

PROTECTING HEALTH CARE FROM VIOLENCE

LEGISLATIVE CHECKLIST

I. INTRODUCTION

To successfully reduce the occurrence of incidents of violence against health care and mitigate their impact, adequate rules in domestic legislation and regulations are required. This document is designed to serve as a practical tool to help the practitioners concerned assess:

- whether the domestic normative framework complies with international obligations and some of the main operational recommendations related to the protection of health-care delivery
- in those cases where gaps are identified, what the appropriate preventive or corrective measures should be.

The document presents a list of questions (a checklist or compatibility study) that cover some of the main challenges related to the protection of health care during armed conflict and other emergencies.¹ (In some cases, the solutions proposed may also be applicable in peacetime.) The objective of this checklist is to provide practitioners with a consolidated overview of their domestic normative framework so that they may quickly spot and address potential gaps or inconsistencies in either international obligations or existing operational and policy recommendations.

The variety of and discrepancies between legal systems around the world necessitate that both analysing domestic normative frameworks and proposing ways to address related issues be carried out on a case-by-case basis. What might be appropriate for one country might not be for other countries. It is therefore up to the practitioner to decide how to fine-tune the use of this checklist and, afterwards, if and how to propose preventive or corrective measures.

Addressing violence against health care in times of armed conflict or other emergencies requires creative solutions that derive from tailored, multidisciplinary approaches. Consequently, no matter how practical or comprehensive this checklist may be, its very nature implies that it must be read and used together with other Health Care in Danger (HCiD) publications² and any other relevant material that will help inform how to set up an effective multidisciplinary approach to the issue at hand. In some cases, practitioners might also find it relevant to add their own questions to the checklist whenever the practical challenges that they encounter in their location require assessment of other areas or aspects of the law than those covered in this document. This checklist should be seen as a practical and flexible tool and certainly should not be used as an exhaustive, stand-alone document.

¹ The term “other emergencies” is used herein to refer to situations that fall short of the threshold for armed conflict but during which security measures or incidents related to security can result in serious consequences for people in need of effective and impartial health care, e.g. death, aggravation of injuries, worsening of illnesses or diseases, or obstruction of preventive health-care programmes. These measures or incidents may 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 security situation prevailing in an area affected by an 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. See The responsibilities of health-care personnel working in armed conflict and other emergencies: <https://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4104-the-responsibilities-health-care-personnel.pdf>, p 12.

² See: <https://healthcareindanger.org/resource-centre/>.

II. METHODOLOGY

The checklist starts with an overview of existing tools and documents on legislation covering the protection of health care. It also gives a brief overview of challenges in the protection of health care. It then provides preliminary questions which should give the user a sense of the place of health-care protection in the general domestic legal system, i.e. the constitution and other law of that State.

The following sections provide substantive questions on the health-care system with examples of legislation from around the world demonstrating what sort of legislation might be required. Questions on the checklist are either closed- or open-ended, depending on the nature of the topics that they address. In all cases though, these questions are intended to trigger genuine reflection on the relevance of the particular aspect of the domestic legal framework, rather than a simple “yes” or “no” or a one-line response. Consequently, answering the questions will not only require researching the mere existence of relevant domestic laws and regulations; more importantly, it will also require looking into the scope of application of those laws and regulations and whether they provide adequate protection against impediments to the delivery of health care in emergencies. As a matter of principle, after having answered the questions, users of the checklist should follow up by asking, “Is this a matter of concern? If so, how should it be addressed?”

The checklist can only be used as part of a more general process, which necessarily entails a reflection on how best to address the gaps identified in the law. The idea is to have a comprehensive overview of what the protections for health care are in a State, with some examples of where changes might be made to legislation.

III. THE 2014 BRUSSELS WORKSHOP AND THE GUIDANCE TOOL

This checklist builds upon pre-existing, important recommendations that discuss strengthening the domestic legal and regulatory framework. For this reason, it should be used in close combination with the two following publications:

- the [report](#) on the 2014 Brussels expert workshop on the domestic normative frameworks for the protection of health care – the report identifies concrete domestic measures and procedures, in particular legislative and regulatory ones, that can be established by State authorities in order to implement the existing international legal framework for the protection of health care in armed conflicts and other emergencies.
- the [guidance tool on the implementation of the Brussels report](#) from the International Committee of the Red Cross (ICRC) Advisory Service on International Humanitarian Law (IHL) – drawing on the recommendations that emerged from the Brussels workshop, this document, which is part of the ICRC Advisory Service [manual on the domestic implementation of IHL](#), was developed as a practical and pedagogical tool to support State authorities in developing effective domestic legal frameworks.

Not only do these two publications present in detail the international legal framework applicable to the protection of health care under both IHL and international human rights law (IHRL) (see in particular Annex 1 of the guidance tool, which is not reproduced in the checklist), but they also present important background information on the main humanitarian consequences of the lack of an effective and comprehensive domestic normative framework in this field.

Users of the checklist are also advised to refer to *HCiD Key Recommendations*³ and examine how the State’s domestic normative framework addresses these key issues.

3 See: <https://healthcareindanger.org/resource-centre/>.

IV. THE MAIN CHALLENGES RELATED TO THE PROTECTION OF HEALTH CARE IN ARMED CONFLICT AND OTHER EMERGENCIES

The main impediments to the adequate delivery of health care in armed conflict or other emergencies include:

- a lack of adequate protection of health-care professionals, patients (wounded and sick individuals), and medical facilities and transports against direct attacks, other forms of assault or interpersonal violence
- a lack of respect for key medical ethics (e.g. medical confidentiality, delivery of impartial medical care), which creates significant dilemmas for health-care professionals.

Specific protection issues related to violence against health care largely depend on context. While some issues are particular to armed conflict, such as warring parties' lack of respect for the fundamental principles guiding the conduct of hostilities, other issues are related to either armed conflict or other emergencies, such as the excessive use of force or other inappropriate or inadequate forms of response by law enforcement to security issues arising during ongoing urban violence or political unrest, or responses to pandemics or epidemics. Other categories of protection issues may result from systemic shortcomings that apply in armed conflict, other emergencies and peaceful situations alike, such as the lack of effective protection for health-care workers against low-level – but nevertheless ongoing and destructive – acts of interpersonal violence committed for various reasons by frustrated patients, their family or friends, or, in some cases, the community at large.⁴ Such violence has manifested itself with particular prominence in relation to the Ebola virus disease and the coronavirus disease pandemic. It is also the feature of some post-conflict settings where elevated health needs are not met by weakened health-care systems.

From the perspective of laws and regulations, solving these issues will almost always require looking – in part or in full – into topics that apply across the board. Each of these protection elements can be broken down into a multitude of facets, which include the necessity for:

- proper awareness-raising and training
- adequate sanctions (criminal and disciplinary) for violations of the law
- clear legal framing of the roles, rights and duties of and restrictions on those concerned (e.g. armed and security forces, the civilian population, State ministerial authorities, health-care professionals, National Red Cross and Red Crescent Societies, relief agencies and non-governmental organizations)
- clear legal framing and protection of the use of the protected emblems
- the integration of the relevant legal prescriptions into professional operational guidelines (civilian and military), standard operating procedures and policies
- effective data collection and emergency-response mechanisms which ensure adequate coordination between all those concerned.

In order to provide users with a tool that will be as encompassing as possible as they work to identify how the domestic normative framework plays into the issues at hand, the checklist tackles areas of law that are of specific relevance to concrete humanitarian problems faced by practitioners, which are addressed first and foremost in the Brussels report as well as in other key HCiD publications. Under each heading are examples of concrete humanitarian problems that arise from inadequacies in the normative framework in that area.

⁴ In armed conflict, civilians are prohibited from using violence against wounded and sick people; see: Art. 18(2) of Geneva Convention I and Art. 17 of Additional Protocol I. The 1987 commentary on Art. 18(1) of Additional Protocol II makes the same argument (even if there is no explicit rule to that effect for non-international armed conflicts). See: <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=086657E594BB4CC2C12563CD0043ADD0>.

V. PRELIMINARY QUESTIONS FOR UNDERSTANDING THE DOMESTIC LEGAL AND CONSTITUTIONAL FRAMEWORK FOR THE PROTECTION OF HEALTH-CARE DELIVERY

The purpose of this section is to give the user of the checklist a good sense of the place of health-care protection in the State's general constitutional and legal framework as a starting point.

Answers to these preliminary questions do not generally require corrective action, nor must the questions be considered in order to use the rest of the checklist.

However, they might either assist in advocating for other actions in sections A through F, below, or provide the legal underpinning for proposing legislative changes as the rest of the checklist is considered.

1. Is the right to health included in the national constitution or otherwise considered to be a fundamental right of individuals in times of both peace and armed conflict? Does it entail the unconditional right to access health care without any adverse distinction founded on sex, race, nationality, religion, political opinions or any other criteria?
2. Does the State have specific legislation addressing how the government or institutions of State must respond during armed conflict or other emergencies?
3. Does domestic legislation include specific provisions related to the respect for and protection of the wounded and sick, medical personnel, facilities and transport during armed conflict?
 - a. Does domestic legislation include specific provisions related to the delivery of health care and the protection of patients and medical personnel, facilities and transports in other emergencies?
 - b. If so, what is the definition of "other emergencies" (i.e. what is the exact scope of application of that legislation)?
 - c. If such provisions exist, how do they differ from the general protection afforded patients and medical personnel, facilities and transports in all circumstances?
4. Is the protection of health-care delivery regulated by way of specific, dedicated law on health care or rather through provisions on that subject that are integrated into existing legislation with a broader scope (penal codes, regulations on health services, disaster mitigation laws, etc.)?
5. Is the protection of health care integrated into military and law enforcement policy in the State (e.g. a military manual or operational guidelines covering law enforcement)? How do these regulations tackle the protection of health care?
6. What legislative act or acts regulate medical activities and the provision of health-care services in the State in peacetime and armed conflict?

7. What bodies supervise health-care activities in the State?⁵ For instance, are health-care activities (e.g. physician, nursing, prosthetic-orthotic, pharmaceutical or ambulance services) organized under the supervision of national professional associations or a similar body?

If so, does domestic legislation clearly define the role and duties of these professional associations, in particular in relation to their members' respect for professional ethics and to participating in the protection of their members against acts of violence?

8. Does domestic legislation or regulation:
- a. provide a clear definition of the following categories: health-care personnel, medical activities, health-care units/infrastructure/facilities, and medical means of transportation?
 - b. clearly define the role and duties of each category of health-care professionals, both in peacetime and during armed conflict and other emergencies?
 - c. provide a clear framework for assigning people or objects exclusively to medical duties or purposes in an armed conflict?
 - d. provide authorization and recognition for people or objects assigned exclusively to medical duties or purposes in an armed conflict?⁶
9. Is there a general obligation under domestic law to rescue or provide assistance to people in need of urgent medical care?
10. If so, does such a law extend to the armed forces and law enforcement agencies, and is violation of that law (i.e. not assisting someone in need of urgent medical care) subject to criminal sanctions in all circumstances?

5 The range of manners in which States regulate health-care activities by way of supervisory bodies is very broad. In some States a national medical council or union that takes care of issues related to the regulation of services, professional registration and labour rights is often combined with a national medical association that is in charge of other, technical aspects; in other States, only one professional association is in charge of all these matters, working in close connection with a body directly under the ministry of health.

6 Ensuring that people and objects are assigned exclusively to medical duties and purposes has the medical benefit of ensuring that there is capacity to meet medical needs in armed conflict. Recognition implies that the authorities of parties to conflicts confirm that a given person or object is intended to serve in an exclusively medical capacity in an armed conflict (and, by extension, that they are not supposed to serve in other, especially military, capacities). Authorization is the reverse side of the coin of this, as it grants to the person or object the entitlements/benefits/rights that come with the medical designation, especially to use one of the protective emblems.

VI. SUBSTANTIVE QUESTIONS

These questions are to be used to assess the compatibility of domestic legislation and other regulations, policies and practices and to provide some understanding of where changes might be required.

A. THE LEGAL AND REGULATORY PROTECTION OF HEALTH-CARE PROFESSIONALS AND FACILITIES (INCLUDING RULES ON HEALTH-CARE ETHICS AND MEDICAL CONFIDENTIALITY) WHICH MIGHT LEAD TO LEGISLATIVE AND OTHER CHANGES

During armed conflict or other emergencies, health-care professionals, from first responders to hospitals' medical teams, are exposed not only to physical violence but also to intense constraints on how they must carry out their core duties.

1. Conflicts between legal and regulatory obligations imposed on health-care professionals and their ethical duties are a long-standing issue during armed conflict and other emergencies. In essence, they result from the misalignment between the State's security (or public health) concerns and the need for health-care professionals to abide by core prescriptions related to their duties irrespective of external circumstances.
2. Health-care workers operating in sensitive and unsafe environments are exposed to acts of interpersonal violence. They must be given the means to plan, prepare and carry out their duties under a framework that guarantees their safety.
3. Although not always linked to armed conflict or other emergencies, low-level acts of interpersonal violence against health-care professionals occurring inside medical facilities, sometimes exacerbated by the ease of illegally bringing weapons into these facilities, is a major protection concern in almost all countries.
4. In all circumstances, in particular during armed conflict and other emergencies, health-care workers must have individual or collective professional insurance that covers the risks they take.

Appropriate domestic legislation and regulation are key to addressing these concerns.

Reference documents:

1. [The Brussels expert workshop report](#)
2. [Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflict and Other Emergencies](#)

Examples of humanitarian issues linked to breaches of medical ethics

- Armed or security forces forcing medical professionals to provide preferential treatment to their own soldiers before other categories of patients or preventing them from providing medical care to injured enemy fighters
- Armed or security forces forcing medical professionals to perform acts that might be perceived as harmful to the patients (approving solitary confinement, supervising "tough" interrogation sessions and so on)
- Domestic legislation making it compulsory for health-care professionals to report certain categories of wounded or sick people before being allowed to treat them
- Domestic legislation making it compulsory to breach medical confidentiality by requesting that health-care professionals forward patients' personal information or medical records

- Domestic legislation criminalizing the mere provision of medical assistance and treatment to certain categories of people considered enemies of the State, in particular those thought to be engaged in acts associated with terrorism
- Health-care personnel discriminating against a category of patients whom they perceive as less deserving of treatment owing to their own prejudices or political allegiances

Examples of patterns of interpersonal violence or intimidation affecting health care

- Acts of physical and verbal violence against health-care professionals carried out by patients and/or their friends or family, triggered by factors such as a patient’s frustration over waiting time, the patient not receiving the diagnosis they expected, the family’s anger at health-care staff following the patient’s death, etc.
- Acts of violence against health-care professionals, patients and facilities carried out by specific communities or by the greater public, often triggered by a collective reaction of distrust, denial or fear during armed conflict or other emergencies⁷
- Other forms of individual or collective attempts to alter the functioning of health services (e.g. refusal to undergo procedures mandated by public-health requirements, demands to be prioritized for treatment)
- General criminality, political tensions or generalized violence affecting the reach of health services in the community or within health-care establishments

Questions

I. Protection of medical ethics

1. Under what domestic law and/or regulations are the ethical duties applicable to health-care professionals regulated and protected?

Have codes of ethics been adopted by national associations of health-care professionals?

2. Do the domestic rules on ethical duties comply with international standards (e.g. [WMA International Code of Medical Ethics](#), [WMA Regulations in Times of Armed Conflict and Other Situations of Violence](#))?
3. Does the vocational training of health-care professionals and emergency responders include briefings on the laws and regulations that apply to them (both their rights and their duties) during armed conflict or other emergencies?
4. Is domestic legislation applicable to health-care professionals consistent with the following ethical duties?
 - a. Always act in the best interest of the patient.
 - b. Provide impartial medical care.
 - c. Respect medical confidentiality.
5. Does domestic legislation guarantee that medical care takes precedence over military and law enforcement activities? In other words, does it ensure that patients receive medical care before being arrested for a crime and in accordance with triage systems without consideration for which armed force they belong to?

Nigeria, [Compulsory Treatment and Care for Victims of Gunshots Bill \(2017\)](#)

Section 1 establishes the right of every person with gunshot wounds to be treated, and section 4 provides that the police shall not remove any person with gunshot wounds from the hospital for the purposes of investigation unless the chief medical director of the hospital certifies that the person is “fit and no longer in dire need of medical care.”

⁷ For instance, during disease outbreaks (such as the coronavirus disease pandemic and Ebola epidemic) or when vaccination campaigns are being rolled out (such as for polio)

6. Does domestic legislation guarantee the right of health-care personnel to perform their medical duties and not to be forced to act contrary to the principles of medical ethics?

Ethiopia, [Criminal Code, Proclamation No. 414/2004](#) (2005), Article 271(1)(c)

“Whoever [...] organizes, orders or engages in compelling persons engaged in medical [...] activities to perform acts or to carry out work contrary to or to refrain from acts required by their respective professional rules and ethics or other rules designed for the benefit of the wounded, sick or civilian population, is punishable in accordance with Article 270.”

7. Does domestic legislation or a medical code of conduct limit or prohibit bringing weapons into health facilities?
8. Does the law regulating the rights and duties of medical personnel guarantee medical impartiality and the full independence of medical professionals as to their ability to assess what the best interest of the patient is in each case and to make decisions accordingly?

France, [Defence Code](#) (2004, as amended in 2008), Article D4122-8

With regard to “medical impartiality” in armed conflict, the Defence Code states that combatants must collect, protect and care for the wounded, sick and shipwrecked without any discrimination on the grounds of race, gender, religion, nationality, ideology or ethnic group.

Peru, [Decree on the Use of Force by the Armed Forces](#) (2010), Article 8.2.1

The decree states that people placed *hors de combat* by illness or wounds must in all circumstances be treated without any unfavourable distinction based on race, colour, religion or belief, sex, birth, socio-economic status or any other similar criterion.

9. Is the provision of health care to certain categories of people (legal or illegal migrants, people categorized as terrorists, fugitive criminals, members of organized armed groups or of other illegal groups, refugees, asylum seekers, etc.) prohibited or conditioned under domestic law? Conversely, are there categories of people to whom preferential medical treatment must by law be given in emergency situations (for instance members of the armed and security forces)?

Afghanistan, [Public Health Law](#) (2009), Article 18

The article guarantees the provision of emergency medical aid by the nearest health facilities to “those whose health condition requires emergency aid, without any discrimination, and by taking into consideration the prioritized status of patients.”

Somalia, [Military Criminal Code](#) (1963), Article 374

The article provides for a penalty of military confinement for “a soldier assigned to the medical service who, during or after combat, fails to lend his assistance to soldiers or other persons regularly accompanying the belligerent armed forces who are sick, wounded or shipwrecked, even if they are enemies.”

United Kingdom, [Law of Armed Conflict Manual](#) (2004), paragraph 7.3.2

It is forbidden “to give the treatment of United Kingdom and allied wounded priority over the treatment of wounded enemy personnel. The only distinction which is permitted in dealing with the wounded or sick is that founded on real medical need.”

10. What are the legal or professional remedies available to health-care professionals in case they have been pressured or forced to breach core ethical duties? Is the applicable reporting or complaint system effective?

United Kingdom, [NHS Employers guidance on violence against staff](#) and [Management of Health and Safety at Work Regulations](#) (1999)

The guidance brings forth an option for judicial remedy, whereby health-care workers who are “abused, threatened or assaulted in circumstances relating to their work” may sue their employers for compensation. As stated in the regulations, employers have an obligation to implement preventive and protective measures to protect their employees from serious and imminent danger.

11. Does domestic legislation guarantee medical confidentiality? What are the exceptions to this principle under domestic law? Under what circumstances can/must a health-care professional disclose patient information to State authorities?

Philippines, [Executive Order No. 212](#) amending Presidential Decree No. 169 on reporting of the wounded by medical practitioners (1987)

The order amends a decree that required medical professionals, under pain of penal and administrative sanctions, to report to military authorities the treatment of patients for serious and less serious physical injuries as defined in the Penal Code. The order maintains the duty of professionals to report such treatment but stipulates that the reports must be made instead to the civilian governmental health authorities.

12. Where there are exceptions to medical confidentiality:
 - are the exceptions consistent with medical ethics (i.e. based on the best interest of the patient – for example, when a patient in need of medical attention is not able to give informed consent) or based on other superior motives, such as in public health emergencies or when divulging personal information will prevent the commission of serious crimes?
 - are the exceptions strictly defined and circumscribed in the law?
 - are the concepts therein (e.g. “international danger to public health”, or “public order”, “security of the State” or “emergency situations”) clearly defined?
 - does the law clearly define the objective and purpose of the communication of personal information to State authorities?
 - is the law clear so that health-care professionals who are not lawyers can easily identify when the transmission of personal information to State authorities is compulsory as opposed to when it is simply permitted?
13. Does the law clearly define the type of information that must be communicated to the State authorities, and is that information limited to what is strictly necessary in relation to both the objective of communicating said information to the State and the circumstance that triggered the exception to medical confidentiality?
14. When the transmission of patients’ personal information is pursued at the request of or following an order from State authorities (e.g. members of the armed forces, law enforcement officials, intelligence agencies, judicial authorities or ministerial authorities), does the law provide sufficient procedural safeguards and remedies to health-care professionals to guarantee that the request or order is not arbitrary and complies with the law?
15. Do exceptions to medical confidentiality applicable in armed conflict or other emergencies differ from those applicable in peacetime?
16. Is the disclosure of patients’ personal information by health-care professionals without the patients’ consent, outside of legal exceptions, subject to criminal and disciplinary sanctions?⁸

8 For examples drawn from 21 countries, see the Swiss Institute of Comparative Law’s *Legal Opinion on the Obligation of Healthcare Professionals to Report Gunshot Wounds*, which covers Australia, China, Colombia, Egypt, El Salvador, France, Lebanon, Mexico, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, the Philippines, Russia, South Africa, South Sudan, Spain, Tunisia, Ukraine and the United Kingdom: <https://www.isdc.ch/media/1834/17-120-final-nov19.pdf>.

17. Are there effective disciplinary and criminal sanctions for forcing health-care professionals to perform acts that are manifestly in contradiction with their ethical duties and with individuals' right to health (for instance by forcing health-care workers to perform acts that are or can be harmful to the patient, by prohibiting them from providing medical treatment or, conversely, forcing them to provide medical treatment preferentially to specific categories of people, or by illegally forcing them to breach medical confidentiality)?

Ethiopia, [Criminal Code, Proclamation No. 414/2004](#) (2005), Article 271(1)(c)

“War Crimes against Wounded, Sick or Shipwrecked Persons or Medical Services. Whoever, in the circumstances defined above [i.e. in times of war, armed conflict or occupation and in violation of the rules of public international law and of international humanitarian conventions] organizes, orders or engages in compelling persons engaged in medical [...] activities to perform acts or to carry out work contrary to or to refrain from acts required by their [...] professional rules and ethics or other rules designed for the benefit of the wounded, sick or civilian population, is punishable [by rigorous imprisonment from five years to 25 years, or, in more serious cases, with life imprisonment or death].”

18. Conversely, are serious breaches of medical ethics wilfully committed by health-care professionals subject to administrative/disciplinary and/or criminal sanctions?

Indonesia, [Law No. 29 of 2004 on Medical Practices](#), Article 69

A medical doctor who is found to have violated medical ethics shall be subject to disciplinary sanctions in the forms of written warning, revocation of a medical license and/or mandatory participation in additional medical training or education.

Mexico, [General Health Law](#) (1984), Article 469

Any medical professional who without just cause refuses to provide assistance to a person in an emergency, putting their life in danger, shall be punished by imprisonment for a period of six months to five years.

II. Protection against interpersonal violence impacting health care

1. Is exposure to violence factored into the management of the health system, and does the regulatory framework require mechanisms aimed at preventing incidents and disruption of programmes due to the security situation?⁹
2. Which government authority (national, regional or local) is in charge of regulating the use of active and passive security measures in health-care facilities to protect health-care professionals and their patients against acts of violence inside these facilities? Under applicable regulation, do government authorities cover the cost of such security measures for health-care facilities located in sensitive or insecure areas? Do such provisions take into account the necessary balance between the facilities' security/personnel's safety and accessibility to the public?
3. Is there a distinction made between public and private facilities in the national/regional/local regulation applicable to the security of health-care infrastructure?
4. Is there a national policy to address interpersonal violence against health-care professionals (not related to conflict or other emergencies)? If so, how is this regulated and supervised?
5. Is there a law, regulation or practice which limits or prohibits the bringing of weapons into health facilities by members of the community, law enforcement or military personnel?

⁹ For instance, is the [Safer Access model](#) – or a similar framework – known and used by the National Society (and possibly by other emergency responders/health-care professionals) when operating in sensitive and insecure environments?

6. Under domestic law, do all health-care professionals and volunteers, first responders and employees of ambulance and pre-hospital services benefit from health insurance in the event of injury, illness (mental or physical) or disability resulting from their work?
7. Does the law distinguish between emergency health services and other state emergency services (such as the police)?

Australia, *Emergencies Act* (2004)

Ambulance services, rescue services and firefighting services are under the authority of the emergency services commissioner. The latter is responsible for the overall strategic direction and management of the emergency services and operational and administrative support to the services. The act does not group the police force with the emergency services but foresees scenarios where the emergency services would render assistance to police officers in dealing with an incident or emergency.

B. PROTECTION AND FRAMING OF THE USE OF THE DISTINCTIVE EMBLEMS PROTECTED UNDER IHL AND OF OTHER SIGNS TO IDENTIFY HEALTH-CARE PROVIDERS

The use of the red cross, red crescent and red crystal emblems as protective and indicative devices by medical personnel, facilities and transports is a fundamental aspect of protecting the provision of and access to health care in times of armed conflict and other emergencies. In some cases, the use of other emblems can also prove to be effective.

It is widely agreed that the framing of such emblems' use in appropriate domestic legislation is instrumental in securing the emblems' protective power.

Reference documents:

1. [The Brussels expert workshop report](#)
2. The ICRC's [model law concerning the use and protection of the emblems](#)
3. The ICRC's [Study on the Use of the Emblems](#)

Examples of misuses of the protected emblems

Misuses of the protected emblems can take various forms, each of which entails various degrees of concern in a humanitarian sense:

- misuses of the emblems for commercial or fundraising purposes by local actors, which can indirectly diminish the prestige and the meaning of the emblems as a visible sign of protection given to health-care professionals or constitute fraud
- the use of the emblems on non-medical military vehicles to transport troops or equipment
- perfidy, which is the most extreme form of misuse of those emblems during armed conflict.

The use of the red cross, red crescent and red crystal emblems is restricted to a specific set of entities and individuals under specific circumstances. Therefore, it is advisable for new logos to be developed and used by all other health-care entities and professionals who are not permitted to use the emblems.¹⁰

Aside from the question of whether there are adequate laws on the emblems, an additional consideration is how and through what process knowledge about the domestic rules governing the use and the protection of the emblems is being disseminated among the general population. How does the National Society address this challenge?

¹⁰ See: <https://www.minsalud.gov.co/salud/PServicios/Paginas/mision-medica.aspx>.

Questions

1. Has the State adopted domestic legislation regulating the use and the protection of the emblems both in peacetime and during armed conflict and other emergencies?

If so, does this legislation:

- a. clearly identify the entities allowed to use the emblems?
- b. clearly identify the uses for which specific permission must be requested?
- c. designate the authorities in charge of regulating the general and exceptional use of the emblems?
- d. specify clear sanctions in case of misuse of the emblems?

For more detailed guidance, please refer to the [model law concerning the use and protection of the emblems](#).

If not, under what regulation is the use of the emblems framed?

Albania, [Law No. 7865 on the Protection of the Emblem and the Name of the Red Cross](#) (1994)

- Article 2: The emblem of the red cross is used as an indicative sign and a protective sign in accordance with the Geneva Conventions, the Additional Protocols and this law.
- Articles 3–4: The Albanian Red Cross, International Red Cross organizations and their staff are authorized to use the emblems at any time.
- Article 5: Use of the emblems during wartime is subject to the authorization of the Council of Ministers or bodies established by them.
- Article 7: Use of the emblems and the name of the Red Cross by natural and legal persons contrary to the manner prescribed in this law, and hence the Geneva Conventions and its Additional Protocols, is a minor administrative offence that is subject to fine of 1,000 to 10,000 local currency.

Armenia, [Law on the Use and Protection of the Emblems of the Red Cross and Red Crescent](#) (2002)

- Articles 9–12 and 14–15: The use of the emblems is subject to the provisions of the Geneva Conventions and Additional Protocols I and II. The emblems may be used, as indicative and protective signs, in times of peace and war by medical personnel of the armed forces, civil medical services and the Armenian Red Cross Society.
- Article 13: The minister for defence's approval and the Armenian Red Cross Society's supervision are required for the use of emblems by humanitarian personnel or units of neutral States and other States not participating in the conflict.
- Article 21: Unlawful use of the emblems is punishable by the relevant legislation.

2. Does domestic legislation regulate the use of emblems related to the provision of health-care services other than those regulated under international law? If so:
 - a. similarly to the red cross, red crescent and red crystal emblems, does the applicable legislation clearly identify the signs chosen, the entities permitted to use them, the use for which they are authorized and the national authority in charge of regulating their use?
 - b. is their use allowed in situations of armed conflict?
 - c. is there a process in place to avoid confusion with other protected emblems during armed conflict or other emergencies?

Brazil, [Law No. 3.960](#) (1961) and [Decree No. 966](#) (1962)

The law contains a description and drawing of the emblem. The emblem is described as “a red serpentine stick on a white background”. The decree allows the emblem to be used as a protective sign by medical and paramedical personnel, units, facilities and vehicles but not by members of the armed forces.

3. Is there a system in place in the State to adequately track, process and sanction misuse of the emblems? Which State authorities are responsible for receiving allegations of such misuses? Does the National Society play a role in helping the authorities concerned look for and report such misuses?
4. Do domestic legislation and regulations include dissuasive disciplinary measures, including criminal sanctions, that can be imposed on members of the armed forces for using the distinctive emblems for purposes other than those authorized by the Geneva Conventions and their Additional Protocols, such as using vehicles of the medical services or medical facilities marked with the emblem to carry or hide weapons or soldiers?

Algeria, [Military Justice Code](#), Article 299 (1971)

“[A]ny individual, whether military or not, who in wartime, in an area of operations [...] and in violation of the laws and customs of war, improperly uses the distinctive signs and emblems defined by international conventions to ensure respect for persons, objects and places protected by said conventions shall be punished by one to five years’ imprisonment.”

Australia, [ADFP 130 – Law of Armed Conflict](#) (1994), paragraph 1315(l)

Misusing or abusing the red cross symbol for the purpose of gaining protection to which the user would otherwise not be entitled constitutes “grave breaches or serious war crimes likely to warrant institution of criminal proceedings”.

United States, [The Manual for Military Commissions](#) (2007), Section 950v(b)(19)

“Any person subject to this chapter who intentionally uses a distinctive emblem recognized by the law of war for combatant purposes in a manner prohibited by the law of war shall be punished as a military commission under this chapter may direct. [...] Maximum punishment. Confinement for 20 years.”

5. More generally, is the misuse of the protected emblems both in peacetime and in wartime and by both civilians and military personnel considered a criminal offence in the State?

Bosnia and Herzegovina, [Criminal Code](#) (2003), Article 184

“Whoever misuses or carries without authorisation [...] the emblem or flags of the Red Cross, or symbols corresponding to them [...] shall be punished by a fine or imprisonment for a term not exceeding three years.”

Chad, [Law No. 053/PR/2014 on Protection and Use of the Red Cross and Red Crescent Emblems and Any Other Distinctive Sign](#) (2014), Article 10

“Imprisonment for a period of 15 days to two years and a fine of 50,000 to 200,000 francs, or either of these sentences alone, shall be imposed on:

- any person who, intentionally and without entitlement, uses the emblem of the red cross or the red crescent or the designation ‘Red Cross’ or ‘Red Crescent’, a distinctive signal or any other sign, name or signal which constitutes an imitation thereof or which might lead to confusion, irrespective of the aim of such use;
- any person who, in particular, displays said emblems or designations on signs, posters, announcements, leaflets or commercial documents, or affixes them to goods or packaging, or sells, offers for sale or places in circulation goods thus marked;
- any person who commits or gives the order to commit the offence in the management of a corporate body.”

C. EFFECTIVE CRIMINAL SANCTIONS FOR VIOLATIONS AGAINST MEDICAL PERSONNEL, FACILITIES AND TRANSPORTS

The lack of effective criminal and disciplinary sanctions for violations of the rules protecting health care committed by private citizens and by civil servants alike – including by armed and security forces and law enforcement officials – is a key area of concern when considering whether the domestic normative framework is appropriate. While issues such as the nature of the sanctions, the scope and means of their application, their specificity and the types of conduct that should be sanctioned must necessarily be assessed in detail, it is also important to consider the relevance of the measures to be taken in order to enhance the sanctions' effectiveness and to ensure that they play their preventive role.

The following questions are addressed elsewhere and concern required criminal sanctions:

1. Is the misuse of the protected emblems both in peacetime and in wartime and by both civilians and military personnel considered a criminal offence in the State and subject to administrative sanctions?
2. Is there a general obligation under domestic law for armed forces and law enforcement agencies to actively assist health-care professionals with the performance of their duties (and *a fortiori* not to impede their work) in emergency situations? Is breach of this obligation subject to disciplinary and/or criminal sanctions?
3. Are there effective disciplinary and criminal sanctions for forcing health-care professionals to perform acts that are manifestly in contradiction with their ethical duties and with individuals' right to health (for instance by forcing health-care workers to perform acts that are or can be harmful to the patient, by prohibiting them from providing medical treatment or, conversely, forcing them to provide medical treatment preferentially to specific categories of people, or by illegally forcing them to breach medical confidentiality)?

Questions

1. Under domestic legislation, are all serious violations of IHL (grave breaches and other serious violations of IHL, included those committed in non-international armed conflicts) that are committed against protected wounded and sick individuals and medical personnel, facilities and transports considered war crimes?

For more detailed guidance, please refer to chapter 3 of the ICRC's Advisory Service [manual on the domestic implementation of international law](#).

Belgium, [Penal Code](#) (1867, as amended in 2003), Article 136quater

"Intentionally directing attacks against medical personnel, material, units or vehicles which use, in line with international law, the distinctive emblems of international humanitarian law" is a war crime, as envisaged in the Geneva Conventions of 12 August 1949, Additional Protocols I and II, of 1977, and the 1998 Rome Statute of the International Criminal Court, and is punishable in accordance with the code.

Romania, [Penal Code](#) (2009, as amended in 2017), Article 442(1)(b)

"Any person who, during an armed conflict with or without international character: (a) triggers an attack against personnel, installations, material, units or vehicles involved in a mission of humanitarian aid or the mission of peacekeeping under the Charter of the United Nations, and enjoys the protection that international humanitarian law [guarantees] civilians or civilian objects; (b) triggers an attack against personnel, buildings, medical units or medical transports

which use the distinctive signs provided by the Geneva Conventions, in accordance with international humanitarian law shall be punished with imprisonment from 7–15 [years'] deprivation of rights.”

Estonia, [Penal Code \(2001\)](#), paragraph 102

Acts of war crime include the “[k]illing of a member of a medical unit with proper distinguishing marks, or any other person attending to sick or wounded persons, a minister of religion, a representative of an humanitarian organisation performing his or her duties in a war zone [or a] representative of the peacekeeping mission [...] if this: 1) causes the death of the victim; or 2) leads the victim to suicide or an attempt of suicide. [The act] is punishable by eight to twenty years’ imprisonment or life imprisonment.”

2. Is perfidy (see Art. 37 of Additional Protocol I) considered a war crime under domestic criminal legislation?

Iraq, [Law No. \(10\) 2005 of the Iraqi Higher Criminal Court \(2005\)](#)

Under article 13.2.L. and 4.I – for the commission of the crime in the context of international and non-international armed conflict, respectively – “[k]illing or wounding treacherously individuals belonging to a hostile nation or army” constitutes a serious violation of the laws and customs of war.

Democratic Republic of the Congo, [Law No. 15/022 amending the Criminal Code \(2015\)](#)

Under article 223(2)(k) and (5)(i) – on the commission of the crime in the context of international and non-international armed conflict, respectively – “for the purpose of this law, ‘war crimes’ means [...] killing or wounding treacherously individuals belonging to the hostile nation or army.”

3. Are occurrences of violence (deliberate attacks or other forms of assault, threats or deliberate serious interference with the provision of health care) committed against medical personnel, facilities and transports considered specific/*sui generis* crimes under domestic criminal law or are they covered by general criminal legislation?

India, [Epidemic Diseases \(Amendment\) Ordinance \(2020\)](#)

The ordinance provides for a criminal penalty of imprisonment between three months to five years and fine between 50,000 and 200,000 rupees for any act of violence against a health-care worker serving during an epidemic and against medical property used in relation to the epidemic. Furthermore, the offence is cognizable and non-bailable.

China, [Law on Practicing Doctors of the People’s Republic of China \(1998\)](#), Article 40

“Those who obstruct medical practice [carried out] by doctors according to law, insult, slander, [threaten] or beat up doctors or violate the personal freedom [of doctors or] interfere with the normal work and life of doctors shall be punished in accordance with the Regulations on Security Administration and Punishment; [c]riminal liabilities shall be prosecuted according to law in case of criminal offenses.”

South Africa, [National Health Act \(2003\)](#), paragraph 89

“A person is guilty of an offence if he or she [...] obstructs or hinders a health officer who is performing a function under this Act [and is] liable on conviction to a fine or to imprisonment for a period not exceeding five years or to both a fine and such imprisonment.”

4. Is the status of a victim as a health-care provider or the status of the perpetrator as a civil servant (including as a member of the armed and security forces) an aggravating factor for sentencing under ordinary domestic criminal law?

Viet Nam, [Criminal Code](#) (2015), Articles 155(2)(c) and (dd), 156(2)(b) and (d)

Crimes of insults to another person and slander carry a longer prison sentence if “committed against a person who [...] provides medical treatment for the offender” and if “[t]he offence involves abuse of the offender’s position or power”.

Bosnia and Herzegovina, [Penal Code](#) (1976), Article 348

“The following shall be aggravating circumstances in the crimes provided for in the preceding Articles of this Chapter: [...] if the perpetrator is one of the public servants or officers entrusted with a public service [...] and has abused his office, position or trust in him.”

5. Do domestic legislation and regulations include deterrent disciplinary measures, including criminal sanctions, that can be imposed on members of the armed forces for using the distinctive emblems for purposes other than those authorized by the Geneva Conventions and their Additional Protocols, such as using vehicles of the medical services or medical facilities marked with the emblem to carry or hide weapons or soldiers?

Côte d’Ivoire, [Law No. 2015-134](#) modifying and supplementing Law No. 81-640 of 1981 instituting the Penal Code (2015), Article 139(2)

Making improper use of the distinctive emblems of the Geneva Conventions that results in death or serious personal injury is a serious violation of the laws and customs applicable in international armed conflict, and is punished with life imprisonment.

Australia, [Criminal Code Act](#) (1995, as amended), Article 268.44(1)(c) and (1)(e)

The war crime of “improper use of the distinctive emblems of the Geneva Conventions [...] for combatant purposes to invite the confidence of an adversary in order to lead him or her to believe that the perpetrator is entitled to protection, or that the adversary is obliged to accord protection to the perpetrator, with intent to betray that confidence; and [...] the perpetrator’s conduct results in death or serious personal injury” carries a penalty of imprisonment for life.

United States, [The Manual for Military Commissions](#) (2007), Section 950v(b)(19)

Any person subject to this chapter who intentionally uses a distinctive emblem recognized by the law of war for combatant purposes in a manner prohibited by the law of war shall be punished as a military commission under this chapter may direct. [...] Maximum punishment. Confinement for 20 years.

D. THE ROLE OF THE ARMED AND SECURITY FORCES AND LAW ENFORCEMENT AGENCIES IN PROTECTING THE PROVISION OF HEALTH CARE

Depending on how they perform their duties in a given situation, armed and security forces and law enforcement officials can either be essential and influential in enabling the protection of health care or, conversely, act disruptively. Integrating rules protecting health care into their policies and operational manuals is key.

Reference document(s):

1. [Promoting Military Operational Practice the Ensures Safe Access to Health Care](#)
2. [Protecting Healthcare: Guidance for the Armed Forces](#)

Examples of humanitarian issues

- Lack of respect for key principles on the conduct of hostilities under IHL
- Medical facilities or transports being directly targeted as intentional parts of military strategies
- Lack of precautionary measures taken before or during active hostilities (both offensive and defensive operations) by the parties to adequately protect health-care infrastructure from collateral damage, causing destruction – for instance, when military targets are located too close to health-care facilities or when the attacking party has not properly mapped the area in order to spot all protected infrastructure before launching an attack
- Lack of respect for the protection afforded under IHL to health-care providers and the wounded and sick (denial of care to the adversary or to communities supportive of the adversary, direct targeting, assault, threats and other forms of ill-treatment)
- Disruptive impact of military, security and law enforcement operations carried out either in health-care facilities or against health-care workers, or otherwise directly affecting the delivery of health-care services during armed conflict or other emergencies – for example:
 - search and arrest operations targeting patients in health-care facilities, which without proper planning and implementation have resulted in completely sealing off access to hospitals for hours or in obstructing access by doctors to parts of hospitals
 - transport of weapons into health-care facilities
 - delays to or denials of passage of medical transports at checkpoints, dramatically affecting the ground evacuation of the sick and wounded and their transit to medical facilities
- Intentional misuse by military and security forces – and/or by law enforcement agencies – of medical facilities or transports (e.g. to transport troops, weapons or military/law enforcement equipment, to shield cooperation command posts in health-care facilities or to otherwise place military units or weapons inside or near health facilities), which, in some cases, can also entail providing health activities as coverup for military activities, such as intelligence gathering

Questions

1. Is the protection of health care part of the training curriculum of the State armed forces (in relation to their IHL obligations) and of security/law enforcement bodies (in relation to their IHRL obligations or commitments under international law enforcement standards in all circumstances, including in emergencies other than armed conflict)?
 - a. If so, at what level does this training occur, and what does it entail?
 - b. Does it include training about the rules governing the use and the protection of the emblems?
 - c. Does it include awareness-raising about the criminal and disciplinary sanctions (including sanctions based on command responsibility) applicable to violations of the rules protecting the provision of health care?
 - d. Does it include briefings or training sessions on:
 - i. the professional and ethical duties incumbent on health-care professionals (impartial care, patients' best interest and medical confidentiality) in all circumstances?
 - ii. how these duties might conflict with some of the professional duties of armed and security forces (especially during armed conflict and other emergencies), and on how these conflicts should be solved, in compliance with the law?
2. How are IHL obligations related to the protection of health care during armed conflict integrated into military doctrine (concerning the conduct of hostilities and protection of people)? (See above.)
3. Are soft-law instruments such as the [Code of Conduct for Law Enforcement Officials](#) and [Basic Principles on the Use of Force and Firearms by Law Enforcement Officials](#) and other relevant standard-setting instruments integrated into law enforcement policy?
4. Is there a general obligation under domestic law for armed forces and law enforcement agencies to actively assist health-care professionals with the performance of their duties (and *a fortiori* not to impede their work) in emergency situations?

Is this obligation explicitly stated in military and law enforcement doctrine?

Is this obligation subject to disciplinary and/or criminal sanctions? (See above.)

5. Do military and law enforcement policy or operational guidelines include specific instructions on:
 - a. the level of authority at which, and the exceptional circumstances in which, movement of medical personnel and vehicles in an area of operations may be restricted?
 - b. how to manage, carry out and assist ground medical evacuations during armed conflict or other emergencies?
 - c. how to appropriately manage checkpoints or to implement curfews to ensure the safe and unimpeded delivery of health-care?
 - d. how to carry out search-and-arrest operations in health-care facilities, for either patients or health-care workers? For instance, does the relevant policy make explicit the exceptional nature of such operations, and does it put in place concrete measures to regulate such exceptional operations?
 - e. whether and what kinds of weapons can be brought into health-care facilities?
 - f. for the armed forces, how to plan and carry out military operations against targets that are situated close to health-care infrastructure?
6. Does military and law enforcement policy provide for their medical services participating in planning operations that, when carried out, might have a disruptive effect on the provision of health care?

For more detailed guidance, please refer to chapter three of the ICRC's Advisory Service [manual on the domestic implementation of international humanitarian law](#).

E. DATA COLLECTION

Appropriate data collection on the nature and scope of violence against health care plays an essential role in authorities' ability to grasp the importance of the issue and to act accordingly. In other words, data on patterns of violence make them visible to policy makers and allow authorities to take preventive and corrective action. It is of paramount importance to establish an independent and transparent national system for collecting data on the occurrence of violence against health-care, one which respects medical confidentiality, is clearly separate from data collection oriented towards accountability and ensures the effective protection of the processed data.

Reference document: [Round Table on National Data Collection \(Madrid, 2019\)](#)

Examples of humanitarian issues

Legislation imposing data-reporting obligations on health-care professionals that conflict with the principle of medical confidentiality – or with other ethical duties of health-care professionals – can have detrimental consequences for their ability to carry out their duties (e.g. the potential for severe erosion of patients' trust in the medical profession and the risk of being perceived as being associated with non-medical security policies). Domestic regulation addressing this kind of data collection must be designed to prevent such situations.

Questions

1. Is there a national data-collection mechanism in place in the State that is aimed at collecting and analysing data on occurrences of violence against medical personnel, facilities and transports?
2. Alternatively, are there subnational (e.g. provincial or local) initiatives to that effect (in federal States, for instance)?
 - a. Under which regulations are these processes addressed?
 - b. Does the applicable regulation related to the collection of data to study violence against health care:
 - i. clearly define the role and responsibilities of each entity involved?
 - ii. precisely define the type of occurrence of violence on which data are to be collected (e.g. whether it includes threats of violence)?
 - iii. precisely define the type of information that must/can be reported in relation to those occurrences and guarantee the possibility to keep the information anonymous? In other words, is this regulation compliant with the principle of medical confidentiality?
 - iv. ensure that coordination in relation to follow-up response(s) and strategies exists between State authorities in charge of the data-collection and analysis system and all other relevant health-care entities and individuals?
 - v. guarantee that the process serves an exclusively analytical purpose and that the collected data will not be used for criminal prosecutions?
 - vi. guarantee that the data collected are properly protected (in terms of use and access)?
3. Is there a system in place in the State to specifically track, process and sanction misuse of the emblems (see above)?

F. COORDINATION MECHANISM

Coordination between interested parties is at the heart of any effective response to acts of violence against health care in a given situation of emergency. It is essential to assess how domestic regulation ensures that military medical services can be associated with decision-making processes when relevant, or that effective platforms exist for exchanges between military or security forces and civilian health-care workers.

Examples of humanitarian issues

- Lack of coordination and planning can result in unnecessarily exposing health services to harm, for example when they find themselves caught in crossfire during active combat or when communication fails during the response to a mass-casualty event.
- A lack of proper coordination is often one of the main reasons for undue impediments to the swift and rapid passage of ambulances and other medical transports through checkpoints during armed conflict or other emergencies. (See section D.)
- When military medical services are not adequately involved in planning security operations to be carried out in health-care facilities, security forces may have a poor understanding of operational limitations imposed by considerations of medical ethics.

Questions

1. Does the State have a national (or regional) plan for coordinating the emergency response during armed conflict and other emergencies? In other words, is there a national response plan specifically designed for such situations (as opposed to responses to natural disasters, which might involve other types of coordinating activities and stakeholders)?
 - a. If so, under what regulation is this process framed?
 - b. Does this plan include aspects specifically designed to strengthen the protection of health-care personnel and facilities during armed conflict or other emergencies (for instance, direct lines of communication with the armed and security forces to request assistance and protection when at risk)?

- c. Are there organized drills and training exercises related to armed conflict or other emergencies? Do they involve the participation of both health-care professionals and of members of armed and security forces?

New Zealand, *Civil Defence Emergency Management Act* (2002)

1. The act aims to “provide for planning and preparation for emergencies and for response and recovery in the event of an emergency [and to] encourage the co-ordination of emergency management, planning, and activities related to civil defence emergency management across the wide range of agencies and organisations preventing or managing emergencies.” For the purpose of this act, emergencies may include, among others, an “actual or imminent attack or warlike act”.
 - When the act is activated, every regional council and every territorial authority within that region shall establish a civil defence emergency management group consisting of representatives of various public institutions, including the police forces and medical services. The group is to “take all steps necessary on an ongoing basis to maintain and provide, or to arrange the provision of, or to otherwise make available suitably trained and competent personnel, including volunteers, and an appropriate organisational structure for those personnel, for effective civil defence emergency management in its area, [...] respond to and manage the adverse effects of emergencies in its area, [and] plan and carry out recovery activities”.
 - Emergency services, comprised of “the New Zealand Police, Fire Emergency New Zealand, and providers of health and disability services” are to cooperate and assist the group in carrying out its functions.
 - The group also has the power to “conduct civil defence emergency-management training exercises, practices, and rehearsals.”

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.