SPECIAL REPORT

HEALTH CARE IN DANGER 2014

Respecting and protecting health care in armed conflicts and other emergencies
The Special Report Health Care in Danger 2014 is designed to satisfy the narrative reporting requirements of donors who have contributed to the ICRC Special Appeal Health Care in Danger 2014. It provides details on activities covered by that appeal, which are enhanced by the information contained in the ICRC Annual Report. Donors’ financial-reporting requirements (statement of contributions and expenditure for the year 2014) will be met by a separate Ernst & Young Ltd auditors’ report providing supplementary information on the Special Appeal.
# TABLE OF CONTENTS

## EXECUTIVE SUMMARY ................................................................. 4

## MAKING THE CASE ............................................................................... 5

A legal base................................................................................................. 6
What the ICRC does, together with the National Societies.......................... 6
ICRC study........................................................................................................ 7
The current Special Report............................................................................... 8

## THE “HEALTH CARE IN DANGER” PROJECT 2012–2015 ................................................................. 9

Goals ................................................................................................................. 9
Approach........................................................................................................... 10
Global plan of action.......................................................................................... 11
- Operational response: consolidating and improving field practice 11
- Operational response: reinforcing respect for existing obligations 12
- Diplomatic mobilization: raising concerns and encouraging action 12
- The Health Care in Danger communication campaign 14

## THE HEALTH CARE IN DANGER PROJECT: 2014 ACTIVITIES AND RESULTS ............................................................. 15

Operational response......................................................................................... 15
- Incident reporting helps increase understanding of the problem 15
- Delegations adapt their approach and activities 16
- Practical measures and training help health-care workers stay safe 17
- Defence forces and other weapon bearers identify ways to mitigate risks 18
- Increasing IHL implementation fosters long-term safety of health care 18
Diplomatic mobilization................................................................................ 19
- Experts share ideas on increasing the protection of health services 19
- States affirm the importance of the issue and commit to addressing it 20
- The health-care community fosters support for the project’s goals 20
- Movement components raise awareness of context-specific solutions 21
Communication campaign .............................................................................. 22

## HEALTH CARE IN DANGER IN DAY-TO-DAY OPERATIONS IN 2014 ......................................................... 24

Strengthening emphasis on an institutional priority........................................ 24
- Enlisting support for safeguarding health services 25
- Stepping up medical response to emergencies 25
- Helping health-care providers build their capacities 26
Example 1: Afghanistan .................................................................................. 27
Example 2: Colombia ..................................................................................... 28
Example 3: Iraq ............................................................................................... 29
Example 4: Lebanon ......................................................................................... 31
Example 5: Syrian Arab Republic ................................................................... 32
Example 6: Yemen ............................................................................................ 34

## FINANCIAL OVERVIEW ........................................................................... 36

Summary........................................................................................................... 36
List of contributions pledged and received ....................................................... 37

## ANNEX: EXPERT CONSULTATION AND DIPLOMATIC MOBILIZATION PROCESS ................................. 38
EXECUTIVE SUMMARY

► Armed conflict and other emergencies generate urgent additional health care requirements for the people affected, especially the wounded and sick. However, it has been found that it is during these times of instability that health care is most inaccessible and insecure. This situation represents a negation of the right of all wounded combatants and civilians to be spared further suffering during armed conflict, and of the protection due to the impartial delivery of health care at all times, as laid down in international humanitarian law and international human rights law.

► The Health Care in Danger (HCiD) project, which was launched in 2011, is being implemented in partnership with other components of the International Red Cross and Red Crescent Movement (Movement). The project entails working with States and other influential actors until the end of 2015 to improve the security and delivery of effective and impartial health care during armed conflict and other emergencies. Its four priority issues are to safeguard health care against: (i) attacks on services and patients; (ii) unlawful obstruction to the delivery of health services; (iii) discrimination in the treatment of patients; and (iv) armed entry by weapon bearers into health structures. The project takes a two-track approach, with both tracks complementing each other: the operational response track, which aims to improve the safety, quality and timeliness of health/medical services during armed conflict and other emergencies; and the expert consultation and diplomatic mobilization track, which involves engaging the interest and support of various external stakeholders, including States, inter-governmental organizations, the health-care community, academia and NGOs, to develop and promote practical solutions to protect health care during such situations. A four-year communication campaign supports both tracks.

► In view of the continued urgency of ensuring the safe delivery of health care and the strong resolve shown by Movement components and members of the health-care community worldwide to addressing the issue, the Directorate decided to extend the HCiD project to the end of 2017. Maintaining the organization’s emphasis on this issue is in line with the ICRC Health strategy 2014–2018, which aims to ensure access to health services for vulnerable populations, and improve the quality of care available to them.

► The current Special Report follows up on the Special Appeal HCiD 2014 and covers: (i) the HCiD project and its goals for 2012–15; (ii) the developments and activities that took place in 2014 that are directly related to the project; (iii) as examples, the ICRC’s operational activities in six selected contexts, which concretely detail the organization’s on-the-ground efforts to ensure access to quality health care even amid insecurity.

► At field level, 45 ICRC delegations worldwide reported activities that they had carried out in relation to the project, employing different modes of action, as necessary, to safeguard the provision of health-care services. This included enlisting support for measures to protect those providing or seeking health care, as well as directly providing emergency and longer-term support to health-care systems. In line with its multidisciplinary approach, the ICRC combines first-aid, primary health-care and mental health/psychosocial support programmes to ensure access to different levels of care.

► Afghanistan, Colombia, Iraq, Lebanon, the Syrian Arab Republic and Yemen are examples of contexts where medical services in conflict-affected areas are particularly vulnerable and face major obstacles. They provide examples of how the ICRC, in partnership with the National Society concerned, adapted its operational responses in 2014 to the problems encountered and how the goals of the HCiD project were especially relevant. In all cases, the objective of National Society/ICRC activities remained the same: sick or injured people, including the weapon-wounded, are respected and have access to effective and impartial health/medical services.

► Two expert workshops took place in 2014, the first in Brussels, Belgium, on domestic normative frameworks for protecting the delivery of health care, and the second in Pretoria, South Africa, on the security of health structures. The sessions brought together specialists and other influential players from around the world to discuss these dimensions of health-care insecurity and practical measures to mitigate them. The resulting recommendations and outcomes were then promoted at regional/international fora.

► Dialogue with States and other actors of influence, thematic events and public communication efforts contributed to raising awareness of the difficulties faced by people seeking or providing health services in armed conflict and other emergencies, and of possible ways to address them. Notably, several resolutions adopted by the United Nations General Assembly recognized the insecurity affecting health care as a pressing issue and underscored the need for effective measures to enhance the protection of health-care providers. To build further commitment to finding and implementing solutions to the problem, the ICRC formed/strengthened partnerships with other humanitarian organizations and key professional associations of health-care providers, such as the International Council of Nurses, the International Hospital Federation, the World Confederation of Physical Therapy, and the World Medical Association.

► The financial results of the ICRC Special Appeal show some direct support from donors, with direct contributions amounting to KCHF 233 out of a total expenditure of KCHF 54,399. The ICRC used its non-earmarked funds to balance the income and expenditure of the appeal.
Colombia, 2014. The Noanama centre has been without any trained medical personnel for the past two years. The community leader has been assisting sick patients and wounded combatants using natural remedies. The nearest medical post is a two-hour boat trip away.

© Juan Arredondo/Getty Images/ICRC

Armed conflict and other emergencies generate immediate health-care requirements, which exceed the peacetime needs of wounded and sick people, whether they are directly involved in violent acts or not.

However, armed conflict and other emergencies, and the accompanying violence, pose the greatest threats to health-care personnel, facilities, equipment and medical vehicles (health-care services); disruption, interference, attacks and other impediments to providing and accessing these services have become commonplace during armed conflict and other emergencies all over the world. Hence, it is during these moments when needs are most urgent that health-care services are also most difficult to access.

Moreover, many of these situations lead to far-reaching secondary consequences when health-care professionals flee their posts: hospitals close and vaccination campaigns come to a halt, leaving entire communities without access to adequate services. A single act of violence that damages a hospital or harms medical personnel affects many other people requiring care; one serious security incident could close a hospital, drastically reducing or eliminating surgical services for wounded people. For example, an independent ICRC surgical hospital would normally treat some 2,000 wounded people per year – its closure would mean increased suffering or loss of life because of the lack of treatment. The murder of more than 20 people, including two doctors and an unverified number of medical students at a graduation ceremony in Mogadishu, Somalia, in December 2009 meant that thousands of consultations would not take place because of that single attack.

The ICRC, together with National Red Cross and Red Crescent Society (National Society) staff and volunteers, operates in contexts where such incidents take place. Health-care providers often suffer direct and indirect threats and attacks when attempting to provide medical treatment. For example, in 2011–14:

---

1 Armed conflict(s): international and/or non-international armed conflict(s), as governed by the Geneva Conventions of 12 August 1949 and their two Additional Protocols of 1977 and customary international law

2 Other emergencies: situations requiring a specifically neutral and independent institution and intermediary, including internal disturbances (internal strife), in conformity with the Statutes of the International Red Cross and Red Crescent Movement, article 5(2)(d) and 5(3), adopted by the 25th International Conference of the Red Cross and Red Crescent in October 1986 and amended by the 26th and 29th International Conferences of the Red Cross and Red Crescent in December 1995 and June 2006, respectively, in Geneva, Switzerland
In April 2013, after conducting medical assistance activities in a remote location in Afghanistan, 2 Afghan Red Crescent Society members were killed and 2 others injured as they were fired at while travelling in a vehicle clearly marked with the red crescent emblem.

In some areas affected by the 2014 Ebola outbreak in West Africa, distrust of health/humanitarian workers has led to attacks against them. For instance, 8 health personnel were allegedly killed after trying to raise awareness about Ebola in a village in Guinea. National Society teams in Guinea and Sierra Leone have experienced security incidents in places where their efforts to prevent the spread of the disease were not understood by the communities.

In Pakistan, 4 health workers conducting a polio immunization campaign in the north-west were killed in 2014; this caused anti-polio efforts in the area to be suspended. Nine volunteers who were part of a similar project in northern Nigeria were killed in 2013, when gunmen shot at their health centres. Nigeria and Pakistan are among the only 3 countries where polio remains endemic.

In August 2013, Médecins Sans Frontières (MSF) announced the closure of its medical programmes in Somalia, prompted by attacks against its staff, including 2 staff members who were killed in Mogadishu in 2011 and 2 others who were held captive in south-central Somalia for 21 months. In June 2014, a car bomb exploded inside the compound of Keysaney hospital, a facility run by the Somali Red Crescent Society with support from the ICRC. A medical student was killed and 7 others, including 2 Somali Red Crescent nurses, were injured in the blast.

In the Syrian Arab Republic (hereafter Syria), between March 2011 and December 2014, 40 Syrian Arab Red Crescent workers and 7 Palestine Red Crescent Society workers had been killed. Several of them were first-aiders. In October 2013, 6 ICRC staff and 1 National Society volunteer were abducted in Idlib, where they had gone to assess the needs in several health facilities and deliver medical supplies. At the time of writing, 3 ICRC staff were still being held.

A LEGAL BASE

Protecting and assisting the wounded and sick, regardless of their affiliations, lies at the core of the mission of the International Red Cross and Red Crescent Movement (Movement). More than 150 years ago, horrified by the suffering he witnessed on the bloodstained battlefield of Solferino, Italy, Swiss businessman Henry Dunant, one of the founders of the Movement, mobilized the local community to help all the injured, regardless of whether they were Austrian or French. From these humble beginnings emerged the recognition of the right of wounded combatants and civilians to be spared further suffering and to receive assistance during armed conflict, as enshrined in the 1949 Geneva Conventions and the 1977 Additional Protocols, and reflected by customary international humanitarian law (IHL). The law also prohibits attacks on health-care services while they fulfil their exclusively humanitarian functions and do not become involved in military operations. Protective symbols – such as the red cross, the red crescent and, later, the red crystal – were introduced to clearly identify medical personnel, facilities and means of transport as specially protected persons and objects. IHL also obliges all parties to an armed conflict to search for and collect the wounded, particularly after battle, and to facilitate their access to health-care facilities, when possible. The impartial delivery of health care at all times is also protected by international human rights law regulating State conduct, including during other emergencies.

Most States are party to applicable IHL and international human rights law treaties, and all States are bound by customary international law; however, some States, particularly those participating in armed conflicts, do not always respect these rules.

WHAT THE ICRC DOES, TOGETHER WITH THE NATIONAL SOCIETIES

The ICRC, often together with the National Society of the country concerned, mounts both immediate and long-term responses to the consequences of armed conflicts and other emergencies around the world, in particular to overcome obstructions, intentional or not, to the delivery of health care. These efforts include a wide range of medical activities such as evacuating the wounded, conducting war surgery, and supporting medical structures and physical rehabilitation services. The ICRC also initiates many short-term initiatives during armed conflict and other emergencies as well as longer-term ones during peacetime to create an environment of respect for IHL and for the work of the Movement. In a bid to encourage support for these among the authorities, weapon bearers, medical personnel and influential members of civil society, the organization spreads knowledge of IHL, the rules protecting health-care personnel, facilities and means of transport, and of the obligations of weapon bearers and the responsibilities of medical personnel. It also engages the authorities and service providers in dialogue on violations committed against health-care services and the measures they should take to stop them. The ICRC negotiates ceasefires between parties to conflict or assurances of safe passage in order to organize the evacuation of the wounded and dead and to facilitate access to health care, including preventive health programmes such as vaccination campaigns. It also negotiates a “fast track” through checkpoints for ambulances and conducts first-aid training for various groups exposed to violence to enable them to treat or stabilize patients before their arrival in a health-care facility, thereby improving the effectiveness of the casualty care chain. Such training also provides an important opportunity to remind weapon bearers of their obligations under IHL.
In conflict- or violence-affected countries, the ICRC conducts “Safer Access Framework” training sessions with National Societies to increase awareness of ways to minimize risks when accessing potentially dangerous areas; it also carries out information campaigns, including through radio programmes and jingles. It provides the Global Positioning System (GPS) coordinates of health-care facilities to all parties to armed conflict, reminding them to spare these structures from attacks, while also reinforcing the physical integrity of health facilities by positioning sandbags, building safe rooms and applying bomb-blast film on windows.

The ICRC works to ensure that people can access hospitals without fearing discrimination, notably by engaging in dialogue with the authorities and medical personnel concerned and, where necessary, supporting mobile health units in serving people who are unable to reach formal medical structures. Where supply chains to health facilities have been broken or disrupted because of armed conflict/insecurity or a lack of investment in infrastructure as a result of prolonged insecurity, it provides technical and material support, often in partnership with the National Society.

The ICRC STUDY

Following the International Conference of the Red Cross and Red Crescent (International Conference) in 2007, the ICRC conducted a study from 2008 to 2011 to look at how armed conflict and other emergencies affect the delivery of health care in 16 countries.

The outcome of the study and the continuing difficulties faced by health-care services led the ICRC, in cooperation with other Movement components, to launch the Health Care in Danger (HCiD) project in 2011.

The data collected in the course of the project has reaffirmed the need to step up efforts to protect health-care services. In May 2013, the ICRC published an analytical report on 921 violent incidents that affected health care in 22 countries in 2012. A second report, released in 2014, builds on the findings of the previous one and examines the incidents documented in 23 countries from January 2012 to December 2013. Information was collected from various sources on over 1,800 instances involving the use or threat of violence against wounded and sick people and health-care personnel, facilities and means of transport. Several key patterns were identified:

- violence against health-care providers affected mostly local personnel; fewer cases involved foreign personnel
- the most common offences against them were looting, direct attacks and disruptive armed entry into their facilities
- military/security forces and armed groups were the main perpetrators: they were allegedly responsible for two-thirds of the incidents reported

The data collected by ICRC delegations provides a factual basis for raising awareness of the issues covered by the HCiD project. The reports are useful in drawing the attention of decision-makers and other actors of influence to the urgent need for action, in pursuing dialogue with potential perpetrators, and in developing ways to mitigate risks.

Another report with an analysis of the incidents documented from January 2012 to December 2013 was published in the first quarter of 2015; this will be presented at the 32nd International Conference.

© ICRC – MAY 2015 – PAGE 7/38
THE CURRENT SPECIAL REPORT

This special report presents an overview of the HCiD project and reports on the plans of action included in the HCiD Special Appeal 2014. In particular, it details:

- developments and activities that took place in 2014, which are directly related to the HCiD project
- related operational activities in the six selected contexts included in the Special Appeal 2014, as concrete examples of how the ICRC works to make quality health care accessible in a timely manner
- financial reporting about expenses and contributions to the Special Appeal 2014
THE “HEALTH CARE IN DANGER” PROJECT 2012–2015

GOALS

Through the HCiD project, the ICRC endeavours to improve the security and delivery of effective and impartial health care in armed conflict and other emergencies by working to ensure that, by 2015:

- ICRC delegations, in partnership with National Societies where appropriate and feasible, have multidisciplinary plans of action to better protect and enhance health care in the field and to secure support for the project’s objectives; they focus their strategies on the following priority issues: attacks, discrimination, unlawful obstruction and armed entry into medical structures and facilities; they address the humanitarian consequences of violence or threats thereof for the wounded and sick and health-care personnel, as well as the effects of damage inflicted upon health-care structures and medical vehicles

  indicator: at least 65 ICRC delegations

- partnerships with National Societies have been established to better implement the project’s operational and expert consultation and diplomatic mobilization tracks (see Approach below), including by: developing objectives, plans of action and other relevant tools; raising awareness among key stakeholders; and training staff and volunteers in a range of related skills such as information gathering and operational responses

  indicator: at least 40 National Societies

- concrete measures and practical recommendations to improve safe access to and delivery of health care during armed conflicts and other emergencies have been identified by credible experts

  indicator: practical and actionable recommendations in 6 thematic areas

- States have assessed their domestic legal regulatory frameworks, shared best practices and started to adapt their laws and policies, with a view to enhancing the protection of health care in situations of armed conflict or other emergencies; a number of countries have targeted number of armed forces has been decreased to 10 to take into consideration the time required to review and adapt their doctrine; conversely, the number of hospitals the organization aims to assist in organizing self-protection measures has been increased from 50 to 100.

7 Following evaluations of the strengths of the project and the opportunities for growth, as well as the constraints and limitations the delegations face, some of the indicators have been adapted to accommodate these factors, while trying to maximize possible impacts. For example, the targeted number of armed forces has been decreased to 10 to take into consideration the time required to review and adapt their doctrine; conversely, the number of hospitals the organization aims to assist in organizing self-protection measures has been increased from 50 to 100.
started national-level processes to implement the recommendations identified during expert consultations

**indicator**: compatibility studies between existing international norms and domestic legislation carried out in at least 20 countries

- armed forces have agreed to integrate health care-related specifics into their doctrine, training and operations, and have begun efforts to do so
  
  **indicator**: at least 10 armed forces

- armed groups are engaged in operational dialogue on the protection of health care, with regular follow-up on progress and results
  
  **indicator**: at least 30 armed groups in 20 ICRC contexts

- hospitals in countries affected by armed conflict or other emergencies recognize the need for and are organizing physical protection for their facilities and notification procedures for their premises and ambulances
  
  **indicator**: 100 hospitals

- national health associations and Ministries of Health have reviewed or are reviewing their doctrines and practices to include measures that address or mitigate the consequences of insecurity on health care
  
  **indicator**: at least 30 national health associations/Ministries of Health

- universities in countries affected by armed conflict or other emergencies have developed or are developing teaching modules for their public health courses on the implications of insecurity for health care
  
  **indicator**: at least 20 universities

- the majority of the public in influential countries perceive the lack of safe access to health care during armed conflict and other emergencies as a major humanitarian concern; they support adopting and implementing measures prioritizing means of addressing health-care insecurity
  
  **indicator**: regular monitoring of mainstream media

**APPROACH**

The project focuses on four priority issues related to the safeguarding of health care:

1. **attacks against health-care services and wounded and sick patients**
2. **unlawful obstructions to accessing health-care services**
3. **discrimination in the treatment of wounded and sick patients**
4. **armed entry by arms carriers into health structures**

As the responsibility for safeguarding health care lies primarily with States and arms carriers, instead of with the health community, the HCiD project is built on **distinct yet interlinked tracks**: the **operational response** track and the **expert consultation and diplomatic mobilization** track. In both tracks, the project emphasizes forging partnerships and building a “community of concern” of key stakeholders to secure their investment in and ownership of the project and their commitment to achieving its goals.

The project assists National Societies and ICRC delegations in their operational response, promoting the exchange of practices and lessons learnt in order to bring coherence to, as well as strengthen, their means of addressing violence and threats of violence against health care and the wounded and sick. It continuously supports activities geared toward accomplishing these specific objectives, including by working to address more effectively problems encountered in the field. It endeavours to provide opportunities for partners in specific contexts to discuss how to improve security of health-care delivery and to promote recommendations generated during consultations with experts, as well as practices developed in the field. It reinforces the training of ICRC and National Society personnel and volunteers, continuing to develop and adapt appropriate tools to do so.

Meanwhile, running in parallel with, gaining from and contributing to the operational response, the project aims to identify existing effective practices and generate practical recommendations through bilateral and multilateral consultations with governmental and independent experts and other stakeholders, particularly within the health community. With the support of its community of concern, the project is **mobilizing stakeholders** within the humanitarian field and beyond, in order to become a sustainable global initiative and produce innovative solutions.

A four-year **communication campaign** supports the aims of the project. During its first phase in 2011–13 it emphasized the issues at stake. Now in its second phase, which will last until the end of 2015, it underscores the positive role different stakeholders can take, on the basis of the recommendations identified, to improve the security and delivery of health care.

In November 2014, the Directorate approved the extension of the project until 2017. This decision was prompted by the prevalence of reported attacks on patients and health personnel/infrastructure, and of obstacles to the delivery of health services in conflict/violence-affected contexts. It also reflects the strong resolve of Movement components to keep up the momentum generated by the ICRC, National Societies and other stakeholders for the project. Maintaining the organization’s emphasis on this issue is in line with the ICRC Health strategy 2014–2018, which aims to ensure access to health services for vulnerable populations, and improve the quality of care available to them. After the 32nd International Conference in 2015, the project will focus on engaging States to increase their involvement in addressing threats to health care and on developing further partnerships with key actors. Working with National Societies and the International Federation of Red Cross and Red Crescent Societies (International Federation), the ICRC will continue to encourage States and other key actors to...
implement the HCiD project’s recommendations in their own contexts, lending its expertise where necessary. Discussions on the project’s post-2015 strategy and plan of action are under way.

The HCiD project is led by a team operating from the ICRC headquarters in Geneva, Switzerland, to which all necessary specialized services (e.g. Assistance, Communication, Legal, Movement, Protection divisions) contribute.

GLOBAL PLAN OF ACTION

OPERATIONAL RESPONSE:
CONSOLIDATING AND IMPROVING FIELD PRACTICE

Data collection and analysis

To develop ways to facilitate the safe delivery of effective and impartial health-care services, there is a need to ensure and improve data collection and analysis of abuses committed against the wounded and sick and health-care personnel and facilities. With a view to gaining a better understanding of the patterns of violence affecting health services, both at global and field levels, selected ICRC delegations have systematically monitored such incidents and shared the information with headquarters. Two sets of data have been compiled:

1. precise and context-specific sets of data on the violence and abuse are used at field level to make interventions to arms carriers, with a view to improving the protection of the wounded, patients and health facilities and personnel; interventions are made in several contexts within the frame of a multidisciplinary approach that targets arms carriers of all affiliations and sides

2. a global set of aggregated data on the abuses faced by health-care services provides a global perspective of the nature and consequences of such incidents; to identify recurring issues and differences across various contexts, the ICRC has consulted many sources of information, including:
   o cases collected by ICRC staff
   o statistics from both National Societies and Health Ministries on incidents affecting their staff, infrastructure and vehicles
   o local and international media, whenever relevant
   o where applicable, additional sources such as medical non-governmental organizations (NGOs) or internet sites, should they be deemed reliable

Making use of the data collected by delegations, the ICRC has produced three analytical reports on violent incidents affecting the safety of health care; these were published in 2013 and 2014 (see page 7). A third one was released in April 2015.

The ICRC will continue to build on the findings of these reports; in particular:

- delegations will be encouraged to keep on compiling information
- support in enhancing methods for gathering information will be given to delegations; data collection and dissemination methods will be shared and further developed with other organizations
- the reports will continue to be used in producing background documents for meetings and consultative fora planned for 2015
- the use of a geographic information system to enhance the analysis and presentation of the data will be explored

Adapting field operations and encouraging the implementation of the project’s recommendations

Many delegations plan to underscore the need to protect the wounded and sick and health-care services, particularly during IHL briefings and first-aid training sessions for government forces and armed groups. More than 60 delegations have integrated objectives related to the HCiD project into their planning documents for 2015. Delegations will be encouraged to further develop their approaches to address the issue, in cooperation with the National Society in their respective countries.

The regular analysis of the information collected, including on successes, failures and follow-ups the delegations made, will help allow:

- ICRC delegations to update and refine their contextualized problem analyses, related objectives and plans of actions and to continue making interventions at local level, with a view to enhancing the protection of healthcare services

- the HCiD project team to better support delegations in planning their HCiD approaches and activities and in adapting the content of their dialogue with the State authorities, the health-care sector (medical associations, nursing associations, etc.), armed groups and other relevant civil society actors, to their environment

- the ICRC to develop operational partnerships with National Societies on issues related to safeguarding health-care services, particularly through regular meetings with the Movement Reference Group

- the HCiD project team to hold bilateral consultations, contribute to thematic workshops and other events, formulate the conclusions and recommendations necessary to address health-care insecurity, and maximize the efficiency of its work with the health community and other civil society actors

The Movement Reference Group comprises 27 National Societies and the International Federation of Red Cross and Red Crescent Societies; it was formed in 2012 to strengthen Movement coordination on the HCiD project.
the engagement and mobilization of the community at global level, particularly through communication campaigns

- the development of internal training initiatives related to operational response for National Societies and ICRC staff

**OPERATIONAL RESPONSE: REINFORCING RESPECT FOR EXISTING OBLIGATIONS**

Existing norms of IHL and international human rights law already address all four priority issues of the HCiD project: attacks against health-care services and wounded and sick patients; unlawful obstruction to the delivery of health care; discrimination in the treatment of wounded and sick patients; and armed entry by weapon bearers into health structures. Thus, practical, regulatory and legislative measures to implement these norms at national level must be identified, and action taken accordingly, in order to:

- **prevent** violations of IHL or other applicable law
- **improve compliance** with these obligations wherever they apply
- **investigate** violations and **punish** the perpetrators

The initial findings of the ICRC’s Advisory Service on IHL, which identified the different domains where action should be taken at national level, were compiled into a fact sheet and shared with ICRC delegations and the members of the 31st International Conference. The document, which was used as input for Resolution 5, “Health care in danger: respecting and protecting health care”,9 covered armed conflict and other emergencies and referred to IHL and international human rights law instruments providing protection to the wounded and sick and to health-care services.

Based on these, work has been ongoing to facilitate and encourage the incorporation of all existing and applicable norms into domestic legal and regulatory frameworks worldwide. In support of these efforts, the Advisory Service on IHL:

- **collects and includes** relevant domestic laws and regulations in the National Implementation database (http://www.icrc.org/ihl-nat) with the support of ICRC delegations, national IHL committees and governmental representatives; maps and analyses this information, with a view to identifying potential best practices, gaps and loopholes, and to drafting proposals to help direct future efforts

- **guides and supports** ICRC delegations and National Societies in approaching national and regional authorities so as to follow up pledges made in relation to the HCiD project at the 31st International Conference

supports the adoption of adequate domestic legal and regulatory frameworks safeguarding health-care services, including by highlighting its importance during dialogue with national IHL committees, meetings and other events promoting the domestic implementation of IHL.

- **together with partners, contributes to** the expert consultation and diplomatic track, sharing with States the results and recommendations of the 2014 workshop in Brussels, Belgium, on national legislation and penal repression preventing and repressing crimes against health care; provides law/policy-makers with copies of the “Guide to the implementation of rules protecting the provision of health care in armed conflicts and other emergencies”, which is being developed on the basis of the workshop’s outcomes and is scheduled to be finished in December 2014

Similar efforts are being made with national armed and security forces in order to ensure that military doctrine, operational procedures and other such frameworks all include measures to safeguard health care. In 2013, 31 bilateral consultations with 29 national armed forces and 2 military defence organizations took place in order to collect information on current doctrine and operational practices aimed at ensuring the protection of the wounded and sick and health services. To the same end, consultations were held with some 34 armed groups in 9 contexts.

National Societies and ICRC delegations also receive assistance in their efforts to increase the inclusion in school and university curricula of existing norms and behaviour that safeguard health care.

The Legal Division provides the necessary expertise to support and guide the ICRC’s operational dialogue on the protection of health care with parties to armed conflict and the actors concerned during other emergencies. In this regard, the overview of relevant IHL and international human rights law prepared for the 31st International Conference is widely used as a reference by ICRC delegates in the field for making representations or giving technical advice. The Legal Division also supports the Advisory Service on IHL and ICRC delegations in encouraging law/policy-makers to develop and adopt legal and regulatory frameworks that safeguard the delivery of health care, and to influence national authorities, weapon bearers and other key actors to implement the recommendations generated by the HCiD workshops.

**DIPLOMATIC MOBILIZATION: RAISING CONCERNS AND ENCOURAGING ACTION**

The ICRC works with States, National Societies and other experts to find practical solutions to better protect health-care services during armed conflict and other emergencies.

---

A five-phase mobilization process, detailed below and represented by the scheme in the annex (see page 38), has begun and will continue to be implemented.

1. **2011: the 31st International Conference**

The first milestone of the expert consultation and diplomatic track was the 31st International Conference held in November 2011. There, States party to the Geneva Conventions and their National Societies adopted a resolution\(^{10}\) giving the HcID project a four-year mandate; 9 States and 26 National Societies made specific pledges.\(^{11}\)

2. **2012–14: Expert workshops and consultations**

In order to maintain the momentum gained at the 31st International Conference and to build up to the 32nd International Conference in 2015, a series of international expert consultations and workshops was held from 2012 to 2014. These workshops, which were organized by the ICRC in cooperation with States, National Societies and NGOs in different countries, covered the following issues:

- responsibilities and rights of health-care personnel
- the National Societies’ role in protecting health care
- military operational practice that ensures safe access to and delivery of health care
- ambulance and pre-hospital care in risk situations
- security of health facilities
- national legislation and penal repression
- the role of opinion leaders

Each workshop brought together experts from 10 to 25 countries, international governmental organizations, international and local NGOs, the health community and academia, and sought to identify practical recommendations and solutions regarding the aforementioned topics. Some workshops were repeated in two different continents, while others were held only once, following extensive preparatory bilateral consultations at country level.

<table>
<thead>
<tr>
<th>2012–14 Workshops</th>
<th>Title</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibilities and rights of health-care personnel</td>
<td>Recommendations defined on best practices are adopted by health practitioners</td>
<td>London (United Kingdom of Great Britain and Northern Ireland), 2012</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cairo (Egypt), 2012</td>
</tr>
<tr>
<td></td>
<td>National Societies’ response to Health Care in Danger</td>
<td>Recommendations ensuring that National Societies are prepared to work in armed conflicts and other emergencies exist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tehran (Islamic Republic of Iran), 2013</td>
</tr>
<tr>
<td></td>
<td>Civil society: mobilizing opinion leaders</td>
<td>Raising awareness among a wider audience, including armed groups, on the necessity to safeguard health care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gaza Strip (occupied Palestinian territory), 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Abu Dhabi (United Arab Emirates), 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Islamabad (Pakistan), 2014</td>
</tr>
<tr>
<td></td>
<td>Ambulance and pre-hospital care in risk situations</td>
<td>Recommendations to improve the security of ambulance services during crises, including risk-mitigation measures, such as the use of protective equipment</td>
</tr>
<tr>
<td></td>
<td>Military operational practice that ensures safe access to and delivery of health care</td>
<td>Recommendations to increase the safety of health-care services during armed conflicts and other emergencies</td>
</tr>
<tr>
<td></td>
<td>The safety of health structures</td>
<td>Practical recommendations to improve the safety of health infrastructure are defined, including in relation to coping with supply chain disruptions owing to insecurity, and the GPS for facilities</td>
</tr>
<tr>
<td></td>
<td>Domestic normative frameworks for protecting the delivery of health care</td>
<td>Context-specific legislation to prevent and repress crimes against health care is available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brussels (Belgium), 2014</td>
</tr>
</tbody>
</table>


\(^{11}\) See pledges related to health-care insecurity at: [http://www.icrc.org/pledges/ByIssuesPledge.xsp?xsp=themeslist&outline=3&option=CNUS-8MDAWZ](http://www.icrc.org/pledges/ByIssuesPledge.xsp?xsp=themeslist&outline=3&option=CNUS-8MDAWZ)
A global communication campaign complements both the operational response and the diplomatic mobilization and expert consultation tracks by shaping public opinion, with a view to creating an environment more conducive to concrete action. The campaign supports the Movement’s operational communication in the field and encourages a change of behaviour in countries where attacks against health services are rampant.

Constantly adapting to changing dynamics and evolving sensitivities that have bearing on the security of health care, the campaign uses different channels – such as the media, the web and conferences or other events – to engage Movement staff and volunteers, health-care communities and other members of civil society.

Specifically, it aims to increase public recognition of health-care insecurity as a major humanitarian problem, to raise awareness of the HCiD project and its objectives, and to enlist support for adopting and implementing practical measures to better safeguard health care. The campaign’s goals correspond to the phases of the project, seeking to elicit strong emotional reactions from their audience, and then focusing on the effective solutions that have been implemented in the field. This aims to foster investment among the stakeholders in adopting and implementing these measures and in establishing new ones.
THE HEALTH CARE IN DANGER PROJECT: 2014 ACTIVITIES AND RESULTS

Afghanistan, 2014. Participants of the first-aid training organized by the ICRC learn how to make a stretcher using a ‘patou’ (shawl) and two pieces of wood. The training programme focuses on using locally available materials when administering first aid. It is organized for all combatants, including armed group members, national defence and police officers, and medics.

© Jessica Barry/ICRC

OPERATIONAL RESPONSE

In 2014, with Movement partners, the ICRC continued to refine its operational response to enable conflict/violence-affected people to receive quality and timely health care, first aid and medical treatment, while seeking to fulﬁl its responsibility to ensure the safety of its staff and of those seeking care. In parallel, it worked with other health/medical personnel to help them do the same.

Doing these required cross-cutting action, such as guiding delegations in understanding and managing the risks they face, responding to those risks, adapting their dialogue with the actors concerned and encouraging the creation of legal and practical conditions that safeguard health care. Therefore, the ICRC’s multidisciplinary approach stayed crucial, with the Assistance (particularly its Health Unit), Legal and Protection Divisions and the Legal Advisory Service all contributing input and supporting delegations, as necessary.

INCIDENT REPORTING HELPS INCREASE UNDERSTANDING OF THE PROBLEM

With a view to gaining a better understanding of the patterns of violence affecting health-care services, both at global and field levels, more than 20 delegations systematically monitored such violent incidents and shared the information with headquarters. Throughout the year, the delegations received support for improving their data collection methods. Delegations participating in the project for the first time established procedures for gathering information with support from headquarters.

In May 2013, the ICRC published a report12 detailing its analysis and mapping of threats against the provision of health care, on the basis of the incidents reported in 2012.

Aside from reports from ICRC field teams, National Society teams and national authorities, information from medical NGOs and other credible sources were also considered.

A second report, published in April 2014, further examined the trends identified in the previous report, paying particular attention to attacks on health-care facilities and ambulances. The findings confirm that disrespect of health-care services is widespread during armed conflict and other emergencies, and that local health workers are particularly at risk. Based on data collected from 2012 to 2014, 91% of the reported incidents of violence affected local health-care providers, including Red Cross and Red Crescent staff or volunteers. The ICRC raised awareness of these concerns among key stakeholders and encouraged them to take action to address the problem. The content of the reports fed into the background documents used at the expert consultations and workshops during the year. Findings were shared with delegations worldwide and presented at various fora.

**DELEGATIONS ADAPT THEIR APPROACH AND ACTIVITIES**

Several delegations undertook context-specific analysis of the obstacles to the delivery of health care; this helped them form a clearer picture of the nature and pattern of the dangers they faced. Where applicable, particular attention was paid to the accessibility of specialized care for victims of sexual violence and other vulnerable groups.

Delegations received guidance in developing their approaches to engaging in dialogue with the authorities, armed groups and other actors concerned. Over 60 delegations integrated project objectives or related activities into their plans for 2015: 45 relayed information to headquarters on the activities they carried out in this domain in 2014 (for examples of activities, see Health Care in Danger in day-to-day operations in 2014 on page 24).

Such efforts enabled them to better adapt their operations to meet the goals of the HCiD project; for example:

**Central African Republic:** The delegation finalized a strategy seeking to involve all its departments in addressing HCiD issues. The strategy aims to support the self-protection measures of health-care personnel and Central African Red Cross Society volunteers, and to spread awareness among weapon bearers and communities of the need to ensure the safe delivery of health care. Efforts to address this issue include: streamlining the delegation’s collection and analysis of data on related incidents; networking with other humanitarian organizations; and producing radio spots and communication materials in cooperation with the National Society.

**Colombia:** At a regional event organized by the Colombian Ministry of Health, the Colombian Red Cross, the Norwegian Red Cross and the ICRC, representatives of 12 Latin American States, the Pan American Health Organization, World Health Organization (WHO) and several National Societies discussed specific ways to implement recommendations from HCID expert consultations. Moreover, the delegation reviewed the progress of its efforts to promote the protection of medical services over the past few years.

**Côte d’Ivoire:** At a round-table co-organized with the National Society, some 30 representatives from the health-care community, armed/security forces, legislative bodies and humanitarian organizations came together to exchange information and experiences on improving the protection of health-care services during crises. Three sets of recommendations were formulated by health-care providers, national defence officers and law-makers, respectively. In Abidjan, students participated in an awareness-raising event on HCID, which was covered by State media.

**Indonesia:** The Ministry of Health Crisis Centre in Indonesia incorporated aspects of the Safer Access Framework in its standard operating procedures and security guidelines, with technical advice from the Indonesian Red Cross Society and the ICRC.

**Iraq:** ICRC delegates highlighted HCID issues in their dialogue with the authorities and weapon bearers in the country. Speaking points on specific concerns were prepared to support them during their interactions with armed group members. The delegation conducted several workshops and dissemination sessions for community/traditional leaders, local council representatives, militias and health workers on ways to safeguard health-care services.

**Kyrgyzstan:** Media professionals, medical practitioners and military officers learnt more about HCID at dissemination sessions. The national IHL committee expressed its willingness to work on Kyrgyzstan’s legal framework for the protection of medical staff.

**Lebanon:** The delegation’s approach to addressing HCID focused on promoting respect for medical structures and personnel among weapon bearers; supporting the medical community in mitigating the risks they face; and raising public awareness of the issue.

**Myanmar:** The delegation held a seminar to introduce the HCID project to health-care professionals, and to consult them on the possibility of carrying out related activities in Myanmar. Senior members of the Myanmar Medical Association and the Myanmar Nurses and Midwives Association, medical university personnel and Myanmar Red Cross Society officers identified issues affecting the delivery of health care, and expressed

---


their support for the development of initiatives addressing these issues. Myanmar military medical doctors were also present during the seminar.

**New York:** The delegation regularly highlighted the issue during its interaction with representatives of United Nations (UN) bodies and member States. It organized a panel debate on the subject on the sidelines of the 69th UN General Assembly (see page 19).

**Pakistan:** The Association of Pakistani Physicians of North America Institute of Public Health opened the “Collaborative Centre for Research on Violence against Health Care” with ICRC support in the form of books and equipment. As they gain better access to materials on HciD, public health students will be better able to take up related issues in their own research.

**South Sudan:** A pilot project launched in two medical facilities aimed to increase the security of hospital premises through practical means. Protective measures were developed in cooperation with local authorities and health workers, with a view to encouraging their ownership of and long-term commitment to the project. The need to ensure the safety of health personnel and infrastructure was systematically raised during IHL dissemination sessions for weapon bearers involved in the armed conflict and other situations of violence. Explanations of relevant norms were based on traditional law. These sessions were often combined with first-aid training. Representations were made at all levels in response to attacks against health-care teams or infrastructure. (see page 25)

**Yemen:** Following reports of incidents threatening the provision of health services, the delegation immediately made contact with all parties concerned, calling on them to protect and respect wounded people as well as health personnel, vehicles and facilities at all times. Work began on organizing a national HciD round-table with a view to facilitating the adoption by the parties to the conflict of standard procedures to prevent attacks against health-care personnel vehicles and facilities. In parallel, the delegation continued to draw attention to the issue in its dialogue with government officials, weapon bearers, NGO representatives and members of the health-care community.

The collection of delegations’ HciD-related activities and safety measures continues. To date, 64 delegations have each assigned a focal point tasked with facilitating the collection of data on relevant field practices, and to ensure effective collaboration between ICRC headquarters and their respective delegations, and between different departments. Data gathering methods were shared with MSF and WHO.

An annual meeting of HciD focal points was held in 2014 in Geneva to discuss HciD project updates, exchange field practices and plan the promotion of the recommendations emanating from the expert consultation process.

Where feasible, and in consultation with the delegation, some field practices will be shared with other organizations working with the ICRC. Relevant measures being implemented by other organizations – such as National Societies, WHO, medical NGOs, national associations of doctors and nurses, ambulance services, health authorities – will also be observed and documented.

A compilation of field practices will be presented at the meeting of HciD project focal points in 2015.

**PRACTICAL MEASURES AND TRAINING HELP HEALTH-CARE WORKERS STAY SAFE**

In the face of the continued danger they face, health teams, including those of the National Society and the ICRC, received guidance in taking immediate action to avoid the dangers to which they are exposed. Drawing on ideas shared and recommendations made during regional expert workshops, delegations were supported in implementing tangible measures or in pursuing preparatory efforts to do so. The ICRC shifted its focus from developing new materials towards promoting the use of existing ones.

Work was ongoing to improve and develop training tools and other related guidance material to help health workers, National Society personnel and ICRC staff carry out health activities safely. Notably, the guide “Health Care in Danger: the responsibilities of health-care personnel in armed conflicts and other emergencies”15 was widely promoted in various national and international fora, including through the International Council of Nurses (ICN) and the World Medical Association (WMA). It was made available in Arabic, English and French. Members of professional health-care organizations have begun using this guide and have provided positive feedback about it. To broaden the reach of the document, the ICRC developed complementary e-learning modules. The module “Rights and responsibilities of health-care personnel in armed conflict and other emergencies”16 was introduced to members of the academe and other key partners. The public can access it via the HciD website and on the online platform for the project’s community of concern.

Academic institutions received support in incorporating topics linked to the protection of health services in their curricula. In Kazakhstan, for instance, the State Institute of Advanced Medical Education and the Kazakh Red Crescent formally agreed to partner in efforts to integrate a course on the rights and duties of medical personnel during armed conflict into the Institute’s curriculum for medical students (see page 22).

National Societies shared and learnt ways to increase their acceptance, security and access in sensitive and insecure contexts. Recommendations from past workshops on National Societies’ response to health care in danger were promoted among National Societies and ICRC delegations.

---


A report on ambulance and pre-hospital services in risk situations\textsuperscript{17}, which was produced in 2013 by the Norwegian Red Cross with the support of the Mexican Red Cross and the ICRC, has been translated into several languages and has been distributed to various stakeholders across the world. Drawing on the recommendations in the report, which were generated during an expert workshop held in Mexico in 2013, the Norwegian Red Cross organized two regional workshops on the same theme in Colombia (see page 15) and Lebanon. During these workshops, representatives of National Societies in the Americas, Middle East and North Africa contributed to the development of procedures and best practices aiming to ensure that Red Cross and Red Crescent ambulance personnel can fulfill their duties safely amid insecurity.

On the basis of experiences gathered from various National Societies, the Safer Access Practical Resource Pack\textsuperscript{18}, set of print, audiovisual and electronic resources, was produced and promoted worldwide to guide National Societies in applying the Safer Access Framework in their activities, especially when providing first-aid or other health-related services in situations of conflict/violence. The materials in this resource pack are available in Arabic, English and French; they have been translated into Mandarin, Russian and Spanish. With the help of ICRC tools and advice, National Societies developed action plans to enhance peer-to-peer learning experiences between different National Societies, for example, in December, the Egyptian Red Crescent Society demonstrated its emergency response procedures to Bangladesh Red Crescent Society representatives at an ICRC-organized session\textsuperscript{19}. Thematic round-tables on ways to address access and security difficulties aim to help Movement components reach more vulnerable populations.

**DEFENCE FORCES AND OTHER WEAPON BEARERS IDENTIFY WAYS TO MITIGATE RISKS**

The ICRC unit for relations with arms carriers, and its network of specialists in the field, pursued its efforts to help military and security forces and armed groups increase respect for medical services, taking into account their unique role in avoiding or minimizing the danger posed to health care during armed conflict and other emergencies. Dialogue with weapon bearers covered three main issues that have an impact on the security of health care: ground evacuation of the wounded and sick, including the passage of patients and medical personnel/vehicles through checkpoints; search operations in health-care facilities; and the precautions weapon bearers can take during attack and defense.

A report on promoting military operational practice that ensures safe access to and delivery of health care\textsuperscript{20} was officially launched at a panel discussion in Australia organized by the Australian Red Cross and the ICRC. It proposes measures that can be incorporated into military orders, rules of engagement, standard operating procedures or training, with the aim of mitigating the effects of military operations in three specific areas: checkpoints, search operations in health facilities, and military operations carried out close to health-care facilities. These measures were developed and collected in 2013 through a year-long consultation process with military personnel around the world. This process involved a workshop, co-organized by the ICRC and the Australian government, that brought together 27 senior officers from 20 countries, as well as bilateral confidential consultations with military personnel in 29 countries and with two multilateral organizations of a military or defense character.

The ICRC raised issues affecting the provision of health services with 36 armed groups during bilateral consultations with them in 10 contexts. The consultations highlighted the need to respect the wounded and sick, as well as health-care personnel, facilities and means of transport. Armed group members deliberated on practical measures that they could adopt to ensure the safe delivery of impartial and good-quality health care. The ICRC is developing a model declaration that armed groups can adopt to express their commitment to abiding by IHL, underscoring the resolve to safeguard the delivery of health care.

**INCREASING IHL IMPLEMENTATION FOSTERS LONG-TERM SAFETY OF HEALTH CARE**

As the existing norms of IHL and international human rights law adequately address the priority issues of the HCiD project, the initiative encourages the implementation of these norms through regulatory and legislative measures adopted at national level. In support of this, the ICRC Advisory Service on IHL helped facilitate the incorporation of relevant norms in domestic legal and regulatory frameworks worldwide.

The ICRC Advisory Service on IHL helped guide the operational dialogue of National Society and ICRC teams, particularly with regard to their approach to engaging with regional and national authorities. This included supporting them in following up on the pledges made at the 31st International Conference in relation to the HCiD project and encouraging the actors concerned to improve their respective countries’ domestic legal and regulatory frameworks accordingly. The importance of domestic IHL implementation was systematically highlighted in the ICRC’s bilateral

\textsuperscript{17} Ambulance and pre-hospital services in risk situations, available at: https://www.icrc.org/eng/resources/documents/publication/p4173.htm


\textsuperscript{19} See an article on the event at: https://www.icrc.org/en/document/bangladesh-red-crescent-study-visit-egypt#.VP_X1ChqsVM

\textsuperscript{20} Promoting military operational practice that ensures safe access to and delivery of health care, available at: https://www.icrc.org/eng/resources/documents/publication/p4208.htm
dialogue with State authorities and national IHL committees, and during multilateral engagements at regional conferences and other occasions. Notably, the matter was discussed at more than 20 regional conferences and related events. Through regional legal advisers and delegations’ legal staff, the adoption/amendment of legislation recognizing the role of National Societies and defining the use of and promoting respect for the protective emblems was encouraged and, in some cases, successfully undertaken.

In 2013, the ICRC Advisory Service on IHL mapped and analysed existing national laws and regulations safeguarding health care and compiled feedback on them from ICRC regional legal advisers. Where feasible, these were included in the database on the ICRC website on IHL and national implementation (http://www.icrc.org/ihl-nat). The relevant normative frameworks of over 40 countries were examined. The results of the study served as a basis for working with National Societies, national IHL committees, other government representatives and ICRC delegations to identify the best features and main gaps in existing laws, with a view to helping them develop proposals on improving domestic IHL implementation.

In January 2014, these proposals were discussed at a regional expert workshop in Brussels on domestic normative frameworks for protecting the delivery of health care. Subsequently, the ICRC Advisory Service on IHL produced a detailed report on the workshop’s outcomes (see below) and, on the basis of these outcomes, published a guidance document to help national authorities implement rules protecting the provision of health care in armed conflicts and other emergencies.

**DIPLOMATIC MOBILIZATION**

**EXPERTS SHARE IDEAS ON INCREASING THE PROTECTION OF HEALTH SERVICES**

National authorities, members of the health-care community and other key stakeholders from across the world came together to discuss different aspects of the threats against health care at thematic expert workshops, conferences and panel discussions on HCI D in regional and international fora. During the expert consultations, participants split into working groups for in-depth discussions and consultations. Good practices, concrete recommendations and other resonant points were shared during plenary sessions.

In 2014, two expert workshops took place:

- **Domestic normative frameworks for protecting the delivery of health care (Brussels):** Some 50 experts from Africa, Asia, the Middle East and South America discussed concrete steps that States can take to: enhance the legal protection for the wounded and the sick and for health-care personnel, facilities and means of transport; strengthen laws relating to the improper use of the distinctive emblems, as defined in the Geneva Conventions and their Additional Protocols; ensure the observance of confidentiality and other ethical principles in health care in armed conflicts and other emergencies; and effectively enforce laws linked to health services. These experts included representatives of Ministries of Foreign Affairs, Defence and Justice, members of national IHL committees or similar bodies, independent IHL experts, parliamentarians, and representatives of various organizations. The workshop was conducted in Brussels, Belgium with the support of the Belgian government (in particular, the Interministerial Commission for Humanitarian Law) and the Belgian Red Cross. The publication “Domestic Normative Frameworks for the Protection of Health Care”21, which summarizes the discussions during the workshop, was produced. Released in February 2015, it is being shared with national authorities and other key stakeholders to help them implement the workshop’s recommendations.

- **The safety of health structures (Pretoria):** The Department of International Relations and Cooperation (DIRCO) of the government of South Africa and the ICRC organized a workshop focusing specifically on the safety of health facilities. Over 40 experts – including hospital managers working in volatile environments and representatives of WHO, International Hospital Federation, WMA and MSF – considered short- to long-term measures to ensure the security and uninterrupted functioning of health-care facilities, and help health staff manage stress under pressure. The participants built on the recommendations from a 2013 workshop on the same topic, which was held in Ottawa. A report on the results of the discussions will be released in 2015.

Thematic events organized within the framework of existing regional and global fora promoted further ownership and implementation by States and other key stakeholders of the recommendations generated during the expert consultation workshops. For example:

- **On the sidelines of the 69th session of the United Nations (UN) General Assembly, the ICRC organized a debate that raised further awareness of the issues covered by the HCI D project, highlighting the importance of a protective environment for national health-care systems and enjoining States to enact measures to strengthen the resilience of these systems to crises.**

- **The African Union (AU) and the ICRC co-organized a conference to promote the practical measures proposed at the HCI D workshops and enhance cooperation with the health-care community in Africa. Members of the**

---

AU Peace and Security Council and representatives of the WHO and the WMA took part in the event, which was held in Addis Ababa, Ethiopia, on 22 October 2014. They considered the recommendations proposed during the workshops in Brussels and Sydney, which were linked to domestic normative frameworks and military operational practices, respectively. Members of the AU Permanent Representatives Committee endorsed 20 recommendations, including: adopting and reinforcing domestic laws designed to protect patients and health-care personnel, facilities and means of transport; raising awareness of these laws among weapon bearers and the wider public; improving coordination among those providing emergency medical care; and enhancing respect for the emblems protected under IHL and vigorous prosecution in the event of any misuse of these emblems.

A regional workshop in Colombia facilitated the exchange of best practices among representatives of Health Ministries from eight Latin American countries and of several National Societies (see page 16).

The outcomes of the expert consultation process and the promotion of recommendations are being compiled and prepared for presentation at the 32nd International Conference.

THE HEALTH-CARE COMMUNITY FOSTERS SUPPORT FOR THE PROJECT’S GOALS

The ICRC continued to forge partnerships and build a community of concern of influential stakeholders invested in addressing threats to the delivery of health care. Constantly engaging in bilateral and multilateral contacts, it formed varying contacts and partnerships with relevant actors such as States and governmental experts, international organizations, NGOs, the health community, academics and media representatives.

After signing partnership agreements with the ICRC, the ICN, the International Hospital Federation, the World Confederation of Physical Therapy, and the WMA participated in expert consultations, discussed the HCID project during their own annual meetings, and mobilized their members to promote recommendations developed by the project, particularly with regard to health-care ethics during armed conflicts and other emergencies. The ICRC also worked closely with the Australian, Belgian and Norwegian governments, the European Commission, the International Committee of Military Medicine (ICMM), MSF, WHO and other key partners supporting the goals of the project. For example, the British Medical Association, the Canadian Medical Association, ICMM, MSF, WMA and the ICRC held a two-day conference in Geneva on ethical dilemmas for health-care workers during armed conflict and other emergencies. Based on such discussions, the ICRC, together with partner organizations, will issue a common declaration on ethical principles in providing health care in such situations.

After launching its own project, named “Medical Care Under Fire”, which seeks to draw attention to the violence af-

---


fecting its operations in several countries, MSF is collaborating with ICRC in finding synergies between their respective projects. The World Federation for Medical Education (WFME) has publicly expressed its support for the HCiD project, with a view to spreading awareness of the project within its regional and global networks.

The International Federation of Medical Students’ Associations (IFMSA) began working with WMA, ICN and ICRC representatives to develop a strategy for limiting the risks faced by health workers. IFMSA started its own campaign promoting ethical principles of health care in armed conflict and other emergencies. In accordance with a training plan for 2014–15, it conducted health-care ethics courses using information resources developed by the ICRC; these courses were held in Sweden and Taiwan, for example.

The 2014 Ebola crisis in West Africa brought to the fore the importance of resilient health-care systems and of measures to safeguard health-care personnel and facilities during emergencies. The WHO and the ICRC continued to work together to promote ways to improve the accessibility and security of health services, particularly in volatile contexts. The WHO Safe Hospitals Initiative seeks to prevent potential damage to hospitals in the event of a disaster. At a side-event at the 67th World Health Assembly, health ministers from around the world took part in a discussion on “Health care under attack: A call for action”. The panel included the WHO director-general, the UN undersecretary-general for humanitarian affairs and emergency relief, the Central African Republic’s minister of public health, Colombia’s ambassador to the UN and the ICRC president.

At another event organized jointly by WHO and ICRC on the sidelines of the UN General Assembly in September 2014, participants made a strong call for action by States to have domestic legal frameworks for protecting health-care systems. These participants included high-level representatives from Côte d’Ivoire, Norway and Sweden, the UN undersecretary-general for humanitarian affairs and emergency relief, the WHO director-general, and the ICRC president.

Some 600 members of the project’s community of concern – which included health-care personnel, representatives of NGOs and international organizations, and ICRC staff – have joined the Health Care in Danger Network, an online platform that enables them to share reference documents, communication tools and other relevant material. The network also allows them to exchange their experiences in implementing the recommendations generated in the course of the project, and provides them with easy access to the background documents and reports on the outcomes of the expert workshops.

In 2014, Movement cooperation remained crucial to promoting the project’s goals and making headway in achieving its central objectives. The Movement Reference Group, composed of representatives from 27 National Societies and the International Federation, served to strengthen Movement coordination for the project. The group played an important role, not only in developing responses within their own contexts, but also in following up the project’s outcomes at a global level. It played a crucial role in supporting expert workshops, many of which were co-organized with the host country’s National Society.

The Movement Reference Group comes together four times a year, with three webinars and one face-to-face meeting. In May 2014, representatives of 20 National Societies and the International Federation attended the Movement Reference Group meeting in Geneva. Through regular webinars – which have been conducted since 2013 – National Societies kept themselves abreast of project developments and exchanged views on key concerns. Such concerns include: ways to address challenges in providing insurance coverage for National Society staff and volunteers, as recommended during past expert workshops; the evaluation of the project’s progress since 2012; and future prospects for the project.

Towards the end of 2014, eight members of the Movement Reference Group – namely, the National Societies of Australia, Colombia, Egypt, Lebanon, the Philippines, Somalia, Sweden and Norway – volunteered to participate in a working group tasked to assist in preparations for the 2015 International Conference. Aside from working in partnership with the ICRC to carry out activities related to the project, many National Societies autonomously launched their own complementary initiatives involving internal and external stakeholders. Many of them have focused on engaging with governments and the health-care community to raise awareness of the problem and jointly identify possible responses. A number of National Societies’ websites have dedicated sections on the HCiD project, featuring the activities held to advance its goals.

Confirming the Movement’s lead role in and ownership of the project, the ICRC significantly drew on the Movement’s wide network of contacts to promote it. National Societies have launched various initiatives to promote the recommendations generated at the HCiD expert workshops. For example:

- A number of National Societies, including Australian Red Cross, Egyptian Red Crescent Society, Red Cross Society of Côte d’Ivoire, Swedish Red Cross, and United Arab Emirates Red Crescent, conducted roundtables and workshops aimed at helping both authorities and health-care professionals adapt the project’s recommended measures to their particular circumstances and develop other possible solutions.
Some National Societies have focused on working with the health-care community to identify context-specific responses to the concerns raised by the HCiD project. For example, the German Red Cross published German translations of HCiD information materials and conducted an awareness-raising session at an annual meeting of the German Medical Association. At workshops co-organized by the Nepal Medical Association, Nepal Red Cross Society and the ICRC, health workers learnt more about the issues raised by the project and the ICRC’s responses to them, and considered measures that could be implemented in Nepal to address these issues. Under a partnership agreement with the State Institute of Advanced Medical Education in Kazakhstan, the Kazakh Red Crescent would provide teaching materials and conduct training on the rights and duties of medical personnel during armed conflict in cooperation with the Institute and the ICRC.

In close cooperation with the Swedish Medical Association and the Swedish Association for Health Professionals, the Swedish Red Cross initiated a one-year training programme, for medical and nursing students and health-care professionals, on the ethical obligations of health-care workers. The programme is partly based on the ICRC-produced booklet and e-learning module of health-care workers. The programme is partly based on the ICRC-produced booklet and e-learning module on the responsibilities of health-care personnel working in armed conflict and other emergencies. The Swedish Red Cross has conducted a study on access to health care in armed conflict and other emergencies, paying particular attention to its gender-related implications. In late 2014, field research was conducted in Colombia and Lebanon with the support of the National Societies and ICRC delegations in those countries. The report on the study is expected to be released in 2015.

The Kenyan Red Cross has developed procedures for providing emergency trauma care to wounded people and for mitigating the risk of being affected by follow-up attacks aimed at harming people attempting to assist the casualties of an earlier attack. Similarly, the Somali Red Crescent Society is mapping out its approach to first aid, taking into account the risks that emergency responders take while performing their duties.

The Afghan Red Crescent Society has established an HCiD Movement Committee, tasked with identifying challenges to meeting the project’s goals and ways to overcome them. This committee includes the International Federation and the ICRC.

The Norwegian Red Cross, through the Norwegian Ministry of Foreign Affairs, has supported the deployment of experts tasked with supporting selected National Societies, including those in Colombia, Iraq, Lebanon and South Sudan, in developing their operational response to ensure safe access to and strengthen the protection of health care.

At a workshop held in October 2014 in Beijing, China, National Societies exchanged views on measures being taken to protect health-care workers, facilities and beneficiaries. Presentations by several National Societies highlighted the part that National Societies could play in protecting health care, not only through their own activities, but also by lobbying influential parties to take action. The Chinese Nursing Association and the ICRC also delivered presentations at the workshop. Discussions, which were held in English and Arabic, were moderated by the Australian Red Cross. The event was held at the sidelines of the ninth Asia Pacific Regional Conference of the International Federation, and was hosted by the Afghan Red Crescent and the Nepal Red Cross.

COMMUNICATION CAMPAIGN

The communication campaign focused on mobilizing specific audiences, supporting operations and promoting awareness of the outcomes of the expert workshops to encourage different stakeholders to contribute to improving the security and delivery of health care. This second phase of the campaign began in 2013.

Large-scale public campaigns, panel discussions, radio spots and competitions, complemented by a strong online presence, reached millions of people in over 20 countries. With the support of the European Commission and the National Societies concerned, visuals promoting how practical measures can help save the lives of the wounded and sick were displayed from late 2013 to early 2014 through outdoor advertisements – in streets, bus shelters and train stations, for instance – in seven European capitals. Some 12 million people saw these images, which were reinforced by traditional and online media activities. A replica of an attacked ambulance was displayed in one of the main squares of Brussels in October and in November at the Planète Santé in Lausanne, Switzerland.

HCiD events organized by ICRC delegations, National Societies, and partner organizations worldwide received regular coverage by traditional local media and those open to the public were well-attended. These events were held in different countries, including Australia, Belgium, Brazil, China, Egypt, Ethiopia, Italy, Jordan, Norway, South Africa, Sweden, and the United States of America.

The communication team produced HCiD-related news releases, operational updates and short videos, allowing major international media to use the ICRC’s nuanced content to draw attention to the plight of people facing difficulties in accessing health care. Regular media monitoring confirmed that the issue of violence against health care continues to receive coverage by the media worldwide. Notably, the organization’s global mapping of violent incidents affecting those seeking or providing medical care received much media attention. The film “Health Care in Danger: the human cost” also brought coverage to the project and its goals and was shown during events in China, Ethiopia and...
and Italy. The production of a brochure on practical solutions from the HCiD expert workshops was ongoing, while a video showing these recommendations was being developed in consultation with ICRC delegations in Afghanistan, the Central African Republic and South Sudan.

The reference materials developed for the project continue to be translated to make them available to a wider range of audiences. The publication “Ambulance and pre-hospital services in risk situations” is being translated into German, at the request of the German Red Cross. “Promoting military operational practice that ensures safe access to and delivery of health care”, launched in English in September 2014, was published in French in January 2015. A new publication titled “Domestic normative frameworks for the protection of health care” and a complementary guidance document were issued in January and March 2015, respectively. The Italian Red Cross translated the posters of the campaign as well as the film “Health Care in Danger: the human cost” into Italian; these materials were used at three events held in Italy.

The campaign continued to have a strong online presence, thanks to:

► its official website, which is available in Arabic, Dutch, English, French, German, Mandarin, Polish and Portuguese, and receives an average of 6,000 views per month

► the Health Care in Danger Network, a dedicated online platform that keeps some 600 members of the project’s growing “community of concern” updated on the project’s developments

► the Health Care in Danger Twitter account (@HCIDproject) which was launched in April 2014 and has reached 620 followers in December with a stable average growth of 35 new members per month

Three Health Care in Danger newsletters were published in English. Over 2,500 subscribers were informed of the latest developments in the project after receiving the third English e-newsletter; this was triple the number of recipients of the two previous editions. Translated into Arabic, French and Spanish, the newsletter served as reference material that could be used by HCiD focal points in the field to supplement their dialogue with the authorities and other stakeholders.

E-learning courses were designed in order to raise awareness of the obligations of the authorities and the rights and responsibilities of health-care personnel in ensuring safe access to health care:

► An introductory course to inform the general public on the responsibilities of the authorities and health-care workers in armed conflicts and other emergencies was developed. A trial version27 was released in August 2014; it is available on the Health Care in Danger Network and on the project’s website. A final version that will work on all browsers and devices is currently being produced.

► A module for health-care personnel28 delves into the ethical dilemmas they face in risk situations. Launched in October 2014, this module was based on the publication “Health Care in Danger: The responsibilities of health-care personnel in armed conflicts and other emergencies”. The module has been widely promoted in cooperation with other Movement components and partner organizations, through the Health Care in Danger Network and mainstream social media, and during HCiD events.

27 Available at: http://www.icrcproject.org/elearning/health-care-in-danger/beta

28 Available at: http://www.icrcproject.org/elearning/health-care-in-danger/
HEALTH CARE IN DANGER IN DAY-TO-DAY OPERATIONS IN 2014

Ukraine, 2014. Colleagues tend to a volunteer who was wounded while on duty in Kiev. © Mstyslav Chernov/Unframe

STRENGTHENING EMPHASIS ON AN INSTITUTIONAL PRIORITY

In 2014, security incidents affecting health-care personnel, facilities and means of transport frequently resulted in delays before they could provide critical treatment or in rendering their services wholly inaccessible to those in need. For example, at a hospital in South Sudan, several patients were killed, supplies were stolen and a therapeutic feeding centre was burnt during clashes in February. Before the attack, the hospital had served a catchment population of 3 million people with ICRC support. While providing medical assistance to casualties of violence in Ukraine, a Ukrainian Red Cross Society volunteer was wounded, and other volunteers/staff were reportedly harassed or otherwise hindered from performing their duties. In a number of contexts, ambulances were blocked or diverted. Such threats and attacks further weakened health-care systems that had already been undermined by years of armed conflict, political instability and/or the lack of resources.

Developed within the framework of the Institutional Strategy 2014–2018, the ICRC’s current Health strategy calls for an increased focus on activities across different departments to promote access to health care. In keeping with the aims of the HCiD project, the ICRC is bolstering its efforts to help conflict-affected people overcome constraints in accessing and providing medical services, and to improve the quality of health care available to them. The ICRC employs its multidisciplinary approach (prevention, protection, assistance and cooperation) and combines different modes of action (support, mobilization and substitution) to help first responders, medical workers and others in the health community safely offer quality and timely services to conflict/violence-affected populations.

At all stages and phases of carrying out its health/medical activities, the ICRC works in partnership with the National Society/ies concerned whenever possible, helping them strengthen their capacities to operate independently while promoting adherence to the Movement’s Fundamental Principles. With their countrywide network of staff and...
volunteers, National Societies are often the main providers of humanitarian aid in remote areas.

**ENLISTING SUPPORT FOR SAFEGUARDING HEALTH SERVICES**

To manage the aforementioned risks and threats, the ICRC, with National Societies, works to balance its goal to address the needs of the most vulnerable populations against its responsibility to ensure the safety of its own staff and personnel. Delegations systematically developed dialogue with the authorities and weapon bearers concerned to raise awareness of IHL and the Movement’s neutral, impartial and independent humanitarian action, with a view to gaining their support for National Society/ICRC activities and to securing guarantees of safe access to all conflict/violence-affected populations. Such dialogue exists in many contexts, including the Central African Republic (hereafter CAR), Georgia, Israel and the occupied territories, Lebanon, Mali, Nigeria, Papua New Guinea and Somalia. First-aid training sessions for military and police officers and other weapon bearers also served as a space to discuss related concerns. Acting as a neutral intermediary, the ICRC facilitated the safe passage of medical workers to serve vulnerable communities, as in the Casamance region of Senegal, or of wounded or sick people to cross administrative boundaries to seek medical care, as in Georgia.

Long-term engagement with the national authorities and other relevant stakeholders is required to ensure that awareness translates into concrete action. In Nepal, for instance, round-tables gathering representatives of political parties, communities, the traffic police and ambulance services have been held for several years now to facilitate safe and appropriate use of ambulances. Following the adoption in 2013 of a code of conduct for ambulance services, round-tables held in 2014 followed up on recommendations and commitments made in previous years. In Afghanistan, following similar discussions with government officials, the Interior Ministry issued an official correspondence urging police officers to allow vehicles carrying wounded or sick people to pass checkpoints without delay. A draft law aiming to ensure the safety of health personnel and facilities was submitted for approval in Venezuela.

Bilateral meetings and dissemination activities, such as those conducted for religious, community leaders and other influential players, contributed to widening acceptance of the Movement’s health activities. For example, at round-tables, over 300 Palestinian religious leaders discussed the importance of safeguarding the provision of health care within the context of IHL and Islamic law. Radio broadcasts, as in Guinea and Peru, and other public communication efforts promoted support for the Movement’s health care activities and/or the goals of the HCID project. In Karachi, Pakistan, an academic institution on public health opened a centre for research on violence against health care, with ICRC support.

Working with National Societies, health care workers and other actors in the medical community, the ICRC promotes practical ways to help them mitigate the risks they regularly face. Whenever possible, the ICRC supports them in carrying out these measures, which are adapted in each context according to prevailing security conditions and local capacities. For example:

- New/improved radio communication systems in South Sudan and Syria helped National Society volunteers/staff notify each other of their movements in violence-affected areas and share security-related information.
- Plans to install solar-powered lighting systems at two hospitals in South Sudan aimed to make the hospitals more easily identifiable at night.
- The provision of uniforms marked with the emblem – for example, in Kyrgyzstan – enabled emergency response teams, including first-aiders, to be recognized more clearly. Efforts to promote respect for the emblem in different contexts contributed to increasing the protection of medical structures and ambulances.
- National Societies worldwide trained their volunteers in the application of the Safer Access Framework. In 2014, such training was conducted for the first time for Red Cross Society of the Democratic People’s Republic of Korea (DPRK) personnel.
- In Côte d’Ivoire, a document outlining best practices for medical staff working in poor security conditions was developed and published by the Ivorian order of physicians with ICRC support.

**STEPING UP MEDICAL RESPONSE TO EMERGENCIES**

As shifting conflict dynamics and other emergencies result in drastic changes in the population’s needs, ICRC delegations maintain flexible approaches in order to undertake emergency measures to meet the most urgent needs while ensuring the safety of their staff. Aiming to ensure that wounded and sick civilians and fighters from all sides can access medical care, these measures often include the ad hoc provision of supplies to medical facilities and the deployment of ICRC medical personnel in conflict/violence-stricken areas. The ICRC’s response to crises in several countries contributed to an increase in the number of hospitals supported worldwide, from 326 in 2013 to 441 in 2014.

In 2014, emergency medical activities proved necessary in a number of contexts; for example:

- In the Central African Republic, hundreds of weapon-wounded people received appropriate care from ICRC-trained first-aiders and from local health workers and ICRC surgical teams at a community hospital in Bangui, which received medical supplies/equipment and funds. In Nana-Grébizi prefecture, health services were enhanced by the ICRC’s multi-dimensional approach, which included deployment of mobile clinics, assistance to health centres and the Kaga Bandoro prefectural hospital, and psychosocial support for victims of sexual violence.
In Nigeria, hundreds of casualties benefited from first aid/medical evacuations carried out by National Society/ICRC-trained responders, who also helped manage several hundred sets of human remains. Thousands of wounded and sick people were treated at ICRC-supported hospitals. During emergencies, ad hoc donations of supplies helped some facilities cope with mass-casualty influxes; furthermore, over 80 people were operated on by the ICRC surgical team.

In the Gaza Strip, thousands of injured people received first aid from the Palestine Red Crescent emergency medical services (EMS), which also operated in the West Bank; those severely wounded were transported to hospital. ICRC support covered the EMS’s operating costs, ensured the availability of medical supplies and helped the National Society obtain crossing/transport permits. Increased material support helped hospitals cope with the influx of patients; donated fuel ensured uninterrupted services. Truckloads of medical materials from the West Bank entered the Gaza Strip under ICRC auspices. Renovations were initiated at heavily damaged hospitals.

In Iraq, as the fighting intensified in Anbar and other parts of the country, the ICRC worked to ensure that vulnerable people, including those wounded and sick, had access to health services and emergency treatment. It provided on-site support/training for primary-healthcare centres, and medical supplies to hospitals and other facilities in conflict-affected areas. It also helped health staff enhance their capacities to cope with the influx of injured patients.

To ensure that weapon-wounded people from Syria can receive proper treatment, the ICRC opened a clinic at a border registration facility in Jordan and two surgical/post-operative centres in Lebanon.

In Libya, especially after the violence in the country escalated, people wounded during attacks/clashes received treatment from Libyan Red Crescent teams and at hospitals and primary health-care centres, which were equipped with ICRC-donated medical supplies. Doctors, surgeons and other medical professionals upgraded their skills in trauma management and war surgery during courses organized with local health authorities. Owing to the volatility of the situation in Libya, some of these courses were held in Tunis, Tunisia.

In South Sudan, as attacks on medical personnel/facilities reduced people’s access to health care, the ICRC increased its support for the delivery of life-saving care to the wounded/sick. In both government- and opposition-controlled areas, 4 ICRC surgical teams and doctors/staff at 46 ICRC-supported medical facilities treated wounded/sick people. The ICRC began providing support for several clinics to fill gaps left by the closure of other medical facilities; these clinics provided primary health-care services such as immunization and therapeutic feeding.

In Ukraine, people injured in protests and clashes received emergency treatment from ICRC-backed first-aid posts and National Society teams. National Society volunteers benefited from training and psychosocial support, including peer-to-peer support. Hospitals and health structures in conflict-affected areas, including the medical service of one armed group, received equipment and supplies to help them treat patients.

HELPING HEALTH-CARE PROVIDERS BUILD THEIR CAPACITIES

By working in partnership with the National Societies of the countries concerned and alongside the local authorities, the ICRC seeks to encourage the sustainability of its projects and the recovery of the communities it works with. In helping local actors strengthen their capacities to provide or manage health services autonomously in the future, the organization also fosters a sense of local ownership over the projects. For example, health facilities offering the different levels of care also receive varying degrees of managerial, material (e.g. provisions of supplies and/or infrastructure rehabilitation) and financial assistance, as well as staff training. These types of support aim to improve services both in the short- and long-term. The scope of the intervention ranges from limited distributions of supplies and equipment (support) to taking responsibility (substitution) for the management of the facility, depending on the population’s needs, local capacities to provide the services themselves, and the delegation’s operational priorities and constraints. For example:

Support for primary health-care services was crucial in preventing and controlling disease outbreaks and malnutrition in vulnerable communities. Local health teams received ICRC support to help them boost their capacity to provide basic health care, for example, in the Democratic Republic of the Congo, Iraq, Nigeria and South Sudan. Such support consisted of supplies, training and/or infrastructure upgrades. Mobile clinics served people in areas without access to hospitals, for example, in the CAR, Pakistan, Philippines and Somalia. In Myanmar, the ICRC covered the transport costs of local health teams and provided them with solar-powered refrigerators, enabling them to conduct monthly immunization campaigns and render other basic services for Buddhists and Muslims, including in remote areas.

Local health workers trained in providing medical/psychological care for victims of abuse. In Mali and Somalia, for instance, midwives provided counselling and specialized care for victims of sexual violence. Several hospitals and clinics in Côte d’Ivoire integrated mental health services into their consultation procedures. Health workers in the Gaza Strip and other contexts underwent training in providing psychosocial support.

To help ensure that casualties of fighting, especially in remote areas, can receive timely care before they are brought to medical facilities, the ICRC conducted or supported basic and train-the-trainer courses on first-aid for National Society volunteers, weapon bearers,
providing health/medical care. While encouraging safer conditions for those seeking or health care needs of conflict/violence-affected populations, the ICRC has provided comprehensive support to hospitals, helping local authorities and health professionals improve the sustainability and quality of their medical services. For instance, the Keysaney hospital in Mogadishu, Somalia has been run by the Somali Red Crescent Society with ICRC support for over 20 years. Three other hospitals in Somalia are also receiving comprehensive ICRC assistance.

In several countries, ICRC surgeons and emergency room staff helped medical practitioners enhance their skills at a total of 42 war-surgery and 32 emergency trauma management courses. Trauma care seminars were organized by the ICRC for the first time in DPRK; some 60 surgeons, including 5 from the Korean People’s Army, attended the sessions.

The following five examples – Afghanistan, Colombia, Iraq, Lebanon, Syria and Yemen – concretely demonstrate in more detail how the ICRC works to meet the health care needs of conflict/violence-affected populations, while encouraging safer conditions for those seeking or providing health/medical care.

EXAMPLE 1: AFGHANISTAN

The armed conflict between the Afghan government and armed groups intensified, reportedly resulting in displacement, limited access to basic services and the highest number of casualties in years. These casualties, along with people suffering from illness, struggled to obtain timely and appropriate treatment, as the increased medical needs strained the resources of the health-care system, and as attacks on health-care staff and facilities impeded the provision of their services. The fragmentation of the political/military landscape and the volatile situation blurred communication lines and limited the ability of humanitarian organizations to assist people affected by the conflict.

Parties to the conflict and the ICRC discussed the need to protect people not/no longer participating in hostilities, including wounded and sick people and health/medical workers, and to facilitate their access to health care and other basic services. However, the political transition posed some difficulties in sustaining such dialogue.

Women and children obtain primary health care

at a National Society clinic run by all-female staff

Various initiatives, in line with the government’s Basic Package of Health Services, helped enhance health care for the conflict-affected. People benefited from preventive/cu-
INTERIOR MINISTRY TAKES STEPS TO PROMOTE RESPECT FOR MEDICAL SERVICES AT CHECKPOINTS

Parliamentarians, government officials and Movement partners convened to discuss ways to protect the safety of medical services. This led to the Interior Ministry sending all checkpoints an official correspondence urging them to ensure that vehicles carrying wounded or sick people were not delayed. Journalists participated in a session on the same subject.

At dissemination sessions, almost 9,800 Afghan National Security Forces personnel, as well as members of armed groups, learnt more about IHL and humanitarian concerns, such as those raised by the Health Care in Danger project. Some 280 army and police personnel sharpened their IHL teaching skills at ICRC courses; army legal officers and ICRC-trained IHL instructors were in charge of some of these courses. With the support of the British government and the ICRC, the newly established Afghan National Army Officer Academy integrated the topic on law of armed conflict into its training curriculum. A military officer participated in a workshop abroad on rules governing military operations. While planning and conducting operations, leaders of armed groups consulted the ICRC on issues related to compliance with IHL.

Government officials participated in various IHL training sessions abroad, including a legislative drafting workshop on IHL. Dari and Pashto versions of the Geneva Conventions, submitted by the ICRC to the Justice Ministry, boosted efforts to incorporate these Conventions’ provisions in domestic law. A draft law on the use and protection of the red crescent emblem remained under review at the Ministry of Justice.

Some 20,000 influential community/religious leaders, academic scholars, ICRC beneficiaries, and members of the media/the general public deepened their understanding of IHL and the Movement through dissemination sessions/presentations by the ICRC or, when insecurity restricted the organization’s access, by the National Society and other local partners. During national/international round-tables/courses, religious scholars, university professors and students refined their knowledge of contemporary IHL-related challenges— including the difficulties faced in providing health care in situations of armed conflict and of the similarities between Islam and IHL. Local and international media used ICRC news releases/operational updates, and information collected during ICRC–organized field trips, to draw attention to humanitarian issues and help promote support for Movement activities. Publications in Dari and Pashto, and features on the ICRC’s website, supplemented these efforts.

MOVEMENT COMPONENTS IN AFGHANISTAN WORK TOGETHER TO ADDRESS SECURITY-RELATED CONSTRAINTS

The Afghan Red Crescent Society remained the ICRC’s main partner in providing medical care to conflict-affected people, many of whom were beyond the reach of overstretched/unreliable government services/other humanitarian actors. The National Society strengthened its coordination of activities related to the Health Care in Danger project in Afghanistan by creating a committee made up of focal points from various Movement partners.

A round-table in Switzerland convened Movement components present in Afghanistan, with a view to developing a common understanding of the evolving humanitarian needs and security constraints in the country, and clarifying and reinforcing their roles in relation to these issues.

EXAMPLE 2: COLOMBIA

While peace negotiations between the Colombian government and the Revolutionary Armed Forces of Colombia—People’s Army (FARC-EP) were under way, armed confrontations between the two parties continued. In December, the FARC-EP declared an indefinite ceasefire, reportedly leading to the lowest level of conflict-related violence in 30 years. Meanwhile, the peace process between the government and the National Liberation Army (ELN) remained in the exploratory stage, and other armed groups continued to fight among themselves or with security forces for control of land, natural resources and trade routes. Mass protests on social and economic issues sometimes led to confrontations between demonstrators and the police.

Tensions between various groups often resulted in casualties, displacement, movement restrictions, weapon contamination, sexual violence, disappearances and/or the disruption of people’s access to medical care and other basic services.

OVER 100 MEDICAL FACILITIES ARE MARKED WITH THE RED CROSS EMBLEM

Acceptance for its role as a neutral intermediary, notably in the context of the peace talks, enabled the ICRC to engage the parties to the conflict in dialogue on humanitarian concerns, particularly protection for civilians and health services. However, discussions on the effects of State policies on communities were limited. Confidential written and oral representations on documented allegations of violations reminded armed actors of their obligations under IHL and other applicable legal norms. In the urban areas of Buenaventura, Medellín and Tumaco, weapon bearers discussed how residents could be protected.

Some 6,700 health personnel/emergency responders familiarized themselves with their rights and duties, while 142 medical facilities were marked with the protective emblem. Mass protesters learnt about the need to ensure the safety of medical services and patients. A teaching manual on humanitarian principles was incorporated into the curricula of 14 high schools in Medellín; this enabled over 25,000 students to learn about these matters.

In Medellín, women and youth enhanced their knowledge of sexual/reproductive health and learnt to provide peer support to victims of sexual violence. Some 380 victims obtained appropriate medical care and psychological support with National Society/ICRC assistance; 75 benefited from referrals to local health services.
Weapon-wounded patients receive timely treatment from trained health-care providers

Through National Society/ICRC assistance, 1,985 wounded and 949 sick people obtained timely medical treatment, and psychological support when needed. During protests, the National Society helped organize humanitarian convoys that delivered medical supplies to hospitals and facilitated safe passage for health personnel/vehicles.

First-aid courses equipped a broad range of people to provide life-saving care to people injured in clashes. These emergency responders included some 1,700 people from 21 conflict/violence-affected communities; 433 health personnel from 85 facilities serving approximately 919,000 people; and 50 weapon bearers.

Over 100 health professionals at 50 health facilities (catchment population: 797,000) in Arauca, Pasto, Popayán and Puerto Asis underwent training in weapon-wound management. Monitoring confirmed that almost half of these facilities later implemented contingency plans and protocols for treating victims. Future doctors attended war-surgery courses co-organized with universities in Bogotá and Medellín; Universidad del Bosque integrated a course on this topic into its curriculum. Nineteen surgeons from various conflict/violence-affected areas participated in train-the-trainer sessions conducted with the Colombian Association of Surgery.

Over 300 National Society volunteers from 13 branches in violence-prone areas strengthened their capacity to respond to emergencies while ensuring their own security using the Safer Access Framework. Movement partners held meetings regularly and exchanged security and operational information, thereby reinforcing communication and coordination mechanisms.

State officials from 12 Latin American countries propose ways to promote respect for health services

Dialogue with the authorities and weapon bearers focused on issues related to the protection of civilians/civilian infrastructure and medical services, and on strengthening acceptance for the ICRC’s role, helping the organization ensure its safe and unhindered access to communities affected by conflict/violence. Political, judicial and security officials jointly organized/participated in several ICRC events on IHL; these activities aimed to increase policy-makers’ knowledge and guide their application of these norms.

The vice-president of Colombia, the Health Ministry, the Colombian and Norwegian National Societies and the ICRC organized the first international conference in Latin America on the humanitarian consequences of the lack of respect for medical services. Representatives from 12 Latin American countries exchanged best practices and proposed action plans.

The IHL technical working group under the National Human Rights and IHL System convened a workshop on the protection of civilian property (including health-care infrastructure) in armed conflict, which was attended by representatives of various State bodies. The parliament adopted a law that would allow victims of sexual violence during armed conflicts to obtain health care and judicial services.

Military officers discuss the need to safeguard the provision of medical care

Military officers attended events that focused on a variety of issues: trends in reported IHL violations, the protection of medical services and the protective emblems. At national workshops, military and police officers discussed law enforcement and the use of force, while at an international symposium, 46 representatives from the army and police enhanced their understanding of internationally recognized norms applicable to their duties. In line with a new Defence Ministry directive, 167 military personnel reviewed the extent to which IHL and internationally recognized standards had been integrated into their operations.

Partnerships with the media and communication efforts contributed to raising public awareness of humanitarian issues – including the difficulties people face in accessing health care during armed conflict – and of IHL and the Movement’s work. These efforts included organizing a public performance in Medellín to further understanding of issues related to violence in urban settings. ICRC seminars enabled over 140 journalists from conflict/violence-affected areas to improve their ability to report on the situation of victims of the fighting. Following these events, some 50 articles on the conflict’s humanitarian consequences, and on the ICRC’s response, were published. Editors from 20 local media outlets exchanged ideas at a round-table on reporting humanitarian issues. Through information sessions, representatives from the government, the international community, private sector, the media and civil society deepened their understanding of the humanitarian consequences of conflict/violence and of the ICRC’s response.

EXAMPLE 3: IRAQ

The armed conflict between government forces and a network of armed groups, including the Islamic State group, that escalated in Anbar in December 2013 spread to other parts of Iraq. Violence further intensified following the Islamic State group’s takeover of Mosul and other areas. At the Iraqi government’s request, a coalition of third-party States, led by the United States of America, launched air strikes against the group and provided support to government forces.

Iraqis’ already limited access to basic services decreased further, as essential infrastructure was damaged and insecurity hampered government operations. Some 1.8 million people were reported displaced, at times repeatedly, owing to shifting frontlines; thousands of people were injured or killed. Amid volatile conditions, international humanitarian organizations present in Iraq encountered difficulties in reaching communities hardest-hit by the conflict.
Parties to the conflict are reminded of their obligation to facilitate civilians’ access to basic services

Contributing to the protection of civilians and helping them cope with the humanitarian consequences of armed conflict and other situations of torture remained priorities for the ICRC. Authorities at all levels and all weapon bearers involved were urged to abide by their obligations under IHL, international human rights law and other applicable norms. Confidential and bilateral dialogue with the central/regional authorities and military/security officers – for instance, during the ICRC’s president’s visit in March – emphasized the need to protect civilians, including IDPs, refugees and medical workers, and to ensure their access to basic services and humanitarian aid. Despite difficulties linked to the multiplicity of armed groups in Iraq, contact with their representatives was pursued; through networking, reminders about humanitarian principles were passed on to their members. Third-party States involved in the international coalition against the Islamic State group were also reminded of their obligations under IHL.

Reports of alleged violations were documented and, whenever possible, followed up with the pertinent parties. In particular, abuses committed against patients and medical workers/facilities were monitored in line with the goals of the Health Care in Danger project.

During workshops, National Society staff and Iraqi military/police officers discussed ways to promote the protection of people seeking/providing health care. At dissemination/training sessions, over 700 armed/security forces personnel, mostly from operational units, furthered their knowledge of IHL and other applicable norms concerning protection for patients/medical services.

Conflict-affected people obtain primary health care

Although contact with the authorities and local/traditional leaders facilitated the ICRC’s safe access to conflict-affected communities, security/access-related constraints still hampered its efforts to address needs as urgently and comprehensively as the situation required.

In violence-prone/affected areas, people received primary health care at 13 State-run centres (estimated catchment population: 268,230) supported by the ICRC, as per a 2012 agreement with the Health Ministry. These centres maintained their services, including mother/child care, through staff training, medical supplies and on-site support provided by the ICRC, despite widespread insecurity hindering its regular access to these facilities. Two centres were rehabilitated, while several received ad hoc material assistance. Referrals to advanced care were monitored and, when necessary, facilitated.

Dialogue with the Health Ministry helped reinforce cooperation and mobilize support for centres in areas with high IDP populations. Discussions with the ministry also covered the status of the 2012 agreement and the eventual handover of responsibilities to local actors.

IDPs in northern Iraq stood to benefit from the deployment of a mobile health clinic within the framework of an agreement signed by the Canadian Red Cross Society and the ICRC in December.

Local hospitals treat the weapon-wounded

Iraqis’ already limited access to medical services was further disrupted by the armed conflict. All parties involved were reminded of their obligations under IHL to protect patients and medical services.

Wounded and sick people obtained emergency care from ICRC-supported facilities and the National Society. Thousands of people were treated at 8 hospitals and 48 health centres that were provided with medical supplies. Staff at some of these facilities honed their trauma management skills at ICRC-organized courses. To boost their capacities, National Society staff/volunteers were trained in administering first aid and applying the Safer Access Framework at workshops led by ICRC-backed instructors; ambulance services were assessed.

At an ICRC-supported hospital in Baghdad, patients received treatment in a more orderly setting, following staff training in mass-casualty management and improvements to the hospital’s emergency room procedures.

The need for legal frameworks for the protection of medical services is discussed with the authorities

The central government formed a national IHL committee, for which it granted observer status to the ICRC. The authorities also signed a memorandum of understanding with the ICRC on training senior government officials in IHL.

Three government legal advisers and four professors added to their knowledge of IHL at courses/events abroad. Dialogue was pursued with the authorities on legal frameworks for the protection of medical services.

At workshops, law professors from across Iraq discussed the inclusion of IHL in their curriculum and ways in which the ICRC could support this process.

The Kurdistan military, with ICRC support, continued to strengthen its capacity to train troops in IHL. However, in light of the prevailing situation, support for the IHL training activities of the armed forces of the central Iraqi government was temporarily suspended. Dialogue in this regard, and contact with operational units and military academies, was maintained. Discussions were initiated with central and regional security/police forces on ways to help them develop their knowledge and application of internationally recognized law enforcement standards.

Journalists learn more about the consequences of armed conflict on access to health care

Members of civil society and the wider public developed their awareness of the humanitarian consequences of the conflict and the ICRC’s response to them. This was achieved partly through media coverage of these subjects and ICRC information/dissemination sessions, which reached over 8,000 journalists, representatives of NGOs,
foreign diplomats, academics and others. At a seminar, 35 journalists learnt more about the Health Care in Danger project and of the protection afforded them by IHL during armed conflict.

National Society bolsters its emergency response

The Iraqi Red Crescent, with technical/material/financial support from the ICRC and other Movement partners, enhanced its ability to respond to the humanitarian needs of conflict/violence-affected people. For instance, within the framework of an agreement with the ICRC, the National Society established an emergency response centre. It also expanded its vehicle fleet, upgraded warehouses and enhanced the working environment in some branches. Staff/volunteers learnt how to assess emergency needs at ICRC-organized courses.

As the number of Movement components in Iraq increased in response to the conflict, coordination among them – with the ICRC as the lead agency – was strengthened through Movement/bilateral cooperation agreements and regular meetings.

EXAMPLE 4: LEBANON

The conflict in Syria and its spillover continued to affect Lebanon, where over a million refugees had reportedly sought refuge since it began. Their presence, mostly in host communities, stretched the capacities of the authorities, the UN and other actors. Violence within Lebanon rose in parallel to the Syrian conflict, causing displacement, casualties and deaths. Opposing positions towards it fuelled longstanding sectarian tensions, leading to bombings and other incidents, including intercommunal clashes in Tripoli. Confrontations between the Lebanese armed/security forces and armed groups also occurred, notably in Arsal. Elsewhere, reprisal attacks by armed groups against Hezbollah-controlled areas continued.

People in Palestinian refugee camps faced difficult living conditions and persistent unrest.

Refugees and residents benefit from improved access to basic health care and clean water

With the National Society, the ICRC boosted its activities for refugees/returnees from Syria, host communities, and people affected by violence within Lebanon. Complementing the humanitarian response of the authorities, UN agencies and their partners, it assisted particularly vulnerable groups, including those ineligible for UNHCR support. Three health facilities were provided with staff training, equipment and supplies, enabling refugees and residents unreached by the UNHCR system to obtain primary health care, including over 105,000 consultations. Improvements to water supply systems serving over 383,000 people helped prevent the spread of water-borne diseases and mitigate potential tensions within the communities. Plans to provide psychosocial support to victims of sexual violence were postponed, pending the results of an assessment (see below).

Medical evacuees receive timely treatment

Medical facilities and EMS providers, particularly in the Bekaa Valley and northern Lebanon, struggled to meet the overwhelming needs of both weapon-wounded people from Syria and casualties of internal violence.

People benefited from first aid and/or medical evacuations carried out by the National Society, bolstered by ICRC financial/material support for its EMS. Donations of additional blood bags helped it treat some 4,600 patients from Syria.

Regular dialogue with the relevant authorities, weapon bearers, local communities and other actors on the ground raised awareness of the need to provide unhindered access to medical care and respect/protect medical personnel and facilities, directly contributing to patients’ safe and timely transfer.

Wounded Syrians treated at ICRC-supported health facilities

Over 9,500 people were treated with the help of ad hoc ICRC material support for ambulance providers and 26 hospitals, of which 23 provided data. These people included wounded and sick Syrians who had entered Lebanon through Arsal, who received treatment at two field hospitals established by Syrian doctors and supported by the ICRC with medical supplies and equipment.

Some 340 critically wounded people had their treatment costs covered. At six ICRC-supported centres, some 1,300 Syrians received extensive post-operative care. During and after their treatment/surgery, Syrian patients had their situation monitored and their protection concerns addressed by ICRC delegates and surgeons, who regularly visited ICRC-supported hospitals.

 Patients begin to have access to good-quality care at ICRC-run facilities in Tripoli

In relation to concerns about the quality and cost of treatment, the ICRC established, after some administrative delays, weapon traumatology centres in two Tripoli hospitals to help ensure the availability of comprehensive, good-quality care for all patients. Starting September, over 70 people, including referrals from ICRC-supported facilities (see above), were treated for severe injuries or post-operative complications.

First-responders and surgeons bolster their emergency-response capacities

To help boost emergency preparedness/response capacities countrywide, some 300 people, including Syrian civilians, Lebanese Armed Forces (LAF) personnel in violence-prone areas and weapon bearers in Palestinian camps trained in first aid and received basic medical kits, and 36 doctors in all honed their skills at two seminars, on weapon-wound surgery and on emergency-room trauma care.

With ICRC financial/material/technical support, the National Society: upgraded/maintained its EMS equipment,
vehicles and stations; covered the costs of fuel and other consumables; and paid the salaries of key staff, including a fundraising manager. It trained over 1,700 existing and almost 900 new EMS volunteers and, as part of the five-year strategy for its EMS, received 14 new ambulances and three mini-vans, which strengthened its ability to transfer patients needing immediate treatment. Via ICRC-sponsored training, staff from major EMS providers improved their ability to manage mass casualties and human remains. Discussions with a university began on the development of a weapon-wound surgery module.

Two hospitals continued their operations with the help of ICRC-donated generators. Following clashes in Ein Helweh Palestinian refugee camp, a damaged hospital underwent repairs; medical kits were pre-positioned at two facilities.

**Weapon bearers are encouraged to facilitate neutral, impartial and independent humanitarian action**

Regular interaction with various actors – as well as beneficiaries, during assistance activities – helped secure acceptance of the Movement and facilitate its work in Lebanon.

Allegations of abuses reported by refugees were shared with the ICRC delegation in Syria, which submitted representations to the parties concerned whenever possible. Meetings were held with community leaders and other actors on the ground to assess the consequences of sexual violence against conflict-affected people from Syria and to inform future ICRC activities to address their specific medical and other needs.

Discussions with the LAF and other weapon bearers emphasized the need to respect and protect civilians, including medical personnel. During ICRC presentations at army/police training institutes, some 100 officers, including 25 State security officers preparing to become judicial investigators, were sensitized to the ICRC’s mandate and internationally recognized standards applicable to law enforcement. At a police academy, 70 officers learnt about international human rights standards applicable to the ICRC’s activities in Lebanon and elsewhere.

Regular coordination meetings among Movement partners, and with UN agencies and other organizations operating in Lebanon and the region, helped maximize the humanitarian response and avoid duplication of effort. The National Society, the International Federation and the ICRC jointly hosted a regional meeting of 26 National Societies on the Movement’s response to the Syrian conflict and its regional consequences. The National Society and the ICRC also organized a workshop on the Fundamental Principles, enabling National Societies to share their experiences and operational challenges.

**EXAMPLE 5: SYRIAN ARAB REPUBLIC**

The armed conflict opposing Syrian government forces and a multitude of armed groups, some of whom were also fighting among themselves, continued. Midyear, a US-led coalition launched air strikes periodically against an armed group operating across Iraqi and Syrian territories. Sustained fighting and a lack of dialogue among the parties to the conflict stymied efforts, such as the Geneva II Conference on Syria, to find a political solution.

Serious and repeated breaches of IHL aggravated the worsening humanitarian situation, with a reported 200,000 people killed since March 2011. The conflict, and the economic sanctions imposed by other countries, seriously affected public infrastructure and access to health care and other essential services. An estimated 10.8 million people required aid; 6.5 million people – nearly half of them children – were reportedly displaced, often repeatedly, within the country. Over 40,000 households were reportedly living in areas besieged by government forces or armed groups for over a year; some 4.7 million people remained in areas made difficult to reach by the systematic denial of humanitarian access by parties to the conflict. Localized
truces occasionally allowed some assistance to reach people living in some of these areas. In July, the UN Security Council adopted a resolution on cross-border aid delivery without the Syrian government’s consent.

Disregard for the safety of medical services persists

The large number of active armed groups and the limited recognition/acceptance for the ICRC continued to challenge the security of field teams. Attacks on patients and health workers/facilities recurred. Between March 2011 and December 2014, 40 staff members/volunteers, including first-aiders, from the Syrian Arab Red Crescent, and 7 from the Palestine Red Crescent had been killed. The three ICRC staff abducted in Syria in October 2013 were still not released by year’s end.

The operational environment remained extremely difficult even when the parties to the conflict allowed the ICRC to cross front lines and enter conflict-affected areas. The government continued to push for local peace/reconciliation agreements and, on some occasions, permitted humanitarian actors to assist victims after the parties concerned had reached an agreement. Some local truces allowed for limited relief for people living in besieged or otherwise hard-to-reach areas. However, truces did not last and were often too fragile for principled/meaningful humanitarian action to take place safely.

In line with the Health Care in Danger project, the ICRC took stock of violations – including outright attacks and targeted obstructions (e.g. blocking the delivery of medicines to facilities outside government-controlled areas) – with a view to sharing its findings with the authorities. The ICRC took every possible opportunity to remind the parties to the conflict of their obligations under IHL with regard to protecting all wounded and sick people, be they civilians or combatants.

Contact/coordination with the Syrian authorities at central and local levels – including during the ICRC president’s visits to Syria – and with community leaders and armed groups in the areas visited, helped facilitate the assistance activities of Syrian Arab Red Crescent/ICRC teams. The ICRC’s limited dialogue with the parties to the conflict emphasized all parties’ obligations under IHL to: take constant care to spare people not/no longer participating in hostilities and protect them from abuse, including sexual violence; respect the prohibition against indiscriminate attacks on civilians/civilian objects, including the use of explosive weapons in densely populated areas; ensure civilians’ safe access to goods essential for their survival, and to medical/humanitarian assistance; respect wounded fighters’ right to health care; and respect/protect medical/humanitarian workers and the red cross/red crescent emblems. However, a broader, systematic and productive dialogue on protection issues had yet to develop. The ICRC so far failed to establish a direct dialogue, on respect for IHL during military operations, with the armed/security forces.

Officials from the Foreign Affairs Ministry learnt more about IHL at a seminar conducted in April at the government’s request. An agreement was also reached with the Syrian authorities on the reactivation of the national IHL committee.

In Syria and abroad, networking and IHL-focused interaction with members of armed groups continued.

People continue to suffer from restrictions imposed on impartial medical care

Health needs continued to outweigh available health services. This imbalance was particularly severe in areas controlled by armed groups and in besieged areas, where the entry of medical supplies, and access for humanitarian organizations, was restricted. To help remedy this, the ICRC reduced its assistance to government health facilities already receiving support from other donors.

With ICRC supply deliveries across frontlines rarely allowed, people living in areas held by armed groups received basic health care or surgical supplies on a few occasions only. In December, for example, 13 hospitals in different areas in Aleppo, controlled by either government forces or armed groups, received 29 sets of surgical instruments. Medical supplies were also distributed, to 4 hospitals (for 600 people) in June and 3 hospitals (for 150 people) in July.

In besieged areas, delivery of medical supplies – excluding surgical materials – was possible on four occasions only: in October, 5,000 chronically ill patients in Al-Waer in Homs, and another 5,000 in Yarmouk, benefited from a three-month supply of medicines; 700 others in Al-Waer benefited from dialysis consumables delivered to Al-Bir Hospital in November; and 3,000 people in Rural Damascus benefited from a delivery of paediatric/obstetric materials in December.

Similar restrictions applied to places where a truce was in effect. In Barzeh (Damascus) for example, a clinic was being renovated; other forms of assistance had been prohibited. Rehabilitation of other health facilities could not be carried out owing to difficulties in securing permits and materials.

IDPs/residents receive basic health care

Vulnerable people in Hama, Homs, Idlib, Rural Damascus, Sweida and Tartous received health services at nine Syrian Arab Red Crescent mobile health units (average catchment population: 5.1 million people). ICRC support for these clinics helped ensure curative/preventive care for some 7,000 IDPs/residents monthly. People also received services at a National Society polyclinic (1,000 consultations monthly) in Hama.

Representatives from all mobile health units attended a workshop on primary health care, the Safer Access Framework, Health Care in Danger and stress management. Fifteen members of Syrian armed groups attended a first-aid training course abroad. Thirteen doctors benefited from a war-surgery seminar abroad; other planned training sessions could not be held.
Preparations – delayed by staffing constraints and visa processing – for further support in the fields of primary health care, first aid, biomedical engineering, haemodialysis and physical rehabilitation were in progress.

**Media coverage fosters support for neutral, impartial and independent humanitarian action**

Communication efforts focused on enlisting support for ICRC field operations among civil society and the wider public, including actors with direct influence on the parties to the conflict. During a question-and-answer session with the ICRC president, Damascus-based journalists were briefed on ICRC operations, IHL and the Health Care in Danger project, and on the organization’s call for broader humanitarian access.

Through ICRC operational updates and social media releases, a wide array of actors in Syria and abroad kept abreast of humanitarian developments in Syria. Networking with key media actors, regardless of their affiliations in the conflict, continued, enabling the ICRC to share its humanitarian concerns and distribute multimedia informational materials. By covering ICRC activities, local/international media helped increase people’s awareness of the organization’s principled humanitarian action. ICRC social networking platforms launched IHL-themed animated clips; an audio recording on IHL was produced, for distribution to armed groups in Syria and neighbouring countries.

Events targeting other sectors of civil society could not be organized owing to the insecurity and lack of permission and human resources.

**Improved radio communication system contributes to the safety of National Society staff**

The Syrian Arab Red Crescent sustained its humanitarian response to growing needs, with ICRC financial, material and technical support – which also helped it cover operating/administrative costs at its headquarters, 12 branches and 6 response centres, including a new centre in Homs built through ICRC funding. It boosted its logistical capacities with ICRC-donated vehicles, and upgraded its radio communication system, thereby increasing staff security in the field.

With ICRC support covering staff salaries and equipment needs, the National Society worked on enhancing its communication capacities, and developed a communication policy and organizational tools. Through an ICRC legal adviser working with its communication team, it also received technical support for maintaining its neutrality, independence and accountability, particularly in relation to organizations outside the Movement. Communication focal points from all National Society branches attended three ICRC-organized workshops; volunteers from the Homs branch familiarized themselves with basic IHL principles.

Through regular meetings, Movement components coordinated their activities – capitalizing on their complementary capacities – thereby increasing the impact of the Movement’s response and strengthening its positioning. Joint statements consolidated the Movement’s position on pressing humanitarian issues. In December, the collaborative website “redforsyria.org” began its all-inclusive reporting on Movement activities in Syria.

Coordination with the Palestine Red Crescent facilitated the delivery of assistance in Yarmouk.

Lack of either human resources or authorization forestalled training in first aid. Some National Society staff/volunteers were trained in emergency response; others attended courses abroad, their travelling expenses covered by the ICRC. Work on emblem legislation and the National Society statutes was set aside in favour of emergency/operational priorities.

**EXAMPLE 6: YEMEN**

Yemen continued to be besieged by multiple armed conflicts and other situations of violence, with the insecurity escalating in many parts of the country and between different groups, as in the case of the Houthis and the Al-Qaeda in the Arab Peninsula (AQAP). After months of intense fighting in Dammaj, Sa’ada, the Houthis and Salafi supporters reached a tenuous ceasefire in January; however, clashes persisted intermittently. In the south, Ansar al-Sharia (AaS) and AQAP carried out targeted killings, and US-backed air strikes against the two groups continued. Security/military forces were involved in the fighting throughout the country.

The lack of basic goods and services such as water and electricity, as well as the alleged mismanagement of national resources, continued to cause protests countrywide.

**Contact with community leaders facilitates humanitarian assistance**

The ICRC strove to develop its dialogue with the various authorities and weapon bearers and other actors of influence across the country, to remind them of their obligation to protect civilians and allow humanitarian workers safe access to vulnerable groups/people. It backed up its dialogue with documented and reported cases of violations collected on the basis of its monitoring of the situation; thus, oral and written interventions focused on the conduct of hostilities, arrest and detention, human remains management, and the issues covered by the Health Care in Danger project, as well as on the importance of humanitarian action.

**Health staff receive training in mother-and-child care**

On average, an estimated 220,000 people had access to affordable health care at 11 ICRC-supported primary health centres: six in Sa’ada, two in Abyan and one each in Amran, Al Dale and Sana’a. Regular provision and monitoring of supplies and drugs, on-the-job training for staff and, when necessary, donations of furniture helped these centres ensure the quality of their services.

Women and children, in particular, benefited from this assistance – 29,000 consultations were carried out for children under the age of five, and some 10,000 ante/post-natal
sessions for women. More than 950 home delivery kits were distributed, which helped to reduce the dangers of giving birth at home; 450 mosquito nets were given to pregnant women at risk of malaria. Having learnt more about reproductive health at training sessions organized in cooperation with an international partner, 28 midwives helped boost the long-term availability of care for pregnant women in the south and in Sana’a. Vaccinations conducted through the centres benefited mainly children; in all, some 118,000 polio and 42,000 measles vaccines were administered to children under the age of five. An immunization campaign against measles was conducted in Amran, for which the ICRC provided logistical support.

Thousands of people were served by continued health services at eight centres and three rural hospitals, owing to rehabilitation work carried out by the ICRC.

In tandem with better health-care services, over 1,093,000 people in urban areas and 46,400 in one rural community had access to clean and safe water, as a result of the joint efforts of local water authorities and the ICRC to improve water supply/distribution infrastructure. Such cooperation created space to remind the authorities of the need to regularly maintain existing infrastructure.

Casualties of fighting receive timely treatment

During fighting in Dammaj, 35 injured people were evacuated to Sana’a, where they received urgent medical treatment; this was made possible by ICRC negotiations with all the parties involved and by their acceptance of the organization’s role as a neutral intermediary.

Wounded and sick people increased their chances of receiving emergency care in a timely manner, following National Society/ICRC training sessions for over 100 health personnel and 300 combatants. Owing to the surge in violence during the second half of the year, first-aid training sessions were intensified. Potential first-responders also received first-aid supplies, such as dressing kits and stretchers.

Comprehensive support for Al-Razi hospital helps improve higher-level care

People in need of advanced hospital services benefited from regular donations of medical equipment/drugs to Al-Razi hospital, on-the-job training for its staff, and maintenance work on the building. Moreover, 45 staff members honed their emergency room management capacities at a thirty-week training programme developed by the ICRC and a local institute.

Twenty-two hospitals around the country coped with patient influxes during bouts of violence, with the help of donations of dressing material and treatment kits for the weapon wounded.

Military officers deepen their understanding of IHL and the use of the emblems

In view of the volatile security situation and government set-up, the ICRC kept up efforts to engage with the authorities and the de facto authorities, armed forces and other weapon bearers, and key civil society figures, in a bid to secure respect for and access to violence-affected groups or people. Over 100 religious leaders from across central and south Yemen gathered in Aden and Sana’a to discuss the links between Islam and IHL. Around 60 military officers from Aden learnt about the use of the emblems and the ICRC’s activities and its neutral approach, as well as some key components of IHL and international norms on law enforcement. These efforts were complemented by communication initiatives targeting the wider public – potential beneficiaries learnt about ICRC activities through increased online/broadcast media coverage, including audio-visual material detailing various religious/tribal leaders’ experiences with the ICRC.

On several occasions, such contact directly led to the ICRC being able to conduct its activities. At the organization’s encouragement, the country’s officials convened at a national round-table to discuss measures to address health-care security; this followed up on a similar session in Sana’a during the first part of the year.

Efforts to disseminate and implement IHL ran aground because of the prevailing situation. Nonetheless, senior officers took part in an advanced course in San Remo, Italy. Reference documents and other materials, including ICRC-produced articles published in the armed forces’ monthly magazine, gave military officials the opportunity to increase their knowledge of IHL.

Judges become more adept at teaching IHL

A number of government officials also participated in regional and national IHL sessions. Notably, Yemeni officials contributed to the discussions at a course for Arab government experts, and seven persons affiliated with political parties, Islamic groups or the academe attended a regional course on IHL and international human rights law.

At a workshop for trainers, 11 judges, who also taught at the judicial institute, strengthened their ability to instruct others in IHL. Elsewhere, students at several law and journalism faculties took part in talks and round-tables on IHL.

The Yemeni Red Crescent continues to develop its emergency response capacities

Yemeni Red Crescent branches continued to respond to some emergencies in parts of the country, particularly by administering first aid to the wounded, transferring the seriously injured to hospital, training future first-responders, and contributing to proper human remains management – activities for which they received some support from the ICRC, in line with an emergency response agreement between the two organizations.

Amidst security and procedural concerns, Movement components met regularly to coordinate activities and promote adherence to the Fundamental Principles. However, the ICRC and the National Society were unable to conclude a broader partnership framework agreement for 2014.
FINANCIAL OVERVIEW

SUMMARY

The ICRC Special Appeal Health Care in Danger 2014 focused on the ICRC project budget and on parts of the budgets of some operations.

The financial results of the ICRC appeal show a low level of direct support from donors, with direct contributions amounting to KCHF\(^{30}\) 233 out of a total expenditure of KCHF 54,399. The ICRC has used its non-earmarked funds to balance the income and expenditure of the appeal.

The table below gives more insight into the financial situation for the year 2014. Overall contributions (i.e. direct contributions to the Health Care in Danger Special Appeal plus the non-earmarked contributions allocated from the ICRC Headquarters Appeal and Emergency Appeals) received for 2014 amounted to KCHF 54,399. Given the zero balance brought forward from 2013, the balance at the end of 2014 is also zero.

Breakdown of the Special Appeal “Health Care in Danger” 2014 (in KCHF)

<table>
<thead>
<tr>
<th></th>
<th>Budget in KCHF</th>
<th>Expenditure</th>
<th>Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Health Care in Danger”: ICRC Project Budget</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project team and support</td>
<td>2,287</td>
<td>2,054</td>
<td>15</td>
</tr>
<tr>
<td>Funded out of contributions to the Headquarters Appeals 2014</td>
<td></td>
<td></td>
<td>2,038</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>21,189</td>
<td>16,367</td>
<td>218</td>
</tr>
<tr>
<td>Colombia</td>
<td>2,868</td>
<td>2,694</td>
<td>0</td>
</tr>
<tr>
<td>Iraq</td>
<td>8,686</td>
<td>8,506</td>
<td>0</td>
</tr>
<tr>
<td>Lebanon</td>
<td>14,631</td>
<td>10,217</td>
<td>0</td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>15,088</td>
<td>10,371</td>
<td>0</td>
</tr>
<tr>
<td>Yemen</td>
<td>3,624</td>
<td>4,191</td>
<td>0</td>
</tr>
<tr>
<td>Funded out of contributions to the Emergency Appeals 2014</td>
<td></td>
<td></td>
<td>52,127</td>
</tr>
<tr>
<td>Total</td>
<td>68,372</td>
<td>54,399</td>
<td>54,399</td>
</tr>
</tbody>
</table>

Figures in these tables are rounded off, may vary slightly from the amounts presented in other documents and may result in differences in rounding-off addition results.

For more specific details on expenditure and contributions at country level, we refer the reader to the separate auditors’ report, Health Care in Danger: Auditors’ report on supplementary information on the Special Appeal; Statement of contributions and expenditure, December 31, 2014 issued by Ernst & Young Ltd.

Funds are subject to standard ICRC reporting, audit and financial control procedures. These include the following documents issued yearly:

a) ICRC Annual Report
b) ICRC Health Care in Danger Special Report
c) Ernst & Young Ltd auditors’ report on supplementary information on the Special Appeal

\(^{30}\) Thousand Swiss Francs
# LIST OF CONTRIBUTIONS PLEDGED AND RECEIVED

<table>
<thead>
<tr>
<th>Contributions</th>
<th>Amount (in CHF)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governments</strong></td>
<td></td>
</tr>
<tr>
<td>Liechtenstein</td>
<td>200,000</td>
</tr>
<tr>
<td><strong>Sub-total: Governments</strong></td>
<td><strong>200,000</strong></td>
</tr>
<tr>
<td><strong>National Societies</strong></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>15,305</td>
</tr>
<tr>
<td><strong>Sub-total: National Societies</strong></td>
<td><strong>15,305</strong></td>
</tr>
<tr>
<td><strong>Various</strong></td>
<td></td>
</tr>
<tr>
<td>Fondation Sanofi Espoir</td>
<td>16,950</td>
</tr>
<tr>
<td>Spontaneous donations from private individuals</td>
<td>1,112</td>
</tr>
<tr>
<td><strong>Sub-total: Various</strong></td>
<td><strong>18,062</strong></td>
</tr>
<tr>
<td><strong>Sub-total: contributions to the Health Care in Danger Special Appeal</strong></td>
<td><strong>233,367</strong></td>
</tr>
<tr>
<td>Funded out of contributions to the Headquarters Appeal 2014</td>
<td>2,038,270</td>
</tr>
<tr>
<td>Funded out of contributions to the Emergency Appeals 2014</td>
<td>52,127,451</td>
</tr>
<tr>
<td><strong>Total receipts for 2014 as at 31.12.2014</strong></td>
<td></td>
</tr>
<tr>
<td>No balance brought forward</td>
<td></td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>54,399,088</strong></td>
</tr>
</tbody>
</table>

Figures in these tables are rounded off, and so may vary slightly from the amounts presented in other documents and may result in differences in rounding-off addition results.
ANNEX: EXPERT CONSULTATION AND DIPLOMATIC MOBILIZATION PROCESS

Health Care in Danger – Priority issues

<table>
<thead>
<tr>
<th>Attacks</th>
<th>Illegal obstruction</th>
<th>Discrimination</th>
<th>Armed entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wounded and sick</td>
<td>Health structures</td>
<td>Health personnel</td>
<td>Medical transport</td>
</tr>
</tbody>
</table>

Nov. 2011 1

31st International Conference of the Red Cross and Red Crescent
Resolutions, pledges and plans of action

Experts Workshops x 10

<table>
<thead>
<tr>
<th>2012 to 2014</th>
<th>2</th>
</tr>
</thead>
</table>

2013 3
Council of Delegates of the International Red Cross and Red Crescent Movement
Recommendation to the 32nd International Conference of the Red Cross and Red Crescent
Participation in bilateral and multilateral consultations in existing regional and global fora
Promotion of recommendations

2014 4

2015 5
32nd International Conference of the Red Cross and Red Crescent
Resolutions, pledges and plans of action

2016 to 2017 6
Support for States’ initiatives
Further development of partnerships
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.