



ICRC

**HEALTH CARE IN DANGER** **IT'S A MATTER OF LIFE & DEATH**

Statement by the International Committee of the Red Cross (ICRC)  
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Thank you, Chairman McGovern and Chairman Smith, for holding this hearing on the protection of health care in armed conflict, and for the invitation to offer the perspective of the International Committee of the Red Cross (ICRC). It is an honor to be here.

The ICRC is a global humanitarian organization composed of 18,000 staff working in more than 90 countries. We operate in a neutral, impartial and independent manner, working for the sole benefit of the most vulnerable people caught up in situations of armed conflict and other situations of violence. Our mandate is derived from International Humanitarian Law (IHL), a body of rules that are largely codified in the Geneva Conventions of 1949.

As guardians of the Geneva Conventions, we advocate for the protection of those who do not take part in the fighting. At the same time, we remain staunchly pragmatic in our ways, recognizing that death and destruction is an inevitable part of war. We seek to minimize suffering by engaging armed actors directly on their behavior on the battlefield, and by remaining close to the people we serve. Proximity and dialogue require access, acceptance and security for our staff, all of which is a daily challenge for a 'frontline organization'. The US Government, including Congress, has been a steady supporter of our work, and I seize this opportunity to express our appreciation for this support.

When it comes to the protection of hospitals, medical personnel and ambulances, the ICRC has taken an unusually assertive and visible stance. The problem is rampant; it is multi-faceted; and it is in many ways personal. Attacks against health personnel and facilities are the antithesis of humanitarian action. Not only are they an affront to the basic notion that the wounded and sick must be cared for in war, they have long term consequences and ramifications that are equally if not more serious.

This was acknowledged by the international community in 2016 when the United Nations Security Council adopted Resolution 2286, the Council's first ever resolution on the protection of health care in armed conflict. The community of actors this panel represents has been working hard to turn the political will reflected in this resolution into concrete action.

In what follows, I would like to share some thoughts on the problem as we see it, tell you what we have been doing about it and offer some recommendations on what more can be done.

## **Here's what we know about the problem today**

**It is global in nature.** Attacks against health care workers and facilities are happening in most crisis situations in the world, be it in countries that are at war or in countries that are deemed to be at peace. First responders around the globe experience violence. While the focus of today's hearing is on what happens in war, we feel that it is important to broaden out the lens, so that policy makers and the public at large are able to connect with what is happening in countries that are geographically far away, and to see the parallels with some of the painful experiences and unacceptable situations that are taking place closer to home.

**It has different causes.** Attacks on health care may be part of a deliberate strategy to target civilians, it may be the result of ignorance or negligence, or it may happen because there is no more trust in the enemy's use of medical premises and staff. Indeed, parties to conflict continue to misuse medical facilities and vehicles by employing them for military purposes. In some places, health care workers themselves are being co-opted by political and military strategies, or are simply following their own deeply held views, when they deny care, for unlawful reasons, to wounded and sick people. Different causes require different responses.

**It manifests in multiple ways and its effects are far reaching.** In many countries, large swathes of land or portions of cities remain off-limits to national health workers and international humanitarian workers. Blockades, sanctions, and invisible borders established by States, non-State armed groups and other actors in communities prevent the movement of health staff, medical supplies and patients. All this results in the suspension of preventive and curative health programs and has disastrous consequences for the population for whom these programs are intended – and it also often reverses decades of development work or impedes the containment of epidemics.

**It is not new but it is not getting better.** Protecting hospitals, health personnel and humanitarian workers in times of war has always been a challenge. There has never been a golden age of respect for the rules of war. What is new is the increasing number of actors on the battlefield, many of whom do not feel bound by the rules of war. What is new is the notion that certain armed groups are not worthy of the protection that the law bestows on parties to an armed conflict because of their extremist views and actions. What is new is the extent of the problem and of what is at stake if we do not manage to curb the violence epidemic that plagues health services in armed conflict today.

## **Here's what we are doing about it**

These high stakes explain why the phenomenon has become an issue of global concern. In 2011, the ICRC launched the Health Care in Danger initiative<sup>1</sup>, together with our Red Cross and Red Crescent partners. The starting point was a 16-country study that highlighted the multi-faceted nature of the violence and the need for a collective response. The end goal was to prevent this violence by formulating practical recommendations for making the delivery of health care safer in times of armed conflict and emergencies. The end goal was a world where “my enemy's doctor is not my enemy”.

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<sup>1</sup> See the Health Care in Danger (HCID) website for more details: <http://healthcareindanger.org/hcid-project/>

Since the initiative was launched, we have published a number of research papers containing more than 100 evidence-based recommendations addressed to militaries, armed groups, health care providers, first responders as well as law and policymakers.<sup>2</sup> These recommendations cover a very broad range of topics, starting with how to go about understanding the problem in any given space to how to assess the risk exposure, security and preparedness level of a health facility operating in a war zone. They are concrete and actionable, and we are seeing results. I would like to share a couple success stories with you today.

In South Sudan, a country that has seen very high levels of violence against humanitarians and healthcare providers, ICRC colleagues have worked with more than a dozen health structures to “harden” their passive security measures, providing them lights, “no weapons” signs, training for guards, and other materials to secure these facilities. While attacks on health care and the broader civilian population still occur too frequently in South Sudan, we have seen a considerable decline in security incidents affecting the facilities that we have worked with. Just this month, the Ministry of Health approved a national “No Weapons Policy” that prohibits weapons in all health facilities in South Sudan.

In Karachi, Pakistan’s largest city of 20 million, we found that 2/3 of healthcare workers had experienced violence of one form or another, and that ambulances were rarely given the right of way. There appeared to be a general lack of trust in and respect for health services. We worked to understand the reasons that led to the negative perceptions and we discovered that many violent incidents in the wards began with verbal altercations. So we developed training material for hospital staff on communication techniques in high stress environments. In parallel, we worked with local lawmakers to address gaps in the law protecting healthcare workers and we launched a media campaign to draw attention on giving way to ambulances. Following this project, we observed a 16% improvement in motorists’ behavior towards ambulances. The Karachi example demonstrates the multifaceted nature of the problem of violence against healthcare, and the importance of investing in understanding root causes.<sup>3</sup>

Before turning to our recommendations to the US Government, we would like to acknowledge that political will translated into military guidance is a key ingredient for the long-term success of any strategy that aims at changing behavior and culture in war. A case in point of this is the Tactical Directive on Medical Facilities adopted by US-led Coalition in Afghanistan in 2011, under the leadership of General Allen. This Directive codified the Commander’s intent to accord the fullest protection possible to Afghan medical facilities and was deemed to positively influence the behavior of international forces on the ground.

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<sup>2</sup> All of these reports are available here: <http://healthcareindanger.org/resource-centre/>

<sup>3</sup> For more details, see “A Matter of Life and Death: Tackling Violence Against Health Care in Pakistan, Peru and El Salvador,” ICRC Report, 2017, available at: [http://healthcareindanger.org/wp-content/uploads/2017/12/4330\\_002\\_HCiD\\_Selected\\_Experiences\\_pakistan-peru-el-salvador-12-2017-.pdf](http://healthcareindanger.org/wp-content/uploads/2017/12/4330_002_HCiD_Selected_Experiences_pakistan-peru-el-salvador-12-2017-.pdf)

## Here's what you can do

Chairman McGovern, Chairman Smith, here are some of the actions that we are recommending you take to improve the protection of medical care in situations of armed conflict and emergencies:

1. **Keep Promoting Respect for IHL.** The rules established in the Geneva Convention of 1949 and the Additional Protocols of 1977 protecting health care in armed conflict are extremely robust. There is little ambiguity around these rules. Every state has signed up to the Geneva Conventions, and thus these rules are binding on every state in the world. Earlier this year, in May, the US Senate Committee on Foreign Relations adopted a resolution reaffirming the US Government's commitment to international humanitarian law on the occasion of the 70<sup>th</sup> anniversary of the Geneva Conventions.<sup>4</sup> Initiatives like these are critical to keep the commitment to IHL effective and alive. We understand that Chairman McGovern as well as Members on the House Foreign Affairs Committee are working on pieces of legislation concerning the protection of health care and respect for IHL. We applaud that and stand ready to offer advice.
2. **Include Protection of Health Care in US Military CIVCAS Policy.** US military doctrine, procedures and practice must emphasize the protection of medical care. Our research suggests more guidance could be developed in this area, which is a message that we are delivering to the Department of Defense.<sup>5</sup> As you may know, the DoD is working on a civilian casualty mitigation instruction, and we believe this is a great opportunity to reaffirm and highlight the protection of medical care.
3. **Include Protection of Health Care in Security Cooperation Arrangements.** Security Cooperation Agreements provide an opportunity for the US to incentivize its partners to better respect international humanitarian law. There are a myriad of ways that partner military forces can be engaged on this issue, from promoting good military practices relevant to the protection of health care with partners, to expanding operational training on the same in US train, advise and assist programs.
4. **Invest in Reliable, Systematic Data Collection and Research.** Initiatives aimed at documenting, researching and quantifying the amount of violence against health care are growing in number. They have not yet achieved their goals of establishing reliable local baselines of violence and quantifying impact. There has been significant attention on the devastating attacks in Syria and Yemen, for good reason. Yet, attacks go undocumented and monitored in other places, and therefore unnoticed by decision-makers. We need a better understanding of why attacks on health care

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<sup>4</sup> "S.Res.206 - A resolution marking the 70th anniversary of the four Geneva Conventions of 1949...", Available here: <https://www.congress.gov/bill/116th-congress/senate-resolution/206/text>

<sup>5</sup> Our recommendations to the US military are based on the key issues and practical recommendations in a 2015 ICRC report, entitled "Promoting Military Operational Practice that Ensures Safe Access to and Delivery of Health Care." The ICRC would encourage every military to ensure that the practical measures identified in this report are integrated into their doctrine, guidance and training. <http://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4208-promoting-military-op-practice-ensures-safe-access-health-care.pdf>

occur and where, and we need to find a way to measure the knock-on effects of this type of violence.

5. **Ensure that US Counter-Terrorism Laws do not Criminalize the Provision of Health Care.** According to international humanitarian law, medical activities, including those in favor of wounded and sick fighters, must never be considered as a form of unlawful support to non-State actors or individuals designated as terrorists so long as the activities are compatible with medical ethics, and parties to a conflict must allow and facilitate the rapid and unimpeded passage of humanitarian relief for civilians in need. We urge the US government to ensure that its counterterrorism laws and policies provide “humanitarian exemptions” for medical and humanitarian activities.

## **Conclusion**

To reverse this trend, we need to keep working together to narrow the gap between the rules on the books and the behavior we observe on the battlefield. We need to push back on a ‘new normal’ that accepts attacks against health care as just another reality of war. Hearings such as these are a step in the right direction. Thank You.