or organized armed groups.

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Catalina Martin-Chico/COSMOS

1. INTRODUCTION

1.1. Armed conflicts and other emergencies: When health care is needed most

Inevitably, during armed conflicts and other emergencies, people are wounded or become sick. The more intense and widespread the violence, the greater the need for health care. However, it is often the case that needs are greatest when it is most difficult to deliver health care. Health-care personnel working in insecure environments may find it particularly challenging to identify and discharge their responsibilities precisely when it is most difficult to think clearly about these responsibilities. They may have to think about their rights for the first time; they may even be unaware of what these rights are.

1.2. Scenarios

Armed conflicts and other emergencies give rise to many difficult dilemmas for health-care personnel. Here are some scenarios to consider. What would you do?

- You are a military doctor. Ten wounded soldiers are brought to your mobile surgical hospital following intense fighting. Two of the wounded are enemy soldiers; one has a serous abdominal wound. A senior officer orders you not to treat the wounded enemy soldiers until later.
- You are a Red Cross ambulance driver on your way to a part of town where there are wounded civilians. A soldier at a checkpoint does not let you through. The soldier, who is aggressive, says that Red Cross ambulances carry weapons to insurgents.
- You are the head nurse at a hospital run by a relief agency oriented towards health care. There is intense media interest in the conflict taking place around you. A colleague who wants to "show the world what is happening," brings a television camera team into your emergency room to film the suffering of the wounded and the sight of the hospital being stretched beyond the limits of its capacity.
- You are a pharmacist in your town's main public hospital, which has admitted a large number of people

who were injured during widespread violence in the town. You have the key to the pharmacy, which contains all essential drugs. In the morning, when you are due to go to work, you are not sure if you will be able to reach the hospital safely.

- You are a hospital administrator. There has been intense fighting nearby for ten days. The hospital mortuary, which is being stretched beyond its capacity, can no longer hold unclaimed and unidentified dead bodies.
- You are an army medic carrying only a pistol and wearing a red cross armband. You are giving basic care to a wounded comrade. It seems likely, as prolonged fighting against superior numbers of enemy troops draws to a close, that your small unit will be captured.

None of these scenarios is rare. They make manifest the difficult decisions that must be taken by health-care personnel when discharging their responsibilities in armed conflicts and other emergencies.

1.3. Responsibilities and rights: Linked in law

People who are wounded or who fall sick during armed conflicts or other emergencies are protected by a number of international legal instruments (Section 3). They must not be attacked or subjected to any other kind of violence or affront to their dignity. They also have a right to health care, which gives them another layer of protection. The responsibilities of health-care personnel are derived from these rights of the wounded and sick and from a sense of professional duty. Your responsibilities can involve taking action (for example, caring for the wounded and sick humanely, effectively and impartially) and abstaining from doing certain things (for example, from experimenting on people in your care). In armed conflict, because you bear these responsibilities, humanitarian law grants you certain other rights (Section 4).

1.4. A reality check

In all circumstances, there are two necessary conditions for delivering health care to the wounded and sick:

- the availability of infrastructure and materials;
- the application by the health-care worker of professional knowledge and expertise within a relationship of trust.

Health care is vulnerable to a variety of constraints in armed conflicts and other emergencies because one or both of these conditions may be unmet. The following are among the most important constraints: lack of access for the wounded and sick to health-care facilities, inadequate or destroyed buildings, lack of materials or suitably qualified people and the stretching of existing capacity beyond its limits. Nevertheless, even in the most rudimentary conditions, when the required materials are lacking, effective health care can often still be delivered. "Application by the health-care worker of professional knowledge and expertise within a relationship of trust" is still possible. However, the one overriding constraint is lack of security; this is also the most difficult constraint to address. When you, your colleagues and the people you are trying to care for are in danger, frightened, tired or shocked, giving even the most basic forms of treatment can be difficult or impossible and the essential notion of trust made irrelevant.

You must also recognize that health care in armed conflicts or other emergencies provides the unscrupulous with many opportunities for engaging in dangerous or unethical activities on a large scale – for example, distributing, prescribing and selling expired, inappropriate or counterfeit drugs. Those involved in such activities take advantage of the circumstances, the vulnerability of the wounded and sick, and the absence of oversight of health care in such situations.

When they are stretched to their physical and psychological limits, many health-care personnel working in dangerous situations find it very difficult to think about issues linked to their responsibilities. But, the worse the situation in terms of the constraints, the more important these issues become; unfortunately, when these health-care personnel are confronted by these issues, their reactions are often extremely emotional. Heated arguments between health-care personnel, amidst large numbers of wounded or sick people, are regrettably frequent and undignified in the extreme; they must be avoided. On the other hand, in certain difficult circumstances, a calm discussion with colleagues may be impossible; and when such discussions are possible, they may be unhelpful or lead to people being excessively critical of one another – or give the appearance of being both. In brief, your intellectual abilities are required most, precisely when it is most difficult to apply them.

Another important factor – which can be a constraint – is the media. Armed conflicts and other emergencies are the most important subjects in world news. The media has an important role in focusing attention on the situation in question, and health care can be a source of newsworthy images and stories. However, journalists can be extremely intrusive. When faced with an enquiry from the press, many health-care workers feel that they should "tell their story," give their opinion or respond to demands for access to the wounded and sick. This may not be in the interests of either the personnel concerned or the people they are trying to help. In addition, health-care personnel often provide testimonies – assumed, as a matter of course, to be authoritative – about the nature and extent of the violence, the weapons used or the impact of the violence. Whether or not these testimonies are accurate, there are obvious political and security implications. That is why this guide contains sections on witnessing violations of international law and on interacting with the media (Sections 11 and 12).

You should also bear in mind that your responsibilities as well as your rights, as defined by law, may vary according to whether you are working in military or civilian health care or in an armed conflict or some other emergency. In particular, some of the special rights for health-care personnel that are set out in humanitarian law are applicable only to situations of armed conflict (Section 4).

Christoph Von Toggenburg/ICRC

2. YOUR RESPONSIBILITIES

2.1. Overview

The responsibilities of health-care personnel working in armed conflicts or other emergencies, which are listed below, are based on the principle of humanity and drawn mainly from humanitarian law, human rights law and health-care ethics. However, some of them are drawn from established practice or based on common sense. Some responsibilities are absolute: "you must" fulfil them. Others may be difficult to fulfil under certain circumstances: hence, "you should if possible."

2.2. "You must"

You must in all circumstances:

- treat the wounded and sick humanely;
- not abandon the wounded and sick;
- not take part in any act of hostility if you want to be protected as medical personnel under humanitarian law;[6]
- not pose an immediate threat to the lives or the physical integrity of others if you want to be protected from the use of force under human rights law;
- remind authorities of their obligation to search for and collect the wounded and sick and to ensure their access to health care without discrimination on grounds other than medical condition;
- advocate and provide effective and impartial care for the wounded and sick without any adverse distinction;
- not take undue risks while discharging your duties;
- respect every wounded or sick person's wishes, confidence and dignity;

6 In armed conflict, humanitarian law permits 'medical' personnel assigned to parties to the conflict to carry "light individual weapons" to defend themselves and the wounded and sick in their care. 'Light individual weapons' are weapons that are generally carried and used by individuals: for example, pistols and military rifles. Heavier weapons that cannot easily be transported by an individual and that have to be operated by a number of people are not permitted by humanitarian law. When 'medical' personnel undertake hostile acts beyond self-defence, they lose the protection afforded to them. In all other situations, whether health-care personnel may carry weapons is determined by the domestic law applicable.

- shield the wounded and sick from public curiosity and media attention;[7]
- not exploit the situation or the vulnerability of the wounded and sick for personal gain;
- not undertake any kind of experimentation on the wounded and sick without their genuine and valid consent;
- ensure that your practices are compatible with humanitarian law, human rights law and health-care ethics;
- give special consideration to the greater vulnerability of women, children, the elderly and people with disabilities, and to their specific health-care needs;
- give special consideration to the specific health-care needs of victims of sexual violence;
- respect the right of a family to know the fate and whereabouts of a missing relative;
- be aware that, during armed conflicts or other emergencies, health care becomes increasingly susceptible to unscrupulous practices and the distribution of poor quality / counterfeit materials and medicines;
- encourage authorities to recognize their obligations under humanitarian law and other pertinent bodies of international law with respect to protecting health-care personnel and infrastructure in armed conflicts and other emergencies;
- do everything within your power to prevent reprisals against the wounded and sick or against health-care workers and facilities;
- refuse to obey orders that are unlawful or that compel you to act contrary to health-care ethics;[8]

7 This includes visits for media purposes by important political figures; the injunction also applies, with particular force, when important political figures are among the wounded and sick.

8 This relates principally to military medical personnel working in armed conflict. Whilst humanitarian law stipulates that you must not be punished for refusing to obey an unlawful order or an order that involves acting contrary to medical ethics, it must be acknowledged that following such an order (which might even entail assisting in the commission of a war crime) might be excused in exceptional circumstances – for instance, when refusing to obey would endanger your life.

- be aware of your legal obligations to report to authorities the outbreak of any notifiable disease or condition.

2.3. "You should if possible"

There are other situations where the provision of health-care might be compromised, but where dilemmas arise nevertheless. You should if possible:

- give careful consideration to any dual loyalties that you may be bound by and discuss them with colleagues and anyone in authority;
- listen to and respect the opinions of colleagues;
- reflect on and try to improve the standards of care appropriate to the situation;
- report the unethical behaviour of colleagues to your superiors;
- be identifiable as a health-care provider, and by means of a distinctive emblem if authorized to wear one (Section 5);
- keep adequate health-care records;
- provide support for restoring and maintaining the provision of civilian health care disrupted by armed conflicts or other emergencies;
- report to your commander or to the relevant authorities if health-care needs are not being met;
- give consideration to how you and other health-care personnel might curtail or mitigate the consequences of the conflict or emergency in question by, for example, tackling violations of humanitarian law or human rights law;
- inform authorities or others responsible about any security incident.

Ursula Meissner/ICRC

3. THE SOURCES OF YOUR RESPONSIBILITIES

3.1. Overview

People who are wounded or who fall sick in armed conflicts or other emergencies must be respected and protected; and they must also be provided with effective and impartial health care. These rights, rarely debated, are anchored in international law, which is made up of rules arising from treaties (also referred to as conventions or protocols) to which States have agreed. States that agree to be bound by a treaty must bring their own domestic law in line with that treaty, where necessary. Other rules of international law come from "customary international law," the importance of which rests on the fact that it binds all States whether or not they have ratified or acceded to pertinent treaties and on the fact that it may contain rules that are not to be found in treaties.[9]

The two main bodies of international law that are pertinent to you are:

- international humanitarian law or **humanitarian law**; and
- international human rights law or **human rights law**.

Human rights law protects individuals at all times – in peacetime and during emergencies or armed conflicts. Humanitarian law was designed specifically for situations of armed conflict. Generally, in situations of armed conflict, both humanitarian law and human rights law apply. However, humanitarian law frequently contains the more precise rules: where this is the case, it prevails over human rights law. For instance, humanitarian law, not human rights law, contains provisions that specifically protect health-care personnel. On the other hand, in emergencies other than armed conflicts, only human rights law applies. Domestic law – which incorporates international obligations – is also part of the applicable legal framework.

9 The rules of customary international law originate in the legal recognition (*opinio juris*) of the virtually uniform, extensive and representative practice of States in a certain area.

Your responsibilities are anchored not only in law, international and domestic. They are also derived from health-care ethics, established practice and common sense, as shown in Section 2. Ultimately, however, it is the principle of humanity that safeguards the provision of health care in armed conflicts and other emergencies; furthermore, humanitarian law, human rights law, and health-care ethics all rest on this principle, which is also at the origin of the International Red Cross and Red Crescent Movement (Movement).

3.2. The principle of humanity

The principle of humanity is expressed in a number of different ways. For the purposes of this guide, it means delivering health care as an act of compassion. This implies treating the wounded and sick humanely: it is equivalent to saying to yourself, "What would I want if my family or I were wounded or sick?" Inherent in the principle of humanity is the imperative to preserve human dignity.

Humanity is also the central guiding principle for the Movement. The Fundamental Principles of the Movement declare: "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 to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples."[10] Humanity is one of the principles on which protection for victims of armed conflicts, under the specific rules of humanitarian law, is based.

3.3. International humanitarian law

International humanitarian law or **humanitarian law** – also known as 'the law of armed conflict' or 'the laws of war' – is

10 The Fundamental Principles of the International Red Cross and Red Crescent Movement, adopted at the 20th International Conference of the Red Cross and Red Crescent, Vienna, 1965.

a body of international law that applies only in situations of armed conflict. It has two major branches:

- rules protecting victims of armed conflicts, i.e. military personnel who are no longer taking part in the fighting, including military wounded and sick, and people who are not actively involved in hostilities, i.e. civilians, including wounded and sick civilians, or military and civilian medical personnel;
- rules regulating the way military operations are conducted by military personnel (methods of warfare) and limiting the weapons (means of warfare) military personnel may use.

Almost all of the rules contained in the four Geneva Conventions of 1949 apply to international armed conflicts; only one provision, Article 3 common to the four Geneva Conventions (common Article 3), applies to non-international armed conflicts. Furthermore, Protocol I of 8 June 1977 additional to the Geneva Conventions (Additional Protocol I), which deals with international armed conflicts, is much more detailed than Protocol II of 8 June 1977 additional to the Geneva Conventions (Additional Protocol II), which deals exclusively with non-international armed conflicts. However, the development of customary humanitarian law has been such that the same rules largely apply in both types of armed conflict.

The Geneva Conventions have been ratified or acceded to by virtually all States, but that is not the case for the Additional Protocols. Thus there is a disparity in applicable international treaty obligations between those States that have ratified or acceded to the Additional Protocols, and those that have not done so. However, many of the rules contained in the Additional Protocols are recognized as customary humanitarian law, and are thus binding on even those States that have not ratified or acceded to the Additional Protocols.

Protection and access to health care for the wounded and sick in armed conflict, and the responsibilities and rights of health-care personnel deriving from the protection granted the wounded and sick, are all based on the following: the First, Second and Fourth Geneva Conventions; Additional Protocol I, Part II (Articles 8-34); and Additional Protocol II, Part III (Articles 7-12). The pertinent rules in the ICRC's study on customary humanitarian law are rules 25-30 and rules 109-111. The most important are these:

- the wounded and sick must be provided with medical care and attention, to the extent possible, with the least possible delay and without any adverse distinction on any grounds other than medical ones;
- the wounded and sick must be searched for, collected and evacuated, to the extent possible, particularly after the fighting has ended;
- neither the wounded and sick nor health-care personnel carrying out their exclusively humanitarian task must be attacked or ill-treated;
- the passage of medical transports conveying the wounded and sick or health-care personnel must not be arbitrarily denied or restricted;
- health-care personnel must not be punished for carrying out activities compatible with health-care ethics. In fact, they must be assisted in their tasks.

Common Article 3, an important element of the 1949 Geneva Conventions, is recognized as customary law. It states:

"In the case of armed conflict not of an international character (…)

1. Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed 'hors de combat' by sickness [or] wounds (…) shall in all circumstances be treated humanely (…) To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

(a) violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
(b) taking of hostages;
(c) outrages upon personal dignity, in particular humiliating and degrading treatment;
(d) the passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court, affording all the judicial guarantees which are recognized as indispensable by civilized peoples.

2. The wounded and sick shall be collected and cared for."

Importantly, the International Court of Justice (ICJ), the judicial organ of the United Nations competent to decide disputes between States, considers common Article 3 to reflect "elementary considerations of humanity," and as such to be applicable in all types of armed conflict.[11] Humanitarian law also includes the so-called Martens Clause, which states, "in cases not covered by this Protocol or by other international agreements, civilians and combatants remain under the protection and authority of the principles of international law derived from established custom, from the principles of humanity and from the dictates of public conscience."[12] Both common Article 3 and the Martens Clause are important for you as they can be used to argue that authorities and weapon-bearers have a basic legal responsibility for the wounded and sick, whatever the type of armed conflict.

11 ICJ, *Military and Paramilitary Activities in and against Nicaragua* (*Nicaragua* v. *United States of America*), Merits, 27.06.1986, para. 218; ICJ, *Corfu Channel* (*United Kingdom of Great Britain and Northern Ireland* v. *Albania*), Merits, *ICJ Reports 1949*, p. 22.

12 The Martens Clause was originally introduced into the preamble to the 1899 Hague Convention (II) on the Laws and Customs of War on Land. The clause took its name from a declaration read by Fyodor Fyodorovich Martens, the Russian delegate at the Hague Peace Conferences 1899, and was based upon his words: "Until a more complete code of the laws of war is issued, the High Contracting Parties think it right to declare that in cases not included in the Regulations adopted by them, populations and belligerents remain under the protection and empire of the principles of international law, as they result from the usages established between civilized nations, from the laws of humanity and the requirements of the public conscience." It finds modern expression in Art. 1.2 of Additional Protocol I.

Non-State actors party to non-international armed conflicts are also bound by treaty law (common Article 3 and Additional Protocol II) and customary rules of humanitarian law.

3.4. International human rights law

The source of all modern human rights treaties is the Universal Declaration of Human Rights (1948).[13] One set of fundamental rights protecting everyone, regardless of the context – and therefore you and the wounded and sick – is contained in the International Covenant on Civil and Political Rights (1966). These fundamental political and civil rights include: the right to life, the right to be free from cruel, degrading and inhuman treatment and the right to be free from all forms of discrimination. Obviously, they also apply to the wounded and sick and to health-care professionals. They are of significance to you because the wounded and sick may be suffering the consequences of their violation (Section 10).

Another important human right in this context is the "right to health." It was first formulated as such in the Constitution of the World Health Organization (1946) and in the International Covenant on Economic, Social and Cultural Rights (1966).[14] It was reaffirmed by documents like the Alma-Ata Declaration (1978).[15] It is generally understood to mean a right to enjoy the highest attainable standard of health.[16] It is *not* a right to be healthy. The right to health should ensure that a nation's health-care system is responsive to the health-care needs of the population, including

13 Universal Declaration of Human Rights, 10 December 1948, UN-GA Res 217, Annex.

14 Constitution of the World Health Organization (1946); International Covenant on Economic, Social and Cultural Rights (1966), Art. 12.

15 Declaration of Alma-Ata, International Conference on Primary Health Care, 6-12 December 1978.

16 For the most elaborate formulation to date of what the right to health encompasses, see Committee on Economic, Social and Cultural Rights, General Comment No. 14, "The right to the highest attainable standard of health" (2000).

disadvantaged groups. It should ensure:

- availability of health-care services;
- access to these services, i.e. lack of discrimination, physical access, affordability and information;
- acceptance within the culture of the society concerned;
- health-care services of appropriate quality.

This broad definition of the right to health means that it is related to other human rights such as the rights to food, housing, education, safe working conditions and ultimately, the right to life.

The right to health imposes an obligation on authorities to respect and protect the provision of health care, and address any imbalances in it, as well as to promote activities that will benefit the health of the population in question. The extent to which this right is upheld varies.[17] It bears noting that two United Nations instruments of "soft law" clearly set out an obligation for law enforcement officers to bring health care to wounded and sick people.[18] The importance of the neutrality of health care has been emphasized by the World Medical Association.[19]

In places where armed conflicts or other emergencies are taking place, often, access to health care is already limited; this situation is exacerbated by the insecurity that is, almost inevitably, a consequence of such crises. It is most difficult to uphold the right to health precisely when and where that right is most important. Nevertheless, authorities cannot claim that the right to health is a derogable right i.e. that it can be fully waived when, for example, national security is threatened. However, in such situations, this right can be *limited* as long as the purpose of doing so is to

17 G. Backman, P. Hunt, R. Khosla, *et al*. "Health systems and the right to health: An assessment of 194 countries," *Lancet*, 372, 2008, pp. 2047-85.

18 United Nations Code of Conduct for Law Enforcement Officials, Art. 6. See also: United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Principle 5 (c).

19 World Medical Association Council Resolution supporting the Preservation of International Standards of Medical Neutrality. Adopted by the 182nd WMA Council Session, Tel Aviv, May 2009.

assure the welfare of the general population. Regardless of the context, the right of people to the highest achievable standard of health care creates an imperative for health-care personnel to do everything to ensure that this right is upheld.

3.5. Health-care ('medical') ethics

The ethical issues associated with various aspects of health care have been examined largely in relation to the practice of doctors. National medical associations and their federation, the World Medical Association, are the leading authorities.[20] The guidelines on health-care ethics drawn up by these institutions grew out of decades of case-based discussions about difficult ethical issues faced by doctors every day. These guidelines are now recognized as applicable to all other health-care professionals. 'Health-care ethics' is, generally, the preferred term, but using the alternative, 'medical ethics,' does not imply that other health-care personnel, such as nurses, paramedics, physiotherapists, dentists and pharmacists are free of the obligation to consider ethical issues.

There is a close link between health-care ethics and human rights. The World Medical Association has stated that "medical ethics has been greatly influenced by developments in human rights. In a pluralistic and multicultural world, with many different moral traditions, the major international human rights agreements can provide a foundation for medical ethics that is acceptable across national and cultural boundaries."[21]

Modern thinking about health-care ethics takes into account certain rules (such as "treat everyone as equal"), outcomes (such as the consequences of your actions), principles (such as "do no harm") and personal virtues (such as honesty). Together, these influence your beliefs

20 The World Medical Association, *A Manual on Medical Ethics*. WMA, Ferney-Voltaire 2005.
21 *Ibid*, p. 11.

and conduct, as well as the way you reach decisions. When you are faced with a dilemma, these rules, principles, outcomes and personal virtues have to be considered and balanced against each other. There is no universally accepted formula for determining what, in the context of health care, constitutes ethical conduct, an ethical practice or an ethical decision. However, it is often obvious whether something is ethical or not: one decides by combining one's sense of humanity and professional duty with common sense, whilst bearing in mind the three pillars of health-care ethics. These are:

- respect for the autonomy and dignity of the individual;
- maintaining confidentiality; and
- ensuring genuine and valid consent for any procedure.

Health-care ethics stipulate that you refrain from carrying out criminal or immoral acts (such as trafficking in organs for transplantation). There is no need to discuss whether or not such acts are "wrong."

Health-care ethics also provide guidance when you have to take decisions or resolve dilemmas with an ethical element: for example, deciding whom to treat first: a pregnant woman requiring a Caesarian section or a soldier who requires an abdominal operation for a penetrating wound. In such cases, there are often no right or wrong answers. However, regarding them as ethical dilemmas might help you not to make a decision that is definitely wrong.

Health-care ethics do not become irrelevant in armed conflicts or other emergencies.[22] The change from peacetime practice is this: health-care ethics apply in different ways and the issues to which they apply are different. For example, considering the risks to yourself in discharging your duties is not an everyday consideration in peacetime civilian practice for most health-care personnel. Whilst

22 World Medical Association Regulations in Times of Armed Conflict, Adopted by the 10th World Medical Assembly in Havana, Cuba in October 1956 and revised at the 173rd Council Session in Divonne-les-Bains, France in May 2006.

health-care ethics provide a framework for ethical practice in all circumstances, this guide should help to apply that framework in circumstances when thinking about health-care ethics is most difficult and yet of critical importance for the well-being of the wounded and sick, and for your own safety as well.

The key to resolving an ethical dilemma when bringing health care to the wounded and sick in armed conflicts and other emergencies is to recognize that it exists. This alone can ease much of the emotional burden imposed by such dilemmas. Discussing the dilemma with colleagues may yield the best answer. The next important thing is to recognize that it may not be possible to find a clear "right" answer. If you have at least recognized the existence of the dilemma, and better still, discussed it with colleagues, you can probably justify your decision. Ultimately, the object is to strike a suitable balance between possible outcomes by honest consideration of all competing interests. If you do not even face the dilemma or balance various possible outcomes and competing interests, your decision or practice will run the risk of being unethical.

Here are some questions that you should ask yourself first, when making a decision or taking action in relation to wounded and sick people in armed conflicts and other emergencies, and when an ethical dilemma is involved.

- Is my behaviour towards the wounded and sick in keeping with the principle of humanity?[23]
- Are my actions consistent with humanitarian law, human rights law and domestic law?
- Will my actions do more good than harm for the wounded and sick, individually and collectively?
- Is there any risk to myself in acting or not acting?

23 This should not be read as taking a moral stance, but rather as implying a duty to act. See the World Medical Association International Code of Medical Ethics, adopted by the 3rd General Assembly of the World Medical Association in London, England in October 1949 and last amended by the 57th WMA General Assembly in Pilanesberg, South Africa in October 2006.

- Is what I am planning to do the best thing for the wounded or sick person? Do I have the necessary competence?
- Is what I am planning to do the best thing for the wounded and sick as a whole?
- What is the best thing for the society or group to which the wounded or sick person belongs?
- Have I considered all my possible loyalties and interests and put the interests of the wounded and sick first?
- Am I providing the most appropriate standard of care, given the constraints I am working under?

Clearly, some of these questions yield answers that work against each other. The most obvious example is that the "best" thing for a severely wounded person may drain away so many resources that the less seriously wounded may be denied the effective treatment that they would have received otherwise.

3.6. Witnessing violations of international law

While providing health care in armed conflicts and other emergencies, health-care personnel may witness the human impact of violations of international law. This may be unavoidable. Possessing information of this kind can create difficult dilemmas for health-care personnel. On one hand, they may feel a pressing need to pass on such information to a competent authority or institution or even the media; on the other, passing on this information may endanger you, your organization or the people you are trying to help. Section 11, on gathering data on the impact of such violations, examines how this dilemma might be handled.

Scott Olson/Getty Images

4. YOUR RIGHTS

4.1. Overview

So far, this guide has focused on your responsibilities in armed conflicts and other emergencies. Given the weight of these responsibilities, it is reasonable to ask what your rights are in these contexts.

4.2. Your rights in armed conflict

You have certain special rights if you are working in an armed conflict. These rights are derived from the same rules of humanitarian law as your responsibilities: the First, Second and Fourth Geneva Conventions; Additional Protocol I, Part II (Articles 8-34); Additional Protocol II, Part III (Articles 7-12); and customary humanitarian law.

If you are working in the context of armed conflict, you have the right:

- to be respected and protected, as do the wounded and sick you are caring for;
- to demand that the authorities assist you in carrying out your work;
- to demand that the authorities give you access to the wounded and sick;
- not to be punished for discharging your responsibilities in accordance with accepted standards of health care;
- not to be compelled to act in a manner contrary to the law and/or health-care ethics;
- not to be compelled to give information about wounded and sick people beyond what is required by domestic law or in terms of notification of infectious diseases;
- if you are detained, to continue your professional work whenever possible;[24]
- not to be punished for disobeying an illegal or unethical order;
- to carry a light weapon to defend yourself and the wounded and sick in your care.[25]

24 This applies only in international armed conflict or during occupations when medical personnel are "retained" because they are deemed indispensable for caring for the wounded and sick.

25 See Note 6.

4.3. Your rights in other emergencies

In other emergencies you have the same rights as any other person under the jurisdiction of a State. While you have no rights in international law specific to your role in health care, unlike your specific rights in armed conflicts, listed in section 4.2, you benefit from the general protection granted by human rights law.

Like all other individuals under the jurisdiction of a State, you are protected, for instance, from being killed arbitrarily or from being tortured or ill-treated by State security or police forces. In addition, the right of individuals to non-discriminatory access to health care under human rights law implies that State authorities must permit you to treat people in need of health care, assist you in your work and protect you from arbitrary interference with your work. There may also be provisions of domestic law that enhance your legal protection and your ability to bring assistance to the wounded and sick.

Boris Heger/ICRC

5. THE EMBLEMS OF THE RED CROSS, THE RED CRESCENT AND THE RED CRYSTAL

5.1. Three distinctive emblems

The red cross and red crescent emblems are widely recognized as affording protection to those who bring assistance to victims of armed conflict. In accordance with Protocol III of 8 December 2005 additional to the Geneva Conventions (Additional Protocol III), a third emblem – the red crystal – may, like the red cross and the red crescent, be used under humanitarian law for "protective" or "indicative" purposes.[26]

The three emblems are free from any religious, cultural or political connotations. The red crystal was created in 2005 for National Red Cross and Red Crescent Societies (National Societies) that did not want to use either the cross or the crescent as an emblem.

5.2. Protective use of the emblems

The emblems should be displayed on medical buildings and means of transport, and on personnel (on arm bands, badges or bibs); they should be as large and as visible as possible. Their function is to notify parties to an armed conflict that a certain object or person is protected under humanitarian law. In other words, it is not the emblem itself that confers protection but the law. The emblem only enables parties to an armed conflict to identify the existence of such protection.

In armed conflict, you may use a protective emblem if you are part of:

- the health-care services or religious personnel of the armed forces;

26 Additional Protocol III entered into force on 14 January 2007.

- the health-care services of National Societies when placed at the disposal of the health-care services of the armed forces and when subject to military laws and regulations;
- civilian health care or voluntary health care, but only with the express authorization of the government and when under its control.

In situations other than armed conflict, you may use a protective emblem if you are part of:

- the health-care services or religious personnel of the armed forces;
- health-care services provided by a National Society that will, with the consent of authorities, function as such in the event of armed conflict.

The ICRC and the International Federation of Red Cross and Red Crescent Societies (International Federation) may use the red cross as a protective emblem at all times without restriction.[27]

You do not have the right to use one of the emblems simply because you are providing health care in an armed conflict or in some other emergency.

5.3. Indicative use of the emblems

An emblem is used for "indicative" purposes to signal that the person or object displaying it has a link with the Movement. For such use, the emblems must be small; they may bear additional information, such as the name or initials of a National Society. They must never be displayed in any way that may cause confusion about their purpose: in other words, it must always be unambiguously clear

27 Article 4 of Additional Protocol III also recognizes that the ICRC and the International Federation may, in exceptional circumstances and to facilitate their work, use the red crystal as a protective emblem. While the same possibility is not explicitly foreseen for the red crescent in any treaty of humanitarian law, the ICRC in its 2009 *Study on Operational and Commercial and other Non-Operational Issues Involving the Use of the Emblems* has recognized this by analogy to Article 4 of Additional Protocol III.

that they are being used for "indicative," not "protective," purposes.

National Societies, the ICRC and the International Federation may make indicative use of the emblems in all contexts. Indicative use of the red cross, the red crescent or the red crystal by a National Society must be compatible with domestic legislation.

5.4. Misuse of the emblems

The emblems can be misused in three ways:

- *imitation:* use of a sign that, owing to its shape and colour, may be confused with one of the emblems;
- *improper use:* use of an emblem in a way that is inconsistent with the relevant rules of humanitarian law, by unauthorized people or bodies (such as pharmacies or doctors' private clinics), or for purposes that are inconsistent with the Fundamental Principles of the Movement;
- *perfidy:* use of an emblem during an armed conflict in order to feign protected status and invite the confidence of an adversary with the intention of betraying this confidence. Killing, injuring or capturing an enemy by resorting to perfidy is prohibited. Perfidy is a particularly reprehensible misuse of the emblem, as it may lead an adversary to abandon respect for protected health-care personnel and facilities altogether.

Thomas Pizer/ICRC

6. TOWARDS APPROPRIATE STANDARDS OF CARE

6.1. Overview

The objective of this section is to help you to think clearly about and to justify the standard of care that you are providing to wounded and sick people during armed conflicts and other emergencies. You have a responsibility to ask yourself: "Given the constraints, is the standard of care appropriate"? This is a critical question, but difficult to answer, especially when the constraints in question are violence – both real and threatened, against health-care workers and facilities – and general insecurity. However, even if a definitive answer cannot be found, asking the question can be valuable.

An 'appropriate standard of care' for the wounded and sick in armed conflicts and other emergencies implies use of appropriate materials and technology and the application by the health-care worker of professional knowledge and expertise within a relationship of trust. It does not mean sophisticated or highly specialized care; neither does it mean the use of high technology. At the same time, it does not mean simply allowing standards to drop whilst claiming that a "basic" or "local" standard of care is appropriate.

Regardless of whether it is pre-hospital or hospital care, providing and upholding an appropriate standard has importance beyond the treatment you provide for the wounded and sick. This standard is also of keen interest to people who will potentially benefit from your care, the community as a whole, local authorities and likely financial supporters. How you talk about the standard of care you are providing in a given context can influence the motivation of other people, the access of the wounded and sick to health care and the resources available to you. Your reputation – and therefore possibly your safety – as well as that of your colleagues and your organization may also be at stake. In other words, your ability to provide *effective* and *impartial* health care in a given context may depend on broad recognition and understanding of the standard of care you are providing; you must be able to convey this information clearly.

6.2. Towards appropriate standards of health care in armed conflicts and other emergencies

The standard of health care provided in a developed country is rarely deliverable in contexts of conflict. The military medical services of such countries when deployed overseas in armed conflicts and other emergencies may provide for their wounded and sick personnel health care of a comparable standard; the technology and practice from "home" provide the points of reference. In the absence of such services and without such points of reference, defining an "appropriate" standard of care in objective terms is extremely difficult. The best point of departure is to align your practice and technology with that of others who have provided health care in similar contexts under similar constraints. This is a realistic approach. Therefore, your first responsibility with respect to standards is to refer to published guidelines.[28] Your second responsibility goes beyond referring to existing guidelines: you must be able to demonstrate that these guidelines are being followed and put into practice for the benefit of the wounded and sick. You can justify the standard of care you are providing when you fulfil these responsibilities. Inability to show that guidelines are being followed does not relieve you of the responsibility of thinking about standards of care: this is extremely important.

28 Here are examples of guidelines published by the ICRC, the World Health Organization and Médecins Sans Frontières: ICRC, *First Aid in Armed Conflicts and Other Situations of Violence*, ICRC, Geneva, 2006; C. Giannou, M. Baldan, *War Surgery: Working with Limited Resources in Armed Conflict and Other Situations of Violence*, ICRC, Geneva, 2009; J. Hayward-Karlsson *et al.*, *Hospitals for War-Wounded: A Practical Guide for Setting Up and Running a Surgical Hospital in An Area of Armed Conflict*, ICRC, Geneva, 1998; World Health Organization, *Hospital Care for Children: Guidelines for the Management of Common Illnesses with Limited Resources*, WHO, Geneva, 2007; World Health Organization, *Manual of Basic Techniques for a Health Laboratory*, 2nd edition, WHO, Geneva, 2003; World Health Organization, *Surgical Care at the District Hospital*, WHO, Geneva, 2003; Médecins Sans Frontières, *Clinical Guidelines: Diagnosis and Treatment Manual for Curative Programmes in Hospitals and Dispensaries*, 7th edition, MSF, Paris, 2006; Médecins Sans Frontières, *Obstetrics in Remote Settings: Practical Guide for Non-Specialized Health Care Professionals*, MSF, Paris, 2007; Médecins Sans Frontières, *Essential Drugs: Practical Guidelines Intended for Physicians, Pharmacists, Nurses and Medical Auxiliaries*, 3rd edition, MSF, Paris, 2006.

The ICRC has published guidelines for the surgical management of wounded people in situations where technological resources are limited and where a surgeon has to work in all fields of surgery.[29] The example given below, of managing ballistic fractures in ICRC hospitals, illustrates how the ICRC, by providing guidelines, justifies the standard of care given, even though this standard might not be the equivalent of orthopaedic trauma care in the developed world.

When deployed to an ICRC hospital, every surgeon, irrespective of his or her area of specialization, must be prepared to treat ballistic fractures because:

- there is no guarantee that an orthopaedic surgeon will be deployed as well;
- the conditions in which the surgical work is undertaken precludes high-technology solutions, such as internal fixation, which requires specialist application, is expensive and may even be dangerous in non-sterile conditions;
- the pathology (ballistic trauma) is specific and few surgeons have experience of this pathology before their first deployment; modern specialist skills dependent on sophisticated technologies may be out of place;
- experience in ICRC hospitals has shown that a ballistic fracture must be managed as part of a wound and that ballistic wounds are best managed by general surgical principles applicable by all surgeons.

Managing ballistic fractures by relying on basic principles of wound management and by using basic means of fracture fixation has proven effective and safe so far: hundreds of ICRC surgeons with various specialist backgrounds have been doing this for over thirty years.

6.3. Performance review

Health-care personnel working in armed conflicts and other emergencies have another responsibility, which is

29 C. Giannou, M. Baldan, *War Surgery: Working with Limited Resources in Armed Conflict and Other Situations of Violence*, ICRC, Geneva, 2009.

related to reviewing performance. One can measure *output* – or what you do – by indicators such as number of people transported or treated. One can use indicators for measuring quality of care, such as:

- whether correct diagnoses are made;
- whether correct treatment is undertaken;
- for people with lower-limb fractures, the number of days in hospital;
- for people with open wounds, the number of operations per patient.

But these indicators do not indicate the *outcome* of the care. Ultimately, the only real measures of outcome are:

- overall hospital mortality rate for a given condition;
- mortality rate, for example, among those who have had an abdominal operation;
- the residual disability or disfigurement;
- for public health programmes, deaths, diseases and disabilities in a given population.

These measures of outcome will have meaning only if they are compared with a different context or with the same context in the past.

Reviewing performance can be difficult in the contexts of concern because it is time consuming and may appear impracticable. You should nevertheless try to do so as soon as possible after the emergency. Obviously, such review is meaningless if no action is taken afterwards. Remember: you do not have to wait for a review to be over before thinking about or implementing an appropriate standard of care, or attempting to improve the standard of care.

6.4. Recognizing an unacceptable standard of health care

A parallel approach – and a necessary one – to the question of standards of health care in armed conflicts and other emergencies involves recognizing that, regrettably, many wounded and sick people end up receiving health care

that is of an unacceptably low standard. This is sometimes justified by the argument that sub-standard care is better than nothing, which ignores the possibility that such sub-standard health care may make the situation worse for the wounded and sick. It is immediately clear to experienced health-care professionals when attempts to achieve an appropriate standard of care have been abandoned.

A health-care facility operating during an armed conflict or some other emergency**,** in which all thought of standards has been abandoned, is recognizable by certain features that usually exist simultaneously. These include:

- absence of admission register;
- excessive waiting times for consultation;
- no separate provision for emergency treatment in hospital routine;
- procedures being undertaken by unqualified, inexperienced or unsupervised personnel, or without patients' consent;
- no provision for 24-hour care (no lights on at night, no personnel on night duty, etc.);
- responsibility for purchasing services, drugs and dressings shifted to the wounded or sick person and his or her family;
- initiating a treatment despite being fully aware that it cannot be completed;
- prescribing inappropriate treatment or giving treatment when none is required;
- unsafe blood transfusion practice;
- poor hygiene;[30]
- absence of adequate health-care records;
- unmotivated staff.

Addressing one or a few of these features is unlikely to provide a fix for the situation; these are signs of systemic dysfunction and it is the entire system that must be addressed.

30 Inadequate toilets, uncollected garbage, no running water, animals in the wards, etc.

Furthermore, correcting the system does not necessarily require the injection of resources; much can be done to deliver effective health care under difficult circumstances by maintaining a professional attitude, making the best use of available resources and applying common sense.

6.5. When it is impossible to deliver health care

What can you do when, because of the limitations of the facility and the strain on its capacity, you cannot deliver any semblance of an appropriate standard of care? In such circumstances, it may be necessary to withold some elements of treatment with a view to avoiding interventions that cannot be carried out correctly and are therefore dangerous. For example, when caring for the wounded, you may be faced with constraints so severe that surgical operations are impossible and the wounded best treated with only dressings, analgesia and antibiotics.[31]

In the worst situations, when conventional health care is simply impossible, you can still care for the wounded and sick: for instance, by insisting that they be protected. For the wounded and sick, this means a lot: it reassures them that they have not been abandoned.

6.6. Guidance

Here are some questions regarding standards of care in a given situation. Even if they cannot be answered definitively, thinking about them and discussing them with colleagues may ensure that your decisions and practice are appropriate to the context:

- Do I have a clear idea of the standard of care I wish to deliver? Can I deliver it?
- To what publications or experience does that standard refer?

31 R.M. Coupland, "An epidemiological approach to the surgical management of casualties of war," *British Medical Journal*, 308, 1994, pp. 1693-1697.

- Have I done everything possible to raise the standard of care, in terms of infrastructure and materials or professional expertise?
- Have I identified the constraints that prevent me from delivering the desired standard of care?
- Have I done everything possible to overcome the constraints created by lack of expertise or infrastructure?
- Have I identified the main dilemmas? Have I discussed these dilemmas with others, including colleagues, senior figures in my organization and professional associations?
- Do I know which person or organization I might turn to for help and advice about standards?
- If I am responsible for imported health care – especially military health care deployed overseas – have I understood that, to maintain an appropriate standard, I may have to adapt my practice according to whom I am treating? (You may have to think differently about your practice according to whether you are treating a wounded soldier who is to be transported back to his or her home country or a civilian afflicted with a chronic disease.)
- Do I recognize any of the signs of inadequate or inappropriate health care that are listed in Section 6.4?
- To what extent is the delivery of health care driven by media or political interests rather than the desire to have a real impact on the wounded and sick?

If you do not take these questions into consideration, you may risk adopting a standard of care that is inappropriate, ineffective and even dangerous. You may not fulfil your responsibilities to the wounded and sick. You may even be risking professional malpractice. Ultimately, if you don't care about standards of health care in armed conflicts and other emergencies, you should ask yourself whether you should be attempting to deliver health care at all.

Wojtek Lembryke/ICRC

7. HEALTH CARE FOR PEOPLE WITH PARTICULAR VULNERABILITIES

7.1. Overview

Health-care needs in armed conflicts and other emergencies cannot be assessed correctly without taking into account the specific vulnerabilities of women, children, the elderly, and people with disabilities – vulnerabilities that are recognized in international law. There are others who, because of their vulnerabilities, have been subject to sexual violence. You have a responsibility to consider and, if possible, address these vulnerabilities in your policies and practice. Section 7 (7.2 to 7.6) contains questions that may be pertinent to the context you are working in.

7.2. Specific vulnerabilities of women

- Do women have unimpeded access to health care? If not, what is the reason? Prevailing insecurity? Financial or cultural constraints?
- Does local custom stipulate that women should be treated only by female health-care personnel?
- Do women become especially vulnerable to, for example, trafficking or sexual violence when trying to reach or benefit from health care?
- What can I do to curb practices such as female genital mutilation and mitigate their effects?
- What child-care facilities are available for women seeking health care?
- Can I direct women to health-education programmes, including family planning?
- Are women who have to pay for their health care or the health care of their families, vulnerable to sexual exploitation?

7.3. Specific vulnerabilities of children

- Do children have unimpeded access to health care? If not, what is the reason? Prevailing insecurity? Financial or cultural constraints?
- Do children become especially vulnerable to, for example, abduction for trafficking, sexual violence or coercion to join armed forces or armed groups when trying to reach health care?

- Am I clear about what I should do with unaccompanied children regarding, for example, consent for treatment and discharge from hospital?

7.4. Specific vulnerabilities of the elderly

- Do the elderly have difficulty reaching health care? Are they confined to their homes?
- Is there any information as to how health care for elderly people has been affected by the armed conflict or other emergency?
- Can the elderly claim their pensions, so that they can pay for their health care?

7.5. Specific vulnerabilities of people with disabilities

- Do people with disabilities have difficulty reaching health care or rehabilitation? Are they confined to their homes? What means of transport are available for them?
- Are people with disabilities discriminated against in terms of access to health-care services?
- What institutions provide services for people with disabilities? Is there any information about how facilities upon which people with disabilities depend – including health-care facilities – have been affected by the conflict?
- Is there any danger of people with disabilities being taken advantage of as a result of the insecurity created by the armed conflict or other emergency?
- Are people with disabilities able to pay for their health care?

7.6. Victims of sexual violence

- Are the specific health-care needs of victims of sexual violence addressed? Do I know what these needs are?
- Do I have the necessary authority, qualifications and experience to investigate, document or verify sexual violence? If not, where can I find someone who does?
- Do I know where to direct victims of sexual violence for appropriate psychosocial assistance?

Christoph Von Toggenburg/ICRC

8. IMPORTING HEALTH CARE DURING ARMED CONFLICTS AND OTHER EMERGENCIES

8.1. Overview

When people are wounded or fall sick as a result of armed conflicts or other emergencies, it creates health-care needs in addition to those normally associated with the same population. The insecurity inherent in these contexts is a direct cause of wounds and sickness; thus, health care is most needed where it is most difficult to deliver. Health care is frequently imported into these contexts by military forces, international organizations or non-governmental organizations; this may happen with or without the agreement of local authorities.

Health-care personnel involved in importing health care have responsibilities in addition to those already outlined in this guide. Broadly, these relate to:

- understanding the context into which health care is being imported;
- assessing available health-care services and how imported health care might help;
- safety and security considerations.

Whilst the provision of health care is the obvious goal, each such agency can have different standards, provide different services, be guided by different ethics, and may even operate within a different legal framework. Whilst importing health care must always be a part of neutral and impartial humanitarian action, the reasons for doing so in these contexts may differ. They may be religious, strategic or political; some agencies may even be doing so to raise their profile in the media. Imported health care is rarely free of such objectives. Health-care personnel, independently of their employing agency, have a responsibility to ensure that the health care delivered remains compatible with health-care ethics, whatever the reasons for its delivery in that context.

Imported health care frequently brings material and people into an existing health-care infrastructure that is already or is likely to be overwhelmed, over-crowded and functioning with difficulty if at all. Health-care personnel already

working there may not have received salaries or remuneration because of the violence and the breakdown of administrative systems. Those responsible for importing health care must consider not only how to make the infrastructure function, but also some form of remuneration for local personnel, for work being done and for unpaid work done in the past. The issue of remuneration can be an extremely difficult one and discussions about it can consume time and energy made even more valuable by an emergency.

Imported health care may not always be regarded with favour by authorities. It may draw attention to their deficiencies or discriminatory policies, and may be seen as aiding opponents. Any perception that imported health-care personnel are providing incorrect care or conducting themselves in an inappropriate manner might be used to threaten or expel them or the organizations to which they belong. Imported health care may also disrupt existing health-care services and, by providing services free of charge, threaten the financial well-being of health-care personnel already working in that area.

Another important consideration when importing health care is related to the technology that may be used: Is it appropriate for that context and is it sustainable?

8.2. Critical questions

Here are some questions to consider if you are requesting, organizing, sending or participating in imported health care in a given context:

- Has a reliable and impartial assessment of the health-care needs been made? Have the unmet needs been identified?
- To what extent are the authorities, local and national, willing or able to meet the unmet needs?
- Is importing health care the best way to address these needs? Can the unmet needs be addressed by other means (such as finding additional staff in the context, transferring wounded and sick people to health-care

facilities out of the context or administrative measures such as suspending all operations that are not urgent)?

- Are the authorities aware of and in agreement with the health care being imported into that context?
- Is there a realistic chance that by importing health care some or all of the unmet needs will be met?
- Are the available materials and expertise appropriate to meet the unmet needs?
- Has an assessment been made of the adverse impact that imported health care may have on existing health care?
- Whether the imported health care has met some or all of the unmet needs: How will this be evaluated?
- Are the qualifications of imported personnel valid in that context and recognized by the authorities?
- Is meeting unmet needs the importing agency's primary objective for importing health care? Or is the objective something else?
- What is the legal and professional framework within which health care will be imported?
- What are the rights of imported health-care personnel in the context in question (Section 4)?
- Has adequate consideration been given to the acceptability within that culture of the idea of imported health care and to the views of health-care personnel already working there?
- Has adequate consideration been given to people with special vulnerabilities and to victims of sexual violence (Section 7)?
- Has a realistic assessment been made with respect to the safety of both imported and local health-care personnel? Who is responsible for the safety of health-care personnel?
- Is there a policy about the possession of sensitive information, with regard to possible violations of international law (Section 11), and about dealing with the media (Section 12)?
- Who is responsible for the general well-being (insurance, accommodation, food, etc.) of the health-care personnel being imported?

Boris Heger/ICRC

9. HEALTH-CARE RECORDS AND TRANSMITTING HEALTH-CARE INFORMATION

9.1. Overview

The process of creating and maintaining health-care records is an essential part of caring for the wounded and sick. Being able to find the wounded and sick who have been given treatment, knowing what has happened to them and keeping track of them is essential for their continued care, from the emergency scene to hospital. Every first-aid post, clinic, hospital or rehabilitation centre must keep a record of the people that it has treated and, in the case of ambulances, transported.

Like other aspects of health care, keeping records may be more difficult under the constraints imposed by armed conflicts and other emergencies.

You have a responsibility to:

- keep accurate records at every stage, whether at a health post or anywhere else along the health-care chain: from first aid, through transport and hospital care, to rehabilitation;
- permit people to have access to their health-care records;
- limit everyone else's access to these records;
- give consideration to the best way of storing records: ensuring confidentiality but at the same time allowing other health-care providers access when necessary;
- handle these records in a manner compatible with the patient's best interests in case of mental incapacity caused by severe injury or coma, for instance.

9.2. What are health-care records and why keep them?

All health-care personnel tending to the wounded and sick must keep health-care records; in many contexts, this may not be a legal requirement, but it is an ethical duty everywhere.

There are three basic principles governing the keeping of health-care records:

- there must be an accurate record of what the wounded or sick person's principal problem is, what has been done and by whom, and what is planned;
- access to these records must be restricted, for the purposes of ensuring confidentiality;
- the records must be accessible at every stage of the person's treatment.

An individual's health-care record includes:

- personal details such as his or her name, address, date of birth and hospital number, and the names of his or her relatives;
- any documented clinical information pertaining to diagnosis and treatment;
- photographs, X-rays, videos of the person;
- the names of people who have provided health care to this person;
- a record of any consent given;
- where the person has gone (home, to another hospital, etc.).

The confidentiality of such information when sent by radio or the Internet, for example, must be assured.

With respect to their health-care records, wounded or sick people have a right to:

- absolute confidentiality with regard to their identity and other personal information, their diagnosis and the treatment they received;
- know the identity of the health-care provider or service that is treating them;
- see their health-care records;
- have copies of their health-care records;
- be able to decide who may have access to their health-care records and under what circumstances.

Information derived from individual records to compile statistics regarding hospital activity, for example, or to document violence (Section 11), should be kept anonymous as much as possible.

9.3. Adapting health-care records to the context

As with other aspects of delivering health-care, circumstances may dictate standards of record keeping. You have a responsibility to make appropriate adjustments. Health-care records that are most useful in armed conflicts and other emergencies have the following characteristics:

- they are designed in such a way that a maximum of information can be recorded routinely and consistently with a minimum of effort;
- the admission procedure and the first 24 hours of care should be recordable on one page;
- they should be usable as triage cards as well;
- the materials used must be durable.

9.4. Disclosing information

In certain circumstances, domestic law will override the absolute requirement for confidentiality. In some countries, you might have a responsibility to report certain kinds of information to authorities: gunshot trauma and certain infectious diseases, for example. In a military context, there are clearly times when information about a person's condition must be shared with a superior officer. The person concerned must be informed that disclosing this information in this way is a legal or military requirement.

A person receiving health care may refuse to consent to sharing his or her health-care information. If it is not possible to comply with the person's wishes, it is your responsibility to explain why and what the result of doing so is likely to be.

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NAME: NUMBER:

COMING FROM: MALE / FEMALE AGE:

DATE: _____ / _____ / _____ TIME: _____ GSW MI UXO FRAGMENT BLAST BURNS OTHER

TIME SINCE INJURY: _____

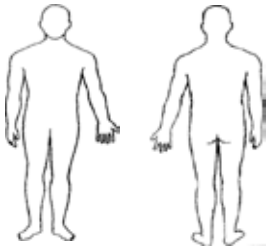
Allergies:

Medications:

Past med history / pregnancy:

Last meal:

Events (circumstances of accidence):



MEDICAL ASSESSMENT

PULSE: BP: RESP: TEMP:

GENERAL CONDITIONS:

good: bad: critical:

PRE-OPERATIVE INSTRUCTIONS

IV FLUIDS:

ANTIBIOTICS:

ANALGESICS:

Hb: Hct: X match: ATS / ANATOXAL: NPO from:

X ray:

TRIAGE: I Serious II Secondary III Superficial IV Supportive

OPERATION NOTES

POST-OPERATIVE INSTRUCTIONS

IV fluids:

Antibiotics:

Analgesics:

Position / Physio / Drains / Traction

By mouth: Food / Fluids / Nil

Other:

Next in OT:

PENETRATING WOUND SCORE

E ☐ X ☐ C ☐ F ☐ V ☐ M ☐

E ☐ X ☐ C ☐ F ☐ V ☐ M ☐

OTHER INFORMATION

Marko Kokic/ICRC

10. THE DYING, THE DEAD AND HUMAN REMAINS

10.1. Overview

In regular civilian practice, care for the dying and ensuring death with dignity are routine elements of health care; and most health-care systems routinely deal with dead bodies in a way that is culturally accepted. Usually, identifying the body of a person who has died of wounds or sickness while receiving health care is not an issue. Furthermore, military bodies that are sufficiently organized to provide health care for their wounded and sick personnel are likely to have in place mechanisms to identify, manage, transport and dispose of the remains of dead comrades. Such practices ensure a family's right to know the fate of their relatives and are a necessary part of the grieving process. However, in the contexts for which this guide is written, mechanisms for identifying human remains cannot be taken for granted.

In armed conflicts and other emergencies, the systems permitting the necessary practices and routines are easily rendered dysfunctional just when the need for them increases. The health-care systems – already overloaded or under strain because of the additional needs generated by the armed conflict or emergency – are further overloaded or strained by dying and dead people; and a high proportion of the dead may not be identified. This can lead to harrowing scenes of families looking for their relatives among piles of dead and unidentified bodies in or around a health-care facility. This situation is also extremely distressing and disruptive for health-care personnel who must continue to go about their work of caring for the wounded and sick. Adequate mechanisms for dealing with dead bodies and their identification serve to facilitate health care in these contexts by ensuring that health-care infrastructure is used properly, and by limiting the emotional impact on health-care personnel.

10.2. The "right to know"

The right of families to know the fate and whereabouts of family members applies in both armed conflicts[32] and other

32 See Additional Protocol I, Art. 32.

emergencies.[33] You have a responsibility to do everything possible to help authorities uphold this right; this pertains to facilitating – certainly not impeding – the process of identifying dead bodies. You may have to inform a family of a particular death; you may also be involved in returning the body to the family and, in certain circumstances, letting the family know how that person died.

10.3. Your responsibilities

This section does not explain how to care for the dying. Guidance about the management of human remains can be found elsewhere.[34] However, here are some general points with respect to your responsibilities:

- treat the dying or dead person and any relatives humanely and with respect;
- recognize that confirming death legally is important for the person's dignity and for his or her family (this can be done only by qualified persons);
- ensure that the dying and the dead are shielded from curious people and photographers;
- remind authorities that it is their responsibility to ensure proper disposal of dead bodies and human remains;
- ensure that dying or dead people, or human remains, are handled in a culturally sensitive manner;
- ensure that messages communicated by someone who is dying, or found on someone who has died, are recorded and personal items stored, so that they can be given to the family;
- if the body is unidentified and/or not claimed by relatives, ensure disposal of the remains in a manner – such as temporary burial – that will facilitate identification in the future;

33 For example, Article 24 (2) of the International Convention for the Protection of All Persons from Enforced Disappearance (2006) provides that "[e]ach victim [i.e. the disappeared person and any individual who has suffered harm as the direct result of a forced disappearance] has the right to know the truth regarding the circumstances of the enforced disappearance, the progress and results of the investigation and the fate of the disappeared person. Each State Party shall take appropriate measures in this regard."

34 PAHO, WHO, ICRC, IFRC, *Management of Dead Bodies After Disasters: A Field Manual for First Responders*, 3rd edition, 2009.

- clearly mark any personal effects (including clothing) associated with an unidentified body and store them in a manner that ensures their preservation and makes it possible to match these effects with the body at a later date;
- do not destroy any personal effects or mix up personal effects linked to different bodies.

Anna-Lena Lundqvist/ICRC

11. GATHERING DATA AND WITNESSING VIOLATIONS OF INTERNATIONAL LAW

11.1. Overview

The primary duty of health-care personnel caring for people who are wounded or sick as a result of armed conflict or other emergencies is to provide appropriate, effective and impartial health care. However, health-care personnel also have a responsibility, in all contexts, to gather data about people in their care, with a view to making improvements in the future; and data gathering is possible during armed conflict.[35] Data gathering may help to organize the hospital and prepare and train staff; it may also provide the basis for improving treatment regimes. Publication of such data in professional journals enables other health-care personnel to benefit from the information. It may also constitute part of performance review (Section 6.3).

Health-care personnel may, during armed conflicts and other emergencies, be caring for people whose wounds or sickness are also physical evidence of the impact of violations of international law (Section 3.6). This, together with the data in their possession, creates difficult dilemmas for these personnel.

11.2. The "data dilemma"

Basic data collected during armed conflicts and other emergencies may relate to: the number of people injured or sick, who they are, the nature of their wounds or illnesses and the circumstances in which they were wounded or fell sick. When analysed and reported, the data may draw attention to the effects of armed conflicts and other emergencies on people's lives and well-being. This has been termed the "science of human security."[36]

However, when the responsibilities of health-care personnel are widened to include the gathering of data under these

35 D. Meddings, "The value of credible data from under-resourced areas," *Medicine, Conflict and Survival*, Vol. 18 (4), 2002, pp. 380-388. See also, R. Coupland, "Security, insecurity and health," *Bulletin of the World Health Organization*, Vol. 85 (3), March 2007, pp.181-183.

36 N. Taback, R. Coupland, "The science of human security," *Medicine, Conflict and Survival*, Vol. 23 (1), 2008, pp. 3-9.

circumstances, it may happen that these personnel come into possession of precise information about the human impact of violations of humanitarian law or human rights law. In effect, such data amounts to evidence of crimes and its gathering and reporting can contribute to a process of justice under domestic or international law. As a result, health-care personnel may find themselves faced with an acute and unavoidable dilemma. On one hand, it may be possible to pass on such information to a person or body responsible for bringing justice to bear, to the media (Section 12) or to other people who can stop or limit such violations. On the other hand, passing on such "sensitive" information may raise serious security issues for the wounded and sick, the health-care personnel concerned and even the institution responsible for providing health care.

This section aims to provide you with some guidance for tackling this dilemma; it also explains how this dilemma might change according to the kind of information you possess.

11.3. What is potentially "sensitive" information?

The sources of the kind of information that might lead to health-care personnel facing the "data dilemma" are:

- the admission register;
- individual patient records, including X-rays or clinical photos;
- hospital or other routine statistics;
- dedicated data gathering about the impact of violence, beyond compilation of hospital or other routine statistics.

The difference between the first three sources and the fourth is this: keeping an admission register, maintaining individuals' health-care records and compiling hospital or other routine statistics are an integral part of a system of health care. Gathering data of another kind – about the wounded and sick and the circumstances of their being

wounded or falling sick – is an additional activity. It may generate the most powerful kind of data and therefore the most "sensitive": evidence of widespread crimes. As a result, addressing the "data dilemma" becomes more pressing in relation to gathering data of this kind.

11.4. Guidance

Some health-care personnel express outrage in public at what they have witnessed, in the expectation that this will improve the situation. In such instances, an assumption is being made by the health-care worker and by the general public – and hence the media – that the testimony of health-care personnel directly involved in treating the wounded and sick in a particular context is both credible and authoritative. Therefore, you should weigh the benefits of such public expression against the risk to the wounded and sick, to yourself, to other health-care personnel and even to the organization providing health care. This is especially applicable to humanitarian agencies importing health care.

However, data gathered for a specific purpose, using a valid methodology, may be reported in an objective manner in professional journals or at health-related, legal or diplomatic conferences. Whilst this may be a less spectacular means of communicating the reality of a context and advocating changes, it can have a major impact in the long run. Nevertheless, whatever the kind of data and whatever the manner of communication, the "data dilemma" applies.

If you are at all concerned that publication of data from the context you are working in might endanger the wounded and sick, you, your colleagues or your institution, you have been caught in the "data dilemma." Here are some guidelines for dealing with it:

- do not put yourself or others in danger by communicating information that you possess as a result of your work;

- if in doubt, gather only data that are part of routine data collection, such as hospital admission data or whatever is required for medical records;
- do not talk to the media about the data unless you are absolutely sure there is no danger to you or others;
- discuss the data gathering with colleagues and with any professional associations who may be able to offer guidance;
- make sure you are completely open with all your colleagues about any data gathering exercise, especially gathering data specifically related to violence;
- make sure that the gathering of data for a specific purpose is done in keeping with standards that have scientific integrity and are compatible with health-care ethics;
- ensure that you have your employer's permission and, where necessary, the approval of an ethical committee for any data gathering that entails more than standard documentation;
- do not make statements of law, such as "This is a war crime!"
- if photographs are taken, it should not be possible to identify from them the wounded or sick person or establish his or her affiliation (for instance, that the person belongs to a particular armed group);
- in the most difficult and precarious circumstances, it may be best not to gather data at all.

Amon Gutman/ICRC

12. THE MEDIA

12.1. Overview

The media, if it has a realistic picture of what is happening in a given violent context, can bring about positive change. Accurate media coverage may result in more resources becoming available for health care, may influence the nature and extent of the violence in that context and may even help to end a conflict. This can create a dilemma for you that is similar to the "data dilemma" outlined in Section 11. However, if you take advantage of your position as a health-care worker – and therefore of your supposed credibility as a witness – to claim that humanitarian law or human rights law is being violated, when such claims cannot be verified, you endanger not only your own safety and that of others, but you also run the risk of escalating the process of accusation and counter-accusation that is a feature of any armed conflict or other emergency. This is serious professional misconduct. As the media are avid for such claims from health-care personnel, all requests for information, interviews and images must be handled with great caution.

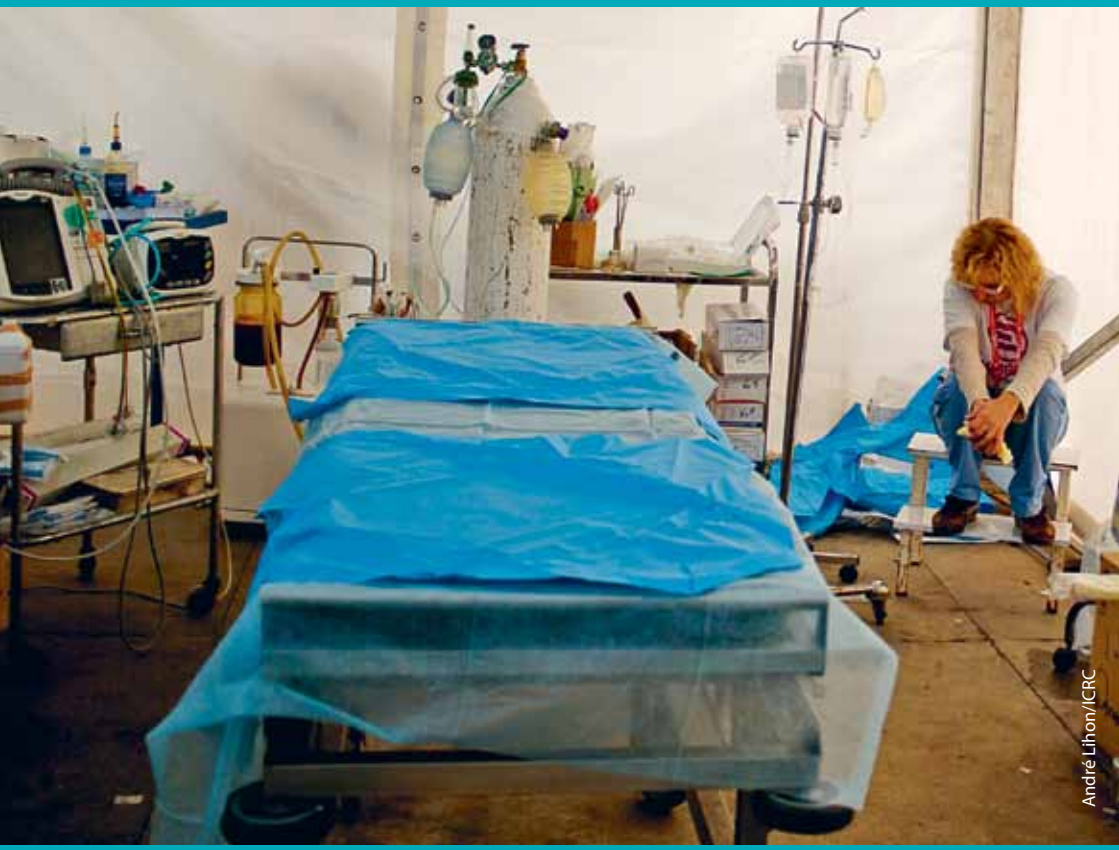
12.2. Guidance

Some points to guide you when dealing with the media are given below.

Choose someone in your organization or hospital to be the contact person for all media matters. Make sure a media policy for you and your colleagues is drawn up, and also make sure that any journalist who wishes to interview you or enter the health-care facility has a copy. Here are some points to bear in mind:

- the well-being and privacy of the wounded or sick person always takes precedence over the media's curiosity or needs;
- shield the wounded and sick from media scrutiny;
- ask to see the credentials of anyone who presents himself or herself as a journalist;

- do not allow yourself to be intimidated into giving answers if you do not wish to do so;
- do not respond to questions designed to stir your emotions;
- make sure that you know when you are talking on and off the record (a journalist may consider a conversation with you to have been an interview). If you cannot be certain, assume that you are talking on the record;
- be aware of hidden recording devices and cameras;
- before making any public statements, give careful consideration to their veracity and the implications for your own safety and that of the wounded and sick, as well as that of your colleagues.



André Lihon/ICRC

13. YOUR RESPONSIBILITY TO YOURSELF

13.1. General advice

Providing care for the wounded and sick in armed conflicts and other emergencies can be extremely stressful. You must take measures to secure your own well-being in order to continue to fulfil your responsibilities.[37]

With respect to your general well-being, you should:

- do everything to ensure your own safety;[38]
- follow local security guidelines if they exist;
- not take unnecessary risks;
- be aware of changes in the context;
- get enough rest;
- know your limits;
- eat regularly and avoid alcohol and drugs;
- fit into the team and not isolate yourself;
- talk to friends and colleagues about what concerns you, especially if you are feeling stress;
- take exercise;
- pay attention to your personal hygiene.

13.2. Stress

Stress can be a form of self-protection when it is a normal and useful reaction to a given situation. However, this can lead to higher and more serious levels of stress. There are three kinds of severe stress felt by people working in armed conflicts and other emergencies. These can be harmful if they are not recognized and dealt with. They are:

- basic stress, which is the result of an abrupt shift to an unfamiliar context;
- cumulative stress, which is caused by a number of factors, including concerns for one's own safety. This can build up slowly or rapidly, and is often foreseeable;
- traumatic stress, which is caused by an unexpected and violent event accompanied by a threat of physical or psychological harm to you or to someone close to you.

37 ICRC, *First Aid in Armed Conflicts and Other Situations of Violence*, ICRC, Geneva, 2006.

38 David Lloyd Roberts, *Staying Alive: Safety and Security Guidelines for Humanitarian Volunteers in Conflict Areas*, ICRC, Geneva, 1999.

Post-traumatic stress disorder, or PTSD, is a delayed response to acute psychological trauma. Both traumatic stress and PTSD require professional help at the earliest opportunity.

The ICRC has published a useful guide for humanitarian aid workers, which helps them to recognize, assess and deal with these different forms of stress.[39]

39 Barthold Bierens de Haan, *Humanitarian Action and Armed Conflict: Coping with Stress*, ICRC, Geneva, 2005.

Malagasy Red Cross Society

14. REVIEW

This guide should help health-care personnel working in armed conflicts and other emergencies deal with dilemmas that manifest themselves under the most difficult circumstances. The sources on which it relies include humanitarian law, human rights law and health-care ethics.

There are a number of questions that you should consider in relation to your responsibilities and your rights in armed conflicts and other emergencies. Preferably, you should do so before you are faced with the difficult situations to which they pertain or, in the case of imported health care (Section 8), before deployment. Here are a few:

- Do I have a clear picture of my responsibilities, as set out in humanitarian law, human rights law and health-care ethics?
- Do I have a clear understanding of my rights (which may be determined by the context)?
- To which texts or set of experiences should I turn when determining the appropriate standard of care in a given context?
- How might I show that I am delivering an appropriate standard of care?
- Have I given enough consideration to the needs of especially vulnerable people?
- Do I know what I should and should not do when faced with someone who is a victim of sexual violence?
- Have I thought through all the implications of importing health care into armed conflicts and other emergencies?
- In the process of making, keeping and transmitting medical records, have I taken all measures possible to assure confidentiality with respect to the identity and condition of the people under my care?
- Do I know my responsibilities with respect to dying people and dead bodies in the context I am working in?

- How do I manage the dilemmas that arise as a result of my possessing important information about wounded or sick people and of having at the same time to take into account the safety and well-being of the people in my care, my colleagues and myself?
- Am I sufficiently prepared to deal with the media?
- Have I taken all reasonable measures to assure my own safety, health and well-being?

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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