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House Foreign Affairs Committee
Tom Lantos Human Rights Commission

Hearing
on
Protecting Health Care During Armed Conflict

October 30, 2019 – 10:00 a.m.
Room 2200, Rayburn House Office Building
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Good morning and thank you to Chairman McGovern, Chairman Smith and the Tom Lantos Human Rights Commission for the privilege of testifying before you today on behalf of the American Red Cross. We applaud the Commission for holding this hearing and for your interest in the topic of protection of health care workers and facilities in armed conflicts.

It is the mission of the International Humanitarian Law (IHL) team at the American Red Cross to inform members of the American public about IHL so that they are informed of the rules of war and are equipped with an analytical framework with which to evaluate events in armed conflicts around the world. Forums, such as this one, allow us to do that.

I want to begin my comments today by commending the United States (U.S.) government for its work and leadership in IHL and more specifically in the area of protecting health care workers and facilities in armed conflicts. While no nation is perfect in this area, the U.S. is recognized as a leader in IHL, setting an example that is emulated around the world.

During the U.S. Civil War in May 1862, just a few hours west of here in Winchester, Virginia, seven Union military doctors were captured by Confederate forces. Recognizing that it helped no one to hold doctors as prisoners of war, the senior Confederate medical officer negotiated an agreement with the Union doctors to not only release them, but also agreeing to work towards the release of all medical officers, from both the North and South. In April of the next year, General Order 100 was issued by President Lincoln to Union forces.

The Lieber Code, as this order came to be known, contained two articles that specifically related to the treatment of medical personnel and wounded soldiers. These articles form the basis of the rules that are still found in IHL today – that medical workers are not combatants and that they should treat all those in need with impartiality. Over time, these concepts have grown into broader protections for medical assets and extend well beyond protecting just military medical personnel. IHL now protects both military and civilian health care assets.

In today's conflicts, most of the casualties are civilians. Even if civilians are not deliberately targeted, they may be unintentionally injured in an attack. When they are wounded, they often have less access to medical treatment than soldiers. Movement by civilians in conflict zones, already dangerous, can be even more deadly as they move through checkpoints to seek medical care.

I am a 30-year veteran of the U.S. Army, serving early in my career in the infantry and the later part as a Judge Advocate. During my time in uniform, I deployed to combat zones four times. I am proud of the U.S. military's efforts in protecting medical assets, however, I know that there is more that can be done. Measures that will not only improve how the U.S. military operates but will serve as a catalyst for change in militaries around the world.

First, our military should develop specific doctrine and training on how to expedite medical evacuations through checkpoints. In military operations, measures to deny the enemy freedom of movement are critical. Though critical, these measures can frustrate those in need of medical care. At best, checkpoints impede traffic and delay care. At worst, vehicles rushing someone to medical care may be mistaken for a threat and fired upon by soldiers. Complicating the issue is that in many countries, medical transportation doesn't look like it does in the U.S. In many parts of the world people are routinely transported to hospitals by private vehicle.

I personally witnessed how coordination with local officials and aid workers, followed by training of security forces, can make a difference. For example, in southern Afghanistan, the International Committee of the Red Cross (ICRC) established a medical evacuation system for the sick and wounded. When a person needed emergency medical transportation, someone would call the ICRC and they would dispatch a local taxi driver to pick up the person and bring them to the hospital in Kandahar. In Afghanistan, a taxi isn't a yellow car with a sign on top, it is someone who drives his personal car. With the taxi being just a man in a car with a wounded person in the backseat, it was common for these drivers to be detained for interrogation at the checkpoints resulting in delayed medical treatment and sometimes death. After coordinating this system with US and local forces, an agreement was reached where the ICRC provide identification cards to these drivers. The soldiers were then trained that once a driver was identified as a medical driver, they should allow his vehicle to pass without a lengthy interrogation. While this is a success story, it is an ad hoc solution in one country. We need to build on this success by writing into Department of Defense doctrine the ability to apply other similarly flexible solutions to ensure people can reach medical care.

Second, US military leadership needs to raise awareness within our armed forces of respect for local medical personnel and facilities. Civilian medical personnel and facilities may often not display the protective emblems of the Red Cross, Red Crescent or Red Crystal. Failure to display these emblems does not deny them protection. Under IHL, it is still incumbent upon the fighters to respect and protect all medical personnel and facilities. And not just to protect them from deliberate attack, but also to protect their freedom to do their work. This means the ability to

freely travel and conduct medical operations around the area of operation and to bring in medical supplies.

Finally, as a nation, we must be cautious that we do not allow domestic law to have the unintended effect of criminalizing humanitarian aid work. Laws that broadly criminalize "aid to the enemy," may have a definition of "aid" so broad as to potentially criminalize providing medical aid to sick and wounded enemy fighters or the training of people to administer medical treatment to them. In this regard, it was encouraging to see that in March of this year the U.N. Security Council included in its unanimous resolution, on "Countering the Financing of Terrorism", language requiring States to consider the potential effects these new laws may have on exclusively humanitarian activities, including medical activities, that are carried out in a manner consistent with IHL. We encourage any new U.S. legislation to also be reviewed to ensure that it does not inadvertently criminalize humanitarian aid.

The overarching principle of International Humanitarian Law is to spare civilians, as much as possible, the suffering of war. Protecting and respecting health care workers and facilities goes directly to the heart of this principle. Doing so meets our treaty obligations under the Geneva Conventions, but perhaps even more important, it reflects who we are as Americans. Thank you.