SPECIAL REPORT

HEALTH CARE IN DANGER 2015
Respecting and protecting health care in armed conflicts or other emergencies
The Special Report Health Care in Danger 2015 is designed to satisfy the narrative reporting requirements of donors who have contributed to the ICRC Special Appeal Health Care in Danger 2015. 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 2015) will be met by a separate Ernst & Young Ltd auditors’ report providing supplementary information on the Special Appeal.
SPECIAL REPORT

HEALTH CARE IN DANGER 2015

Respecting and protecting health care in armed conflicts or other emergencies

West Bank, occupied Palestinian territory, 2015. A volunteer of the Palestine Red Crescent Society, which draws on ICRC support for sustaining its operations and obtaining transport/crossing permits, administers first aid to two violence-affected people in Ramallah city. ©Atta Jabr /ICRC
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HEALTH CARE IN DANGER IN DAY-TO-DAY OPERATIONS IN 2015

STRENGTHENING EMPHASIS ON AN INSTITUTIONAL PRIORITY
- Enlisting support for safeguarding health services
- Stepping up medical response to emergencies
- Helping health-care providers build their capacities

Example 1: Afghanistan
Example 2: Central African Republic
Example 3: Colombia
Example 4: Israel and the Occupied Territories
Example 5: South Sudan
Example 6: Syrian Arab Republic

FINANCIAL OVERVIEW
- Summary
- List of contributions pledged and received

ANNEX: EXPERT CONSULTATION AND DIPLOMATIC MOBILIZATION PROCESS
EXECUTIVE SUMMARY

Armed conflict or 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 IHL and international human rights law.

The Health Care in Danger (HCiD) project, launched in 2011, is a Movement-wide initiative. The project entails working with States and other influential actors to improve the security of the delivery of effective and impartial health care during armed conflict or 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 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 ICRC Directorate decided to extend the HCiD project from end-2015 to end-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 2015 and covers: (i) the HCiD project and its goals for 2012–15; (ii) the developments and activities that took place in 2015 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 amid insecurity.

At field level, ICRC delegations continued to update the HCiD team in Geneva, Switzerland, on ongoing 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. These 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, the Central African Republic, Colombia, Israel and the occupied territories, South Sudan and the Syrian Arab Republic 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 2015 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 those weapon-wounded, are respected and have access to effective and impartial health/medical services.

The achievements of the HCiD project from 2012–15 were presented at the 32nd International Conference through a report. While commending the efforts of States, health-care community representatives and other key actors in promoting and implementing measures to safeguard health care, the report also urged these parties, particularly States, to step these up and see through their fulfilment. Thus, States party to the 1949 Geneva Conventions and the National Societies adopted a resolution that renewed the call for all pertinent actors to continue and, where necessary, to strengthen, their cooperation in this regard.

The financial results of the ICRC Special Appeal show some direct support from donors, with direct contributions amounting to KCHF 2,748 out of a total expenditure of KCHF 99,911. The ICRC used its non-earmarked funds to balance the income and expenditure of the appeal.
## Abbreviations and Definitions at the ICRC

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<th>Abbreviation</th>
<th>Description</th>
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<td>Additional Protocol I</td>
<td>Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts (Protocol I), 8 June 1977</td>
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<tr>
<td>Additional Protocol II</td>
<td>Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), 8 June 1977</td>
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<tr>
<td>Additional Protocol III</td>
<td>Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Adoption of an Additional Distinctive Emblem (Protocol III), 8 December 2005</td>
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<tr>
<td>1977 Additional Protocols</td>
<td>Additional Protocols I and II</td>
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<td>armed conflict(s)</td>
<td>International and/or non-international armed conflict(s): International armed conflicts exist whenever there is a resort to armed force between two or more States. Non-international armed conflicts are protracted armed confrontations occurring between governmental armed forces and the forces of one or more organized armed groups, or between such groups. The armed confrontation must reach a minimum level of intensity. International armed conflicts are governed, <em>inter alia</em>, by the Geneva Conventions of 12 August 1949 and Additional Protocol I, as applicable, while non-international armed conflicts are governed, <em>inter alia</em>, by Article 3 common to the 1949 Geneva Conventions and Additional Protocol II, as applicable. Customary international humanitarian law also applies to both international and non-international armed conflicts.</td>
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<td>CHF</td>
<td>Swiss francs</td>
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<td>Directorate</td>
<td>The Directorate is the executive body of the ICRC. Its members are the director-general and the heads of the ICRC’s five departments: Operations, International Law and Policy, Communication and Information Management, Human Resources, and Financial Resources and Logistics. The Directorate is responsible for applying the institutional strategy, as defined by the Assembly – the supreme governing body of the ICRC – and setting and implementing its objectives accordingly. The Directorate ensures that the organization, particularly its administrative structure, runs smoothly and efficiently. The members of the Directorate are appointed by the Assembly for four-year terms. The current Directorate took office on 1 July 2014.</td>
</tr>
<tr>
<td>Fundamental Principles</td>
<td>Fundamental Principles of the International Red Cross and Red Crescent Movement: humanity, impartiality, neutrality, independence, voluntary service, unity, universality</td>
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| 1949 Geneva Conventions | Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 12 August 1949
Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, 12 August 1949
Convention (III) relative to the Treatment of Prisoners of War, 12 August 1949
Convention (IV) relative to the Protection of Civilian Persons in Time of War, 12 August 1949 |
<p>| ICRC | International Committee of the Red Cross, founded in 1863 |
| IDPs | internally displaced people |
| IHL | international humanitarian law |
| International Conference | International Conference of the Red Cross and Red Crescent, which normally takes place once every four years |
| International Federation | The International Federation of Red Cross and Red Crescent Societies, founded in 1919, works on the basis of the Fundamental Principles, carrying out relief operations in aid of the victims of natural disasters, health emergencies, and poverty brought about by socio-economic crises, and refugees; it combines this with development work to strengthen the capacities of its member National Societies. |</p>
<table>
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<th>Term</th>
<th>Definition</th>
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<td>IOM</td>
<td>International Organization for Migration</td>
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<tr>
<td>KCHF</td>
<td>thousand Swiss francs</td>
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<td>Movement</td>
<td>The International Red Cross and Red Crescent Movement comprises the ICRC, the International Federation of Red Cross and Red Crescent Societies, and the National Red Cross and Red Crescent Societies. These are all independent bodies. Each has its own status, role and mandate.</td>
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<tr>
<td>National Society</td>
<td>The National Red Cross or Red Crescent Societies embody the Movement’s work and Fundamental Principles in 190 countries/contexts. They act as auxiliaries to the public authorities of their own countries in the humanitarian field and provide a range of services, including disaster relief and health and social programmes. In times of conflict, National Societies help civilians and, where appropriate, support the military medical services.</td>
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<tr>
<td>NATO</td>
<td>North Atlantic Treaty Organization</td>
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<td>NGO</td>
<td>non-governmental organization</td>
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<td>other emergencies</td>
<td>This refers to situations, such as internal disturbances (internal strife) and natural disasters, that cause human suffering, in which the mission of the Movement is to protect life and health and ensure respect for the human being, as set forth in, among others, the Statutes of the International Red Cross and Red Crescent Movement, adopted by the 25th International Conference in October 1986 and amended by the 26th and 29th International Conferences in December 1995 and June 2006, respectively, in Geneva, Switzerland.</td>
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<tr>
<td>other situations of violence</td>
<td>This refers to situations of collective violence that fall below the threshold of an armed conflict but generate humanitarian consequences, in particular internal disturbances (internal strife) and tensions. The collective nature of the violence excludes self-directed or interpersonal violence. If such situations of collective violence have significant humanitarian consequences to which the ICRC can provide a relevant response, the ICRC may take any humanitarian initiative falling within its mandate as a specifically neutral, impartial and independent organization, in conformity with the Statutes of the Movement, article 5(2)(d) and 5(3).</td>
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<td>Safer Access Framework</td>
<td>a set of measures and tools, grounded in the Fundamental Principles, that National Societies can use to prepare for and respond to context-specific challenges and priorities; such measures put a premium on mitigating the risks they face in sensitive and insecure contexts and on increasing their acceptance and access to people and communities with humanitarian needs</td>
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<tr>
<td>San Remo</td>
<td>The International Institute of Humanitarian Law, in San Remo, Italy, is a non-governmental organization set up in 1970 to spread knowledge and promote the development of IHL. It specializes in organizing courses on IHL for military personnel from around the world.</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>UNHCR</td>
<td>Office of the United Nations High Commissioner for Refugees</td>
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<td>WHO</td>
<td>United Nations World Health Organization</td>
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Armed conflict and other emergencies generate immediate health-care requirements exceeding peacetime needs. Wounded and sick people, whether or not they have been directly involved in violent acts, need medical aid.

However, armed conflict or other emergencies, and the accompanying violence, pose the greatest threats to health-care facilities, equipment, personnel and medical vehicles (health-care services); disruption, interference, attacks and other impediments to providing and accessing these services have become commonplace during armed conflict or 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. Concretely, 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, represented thousands of consultations every year that would not take place because of that single attack.

The ICRC, together with the staff and volunteers of the National Societies, 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 2011–15:

- An airstrike in Kunduz, Afghanistan, in October 2015, hit a Médecins Sans Frontières (MSF) hospital, killing some 20 people, among them 12 MSF staff and 10 patients, including three children. More than 30 others were injured, including 19 MSF staff. In April 2013, after conducting medical assistance activities in a remote location, 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, distrust of health/humanitarian workers has led to attacks against them. In Guinea, for instance, 8 health personnel were killed after trying to raise awareness about Ebola. National Society teams in Guinea and Sierra Leone experienced security incidents in places where their efforts to prevent the spread of the disease were not understood by the communities.

- In Pakistan, several health workers conducting immunization campaigns, particularly in the north-west, were killed in 2013, prompting WHO to suspend its polio-eradication initiative. Nine volunteers who were part of a similar project in northern Nigeria were killed when gunmen shot at their health centres in the same year.

- In August 2013, 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 the Syrian Arab Republic (hereafter Syria), between March 2011 and August 2015, 50 staff/volunteers from the Syrian Arab Red Crescent and 8 from the Palestine Red Crescent Society were killed while carrying out their duties. Several of them were first-aiders.

These incidents mean that hundreds of thousands of people will be unable to access the services these facilities and health-care workers were providing prior to the attacks. Violence, both actual and threatened, against patients and health-care workers and facilities is one of today’s most crucial yet overlooked humanitarian issues.

**A LEGAL BASE**

Protecting and assisting the wounded and sick, regardless of their affiliations, lie at the core of the mission of the 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 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, particularly 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 or 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 calls for ceasefires between parties to a 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 calls for 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 countries affected by armed conflict or other emergencies, the ICRC supports National Societies in their efforts to apply the Safer Access Framework through workshops and other capacity-building approaches. This assistance helps them broaden their access and increase their awareness of ways to avoid or mitigate risks when working in potentially dangerous areas, for instance, by strengthening their networking and operational communication strategies using various means, including radio programmes and jingles.

The ICRC provides the Global Positioning System (GPS) coordinates of health-care facilities to all parties to armed conflict, reminding them to spare these structures from attack, 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, particularly 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 pertinent National Society.
Following the 30th International Conference in 2007, the ICRC conducted a study from 2008 to 2011 to look at how armed conflict or other emergencies affect the delivery of health care in 16 countries. The outcome of the study\(^1\) 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\(^2\) on 921 violent incidents that affected health care in 22 countries in 2012. The next report,\(^3\) released in 2014, builds on the findings of the previous one and examines over 1,800 incidents documented in 23 countries from January 2012 to December 2013. The last report,\(^4\) released in April 2015, examines the incidents documented in 11 countries from January 2012 to December 2014. Information was collected from various sources on 2,398 instances involving the use or threat of violence against wounded and sick people and health-care personnel, facilities and means of transport.


This latest report confirms that violence against health care remains a serious humanitarian concern. Such violence includes the following examples:

- Patients are killed, wounded, beaten and/or arrested.
- Health-care personnel are threatened, physically assaulted, arrested and/or coerced to provide treatment.
- Obstructions and attacks against medical vehicles take place on the way to and from a health-care facility, at checkpoints and in public spaces.
- Incidents against health care most often take place against, inside or within the perimeter of health-care facilities; these facilities are often subject to attack, armed entry, takeover or looting.

**THE 2015 STUDY’S FINDINGS (NUMBERS)**

- 91% of the documented incidents affected local health-care providers, including National Society staff
- At least 4,275 people were affected in 4,770 acts or threats of violence
- 598 health-care personnel were killed and/or beaten/wounded
- 728 medical vehicles were affected in 785 acts or threats of violence
- 1,222 of the incidents took place against, inside or within the perimeter of health-care facilities

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.

**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 2015. In particular, it details:

- developments and activities that took place in 2015, which are directly related to the HCiD project
- related operational activities in the 6 selected contexts included in the Special Appeal 2015, 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 2015

The HCiD Special Appeal 2015 and the HCiD Special Report 2015 are the last documents of their kind that will be published, but the HCiD project will continue until 2017 (see page 17).
From 2012–2015, the main priorities of the HCiD project were to: raise awareness of the insecurity of health care through a global communication campaign; mobilize other stakeholders through the creation of a community of concern to address the issue; launch or reinforce field activities addressing needs related to the security and delivery of health care; organize a series of expert workshops and consultations (see page 21); and disseminate, and encourage action on, the recommendations arising from these workshops and consultations through dialogue, publication and other efforts.

GOALS

Through the HCiD project, the ICRC endeavoured to improve the security and delivery of effective and impartial health care in armed conflict or other emergencies by working to ensure that, by end-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 page 17), 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 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 health ministries 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/health ministries

- 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

In November 2015, the ICRC Directorate approved the extension of the HCID 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 contexts affected by armed conflict or other emergencies. It also reflects the Movement’s resolve to keep up the momentum generated by the ICRC, National Societies and other stakeholders for the project. The project’s achievements – including the wide recognition of the issue as a serious humanitarian concern, the active engagement of National Societies in the project, the enlargement of the discourse on medical ethics to include dilemmas arising from political issues, and the production of HCID-related material that can be used with a wide range of audiences – reinforced the decision to extend the project.

Thus, the following activities will continue towards the fulfilment of the above-mentioned goals, modified or added to as necessary:

- promoting and supporting the engagement of States and National Societies, particularly in initiatives at the national level;
- integrating, into field operations, multidisciplinary strategies related to HCID;
- collecting and analyzing data from the field;
- bringing the issue to the fore, on a regular basis, in global and regional forums; and
- facilitating platforms for discussion with various stakeholders

All these will be supported and reported upon using the tools and platforms that have been developed for the strategic communication campaign of the project (see page 35).

**APPROACH**

The HCID project covers four priority issues related to the safeguarding of health care:

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

As the responsibility for safeguarding health care lies primarily with States and weapon bearers, rather than with the health-care community, the HCID project was built on **distinct yet interlinked tracks:** the **operational response track** and the **expert consultation and diplomatic mobilization track.** In both tracks, the project emphasized 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 assisted National Societies and ICRC delegations in their **operational response,** promoting the exchange of practices and lessons learnt in order to bring coherence to, and strengthen, their means of addressing violence and threats of violence against health care and the wounded and sick. It supported activities geared toward accomplishing these specific objectives, including by working to address more effectively problems encountered in the field. It endeavoured 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 good practices developed in the field. It reinforced the training of ICRC and National Society personnel and volunteers, continuing to develop and adapt appropriate tools to do so. In the project extension period (2016–17), operational responses will focus on initiatives at national level.
Meanwhile, running in parallel with, gaining from and contributing to the operational response, the project aimed 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 mobilized stakeholders within the humanitarian field and beyond, in order to become a sustainable global initiative and produce innovative solutions.

A communication campaign supported the aims of the project. During its first phase, in 2011–13, the campaign emphasized the issues at stake. In its second phase, ending in 2015, the communication campaign underscored the positive role different stakeholders could take, on the basis of the recommendations identified, to improve the security and delivery of health care. In the project extension period, from 2016–17, communication activities will focus on supporting the efforts of ICRC delegations and the National Societies.

Maintaining the organization’s emphasis on this issue is in line with the ICRC Health strategy 2014–18, 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 December 2015, the project focused on engaging States to urge their increased involvement in addressing threats to health care and on developing further partnerships, particularly at a national level. Working with National Societies and the International Federation, the ICRC encouraged States and other key actors to implement the HCiD project’s recommendations in their own contexts, and lent expertise where necessary.

Within the ICRC, a team formed in connection with the HCiD project operates from the ICRC headquarters in Geneva, providing support to delegations in the field and coordinating efforts with the units concerned.

GLOBAL PLAN OF ACTION

OPERATIONAL RESPONSE: CONSOLIDATING AND IMPROVING FIELD PRACTICE

DATA COLLECTION ANALYSIS

To develop ways to facilitate the safe delivery of effective and impartial health-care services, the reinforcement of data collection, and of analysis of abuses committed against wounded and sick people and health-care personnel, vehicles and facilities, was necessary. 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 systematically monitored such incidents and shared the information with headquarters over the period 2008–2014 (see page 13). Two sets of data were compiled:

1. **Context-specific sets of data** on violence and abuses were 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 were made in several contexts within the frame of a multidisciplinary approach that targets arms carriers of all affiliations and sides. The data collected was used to devise specific operational measures that could be taken in order to improve access to health care in the different contexts.

2. **A global set of aggregated data** on the abuses faced by health-care services provided a global perspective of the nature and consequences of such incidents. To identify recurring issues and differences across various contexts, the ICRC consulted many sources of information, including:
   - cases collected by ICRC staff;
   - statistics from both National Societies and health ministries on incidents affecting their staff, infrastructure and vehicles;
Making use of the data collected by delegations over the course of the project, the ICRC produced three analytical reports on violent incidents affecting the safety of health care; these were published in 2013, 2014 and 2015 (see page 13).

Over the course of the project, delegations received support to enhance their methods for gathering and managing information. In 2015, although incidents against health care were not aggregated for the purpose of producing an analysis as in previous years, a number of delegations continued to collect data at field level, enabling them to adapt their activities so as to better contribute to the enhanced protection of patients and health workers.

ADAPTING FIELD OPERATIONS AND ENCOURAGING THE IMPLEMENTATION OF THE PROJECT’S RECOMMENDATIONS

More than 60 delegations integrated objectives related to the HCiD project into their planning documents for 2015. Afghanistan, the Central African Republic (hereafter CAR), Colombia, Israel and the occupied territories, South Sudan and Syria are examples of contexts where multidisciplinary HCiD-related approaches were designed. These and other delegations continued underscoring the need to protect wounded and sick people, and health-care services, as part of their ongoing humanitarian dialogue with their interlocutors, particularly (but not exclusively) during IHL briefings and first-aid training sessions for government forces and armed groups. More generally, ICRC delegations continued to receive support in developing their approaches to addressing the issue of violence against health care, in cooperation with the National Society in their respective countries and, when necessary, with the support of the HCiD project team in Geneva.

A number of delegations assigned a focal point to ensure effective collaboration between the ICRC headquarters and the delegations, and to facilitate internal communication/coordination among the different departments.

OPERATIONAL RESPONSE: CONSOLIDATING AND IMPROVING FIELD PRACTICE

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; obstructions to the delivery of health care; discrimination in the treatment of wounded and sick patients; and armed entry by weapon bearers into health structures. Practical, regulatory and legislative measures to implement these norms at national level needed to be identified, and pertinent action had to be taken, in order to:

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

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. Following the workshop on national legislation and penal repression preventing and repressing crimes against health care held in Brussels, Belgium in 2014, the Advisory Service prepared a publication detailing

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these results and recommendations\(^7\) and a guidance tool,\(^8\) both of which were published, in a number of languages, in January 2015.

These documents were shared with ICRC delegations and with government officials approached by the Advisory Service. The documents, covering armed conflict and other emergencies, referred to IHL and international human rights law instruments providing protection to wounded and sick people and to health-care services.

Based on these, work was in progress 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:

- collected and included relevant domestic laws and regulations in the ICRC website on IHL and national implementation (http://www.icrc.org/ihl-nat) with the support of ICRC delegations, national IHL committees and governmental representatives, and mapped and analysed this information, with a view to identifying potential best practices, gaps and loopholes, and drafting proposals to help direct future efforts;
- guided and supported ICRC delegations and National Societies in approaching national and regional authorities in order to follow up on pledges made in relation to the HCiD project at the 31st International Conference (2011), and prepared model pledges for the 32nd International Conference (2015) and encouraged States and National Societies to support them;
- supported 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; and
- systematically included this issue in the agenda of expert meetings organized by the Advisory Service, including meetings of national IHL committees.

In November 2015, the Advisory Service asked its network of field-based regional legal advisers to provide updated information on any legislative, regulatory or practical measures, on draft laws and regulations, and on domestic case law adopted/taken/passed by States since January 2014 in relation to the protection of health care. Based on the advisers' input, the Advisory Service found that delegations were actively engaging States in connection with the HCiD project. Delegations were identifying, and building relationships with, key stakeholders. The goals of the HCiD project had been incorporated in IHL training sessions or had been presented in stand-alone dissemination sessions to military personnel, government officials, doctors' associations and academics, among others.

It was also found that delegations' efforts to engage States resulted in the drafting of various laws related to the protection of health care. Delegations reported that processes on drafting laws regulating the use of the emblems protected under IHL had been initiated in 15 States, including countries from Africa (Cabo Verde, Côte d’Ivoire, the Democratic Republic of the Congo, Madagascar, South Sudan, Uganda), Asia (Afghanistan, Indonesia, the Lao People’s Democratic Republic), the Americas (Argentina, Peru), Eurasia (Norway, the Russian Federation, Poland) and the Middle East (Iraq). A smaller number of delegations reported the drafting of laws specific to National Societies.

Legislative results were also reported by delegations around the world. Since 2014, laws or regulations pertaining to the emblems protected under IHL or the National Societies had been adopted in

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the Bolivarian Republic of Venezuela (hereafter Venezuela), Chad, Estonia, Iceland, Luxembourg, Mexico, Mongolia and Myanmar.

Similar efforts were made with national armed and security forces in order to ensure that military doctrine, operational procedures and other such frameworks all included measures to safeguard health care. Bilateral consultations were held with 29 national armed forces and 2 multilateral military/defence organizations to collect information on current doctrine and operational practices aimed at ensuring the protection of the wounded and sick and of health-care services. To the same end, consultations were held with 36 armed groups in 10 contexts.

National Societies and ICRC delegations also received 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 provided the necessary expertise to support and guide the ICRC’s operational dialogue on the protection of health care with parties to armed conflict and, during other emergencies, with the actors concerned. In this regard, the overview of relevant IHL and international human rights law prepared for the 31st International Conference was widely used as a reference by ICRC delegates in the field for making representations or giving technical advice. The Legal Division also supported 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. It supported the preparations for HCiD-related activities in the lead-up to, and work during, the 32nd International Conference, particularly through its involvement in drafting and negotiating Resolution 4, entitled “Health Care in Danger: Continuing to protect the delivery of health care together”

DIPLOMATIC MOBILIZATION: RAISING CONCERNS AND ENCOURAGING ACTION

The ICRC worked with States, National Societies and other experts to find practical solutions to better protect health-care services during armed conflict and other emergencies, by way of a five-phase mobilization process, detailed below and represented by the scheme in the annex (see page 50).

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, the States party to the Geneva Conventions and their National Societies adopted a resolution 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 workshops and consultations 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

10. Ibid.
Each workshop brought together experts from 10 to 25 countries, international governmental organizations, international and local NGOs, the health-care community and the academic community, 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.

### 2012-2014 Workshops

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<thead>
<tr>
<th>Title</th>
<th>Objective</th>
<th>Location</th>
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<tbody>
<tr>
<td>Responsibilities and rights of health-care personnel</td>
<td>Adoption by health practitioners of recommendations on best practices</td>
<td>London (United Kingdom of Great Britain and Northern Ireland), 2012</td>
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<td></td>
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<td>Cairo (Egypt), 2012</td>
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<td>National Societies’ response to Health Care in Danger</td>
<td>Formulation of recommendations ensuring that National Societies are</td>
<td>Oslo (Norway), 2012</td>
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<td>prepared to work in armed conflicts and other emergencies</td>
<td>Tehran (Islamic Republic of Iran), 2013</td>
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<tr>
<td>Civil society: mobilizing opinion leaders</td>
<td>Raising of awareness among a wider audience, including armed groups, of</td>
<td>Dakar (Senegal), 2013</td>
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<td></td>
<td>the need to safeguard health care</td>
<td>Gaza Strip (occupied Palestinian territory), 2014</td>
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<td></td>
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<td>Abu Dhabi (United Arab Emirates), 2014</td>
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<td>Islamabad (Pakistan), 2014</td>
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<td>Ambulance and pre-hospital care in risk situations</td>
<td>Formulation of recommendations to improve the security of ambulance</td>
<td>Toluca (Mexico), 2013</td>
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<td>services during crises, including risk-mitigation measures, such as the</td>
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<td>use of protective equipment</td>
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<td>Military operational practice that ensures safe access</td>
<td>Formulation of recommendations to increase the safety of health-care</td>
<td>Sydney (Australia), 2013</td>
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<td>to and delivery of health care</td>
<td>services during armed conflicts and other emergencies</td>
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<tr>
<td>The safety of health structures</td>
<td>Formulation of practical recommendations to improve the safety of health</td>
<td>Ottawa (Canada), 2013</td>
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<td>infrastructure are defined, for instance, in relation to coping with</td>
<td>Pretoria (South Africa), 2014</td>
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<td>supply-chain disruptions owing to insecurity, and to determining and</td>
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<td>sharing the GPS coordinates of facilities</td>
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<tr>
<td>Domestic normative frameworks for protecting the</td>
<td>Formulation of context-specific legislation to prevent and repress</td>
<td>Brussels (Belgium), 2014</td>
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<tr>
<td>delivering the delivery of health care</td>
<td>crimes against health care</td>
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Some 100 countries contributed to these workshops. The outcomes of the workshops fed into the next phase of the mobilization process and continue to be used to improve operational practice.

In addition to the above-mentioned issues, the importance of practicing health-care ethics and the role of armed group members in facilitating safe access to health care were also discussed during consultations with health-care workers and weapon bearers, respectively.

3. 2013: Council of Delegates of the International Red Cross and Red Crescent Movement

The 2013 Council of Delegates took stock of the preliminary outcomes of the expert workshops on the basis of the project’s progress report. With the Movement playing a vital role in the project, significant progress had been made within the Movement and beyond; more work, however, was deemed necessary to prepare for the 32nd International Conference and, ultimately, to accomplish the project’s aims. This was one of the key points discussed during a workshop, where the members of the Council of the Delegates and other experts:

- examined the challenges and obstacles to providing health care in situations of armed conflict and other emergencies, as well as the devastating effects of violence against health-care workers and facilities and the individuals and communities they serve;
- reflected on the project’s aims, progress and impact, particularly regarding measures being implemented by States, National Societies and the health community; and
- deliberated on recommendations from the expert workshops, with a view to: promoting their implementation; exploring how some National Societies are using these recommendations; determining which ones could be implemented in or adapted to their own contexts; and developing other concrete solutions.

4. 2014–2015: Promoting recommendations through bilateral and multilateral consultations in existing regional and global forums

The ICRC promoted further ownership and implementation by States and other parties concerned of the recommendations from expert workshops. It identified regional and global forums where these recommendations could be introduced, and organized thematic events that provided opportunities for governmental and non-governmental experts to discuss practical measures.

For example, on the sidelines of the 69th session of the UN General Assembly in 2014, the ICRC organized a debate that raised further awareness of the issues covered by the HCiD project, highlighting the importance of a protective environment for national health-care systems and urging States to enact measures to strengthen the resilience of these systems to crises. The debate was chaired by the ICRC president and the director-general of WHO; it was attended by high-level representatives of States, international organizations and the humanitarian community.

The African Union (AU) and the ICRC co-organized a conference to promote the practical measures proposed at the HCiD 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 World Medical Association (WMA) took part in the event, which was held in Addis Ababa, Ethiopia, in 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

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14. This consultation and promotion process replaced the Regional Conferences of Governmental and Non-Governmental Experts that had been planned for mid-2012 (and the initial idea of one such international conference). The decision is a result of further consultations with States and National Societies.
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.

Similarly, a regional workshop in Bogota, Colombia, facilitated the exchange of best practices among representatives of Health Ministries from eight Latin American countries and of several National Societies. The event was co-organized with the Colombian Ministry of Health and the Colombian Red Cross.

In 2015, various international events, where representatives of States, international health-care organizations, and/or National Societies took part, together with the ICRC, drew attention to and fostered the development of ways to respond to humanitarian challenges facing the safe delivery of health care (see page 31).

5. 2015: The 32nd International Conference and beyond
The 32nd International Conference, held in December 2015 in Geneva, provided an opportunity to reflect on the good practices that were implemented by States, Movement components and other stakeholders, and to encourage all actors to further adapt the project’s recommendations to the specificities of each context and continue working on their implementation at global and national level (see page 34).

THE HEALTH CARE IN DANGER COMMUNICATION CAMPAIGN
A global communication campaign complemented 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 supported the Movement’s operational communication in the field and encouraged 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 used 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 aimed 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 corresponded 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 aimed to foster investment among the stakeholders in adopting and implementing these measures and in establishing new ones.
THE HEALTH CARE IN DANGER
PROJECT: 2015 ACTIVITIES
AND RESULTS

OPERATIONAL RESPONSE

In 2015, 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 fulfill 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 faced; responding to those risks; adapting their dialogue with the actors concerned; and encouraging the creation of legal and practical conditions safeguarding 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. Delegations received support for improving their data-collection methods. Those participating in the project for the first time established procedures for gathering information with support from headquarters.

In May 2013, the ICRC published a report
15 detailing its analysis and mapping of threats against the provision of health care, on the basis of the incidents reported in 2012. In addition to reports from ICRC field teams, National Society teams and national authorities, information from medical NGOs and other credible sources was also considered.

A second report,
16 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 report showed that disrespect of health-care services was widespread during armed conflict and other emergencies, and that local health workers were particularly at risk.

A third report
17 was published in April 2015, based on 2,398 incidents of violence against health care in 11 selected countries between January 2012 and December 2014. A total of 4,275 people were victims of violence against health care, in 4,770 acts or threats of violence. Moreover, 728 medical vehicles were affected in 785 acts or threats of violence. In addition, it was found that 1,222 of the incidents took place against, inside or within the grounds of health-care facilities. The report showed that violence involved mostly local health-care providers, national NGOs and National Societies.

15. See page 13, footnote 2, for the link to this publication.
16. See page 13, footnote 3, for the link to this publication.
17. See page 13, footnote 4, for the link to this publication.
Community residents of Toribío, a rural area affected by armed conflict, gathered in a local school to participate in a first-aid training session conducted by the Colombian Red Cross and the ICRC. © Edgar Alfonso/ICRC

(overall 91% of recorded incidents), rather than international providers, which were likely to be present in smaller numbers in the areas affected; these findings were consistent with those of previous reports.

The ICRC raised awareness of these concerns among key stakeholders and encouraged them to take action to address the problem. Findings were shared with delegations worldwide and presented at various regional and international forums.

**DELEGATIONS ADAPT THEIR APPROACH AND ACTIVITIES**

Several delegations undertook context-specific analyses 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 continued to receive guidance and support from the HCiD project team in developing their approaches to dialogue with the authorities, armed forces and other parties concerned.

A compilation of some of the most recent and innovative HCiD field practices was shared with all ICRC delegations in 2015. This helped them identify new opportunities to address the issue of violence against health care in their contexts.

Several delegations adapted their approaches and/or carried out activities in line with the goals of the HCiD project. For example:

- **Abidjan (regional):** The delegation, and other humanitarian organizations, made representations to the authorities in Côte d’Ivoire, helping improve patients’ access to health-care facilities. With a view to ensuring that communities had continued access to psychosocial care, the delegation regularly met with the authorities and health staff to share its experiences in this regard, including the challenges it faced and the results it achieved.
Dakar (regional): The delegation maintained dialogue with weapon bearers and other pertinent parties, enabling it, the Senegalese Red Cross Society, and State health workers, which it accompanied, to reach some conflict-affected communities in Casamance, Senegal. It provided health workers with logistical assistance to improve their access to these communities.

Lebanon: The delegation organized information sessions at which staff from health facilities across the country, run by the Lebanese Red Cross or by the Palestine Red Crescent Society, learnt more about their rights and duties during armed conflict.

Mali: The delegation reminded weapon bearers to respect the principles of IHL, particularly the need to protect those not or no longer taking part in the fighting, and to ensure their access to medical/humanitarian assistance. Such reminders helped persuade weapon bearers to leave a health centre they had occupied, allowing staff to resume operations.

Myanmar: The delegation, in partnership with government health directors and the Myanmar Red Cross Society, organized 8 seminars on the safe delivery of health care. At each seminar, some 30 to 40 health professionals, including government and military medical officers, hospital staff, medical academics, doctors, midwives and health-care assistants shared and discussed issues they had faced. More than 350 highly experienced health-care professionals, in total, participated in these seminars.

Pakistan: The delegation designed a mid- to longer-term HCiD strategy involving local actors of influence, primarily academics and health-care managers. In partnership with local consultants representing public and private universities, and one teaching hospital, it initiated a research study – completed in 2015 – on the scope of violence against health care in Karachi. The study resulted in the publication of two reports intended for health-care workers and government officials, as well as for the general public. With Pakistan’s Research Society of International Law, the delegation also initiated a review of the legal framework governing the delivery of health care in Karachi.

South Sudan: The delegation adopted a new plan of action on HCiD in August 2015. The plan aimed to improve safety at selected health facilities, to include HCiD in the training of ICRC staff and in dissemination sessions for weapon bearers, and to increase the involvement of the health ministry and the broader NGO community. In line with this plan, a project was implemented in Wau to enhance the safety of two of the city’s hospitals, and awareness-raising sessions for community members were organized.

At the time of writing, more than 60 delegations had named an HCiD focal point tasked with, inter alia, facilitating the collection of data on relevant field practices, to ensure the effective integration of the HCiD approach within the delegation’s activities, and to maintain coordination between ICRC headquarters and the field and among the different departments of the delegation. At the 2015 meeting of HCiD focal points in Geneva, participants discussed HCiD project updates, identified regional approaches to the issue and made plans for implementing the recommendations resulting from the expert consultation process. A compilation of field practices, gathered in an internal database, was also presented at the meeting.

PRACTICAL MEASURES AND TRAINING HELP HEALTH-CARE WORKERS STAY SAFE

Given the continued danger they faced, health teams, including those of the National Society and the ICRC, received guidance in taking immediate action to avoid the dangers to which they were 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 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, was in progress. Notably, the documents “Health Care in Danger: the responsibilities of health-care personnel in armed conflicts and other emergencies”\(^\text{18}\) and “Ethical principles of health care in times of conflict and other emergencies” were widely promoted in various national and international forums, including through the International Committee of Military Medicine (ICMM), the International Council of Nurses (ICN) and the World Medical Association (WMA). These documents were made available in Arabic, English, French and Spanish. Members of professional health-care organizations have begun using this guide and have provided positive feedback about it. The ICRC developed complementary e-learning modules to broaden these documents’ reach. The module “Rights and responsibilities of health-care personnel in armed conflict and other emergencies”\(^\text{19}\) 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. It was also translated into Spanish, in partnership with the Spanish Red Cross.

Academic institutions received support in incorporating topics linked to the protection of health services in their curricula. In Switzerland, for instance, an online course on the subject, to be offered by the University of Geneva, received funding and was in the process of being developed.

National Societies continued to work towards increasing their acceptance, security and access in sensitive and insecure contexts and to identify and implement relevant and context-specific measures related to HCiD. The exchange of information and experiences through the Movement Reference Group (MRG) and other, regional initiatives of cooperation contributed significantly to these efforts. For example, drawing on the HCiD report on ambulance and pre-hospital services, the Norwegian Red Cross facilitated two regional workshops on the subject in Colombia and Lebanon. During these workshops, representatives of National Societies with operational experience from ambulance services in the Americas, the Middle East and North Africa contributed to the development of a report on procedures and best practices.\(^\text{20}\) To ensure that pertinent exchanges between National Societies and other actors continued, the Norwegian Red Cross was in the process of leading efforts to establish a community of action on ambulance and pre-hospital services. On the basis of experiences gathered from various National Societies, the Safer Access Practical Resource Pack,\(^\text{21}\) a 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 armed conflict or other emergencies. A new “one-stop-shop” Safer Access website (http://saferaccess.icrc.org), in English, was developed, with an updated map showing pertinent National Society experiences. A new “toolbox” feature offered guidelines, tools and reference materials to help National Societies identify ways to carry out the practical actions they identified as important in their context. The production materials were available in Arabic, English, French, Mandarin, Russian and Spanish.

With ongoing support from ICRC field personnel, National Societies continued to develop action plans and take concrete steps to enhance acceptance for their work and ensure their safety, on the basis of assessments and lessons learnt from past experiences.

The ICRC also backed National Societies’ efforts to build their capacities in emergency preparedness – for instance, through Safer Access peer-learning events, such as a workshop conducted in

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\(^{19}\) Available at: http://www.icrcproject.org/elearning/health-care-in-danger/.


Turkmenistan, in 2015, where participants from the National Societies of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan enhanced their understanding of the Safer Access Framework; a Ukrainian Red Cross Society volunteer provided insight to this end.

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, kept up 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 or other emergencies. Dialogue with weapon bearers covered three main issues that had 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 could take during attack and defence.

A report on promoting military operational practice that ensured safe access to and delivery of health care was officially launched at a panel discussion in Australia, organized by the Australian Red Cross and the ICRC in 2014. It proposed measures that could 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 military/defence organizations.

In 2015, the Armed Forces of Liberia incorporated HCiD-related recommendations into their military training manual, with help from the ICRC. In addition to an entire chapter on HCiD, the manual included guidelines for Liberian soldiers on how to conduct military operations while preserving people’s access to health-care services. More specifically, these included detailed procedures on the precautions to be taken during attacks, ground evacuations, search operations in health-care facilities, and other situations where medical personnel, facilities, ambulances, ships and aircraft are protected by IHL. In addition, to ensure respect for and protection of health-care personnel and the wounded and sick, the manual placed emphasis on providing appropriate training for armed forces.

The ICRC raised issues affecting the provision of health services during bilateral consultations with 36 armed groups 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 also developed a model declaration that armed groups could adopt to express their commitment to abiding by IHL, underscoring their resolve to safeguard the delivery of health care. These consultations resulted in a report, published in June 2015, entitled “Safeguarding the provision of health care: Operational practices and relevant international humanitarian law concerning armed groups.”

INCORPORATING 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 encouraged 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. Similar efforts were made in preparation for the 32nd International Conference. The importance of domestic IHL implementation was systematically highlighted in the ICRC's bilateral 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 outcomes24 and, on the basis of these outcomes, published a guidance tool25 to help national authorities implement rules protecting the provision of health care in armed conflicts and other emergencies.

In 2015, the Advisory Service systematically shared the recommendations of the Brussels workshop with its government interlocutors. It also contributed to the preparation of model pledges submitted for consideration to the participants to the 32nd International Conference.

DIPLOMATIC MOBILIZATION

KEY ACTORS TAKE STEPS TO IMPLEMENT BEST PRACTICES FOR ENSURING SAFE HEALTH-CARE DELIVERY

National authorities, members of the health-care community and other stakeholders from across the world came together, at expert workshops, conferences and panel discussions on HCiD in regional and international forums, to discuss different aspects of the threats against health care. The ICRC
cooperated with individual governments and National Societies according to their specific capacities and priorities, and raised awareness of HCiD-related issues.

Good practices, concrete recommendations and other resonant points were shared at these events, helping to promote further ownership and implementation by States and other key actors of the recommendations generated during the expert consultations.

For example, in 2015:

► During the Health Symposium of the European Forum Alpbach, held in Austria, the Austrian Red Cross and the ICRC organized a panel to highlight the serious issue of health-care insecurity, and to promote the development of ways to: ensure that health-care personnel know their rights and responsibilities; define the role of civil society, notably of the media, in broadening awareness of the problem; and take steps, on the part of States, weapon bearers, the health-care community and the Movement, to better address the issue. Among the featured panellists were representatives from the International Pharmaceutical Federation (FIP) and the Swedish Red Cross.

► The Commonwealth Red Cross and Red Crescent Conference on IHL in Australia, hosted by the Australian government, the Australian Red Cross and the ICRC, with support from the British Red Cross, gathered together government officials and Movement representatives from more than 30 Commonwealth States. The conference enabled participants to share insight into various IHL-related matters, including the need to respect and protect health care, and resulted in their making a joint Commonwealth pledge on the subject at the 32nd International Conference (see page 34).

► In Colombia, national IHL committee members from 19 States in the Americas, alongside experts from other governments and representatives of regional organizations, the International Humanitarian Fact-Finding Commission and the ICRC, gathered for the third Conference of National Committees on International Humanitarian Law of the Americas. They discussed the achievements made and challenges encountered with regard to the domestic implementation of IHL, covering, among other humanitarian issues, the protection of medical services.

► A regional IHL seminar in Pretoria, South Africa, co-hosted by the Department of International Relations and Cooperation of the government of South Africa and the ICRC, facilitated exchanges among the officials of 16 governments in the region on best practices for ensuring compliance with IHL and other pertinent norms; representatives from multilateral bodies were also in attendance. This seminar encompassed the results of the discussions during the expert workshop held in the country in 2014 (see page 22).

► In the Islamic Republic of Iran, the National Society and the ICRC held a round-table, with a view to fostering deliberations on how best to safeguard health-care workers during armed conflict and other emergencies, particularly in the Middle East. In attendance were officials of the foreign affairs, defence and health ministries of the Islamic Republic of Iran, representatives of local medical schools, and personnel of the National Societies of Afghanistan and Norway.

All these initiatives, as well as those pursued in the past, fed into the report on the project’s accomplishments that was presented at the 32nd International Conference (see page 34).

**HEALTH-CARE ORGANIZATIONS CONTINUE TO BUILD SUPPORT FOR AND WORK TO ACHIEVE 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 actors
supporting the goals of the project, notably the Australian, Belgian, Norwegian and South African
governments, the European Commission, the ICMM, MSF and WHO.

On the basis of a past conference regarding ethical dilemmas for health-care workers during armed
conflict and other emergencies, the ICRC, together with ICMM, ICN, FIP and WMA, developed a
common document to serve as a guide for such dilemmas, entitled “Ethical principles of health care
in times of conflict and other emergencies”; all five organizations then adopted it. After its public
launch at a conference,26 the document was endorsed by the International Federation of Medical
Students’ Associations (IFMSA), the Junior Doctors Network (JDN) of the WMA, and the World
Confederation of Physical Therapy (WCPT).

The WMA, with the ICRC, tackled the problem of violence against health care, during events that
it supported: a regional seminar in Jordan on health care in detention, at which representatives of
medical associations from ten countries participated; and a meeting in France on incidents against
health workers, convened by the French Medical Council and attended by representatives from
health-care organizations, the health ministry and the French Red Cross.

The IFMSA maintained its own campaign promoting ethical principles of health care in armed
conflict or other emergencies. In accordance with a training plan for 2014–15, it continued
conducting health-care ethics courses using information resources developed by the ICRC. With
the JDN, the IFMSA hosted an event on the sidelines of the 68th World Health Assembly, at which
participants discussed how to ensure that medical students and junior doctors know their rights
and responsibilities, and to incorporate new tools, such as the HCiD e-learning module for health
workers, in existing curricula.

Representatives of the International Hospital Federation (IHF), MSF, WHO and the ICRC formed a
working group, led by the IHF, to explore how to implement the recommendations that grew out of
the expert workshops in Pretoria and in Ottawa, on improving the safety of health facilities (see page
22). As a first step, they agreed to focus on carrying out the recommendation on the GPS mapping of
health-care facilities – where security conditions permit – using collaborative online tools.

The ICN, the IHF, the WCPT, and the WMA, in line with partnership agreements with the ICRC,
continued to discuss the HCiD project at their respective annual meetings, and to mobilize their
members to promote recommendations developed by the project. The project was also on the
agenda of meetings organized by ICMM, FIP and the World Association for Disaster and
Emergency Medicine.

The ICRC began dialogue with the International Alliance of Patients’ Organizations and with the
International Lawyers Association towards encouraging their engagement with the project.

Some 740 members of the project’s community of concern – including health-care personnel,
representatives of NGOs and international organizations, and ICRC staff – joined the Health Care in
Danger Network, an invitational online platform that enabled them to access and to share reference
documents, first-hand experiences, tools and other resources.

**MOVEMENT COMPONENTS ENGAGE INFLUENTIAL PARTIES TOWARDS APPLYING CONTEXT-SPECIFIC SOLUTIONS**

In 2015, Movement cooperation remained crucial to promoting the project’s goals and making
headway in achieving its central objectives. The MRG, composed of representatives from 28 National
Societies and the International Federation, served to strengthen Movement coordination for the
project. The MRG played an important role, not only in developing responses within their own

26. For a summary of the conference and related resources, see: https://www.icrc.org/en/event/ethical-principles-health-care-times-armed-
conflict-and-other-emergencies.
contexts, but also in following up the project’s outcomes at a global level. It also provided crucial support to such events as the expert workshops (see page 22), many of which were co-organized with the host country’s National Society.

As in the past, the MRG came together four times, with three webinars and one face-to-face meeting. Following this latter meeting, held in Geneva, members of the MRG, representatives of professional health-care organizations and the ICRC gathered to: discuss the progress of the HCiD project; explore how to help advance the goals of the project at national level; and prepare to present the accomplishments of the project and propose the way forward at the 32nd International Conference.

Moreover, in the lead-up to the said International Conference, eight members of the MRG – namely, the National Societies of Australia, Colombia, Egypt, Lebanon, Norway, the Philippines, Somalia and Sweden – formed a working group to support the ICRC in drafting a resolution advocating the sustainment of efforts to protect health care, and to produce model pledges – that is, statements of voluntary commitment – on improving the protection of health care, to be made at the International Conference (see also page 34).

Confirming the Movement’s leading role in and ownership of the project, the ICRC drew, to a significant degree, on the Movement’s wide network of contacts to promote it. Aside from working in partnership with the ICRC to carry out activities related to the project, many National Societies autonomously launched complementary initiatives involving actors both within and beyond the Movement. These activities and initiatives include: training for staff and volunteers, particularly in applying the Safer Access Framework; peer exchanges and joint projects; data collection on incidents against health-care workers; dialogue with and/or events for the authorities – notably national IHL committee members – weapon bearers, and members of civil society, such as health-care professionals, religious/community leaders, academics, media workers and students in their respective countries; and public-communication efforts, such as the production and distribution of multimedia resources on the HCiD project in local languages. For example:

▶ Magen David Adom in Israel and the Kenya Red Cross Society worked on a protocol for mass casualties that covers ways to ensure the safety of ambulances. The Bangladesh Red Crescent Society and the Egyptian Red Crescent Society shared best practices in emergency preparedness and response. The Norwegian Red Cross, with financial backing from the Norwegian foreign affairs ministry, continued to support a number of National Societies, notably in Colombia, Lebanon and South Sudan, in building their capacities to better safeguard health-care delivery through the deployment of experts to conduct training sessions and workshops.

▶ The impact of violence on health-care workers in the Americas region, and of measures that National Societies in the region are taking to mitigate such impact, was the subject of a workshop held during the 20th Inter-American Conference of the Red Cross in Houston, Texas, United States of America (hereafter United States). The workshop was jointly hosted by the American Red Cross and the Colombian Red Cross, chaired by the Salvadorean Red Cross Society, and attended by representatives of 25 National Societies, the International Federation and the ICRC.

▶ In its standard introductory course to IHL, “Born on the Battlefield”, the American Red Cross enables its staff and volunteers to learn more about the common origins of the Geneva Conventions and the Movement, and the protection that IHL affords to particular groups of people during situations of armed conflict, notably patients and medical workers. In Colombia, the National Society and the ICRC produced a video, adapted to the local situation, highlighting the importance of respecting health-care providers; this was widely disseminated through media outlets in the country, enabling the general public to access it.
In Oslo, Norway, in February 2015, the Norwegian Red Cross organized a seminar on health-care access in relation to armed groups, at which Norwegian government and military officials, and representatives of humanitarian organizations and research institutions took part. The event helped to shed more light on the rights and responsibilities of armed groups, as well as the multiple roles they play, with respect to health-care provision. The participants also discussed how to influence international policy-makers with regard to ensuring that members of armed groups could safely access health services. In June, also in Oslo, a related ICRC publication was launched during a panel discussion on the subject, where representatives from the Chatham House, the Norwegian Red Cross and the ICRC shared their views.

A 2014 study by a university professor and two Canadian Red Cross Society representatives, which appeared in the official journal of the World Association for Disaster and Emergency Medicine, and identified ways to address gaps in existing security mechanisms in the humanitarian sector so as to improve the safety of health-care personnel, has since been cited in other academic papers on the practice of medicine in conflict and disasters. The Swedish Red Cross, in connection with a pledge it made with the Swedish government at the 31st International Conference, undertook research on access to health care in armed conflict or other emergencies, with particular attention to gender-related issues. It drew on field work conducted in Colombia and Lebanon, in cooperation with the National Societies and the ICRC delegations in those countries, and made the resulting report available online.

STATES AND NATIONAL SOCIETIES RENEW COMMITMENT TO SAFEGUARD HEALTH CARE

The findings and achievements of the HCID project from 2012–15 were presented at the 32nd International Conference by way of a report prepared by the ICRC, in consultation with the International Federation. The report highlighted the positive momentum that the project generated, and acknowledged the engagement of States, health-care community representatives and Movement components, at both the operational and diplomatic levels, in order to promote and implement measures to tackle the problem of health-care insecurity. While commending such efforts, the report also urged the parties concerned, particularly States, to step these up and to see through their fulfilment.

The project was also the subject of a two-session workshop chaired by the director of the Department of International Relations and Cooperation of the government of South Africa, and featured, as panellists, government officials from Colombia and Norway, representatives of the WMA, and officers of the Swedish Red Cross and the Syrian Arab Red Crescent. Of note, the discussion underscored that safeguarding access to health care is incumbent upon all, and that the most effective measures were context-specific and locally adapted.

Towards the end of the International Conference, the States party to the Geneva Conventions and the National Societies adopted by consensus a resolution that renewed the call for all pertinent actors to continue and, where necessary, to strengthen, their cooperation in: enhancing understanding of violence against people who are wounded or sick, health-care personnel and facilities, and medical vehicles; and preventing and addressing such violence, in line with relevant international law, notably through the application of regulatory and practical measures, and the development and use of training tools. The text of the resolution was finalized with input from the participants to the

27. See page 29, footnote 23, for the link to this publication.
28. Essential excerpts from the discussion are available at: https://www.youtube.com/watch?v=c-nzjZHkx8.
31. See page 21, footnote 9, for the link to this resolution.
International Conference, who – upon being presented with the draft prepared by the ICRC, with the support of the MRG – urged the use of stronger language so as to underscore the need to ensure that attacks, threats and obstructions against health-care workers and facilities do not become the norm.

Moreover, as at end-April 2016, 27 pledges32 aimed at reinforcing the thrust of the project and implementing its goals had been made by some 88 actors, including States, NATO, international health-care organizations, National Societies and the ICRC. Several other pledges touched on related issues, such as ascertaining the safety and security of humanitarian workers and broadening acceptance for IHL.

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 seminars, panel discussions and exhibitions, complemented by a strong online presence, reached millions of people in over 30 countries. For instance, an installation of a battered and bullet-ridden ambulance was featured at the Supreme Headquarters Allied Powers Europe, the headquarters of Allied Command Operations, one of the strategic military commands of NATO, in Mons, Belgium, and in several locations in Sweden, between July and August 2015. This and related installations had previously been brought to other places, drawing tens of thousands of visitors. In October 2015, an HCiD photo exhibition was organized in Brazil, while a billboard at the arrival hall of the international airport in Belgium was put up for one month. The ambulance and a photo exhibition were also on display during the 32nd International Conference.

Events on or involving the HCiD project, organized by ICRC delegations, National Societies, and/or partner organizations worldwide, received regular coverage by local media, and those open to the public were well-attended. These events were held in different countries, including Australia, Austria, Germany, Indonesia, Jordan, Norway, Russia, Spain, Switzerland, Turkey, the United States and Zimbabwe (see, for example, pages 30-32).

The communication team produced news releases, articles and short videos 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 was periodically covered. The short film “Health Care in Danger: the human cost”33 continued to be screened at several national and regional events. Instead of producing a second film featuring different operational contexts to illustrate the practical solutions developed during HCiD expert workshops, as planned, the communication team launched several videos, including a series of interviews featuring members of the community of concern, and the recorded proceedings of key events. An animated video, “Protecting health care together”34, was launched at the 32nd International Conference.

The reference materials developed for the project continued to be translated into or released in different languages, in print and online, to make them available to a wider range of audiences. For instance, the following publications, presenting the outcomes of the expert workshops (see page 17) and consultations with the community of concern, with an emphasis on practical measures that could be implemented, were launched in Arabic, English, French and Spanish by the ICRC

32. The database of pledges made in connection with the 32nd International Conference is available at: http://rcrcconference.org/international-conference/pledges/.
33. Available at: https://www.youtube.com/watch?v=Cr3eknFZrWs.
34. Available at: https://www.youtube.com/watch?v=san9YFah6U.
in 2015: “Domestic normative frameworks for the protection of health care”35, and, subsequently, a complementary guidance document36; “Safeguarding the provision of health care: Operational practices and relevant IHL concerning armed groups”37; “Ensuring the preparedness and security of health-care facilities in armed conflict and other emergencies”38; and “Health care in danger: Meeting the challenges”39.

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

- its official website (http://healthcareindanger.org) – re-launched in November 2015 following a redesign to better highlight accomplishments in the field and the initiatives undertaken by partner organizations – which was made available in Arabic, English, Mandarin, Portuguese, Russian and Spanish, and reached an average of 2,000 views per month;
- the Health Care in Danger Network (http://healthcareindanger.ning.com), a dedicated platform that enabled some 740 members of the project’s community of concern to remain updated on the project’s developments; and
- the Health Care in Danger Twitter account (@HCIDproject) which was launched in April 2014 and had about 1,450 followers in December 2015, with an average growth of 70 new members per month.

Two newsletters were published online in Arabic, English, French and Spanish, notably reaching some 2,600 subscribers; the general public could download these free of charge.

E-learning courses continued to be widely promoted by the ICRC in cooperation with other Movement components and partner organizations through the above-mentioned online platforms and during HCiD events.

- The final version of an introductory course,40 which aims to inform the general public of the responsibilities of the authorities and health-care workers in armed conflicts and other emergencies, was completed.
- A module for health-care personnel,41 which delves into their rights and responsibilities and was launched in October 2014, was translated into Spanish in partnership with the Spanish Red Cross.

35. See page 20, footnote 7, for the link to this publication.
36. See page 20, footnote 8 for the link to this publication.
37. See page 29, footnote 23, for the link to this publication.
40. Available at: https://app.icrc.org/elearning/health-care-in-danger2/.
41. See page 28, footnote 19, for the link to this module.
In 2015, 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, in the Democratic Republic of the Congo (hereafter DRC), a clinic in the North Kivu town of Eringeti was targeted. Dozens of people lost their lives, and the severe damage sustained by the clinic’s facilities deprived an estimated 35,000 people of access to health care. In Yemen, close to a hundred attacks against health-care facilities were reported between March and November, endangering the lives of patients and staff members and leaving many such facilities unable to function. This was compounded by obstructions to the delivery of medical and surgical supplies to hospitals in besieged areas. In a number of contexts, emergency responders were allegedly 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 HGiD 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)⁴² 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 have 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

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Society/ICRC activities and to securing guarantees of safe access to all conflict/violence-affected populations. Such dialogue exists, in varying degrees of development, in many contexts, including Bangladesh, Iraq, Lebanon, Mali, Nigeria, Papua New Guinea, Somalia, Ukraine and Zimbabwe. First-aid training sessions for military and police officers and other weapon bearers have also served as a space to discuss related concerns – in Kyrgyzstan, Tajikistan and Uzbekistan, for instance. 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 stakeholders is required to ensure that awareness translates into concrete action. In Afghanistan, sustained dialogue with the parties to the conflict, including the defence ministry, contributed to some parties’ issuing directives to allow safe passage for vehicles carrying wounded or sick people. The Peruvian health ministry, advised by the ICRC, continued efforts to help health personnel work safely and systematize national norms covering the protection due to them, by, for instance, training these personnel in self-protection measures and finalizing information cards for reminding them of their rights and duties.

Bilateral meetings and dissemination activities, such as those conducted for religious and community leaders and other influential players, contributed to widening acceptance of the Movement’s health activities. For example, the Centre for Comparative Studies on Islam and IHL in Qom, Islamic Republic of Iran, conducted research on humanitarian concerns, including the protection of medical services, in the context of IHL and Islamic law with prominent scholars in the region. Radio broadcasts, as in Nepal and Venezuela, 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, academics completed ICRC-supported research on the effects of violence on the delivery of health care in the city, while a think-tank carried out an analysis on the legal framework governing the issue. These resulted in the publication of two reports geared towards health-care workers and government officials, which then fed into ongoing training and policy-revision efforts.
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:

- Psychosocial-support programmes in Côte d’Ivoire, Egypt, Mexico, Syria and Ukraine and in the Gaza Strip helped health-care workers to improve their understanding and management of work-related stress, in turn enabling them to continue providing adequate treatment for patients.
- The Norwegian Red Cross, on the basis of past workshops that it organized with the Colombian Red Cross and the Lebanese Red Cross, published a report that provides practical recommendations for increasing the safety of ambulance services. While the report was developed with Movement operations in mind, many of its recommendations are also relevant for other organizations outside of the Movement.
- Efforts to promote respect for the emblems protected under IHL in different contexts contributed to increasing the protection of medical structures and ambulances. Relatedly, National Societies worldwide trained their volunteers in the application of the Safer Access Framework.

**STEEPING UP MEDICAL RESPONSE TO EMERGENCIES**

As shifts in the dynamics of armed conflict or 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 441 in 2014 to 476 in 2015.

In 2015, emergency medical activities proved necessary in a number of contexts; for example:

- In the DRC, conflict-affected people in North and South Kivu received suitable medical treatment as the ICRC bolstered the casualty care chain by providing medicines, equipment and staff training to health facilities. Civilians obtained good-quality services at ICRC-supported primary-health-care centres; those in need of further treatment were referred to higher-level care. The ICRC also evacuated weapon-wounded people. Some of them were treated by the ICRC surgical team at the hospital in Goma, and others by a team of local surgeons who, having received support from the ICRC team since 2013, took charge of the provision of surgical care to the weapon-wounded in Bukavu starting in July.

- In Mali, where more health facilities were supported than in previous years, people requiring emergency surgery, including for weapon wounds, were treated by ICRC teams in Gao hospital and the Kidal referral centre. Ad hoc assistance to other facilities helped staff cope with influxes of people wounded during clashes. A few weapon bearers wounded in Léré received treatment abroad, after the ICRC, with the authorities’ consent, helped facilitate their medical evacuation.

- In Nigeria, following bombings and other incidents, thousands of casualties were attended to or evacuated by ICRC-trained emergency responders – mainly National Society volunteers – who also helped transfer the remains of several hundred people. Owing to the growing needs of weapon-wounded people in Maiduguri, the ICRC began to focus on providing services directly: in particular, a surgical team was stationed in one hospital from March onwards. Hundreds of people underwent free operations. Elsewhere, hundreds of victims of emergencies
were treated at hospitals that received ad hoc material support, which helped them cope with mass-casualty influxes.

► In Iraq, people in violence-prone/affected areas, such as Kirkuk and around Mosul, received life-saving treatment at facilities that, with ICRC backing, could better manage mass-casualty influxes and critical injuries. Doctors from 7 hospitals trained to boost their trauma-management skills. Sixteen hospitals received medical/surgical supplies for treating over 500,000 weapon-wounded patients; those in Anbar obtained, additionally, 120 tons of such supplies in total from the central health ministry, with ICRC logistical support. In Fallujah city, controlled by armed groups, repairs to one hospital helped restore its water/electricity supplies.

► In Benghazi, Misrata, Tripoli, Sabha and other areas in Libya affected by intense clashes and other situations of violence, wounded/sick people received treatment at 21 hospitals that sustained their services, including obstetric care, with the help of ICRC-donated surgical equipment and medicines, wound-dressing kits and other supplies. A total of 20 other facilities – first-aid posts, primary-health-care centres and branches of the Libyan Red Crescent – also received medical materials, including supplies for treating weapon-wounded people.

► In Ukraine, people wounded during the conflict, or suffering from chronic illnesses, were treated at health facilities – in government-controlled territories and opposition-held areas – that had ICRC support in the form of medical supplies/equipment and/or repairs, alleviating the effects of impediments to the delivery of supplies and of infrastructural damage. Doctors/surgeons treating the weapon-wounded boosted their skills through ICRC training.

► In Yemen, the ICRC focused on helping to ensure people’s access to health/medical care amidst supply shortages and intensified fighting. It donated surgical items, reproductive health supplies and other medical materials to primary-health-care facilities and hospitals; however, it was unable to maintain the regular, on-site support that it was providing at the beginning of the year. To help manage the influx of weapon-wounded patients in Aden, the ICRC deployed a surgical team, first to Al Jamhouria hospital in April, and then to the Al Mansoora hospital in June; the team, however, was forced to withdraw when the fighting intensified.

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 DRC, 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 Jordan, Pakistan, the Philippines and Somalia. In Myanmar, the ICRC provided financial/logistical backing to local health teams, enabling them to conduct 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 conflict. In the CAR, Guatemala and Mali, for instance, victims of sexual violence received counselling and other specialized care. Several hospitals and clinics in Côte d’Ivoire continued the integration of mental-health services into their consultation procedures; the authorities and health professionals discussed the incorporation of these services into national programmes. Health workers in Mexico, Uganda and other contexts learnt more about administering psychosocial support through training.

To improve the likelihood that casualties of fighting, especially in remote areas, would receive timely care before they were brought to medical facilities, the ICRC conducted or supported basic and train-the-trainer courses on first-aid for National Society volunteers, weapon bearers, journalists, religious leaders and/or community members. To facilitate the immediate medical evacuation of wounded/sick people, the ICRC supported local/National Society-run ambulance services, notably by providing vehicles and training drivers in administering emergency care. For example, in Bujumbura, Burundi, scores of people injured during unrest were treated on the spot, where possible, or at National Society first-aid posts; several hundred others were evacuated to hospital.

Long-term comprehensive support to hospitals helped 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 continued to receive comprehensive ICRC assistance.

In several countries, ICRC surgeons and emergency room staff helped medical practitioners enhance their skills at courses on war surgery and emergency room trauma management. For example, in Ukraine, more than 70 doctors/surgeons enhanced their skills at an ICRC seminar on war surgery and at two courses in managing emergency-room trauma. In Kyrgyzstan, 76 surgeons and anesthesiologists participated in trauma-management courses led by ICRC-trained doctors, who autonomously organized one such course and supported others held in Kazakhstan.

The following six examples – Afghanistan, the CAR, Colombia, Israel and the Occupied Territories, South Sudan and Syria – 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 security situation in Afghanistan worsened as the conflict between NATO-backed Afghan armed forces and armed groups intensified. Civilians bore the brunt of the fighting: many were displaced, wounded or killed. There are said to be over 1 million IDPs in the country. The number of civilian casualties in 2015 was reportedly the highest recorded since the beginning of the conflict in 2001. NATO and the United States announced an extension of their technical support to local troops for at least 2016.

Parliamentary elections, originally scheduled for the first half of 2015, were postponed to October 2016. The prolonged political transition, fragmented military landscape and volatile situation further restricted humanitarian access. Attacks on humanitarian/medical workers persisted.

These factors made it difficult for the ICRC to sustain dialogue with parties to the conflict, and delayed some activities related to protecting civilians and providing health care. Nevertheless, vulnerable communities obtained assistance as a result of the close work between partner organizations, notably the Afghan Red Crescent Society, and the ICRC. The National Society also received ICRC support in developing its institutional and branch-level capacities.
Influential actors help ensure safe passage for wounded/sick people

Parties to the conflict – including armed groups who sometimes imposed restrictions on National Society/ICRC aid delivery – and the ICRC discussed the need to: protect people not/no longer participating in hostilities; allow civilians access to basic services, including by protecting humanitarian/medical workers/facilities; and facilitate the Movement’s neutral, impartial and independent activities. Allegations of abuse formed the basis of written/oral representations to weapon bearers, reminding them of their obligations under IHL, with a view to preventing further abuses. These contributed to the issuance of directives to allow the safe passage of wounded/sick people to hospital by some of the parties to the conflict, including the defence ministry.

People obtain health-care services at National Society clinics

People benefited from preventive/curative care at 47 National Society clinics – which covered almost all the provinces of Afghanistan – and at one community-run health centre in Korangal, near Jalalabad. These centres received medical supplies, equipment and technical support from the ICRC. Nearly 967,000 people attended consultations; 502,375 were vaccinated. Follow-up and continuous improvement of care provided at these clinics were challenging for the ICRC owing to the insecurity. The renovation of three National Society warehouses for storing medical supplies – in Jalalabad, Kunduz and Mazar-i-Sharif – was completed.

The public health ministry, UNHCR and WHO continued to administer polio vaccinations in the south; the ICRC facilitated access for them.

Weapon-wounded people reach hospital thanks to the expanded ICRC-funded transport system

Sustained dialogue with weapon bearers, on the need to ensure the safe transport of wounded and sick people to hospital, yielded results, but intensified fighting and persistent attacks on medical staff/facilities impeded health-care services, resulting in more casualties than in 2014. Despite the security constraints, wounded/sick patients still benefited from various kinds of treatment provided by the ICRC and its partners.

Injured people received life-saving care from National Society/ICRC-trained and -equipped emergency responders, including male and female community-based National Society volunteers, ambulance drivers, hospital staff, and weapon bearers. The training they received incorporated points from the Health Care in Danger project. Over 2,100 weapon-wounded people reached hospital through an ICRC-funded transport system consisting of taxis, National Society ambulances and/or ICRC vehicles.

Hospitals have the capacity to respond to influxes of patients during emergencies

Over 65,100 inpatients and 428,200 outpatients received the care they needed at the health ministry’s Mirwais and Shiberghan hospitals. They included some 2,200 weapon-wounded patients, 20,600 patients in need of surgical treatment, and 27,000 women who availed themselves of obstetric/gynaecological care. Patients in need of specialized care were referred to other health facilities. Both hospitals attended to these patients with ICRC material, technical and financial support – including payment of staff salaries – and training.

A seminar on war surgery enabled 35 surgeons to strengthen their capacity to treat weapon-wounded patients. Upgrades to hospital facilities enhanced care for patients; these included the ongoing construction of a paediatric ward and laundry room, and the completion of a blood bank room, at Mirwais Hospital. Some government- or armed group-run hospitals coped with influxes of weapon-wounded people during emergencies with ICRC material support.
Members of civil society further their understanding of humanitarian issues and the Movement

Though sometimes hampered by the protracted political transition and intensified conflict, dialogue with the authorities and weapon bearers – including international forces – on humanitarian issues continued; in some cases, this led the parties to the conflict to address the issues raised by the ICRC. Influential community/religious leaders, including elders and shura council members, as well as academic scholars and members of the media – some 16,400 individuals in all – furthered their understanding of IHL and the Movement through ICRC presentations. Religious leaders and scholars refined their knowledge of the similarities between Islam and IHL, and learnt about contemporary IHL challenges, during round-tables and at courses abroad. Translations, in local languages, of the Geneva Conventions and their Additional Protocols enabled university students to study IHL. Some of them, together with law professors, participated in conferences on IHL.

The public increased its awareness of humanitarian issues, and the Movement and its activities in the country, through publications/videos translated in Dari and Pashto, and the production of posters with key messages on the Health Care in Danger project adapted for the Afghan context. These efforts were reinforced through social media outlets, including features posted on the ICRC’s website. Awareness-raising sessions were held to inform ICRC beneficiaries and the public of services available to them.

Afghan authorities continued to receive ICRC support for incorporating provisions of IHL treaties – the 1977 Additional Protocols and the Convention on Cluster Munitions – in domestic legislation, and for establishing a national IHL committee. ICRC support enabled a number of officials to participate in meetings/seminars on the Arms Trade Treaty and on the Hague Convention on Cultural Property. The combined law on the emblem and the National Society awaited ratification.

Afghan armed forces establish a mobile training team to teach IHL

Instructional materials in the Dari and Pashto languages were distributed to the armed forces, and helped them further their understanding of IHL, humanitarian principles and the ICRC. Instructors attended train-the-trainer courses and strengthened their ability to conduct IHL courses for armed forces personnel independently. Sustained dialogue with the Afghan military contributed to its assuming greater responsibility for IHL training: an army officer was appointed to act as IHL-training coordinator and a mobile training team was established for operational troops.

With ICRC sponsorship, an army officer attended an IHL course in San Remo, while another participated in a workshop abroad on rules governing military operations. These sessions/courses often drew senior military officers, including generals and those likely to hold that rank in the future; they were encouraged to apply what they had learnt. Authorities sought the ICRC’s expert opinion on the draft IHL manual produced by the Afghan National Security Council.

Members of the armed/security forces added to their knowledge of IHL during dissemination sessions, which covered such topics as sexual violence, the use of explosive weapons in densely populated areas and protection for the civilian population. Members of armed groups also attended dissemination sessions, which were often supplemented by first-aid training and by donations of first-aid materials to enable them to treat their wounded.

National Society strengthens its emergency response capacities

The Afghan Red Crescent Society remained the ICRC’s main partner in providing relief and medical care to victims, many of whom were beyond the reach of overstretched/unreliable government services or other humanitarian actors. At times, the National Society required the ICRC’s help in facilitating its safe access to people in need.
With Movement support and cooperation, the National Society developed its institutional and branch-level capacities, for example through workshops on communication, management training and the Safer Access Framework. It also participated in meetings with some National Societies in the region, with the aim of sharing lessons on emergency response/preparedness. It improved its ability to monitor its field activities, including those implemented in cooperation with the ICRC – including communication, emergency response, first aid, transport of human remains – and with other organizations and the Afghan government.

National Society representatives participated in a meeting on the Health Care in Danger project in Geneva, Switzerland.

Movement partners met regularly to coordinate activities and avoid the duplication of efforts.

**EXAMPLE 2: CENTRAL AFRICAN REPUBLIC**

The general situation in the CAR remained volatile. Despite an overall decrease in the prevalence of violence over the past two years, pockets of insecurity and socio-political tensions remained: for instance, there was an outbreak of communal violence in Bangui in late September. A rise in criminal activity targeting the civilian population and humanitarian organizations alike, coupled with security concerns, hampered the delivery of aid to communities. Public services, especially health care, continued to be weak and many medical facilities remained closed. Hundreds of thousands of families displaced in and beyond the country had not returned to their places of origin because of persistent insecurity. Those who returned found their homes and means of livelihood damaged, destroyed or occupied; some were victims of thefts or attacks.

In view of the renewed outbreaks of violence in Bangui, the planned withdrawal of French troops was slowed down and the UN Multidimensional Integrated Stabilization Mission in the CAR changed its approach and focused on restoring stability, in cooperation with local security forces.

**Dialogue emphasizes the protection due to the wounded/sick and to medical/humanitarian personnel**

Amidst a situation made unstable by intermittent tensions, the ICRC continued documenting allegations of abuses, including forced recruitment and sexual violence, reported to it; afterwards, it discussed some of them confidentially with the parties concerned. Authorities and weapon bearers, including multinational forces conducting law enforcement operations, were reminded of their obligations under IHL and other applicable law to protect civilians and their property, the wounded and the sick, and medical/humanitarian personnel and infrastructure.

**Patients and their caregivers receive help to address malnutrition**

After a 2014 assessment found a high incidence of malnourishment among patients in ICRC-supported hospitals, patients and their caregivers in Bangui began receiving monthly food rations to complement the food provided by the hospital. Over 2,700 families in Kaga Bandoro, each of whom had a severely malnourished child undergoing ambulatory treatment, received dry food rations to discourage the sharing of therapeutic food meant for the child with his or her siblings. Some 670 adults accompanying a severely malnourished child to the hospital for treatment benefited from financial support.

In Birao, 10,711 IDPs and residents availed themselves of free tests for malaria, conducted by health workers trained by the ICRC; almost 97% of them were treated for the disease.
Patients and hospital staff benefit from improved infrastructure

To help ensure prompt treatment/evacuation of the wounded, 749 people, including community members and weapon bearers, learnt first aid during National Society/ICRC training. The National Society drew on ICRC expertise in enhancing its training module.

Over 100 critically injured/ill patients were brought to Bangui – mostly by plane – where they were treated by one of two ICRC surgical teams stationed there. The overall decrease in violence meant that fewer people had to be treated for weapon wounds; in total, 395 surgical procedures on weapon-wounded patients were performed at the ICRC-supported hospitals in Bangui and Kaga Bandoro.

Improvements to water, sanitation and electrical infrastructure at health facilities in Nana Grebizi and Kaga Bandoro helped improve working conditions. Infrastructure upgrades began in Bangui, and hospital authorities received assistance in contingency planning. Staff at these hospitals participated in training sessions to strengthen their patient-management skills; technical support and provision of medical supplies/equipment helped them carry out their tasks. ICRC support to the hospital in Kaga Bandoro, including the assignment of a medical team, was discontinued mid-October because of managerial difficulties.

Staff and patients at the hospitals in Bangui and Kaga Bandoro learnt more about the issues covered by the Health Care in Danger project through briefings from the National Society/ICRC. In Bambari, a fence clearly marked with the emblem was built around the hospital to increase the protection of those within against armed elements. At a seminar, hospital personnel devised practical measures for enhancing patient and staff safety.

Government forces and armed groups reinforce their knowledge of IHL and other applicable norms

Dialogue with the authorities, weapon bearers, religious/traditional leaders and community members focused on the humanitarian consequences of the ongoing situation, the importance of protecting the civilian population, and the Movement’s role and activities.

During ICRC briefings, sometimes held in coordination with regional and international actors, more than 2,500 soldiers – including those from newly deployed battalions; the police; the gendarmerie; and members of armed groups – heightened their awareness of their obligations under IHL and international human rights law, particularly the need to facilitate conflict/violence-affected people’s safe access to medical/humanitarian aid. A representative of the army attended a workshop abroad on the rules governing military operations. Multinational and local defence forces, and armed groups, received regular updates on humanitarian concerns and ICRC activities.

Local journalists hone their ability to report on the plight of conflict/violence-affected people

Through information sessions and discussions, nearly 3,000 people from major districts, youth organizations and women’s associations, as well as students and community and religious leaders, learnt more about their roles in contributing to the protection of conflict/violence-affected people and to the safety of humanitarian personnel; such initiatives aimed to facilitate the provision of health-care services and the Movement’s access to violence-stricken communities. Diplomats and representatives of international organizations stayed abreast of the humanitarian situation through bilateral talks or during coordination meetings.

National and international media reported on the humanitarian situation in the country, following information sessions, briefings and interviews with ICRC delegates. Following their participation
in ICRC-organized seminars and sessions, 130 local journalists were better equipped to report on the issues faced by conflict/violence-affected people and knew more about the protection afforded to them by IHL during armed conflict.

**The National Society helps evacuate casualties and manage human remains**

The Central African Red Cross Society maintained its partnership with the ICRC in the areas of restoring family links, distributing relief, promoting hygiene practices and fostering respect for IHL. With ICRC support, the National Society continued to assist the government in evacuating casualties and managing human remains.

Through ICRC technical/financial/material support, which included equipping and training response teams, 27 branches of the National Society enhanced their emergency response capacities, particularly in preparation for the elections, and coordination with Movement partners; however, the implementation of these activities and those related to the Safer Access Framework was minimal/stalled because of National Society administrative issues.

The National Society worked towards management reforms and the revision of its strategic plan, in cooperation with the ICRC and other Movement partners, but these were delayed due to the elections and the outbreaks of violence during the latter part of the year. The National Society’s participation in a regional workshop on the Fundamental Principles and the Movement, an annual National Society legal advisors meeting and Movement statutory meetings received financial assistance from the ICRC.

Movement components in the CAR met regularly to coordinate their activities, thereby avoiding duplication of effort and maximizing impact.

**EXAMPLE 3: COLOMBIA**

Hostilities between the Colombian government and the Revolutionary Armed Forces of Colombia – People’s Army (FARC-EP) abated, owing to the FARC-EP’s unilateral ceasefire declaration in July. This led to the government’s suspending aerial bombings against the armed group, although ground operations continued. At the same time, negotiations to end the armed conflict progressed: the two parties concluded agreements on four of the six points on the agenda, including transitional justice, and on addressing specific humanitarian concerns, including demining; they jointly implemented humanitarian demining activities in two departments of Colombia.

Exploratory talks continued between the government and the National Liberation Army (ELN) on a peace process.

In certain parts of Colombia, other armed groups continued to fight with security forces or among themselves for control of land, natural resources and trade routes.

Communities continued to suffer the effects of conflict/violence, especially with regard to weapon contamination, sexual violence and restricted access to livelihood opportunities.

**Parties to the conflict and other weapon bearers accept the ICRC’s role as a neutral intermediary**

Parties to the conflict and the ICRC confidentially discussed various issues of humanitarian concern, including protection for civilians and health services. Written/oral representations on documented allegations of IHL violations reminded weapon bearers of their obligations under IHL and other applicable laws; the armed forces later informed the ICRC of the actions they had taken after investigating these allegations. Parties affirmed their understanding of and acceptance
for the ICRC’s role as a neutral intermediary, particularly in the context of the peace talks and humanitarian demining.

In violence-affected urban areas, ICRC efforts to strengthen dialogue on humanitarian issues with weapon bearers continued. Youth and women’s networks in Medellin, with ICRC support, promoted measures to protect people from violence and directed victims of sexual violence to the services available.

**Health professionals strengthen their ability to provide care for victims of sexual violence**

With support from the National Society/ICRC, around 6,300 people, mostly health personnel, learnt more about their rights and duties; some 4,500 health staff and 160 facilities and vehicles received markers bearing the red cross emblem.

About 170 victims of sexual violence coped with their situation with the help of psychological care. Through training, almost 350 health professionals from various institutions serving around 1,000 people in 43 municipalities strengthened their ability to provide mental-health care and psychosocial support, particularly for victims of sexual violence.

Infrastructure improvements gave 2,187 IDPs, and nearly 15,800 residents from rural communities, including those affected by weapon contamination, access to improved water/sanitation, shelter and other facilities; hygiene-promotion sessions helped residents decrease their risk of disease/illness. Three health centres enhanced their services with ad hoc ICRC rehabilitation works.

**By attending school, children become less exposed to the consequences of conflict/violence**

During National Society/ICRC workshops on weapon contamination, nearly 18,200 people – members of the community, local authorities and people from academic institutions – learnt more about safe practices and victims’ rights. Construction/rehabilitation of aqueducts and other infrastructure close to their homes helped around 5,200 people mitigate the threat of mines/explosive remnants of war (ERW) to them. Repairs/upgrades to 12 educational facilities in rural communities gave 2,519 children incentive to go to school, in turn minimizing their vulnerability to the consequences of conflict/violence.

**Four academic institutions incorporate war-surgery courses in their curricula**

Around 2,200 people from communities with an average population of 450,000 strengthened their first-aid skills at training sessions. Similarly, 828 health personnel, including 89 from armed groups, learnt more about weapon-wound management; a survey conducted afterwards showed that 76% of the participants had already applied what they had learnt, and that 83% had passed on their skills to colleagues.

Medical students at university attended war-surgery courses offered by four academic institutions that had incorporated the subject in their curricula. A regional conference organized by the Colombian Surgical Association and the ICRC enabled 216 health personnel to learn more about weapon-wound management from experts.

Some 1,400 wounded/sick people obtained adequate health care with the ICRC’s financial assistance. The authorities received encouragement to include weapon-wounded people and victims of mines/ERW in the national welfare system.
Military produces practical IHL guide for its field instructors

Dialogue between the authorities, weapon bearers and the ICRC continued, with a view to facilitating, for the organization and for health services, safe and unhindered access to communities affected by conflict/violence.

In line with an agreement with the ICRC to include provisions of IHL and international human rights law in its new doctrine, the armed forces produced a practical guide to applying in their operations IHL and other relevant laws. The guide was prepared on the basis of operational reviews conducted in 2014 and distributed to field instructors. Military personnel continued to assess the compliance of their operations with IHL, in accordance with a defence ministry directive. A senior official participated in an international workshop on rules governing military operations. The military forces and national police produced a protocol on preventing sexual violence during armed conflict, and among its personnel.

Twenty-six prosecutors, including some from Medellín, and military legal advisers and police officers, learnt how to better prepare for IHL-related cases by studying ongoing cases of alleged IHL violations during a workshop organized by the defence ministry and the prosecutor general, with ICRC support.

At ICRC workshops, some 100 military/police officials and 500 policemen in Medellín furthered their understanding of the proper conduct of law enforcement operations.

Government issues decree to assist the families of missing persons

Representatives of national IHL committees in the Americas region, as well as those of other countries and regional organizations, gathered at a conference organized by the Colombian government, the Colombian Red Cross and the ICRC. They discussed several IHL-related topics, including the humanitarian consequences of the use of certain weapons, the Arms Trade Treaty, cooperation among national IHL committees in the region, and States’ positions on topics to be covered by the 32nd International Conference. In particular, in preparation for the International Conference, the Colombian authorities and the National Society/ICRC discussed the state of implementation of IHL-related domestic legislation, and the government’s support for a resolution on the Health Care in Danger project.

Technical advice and encouragement from the ICRC facilitated the creation or development of national frameworks related to IHL and other international norms. The authorities issued a decree aimed at strengthening the State’s capacity to identify and preserve human remains and at assisting families of the missing through, for example, the organization of commemorative events. Colombia ratified the Convention on Cluster Munitions.

ICRC participation in university courses and events on IHL encouraged academics to promote the subject among their peers and students.

Thousands of people complete a National Society/ICRC online course in basic IHL

Workshops helped more than 120 journalists learn more about the protection afforded to them by IHL. National and international media published key messages on the consequences of conflict/violence, drawing on information from ICRC materials, including articles posted on the delegation’s website and other social media accounts. Some 16,000 people learnt the basic principles of IHL by taking an online course, launched by the National Society/ICRC on the National Society’s website.

Information sessions helped members of the international community stay abreast of the ICRC’s activities for communities affected by conflict/violence.
National Society aids conflict/violence-affected people with ICRC backing
The Colombian Red Cross remained the ICRC’s main partner in responding to the needs of people affected by conflict/violence. It bolstered its ability to do so with ICRC technical and financial support; for example, nearly 400 volunteers were trained to conduct vulnerability and capacity assessments and to apply the Safer Access Framework.
Efforts to reinforce Movement coordination continued, through the exchange of security/operational information and by other means.

EXAMPLE 4: ISRAEL AND THE OCCUPIED TERRITORIES
In the Gaza Strip, Palestinians endured the lingering consequences of the 2014 hostilities between the Israeli authorities and the Hamas de facto authorities and local armed groups. Most people had limited access to basic services and livelihood resources; thousands remained without homes. Certain communities were at risk from mines/ERW. These issues persisted amid longstanding difficulties linked to Israel’s blockade of the Gaza Strip, and were compounded by the closure of crossing points with Egypt. The continued deterioration of ties between the Palestinian Authority (PA) and Hamas, both grappling with budgetary/other constraints, further exacerbated the situation.
Palestinians in East Jerusalem and the West Bank continued to bear the adverse effects of Israeli occupation policies, including those that contravene IHL. Tensions between them and Israelis flared into bouts of violence, which increased in October, leading to casualties, deaths and mass arrests.
The PA ratified/acceeded to several treaties related to IHL and other international norms, fraying already strained relations with Israel.
The ICRC sustained efforts to promote the protection of civilians and help alleviate the situation of Palestinians living under occupation, notably those still enduring the consequences of the 2014 fighting in the Gaza Strip.

Israeli and Palestinian authorities and weapon bearers are reminded of their obligations
Bilateral/confidential ICRC representations to Israeli and Palestinian authorities and weapon bearers, based on documented allegations/first-hand accounts, sought to persuade them, particularly, to: respect/protect civilians/civilian infrastructure, including patients and medical workers/facilities; and address the adverse conditions of people in the occupied territories and in Israel.
The Israeli authorities were reminded of the humanitarian consequences of their non-compliance with IHL. Oral/written representations urged them to ensure that, inter alia:

- military operations abide by IHL - particularly the principles of precaution, distinction and proportionality – and other norms applicable to the conduct of hostilities, and that law enforcement operations respect internationally recognized standards; and
- Palestinians and their property are protected from settler violence.

Dialogue with the de facto authorities and armed groups in the Gaza Strip aimed to promote respect for humanitarian principles, as well as IHL/other pertinent norms, especially the principle of distinction.

Local actors bolster their emergency-preparedness/response capacities
To help ensure people’s access to medical care, the ICRC addressed representations to the pertinent parties. Local actors strengthened their emergency preparedness/response with ICRC backing – notably hospital staff in the Gaza Strip, hewing to the ICRC’s revised approach there. Given
heightened violence, the ICRC reinforced contact with Israeli military/law enforcement personnel, emphasizing the need to ensure safe passage for emergency responders.

The Palestine Red Crescent Society provided emergency medical services across the occupied Palestinian territory, with the ICRC’s financial/material support and help in obtaining crossing/transport permits. Patient transfers from the Gaza Strip to the West Bank and to Israel were monitored.

**Patients receive suitable care**

Thirty-nine doctors and 44 nurses from six Gaza Strip hospitals honed their trauma-management skills at ICRC courses; seven doctors and 3 nurses learnt to instruct their peers in the subject autonomously. Twenty-five mental-health professionals, trained in psychosocial care, helped 455 first responders cope with work-related stress. Five hospitals, heavily damaged in 2014, were refurbished; fourteen received spare parts/tools/back-up generators; and five obtained haemodialysis equipment, facilitating treatment for nearly 600 patients, all with ICRC support. The de facto health ministry had improved medical stock-management capacities following ICRC-backed warehouse renovations. Armed groups trained in first aid during Palestine Red Crescent/ICRC sessions. People affected by increased violence, including those weapon-wounded, received care at facilities under the West Bank health ministry and at one East Jerusalem hospital, which used ICRC-donated supplies.

Weapon-wounded Syrians evacuated to Israel received monitoring visits; hundreds benefited from clothes and medical supplies/equipment provided by the ICRC to the four hospitals treating them. Magen Adom David in Israel, with the health authorities, developed a training module on disaster response.

**Dialogue with key parties helps increase acceptance of IHL**

Dialogue/networking and events with/for Israeli and Palestinian authorities and weapon bearers, and parties influential over them, helped build acceptance of humanitarian principles/IHL, the goals of the Health Care in Danger project and the ICRC’s mandate/activities. The ICRC’s confidential/bilateral discussions with the Israeli Defense Forces (IDF), including senior officials/legal advisers, and with the Gaza Strip de facto authorities – supplemented by its reports – encompassed these parties’ 2014 conduct of hostilities, and encouraged IHL incorporation into their decision-making.

**Influential actors discuss the consequences of occupation policies**

Discussions with the Israeli civilian/military authorities and/or members of the international community, based on an ICRC report, explored ways to address restrictions affecting the Gaza Strip’s economy. Meetings with the authorities on Israel’s water-management policies in the West Bank drew from an ongoing ICRC study.

Interaction with Israeli and Palestinian civil society representatives, including diplomats, journalists and young people, took place through, for example, round-tables and briefings; they had access to multimedia resources in Arabic, English and Hebrew. Such fostered, in Israel, public discussions on the legality and humanitarian consequences of occupation policies on which the ICRC had not had significant dialogue with the authorities: settlements; the annexation of East Jerusalem; and the routing of the West Bank barrier.
IDF deliberates lessons from 2014 fighting

The opening/renewal of communication channels with the IDF helped enhance dialogue with various strategic/operational units. This notably facilitated discussions on lessons learnt from “Operation Protective Edge”, launched during the 2014 fighting – on hostilities in densely populated areas, for instance – and ICRC support for IHL-related initiatives.

Hundreds of IDF personnel, including border guards, attended IHL dissemination sessions. Officers of a unit coordinating civilian matters deepened their IHL knowledge during a training exercise, as did participants of a conference held by the IDF’s legal advisory body. At a workshop organized by a think-tank and the ICRC, local/international military/legal experts discussed ways to enhance the protection of civilians during armed conflict. Owing to logistical constraints, senior IDF officers did not join a workshop abroad.

Military judges enhanced their IHL proficiency during a seminar.

IDF divisions establishing a cyber command received IHL advice on cyber warfare.

Palestinian security services advance IHL integration

Some 550 Palestinian security officers in the West Bank and the Gaza Strip strengthened their grasp of IHL and internationally recognized standards for law enforcement, including the treatment of detainees, during ICRC-facilitated workshops. Armed groups furthered their understanding of humanitarian principles through dialogue/first-aid training.

Gaza Strip security personnel continued incorporating pertinent norms/standards into their training/operations through train-the-trainer courses and revisions to training manuals, in line with an extended agreement between the de facto interior ministry and the ICRC.

Given its accession to/ratification of international treaties, the PA sought ICRC advice on reviving the national IHL committee, inactive since 2009. PA representatives, alongside academics/specialists, attended courses abroad. Foreign-ministry officials joined the 32nd International Conference.

Civil society members bolster their IHL knowledge

Thirty Israelis and Palestinians, among them lawyers, completed an IHL course by a local NGO and the ICRC; it was filmed and posted online in Hebrew. About 200 Israeli university students joined IHL seminars; some participated in a conference, organized with a local university, and/or a moot court competition.

In the occupied Palestinian territory, eight law/sharia faculties continued teaching IHL; 1,700 students and professors exchanged views during round-tables. Several thousand academics/scholars and traditional/religious leaders considered the compatibility of Islamic law and IHL, at an international conference organized with a Gaza Strip university.

National Societies maintain support to the Health Care in Danger project

Magen David Adom and the Palestine Red Crescent strengthened their ability to help vulnerable people; technical/material/financial support from the ICRC and other Movement partners contributed to their safe conduct of activities. They continued supporting the Health Care Danger project.

Both National Societies assisted people in need, including those affected by increased violence. The Palestine Red Crescent’s adherence to the Fundamental Principles, notably impartiality, while responding to an incident in the Hebron area was underscored by ICRC public-communication efforts.
Based on lessons drawn from the 2014 hostilities, the Palestine Red Crescent developed coordination mechanisms for acute crises. It enhanced its capacities during disaster-response and human-remains-management workshops; those on needs-assessment were postponed.

Magen David Adom trained its staff/volunteers in the Safer Access Framework and first aid, and undertook contingency planning/simulation exercises with the authorities. Through a pilot project, it expanded/improved its communication/outreach. It established a logistics hub.

The ICRC sustained support for monitoring the implementation of the 2005 memorandum of understanding between the two National Societies. A 32nd International Conference resolution provided recommendations for advancing such implementation; the ICRC began working to fulfil its role in this regard. It facilitated coordination between Movement components, helping ensure a coherent response.

**EXAMPLE 5: SOUTH SUDAN**

Armed clashes and other situations of violence persisted throughout the year with varying intensity. Fighting continued even after the parties to the non-international armed conflict that began in December 2013 signed a peace agreement in August 2015. Ongoing political/administrative reforms contributed to communal tensions.

Indiscriminate attacks, destruction of property, sexual violence and other abuses were allegedly committed by weapon bearers on all sides. Tens of thousands of people were wounded/killed. As at December 2015, some 1.7 million people were reportedly displaced internally, and over 600,000 fled to neighbouring countries. Around 190,000 people stayed in camps and at “protection-of-civilians sites” of the UN Mission in South Sudan (UNMISS). Food shortages and inaccessibility of health care put people at risk of malnutrition and disease. Many households were unable to pursue their livelihoods.

Security and logistical constraints – including attacks on aid/medical workers and infrastructure – limited humanitarian agencies’ ability to assist vulnerable communities.

Tensions persisted between South Sudan and Sudan, notably in connection with the border region of Abyei.

**The government issues formal directives enjoining troops to comply with IHL**

Civilians reported instances of unlawful conduct by weapon bearers on all sides. Based on documented allegations, and on the observations of its staff, the ICRC reminded the parties to the conflict of their obligations under IHL and other relevant norms. Oral/written representations urged them to: respect and protect people not/no longer participating in the fighting; prevent sexual violence, recruitment of children into fighting forces and other abuses; facilitate access to essential services and humanitarian aid; and protect civilian infrastructure from looting/destruction. In response to concerns raised by the ICRC, the Ministry of Defence and Veterans Affairs and the Sudan People’s Liberation Army (SPLA) issued directives enjoining all troops to conduct their operations in compliance with IHL.

Several people were able to move to safer areas after the ICRC obtained security guarantees for them from the parties concerned.

**Vulnerable people supplement their diets with food rations**

Over 410,000 people (68,400 households) – mostly IDPs in Jonglei, Northern Bahr el Ghazal, Unity, Upper Nile and Western Equatoria – dealt with food shortages with the help of ICRC food rations. Among them, some 159,200 IDPs (26,500 households) in Leer county and the Waat locality in Nyirol
county received rations at lease thrice; plans to assist them every four to six weeks were disrupted by logistical/other constraints. Donations of food supplies helped farming households avoid having to consume seed meant for planting. Children and pregnant/lactating mothers avoided/recovered from malnutrition with the help of nutritional supplements. More beneficiaries than planned were reached, as the ICRC carried out more one-off food distributions.

Victims of sexual violence and other conflict-affected people receive health services

Five clinics in Jonglei and Upper Nile sustained their services with material/technical/financial support from the ICRC, provided per agreements with county health departments. On average, some 2,400 people benefited each week from medical consultations, immunization, obstetric care and other services provided by these clinics. Three other clinics received ad hoc support. Nearly 400 people who required further treatment were referred to suitable facilities.

Victims of sexual violence availed themselves of specialized services at the ICRC-supported clinics, including prophylactic treatment within 72 hours of the incident and psychosocial support; some were referred to other facilities when necessary. At courses/dissemination sessions, midwives showed traditional birth attendants how to assist victims of sexual violence, and clinic staff learnt more about the victims’ needs.

Practical measures mitigate the risk of attacks on patients and medical facilities

Local health workers and the ICRC took steps to ensure the safety of patients and medical personnel/facilities. Parties to the conflict were informed of the coordinates of medical facilities and requested to ensure their protection; large red cross emblems helped identify hospitals more clearly. Solar-powered lighting systems installed at two hospitals in Wau and one in Maiwut helped people to find these facilities more easily after dark, and staff members to identify visitors. ICRC-supported facilities enforced a strict “no-weapons” policy. First responders discussed these and other measures during briefings/training sessions conducted by the National Society/ICRC. Patients and their visitors learnt about ways for self-protection from posters distributed by the ICRC.

Casualties from all sides receive treatment

Wounded civilians and fighters received life-saving care from first responders trained by the National Society/ICRC. In some areas, first-aiders included weapon bearers trained and equipped by the ICRC. Over 540 people were evacuated to medical facilities – by air and other means – after the ICRC obtained security guarantees from the parties concerned.

Staff at 17 hospitals in both government- and opposition-controlled areas treated wounded/sick people with various forms of ICRC support. Two of the hospitals – one each in Kodok and Maiwut – strengthened their ability to provide surgical, obstetric, paediatric and other services with comprehensive ICRC support: supplies, staff supervision, training and on-site assistance from a surgical team assigned to each hospital. Infrastructure at both hospitals, and at two other facilities, was improved. Twelve other hospitals and clinics coped with supply shortages using ICRC-donated medical supplies.

Five ICRC surgical teams helped treat critically wounded/ill patients during the year: two worked at the hospitals in Kodok and Maiwut, one in a major hospital in Juba and two others in various locations, including areas where there were no other medical services. The fifth team was sent out in January, in response to the rising needs. In all, over 1,000 weapon-wounded people benefited from some 5,000 operations performed by these teams. A sixth team was assigned for three months to a hospital in Maridi, Western Equatoria, where it helped treat the causalities of an explosion of a fuel tanker in September.
Dialogue with all sides facilitates access to people in need

Interaction – through meetings, dissemination sessions and other means – with the authorities, weapon bearers and community/religious/civil society leaders helped foster acceptance for the Movement’s work, enabling National Society/ICRC teams to assist vulnerable people accessible to few/no other organizations. Dialogue with weapon bearers promoted compliance with IHL and facilitated medical evacuations.

Weapon bearers further their understanding of the basic principles of IHL

Some 2,300 weapon bearers on all sides learnt more about IHL and the ICRC through dissemination sessions that were often combined with first-aid training. These sessions emphasized compliance with IHL and the need to ensure safe access to medical care and to prevent sexual violence and the recruitment of children into fighting forces. Two SPLA officers attended an advanced IHL course in San Remo.

South Sudan acceded to the Convention on the Rights of the Child, and to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its Optional Protocol.

Meetings/discussions with UNMISS on issues of pressing humanitarian concern enabled the ICRC to organize assistance activities for people staying in UNMISS compounds. Interaction with members of the humanitarian and diplomatic communities helped further the ICRC’s understanding of people’s needs and of the various organizations’ capacities, which resulted in effective coordination.

 Violence-affected people share their concerns and learn more about ICRC activities

At around 1,000 information sessions conducted in connection with livestock vaccinations and food/seed distributions, some 60,000 beneficiaries shared their concerns and learnt how to make the best use of the aid provided to them. For example, families learnt how to prepare the nutritional supplements distributed by the ICRC.

The general public learnt more about the ICRC and the Movement through radio programmes, printed materials in local languages, interviews with ICRC officials and updates on online/social media platforms, and from over 140 information sessions that reached some 43,000 people. These and other public communication initiatives drew attention to various issues of humanitarian concern, such as sexual violence, the challenges faced by humanitarian organizations, and the violence affecting the provision of health care. The National Society backed these efforts and developed its communication capacities with ICRC support.

The National Society encourages community participation in assistance activities

The South Sudanese Red Cross remained the ICRC’s main partner in assisting conflict-affected people (see above). With financial/material/logistical/technical ICRC support, it strengthened its ability to: carry out humanitarian activities, such as responding to emergencies and restoring family links; and promote IHL and the Movement. It bolstered its first-aid capacities by training new instructors and, with support from the Norwegian Red Cross, conducting refresher courses for trainers.

The National Society played a key role in mobilizing community members to participate in resilience-building efforts; for example, ICRC-trained volunteers taught residents how to repair water pumps that were used by some 18,500 people on the outskirts of Juba. National Society volunteers helped in addressing the cholera outbreak in Juba; treating the casualties of an explosion on a fuel tanker in Western Equatoria; and managing human remains after a plane crash in November.

The National Society drew on ICRC expertise to strengthen its managerial capacities, and to develop and implement a plan of action for applying the Safer Access Framework, to ensure the safety of its personnel. Regularly held meetings among Movement partners in South Sudan ensured effective coordination of
activities. National Societies working in South Sudan contributed staff and other resources to support the activities of the ICRC, which, in turn, shared its expertise in assessment, communication, logistics and security management. Coordination with UN agencies and other humanitarian actors continued.

**EXAMPLE 6: SYRIAN ARAB REPUBLIC**

The armed conflict between government forces and numerous armed groups, which were also fighting among themselves, continued unabated across Syria. A US-led military coalition carried out air strikes against the Islamic State group; in September, the Russian Federation began separate air operations. Sustained fighting and the lack of dialogue between the opposing parties stymied efforts, such as UN-backed initiatives and UN Security Council resolutions, to find a political solution to the conflict and to facilitate the delivery of humanitarian aid.

Serious and repeated breaches of IHL exacerbated a situation that was already dire. An estimated 260,000 people had been killed, and over 1.5 million injured, since March 2011. Some 6.5 million people were displaced internally; over 4.5 million people lived in hard-to-reach locations. People in areas besieged by government forces or by armed groups suffered from these parties’ systematic denial of humanitarian access. As at December, UNHCR had registered nearly 4.6 million refugees from Syria.

The conflict, and the economic sanctions imposed by other countries, seriously affected Syria’s economy and public infrastructure/services. More and more people were driven into destitution by the widespread destruction, lack of jobs and progressive scarcity or costliness of food, water, health services and fuel.

**Impediments to principled humanitarian action remain**

The large number of actors involved in the conflict, limited recognition/acceptance of ICRC activities and politicization of humanitarian aid continued to challenge the security of field teams and hamper networking efforts. These factors, as well as government consent, largely determined the ICRC’s access to people in need. Syrian Arab Red Crescent/ICRC teams saw modest improvement in their proximity to beneficiaries: they were able to carry out more field visits and cross-line operations compared with previous years. The operational environment, however, remained extremely difficult and risky. Local ceasefires provided some relief to people in besieged/hard-to-reach areas, but these were often too fragile for principled humanitarian action to take place safely. Overall, fewer people than planned benefited from National Society/ICRC action.

**Some IDPs/residents receive basic health care from National Society facilities**

People in Aleppo, Deir Ez Zor, Hama, Homs, Idlib, Rural Damascus, Sweida and Tartus obtained curative/preventive health-care services, including for scabies, at facilities run by the National Society with ICRC financial/training/material support. These facilities included nine mobile health units and seven polyclinics.

Local authorities and health professionals worked to curb certain communicable diseases with ICRC support, which included medicines for treatment centres. At health ministry/ICRC workshops, 29 Syrian Arab Red Crescent doctors, and 2 from the Palestine Red Crescent, learnt more about preventing/treating leishmaniasis, enabling them to care for people without access to treatment facilities. People’s risk of contracting the disease was mitigated through donations of bed nets. Some 122,000 people benefited from lice-treatment supplies distributed by National Society/ICRC teams.
Parties to the conflict are urged to respect IHL

Given the developments in the situation and the gravity of their consequences for civilians, the ICRC pursued efforts to develop its limited dialogue with the parties to the conflict. Through bilateral meetings, confidential reports and public statements, it emphasized all parties’ obligations under IHL and other applicable norms to: spare people not/no longer participating in hostilities and protect them from abuse; respect the prohibition against indiscriminate attacks; avoid using explosive weapons in densely populated areas; protect civilian objects; ensure safe access to essential goods/services and aid; respect wounded fighters’ right to health care; and respect/protect medical/humanitarian workers and persons/objects lawfully displaying the red cross/red crescent emblems. ICRC representations were based on documented allegations and on first-hand observations; for the first time since March 2011, the ICRC gained direct access to some areas besieged by government forces, enabling it to assess the protection-related needs of people there.

Disregard for the safety of medical services persists

Attacks on patients and health workers/facilities continued to be rampant. Between March 2011 and August 2015, 50 staff members/volunteers from the Syrian Arab Red Crescent and 8 from the Palestine Red Crescent had been killed while carrying out their duties. The case of three ICRC staff kidnapped in 2013 remained unresolved. These abuses against medical workers/facilities and other violations (e.g. targeted obstructions) were monitored and documented, in line with the Health Care in Danger project. On this basis, all parties concerned were reminded – through bilateral dialogue, reports and public statements – of the protection afforded by IHL and other applicable norms to wounded/sick people and medical workers/facilities, regardless of their affiliations.

Despite some deliveries, people continue to suffer from restrictions on impartial medical assistance

Health needs continued to outstrip available services, especially in besieged locations and in areas controlled by armed groups. Opportunities for delivering medical supplies/equipment, especially surgical materials, to these areas remained limited. For instance, ICRC deliveries across front lines were rarely permitted and, if allowed, it was in small quantities only. In October, people in four besieged areas received medical supplies from the ICRC; hundreds of wounded people from these areas were evacuated in December through the coordinated efforts of the Syrian Arab Red Crescent, the UN and the ICRC.

Several hospitals sustained their services with ad hoc ICRC support. Three hospitals each in Aleppo and Deir Ez-Zor received medicines, obstetric kits and other supplies; residents/IDPs in parts of Rural Damascus controlled by armed groups benefited from similar supplies. A hospital in Hassakeh and two in Tartus received surgical sets.

Ten facilities received supplies for 7,450 haemodialysis sessions; some of them had clean water following ICRC-backed infrastructure improvements. Fifteen hospitals/clinics in Aleppo, Homs, Damascus and Hama – including two Palestine Red Crescent hospitals – continued to function despite power shortages, thanks to generators from the ICRC. Five hospitals in Aleppo received material/maintenance support for their biomedical equipment.

Two clinics in Barzeh and Midan were renovated, thereby helping to increase the number of functional facilities in Rural Damascus.

Over 570 Syrian Arab Red Crescent staff/volunteers honed their first-aid skills at ICRC-supported courses; they also received supplies and uniforms. Twenty-six health professionals learnt more about pre-hospital care at a seminar abroad, and 39 surgeons added to their knowledge of weapon-wound management at a seminar in Damascus.
Developing IHL-focused dialogue with parties to the conflict remains a challenge
Contact and coordination with the Syrian authorities at central and local levels, and with community leaders and armed groups, helped facilitate Syrian Arab Red Crescent/ICRC activities, but impediments to impartial humanitarian action remained.
Meetings with Syrian government officials emphasized the right, under IHL/other applicable norms, of all wounded people to receive medical treatment and of civilians to receive humanitarian assistance. Based on a 2014 agreement, the Syrian government reactivated the national IHL committee and, with ICRC guidance, appointed members from pertinent ministries. However, broader and systematic dialogue on protection issues was not established, and direct contact with the armed/security forces remained minimal.
Interaction, in Syria and abroad, with representatives of some armed groups helped familiarize them with IHL, humanitarian principles, the ICRC’s exclusively humanitarian mission and the Movement’s activities.

Various audiences learn more about principled humanitarian action and the ICRC
Public communication efforts sought to enlist support for ICRC field operations from civil society members and the wider public, including among people who had direct influence on the parties to the conflict. People in Syria and abroad kept abreast of developments in the country through ICRC operational updates, multimedia releases, interviews and opinion pieces. These drew attention to the adverse consequences of the conflict, the ICRC’s neutral, impartial and independent humanitarian action and its position on such issues as the protection of medical services and the use of water as a means/method of warfare.
Videos and other material disseminated on ICRC social networking platforms highlighted key provisions of IHL and the activities of the National Society/ICRC. Interaction with members of local/international media, regardless of their affiliation in relation to the conflict, continued. Thirty-five Syrian media professionals learnt more about IHL and the ICRC during workshops co-organized with the information ministry.
Meetings with academic circles were pursued, with a view to stimulating interest in IHL instruction. Two academics attended an advanced IHL course, and 70 instructors from a government training institute improved their understanding of IHL and the ICRC at a seminar. Students from a Damascus university benefited from ICRC-supported courses/dissemination sessions; several universities in Aleppo received reference materials.

The National Society helps address humanitarian needs
The Syrian Arab Red Crescent responded to humanitarian needs with extensive financial/material/technical support from the ICRC, provided within the framework of a 2014–16 agreement. This support helped cover operating/administrative costs at the National Society’s headquarters, 12 branches, 11 response centres and first-aid posts.
The National Society strengthened its internal/external communication capacities and its risk-management measures, to improve the safety of its staff in the field. It upgraded its radio communication system with ICRC-provided training/equipment. Its drivers learnt more about the risks associated with weapon contamination at ICRC-organized information sessions. Donations of vehicles helped bolster its logistical capacities.
During training courses conducted under an ICRC-supported pilot project, 20 volunteers from four branches learnt how to provide psychological support to their peers.
The National Society also took steps to raise awareness of IHL among its staff/volunteers, notably by establishing a specific unit for this purpose.

Coordination with the Palestine Red Crescent Society continued, including by providing equipment/furniture for its offices.

Movement components coordinated their activities, capitalizing on their complementary approaches and thereby increasing the impact of the Movement’s response.
FINANCIAL OVERVIEW

SUMMARY

The ICRC Special Appeal Health Care in Danger 2015 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 2,748 out of a total expenditure of KCHF 99,911. 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 2015. 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 2015 amounted to KCHF 99,911. Given the zero balance brought forward from 2014, the balance at the end of 2015 is also zero.

<table>
<thead>
<tr>
<th>HEALTH CARE IN DANGER: ICRC PROJECT BUDGET</th>
<th>BUDGET</th>
<th>EXPENDITURE</th>
<th>CONTRIBUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROJECT TEAM AND SUPPORT</td>
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<td>2,108</td>
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<tr>
<td>FUNDED OUT OF CONTRIBUTIONS TO THE HEADQUARTERS APPEAL 2015</td>
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<td>2,106</td>
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<tr>
<td>AFGHANISTAN</td>
<td>20,653</td>
<td>20,261</td>
<td>966</td>
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<tr>
<td>CENTRAL AFRICAN REPUBLIC</td>
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<td>10,415</td>
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<tr>
<td>COLOMBIA</td>
<td>4,641</td>
<td>4,120</td>
<td>124</td>
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<td>ISRAEL AND THE OCCUPIED TERRITORIES</td>
<td>16,025</td>
<td>17,146</td>
<td>802</td>
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<td>SOUTH SUDAN</td>
<td>31,987</td>
<td>31,664</td>
<td>112</td>
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<tr>
<td>SYRIAN ARAB REPUBLIC</td>
<td>22,066</td>
<td>14,197</td>
<td>742</td>
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<td>FUNDED OUT OF CONTRIBUTIONS TO THE EMERGENCY APPEALS 2015</td>
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<td></td>
<td>95,058</td>
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<tr>
<td>TOTAL</td>
<td>110,581</td>
<td>99,911</td>
<td>99,911</td>
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</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, 2015* 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

### List of Contributions Pledged and Received

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<tr>
<th>Governments</th>
<th>Amount in KCHF</th>
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<tr>
<td>BELGIUM</td>
<td>802,275</td>
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<td>LIECHTENSTEIN</td>
<td>100,000</td>
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<tr>
<td>NEW ZEALAND</td>
<td>741,500</td>
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<td>NORWAY</td>
<td>135,628</td>
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<tr>
<td>UNITED STATES OF AMERICA</td>
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<td><strong>SUB-TOTAL: GOVERNMENTS</strong></td>
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<table>
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<tr>
<th>Private Sources</th>
<th>Amount in KCHF</th>
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<tr>
<td>SPONTANEOUS DONATIONS FROM PRIVATE INDIVIDUALS</td>
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<tr>
<td><strong>SUB-TOTAL: PRIVATE SOURCES</strong></td>
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<table>
<thead>
<tr>
<th><strong>Sub-total: Contributions to the Health Care in Danger Appeal</strong></th>
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<tr>
<td>FUNDED OUT OF CONTRIBUTIONS TO THE HEADQUARTERS APPEAL 2015</td>
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<td>FUNDED OUT OF CONTRIBUTIONS TO THE EMERGENCY APPEALS 2015</td>
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<td><strong>Total Receipts for 2015 as at 31.12.2015</strong></td>
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<td>NO BALANCE BROUGHT FORWARD</td>
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<td><strong>Grand Total</strong></td>
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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>AFFECTING</th>
<th>ATTACKS</th>
<th>ILLEGAL OBSTRUCTION</th>
<th>DISCRIMINATION</th>
<th>ARMED ENTRY</th>
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<tr>
<td>HEALTH PERSONNEL</td>
<td>WOUNDED AND SICK</td>
<td>HEALTH STRUCTURES</td>
<td>MEDICAL TRANSPORT</td>
<td></td>
</tr>
</tbody>
</table>

**Nov. 2011**

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

**2012 to 2014**

- Experts Workshops x 10
  - Military operational practice that ensures safe access to and delivery of health care (2013: Sydney)
  - National Societies’ response to Health Care in Danger (2012: Oslo 2013: Tehran)
  - Responsibilities and rights of health care personnel (2012: Cairo and London)
  - Civil society: mobilizing opinion leaders (2013: Dakar)
  - Ambulance and pre-hospital care in risk situations (2013: Mexico)
  - Domestic normative frameworks for protecting the delivery of health care (2014: Brussels)
  - The safety of health structures (2x) (2013: Ottawa 2014: Pretoria)

**2013**

- 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

**2014**

- Participation in bilateral and multilateral consultations in existing regional and global fora
- Promotion of recommendations

**2015**

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

**2016 to 2017**

- 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.

MISSION
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