

A Guidance Document for Medical Teams  
Responding to Health Emergencies in   
Armed Conflict & Insecure Environments

Under review and edit

Draft 2.3 – Sept 9 2019

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# Acknowledgments

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This joint endeavour is supported by xx.

The content draws and builds upon the experience and knowledge of hundreds of contributing groups, individuals, organizations, academics, governments, NGOs/Civil Society Organizations, and militaries. During the year of development, the work was led by WHO EMT Secretariat, with the support of ICRC, MSF, DG ECHO, US OFDA, UN agencies, governments, and many NGOs.

Using an iterative drafting process (adapted Delphi method[[1]](#footnote-1)), the co-authors working as *A Peer Review and Drafting Group*, organized workshops, events, peer-to-peer exchanges, literature searches, interviews, and over 300 consultations. The document summarizes the most relevant topics on issues identified by practitioners.

The linked Toolkit provides xx hundred references and expanded guidance.

Co-Authors

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# Abbreviations

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# Structure of the Red Book

*Note: Chapters begins with a list of objectives and conclude with summarized guidance notes.*

|  |  |
| --- | --- |
| **Introduction:**  **What is the Red Book?**  **How to Use the Red Book?** | * Medical Teams and Types Defined * The What, Why, When, Who, Where, When & How? * Guiding Principles for Blue & Red Books * Limitations * Future Scenarios and Challenges |
| **Chapter 1:**  **IHL and Core Humanitarian Principles in Action** | * Do No Harm! & The Humanitarian Imperative * IHL and Core Humanitarian Principles defined and Practical applications * The Realities: Consequences and Implications * Scenario * Negotiations * Community Engagement |
| **Chapter 2:**  **Guidance on Safety and Security Risk Management** | * Hazard and Threat identification * Security Plans for Teams and Patients, * Team Mental Health and Well-being * Medical Evacuation * CBRNE Considerations |
| **Chapter 3:**  **Guidance on Coordination** | * Coordination Principles and Considerations * Types of Teams * Types of Coordination Platforms and Modalities: Clusters, EMT CC, UN Civ-Mil, Movement, and other. |
| **Chapter 4:**  **Guidance on Gender Based Violence** | * Guidance on GBV and Protection * Clinical, safety, protection, and advocacy requirements * Self-care * Media approaches |
| **Chapter 5:**  **Core Technical Standards for Essential Emergency Clinical Care & Rehabilitation** | * Essential Emergency Clinical & Pre-Hospital care (including outbreak) * Rehabilitation |
| **Chapter 6:**  **Selected Topics in Operations: Logistics and Information Management** | * Logistics Information management and Min Data Set (MDS) * Information management and MDS |
| **Chapter 7:**  **Guide to The Toolkit** | * The Details on the "How?" |
| **Annexes & References** | * Readiness for Deployment Checklist for Armed Conflict * Summary Guide to Deployment * References * Contributors |

Table 1 Structure of the Red Book

# Important Note on The Blue Book & Red Book

Under review and edit

The Blue book[[2]](#footnote-2), initially published under the name: 'Classification and Minimum Standards for Foreign Medical Teams (FMT) in Sudden Onset Disasters', has been updated as the main reference document for ‘Emergency Medical Teams’ (EMT) *inclusive of national and international teams* in situations of disasters and outbreak response. The Blue Book provides technical standards for natural disasters and emergencies[[3]](#footnote-3). The Current process for classification and validation has four main types of Medical Teams (Type 1 mobile, Type 1 fixed, Type 2, Type 3), and over 20 specialist teams. The Red Book introduces additional requirements for all teams when responding to health emergencies in armed conflict and insecure environments. With both technical speciation for example for Type 1 teams regarding Trauma Stabilization capacities (see page xx) and in the specificities of different coordination mechanisms see page xx. The two texts should be seen as part of a continuum, with general medical response captured in the Blue Book and the additional specifics of response in armed conflict and insecure environments captured in the Red Book.

|  |
| --- |
| EMTs[[4]](#footnote-4) are defined as groups of health professionals (doctors, nurses, paramedics, support, logistics, etc.) that treat patients affected by an emergency or disaster. They come from governments, charities (NGOs), militaries and international organizations such as the International Red Cross/Red Crescent movement. They work to comply with the classification and minimum standards agreed by the EMT community and partners, and come trained and self-sufficient so as not to burden a national system.  The guidance provided by the Red Book is intended for medical teams who deploy into armed conflict and insecure environments, and *therefore the technical content is appropriate to classified EMTs and medical teams* |

|  |
| --- |
| How to Use the Red Book?  The Red Book provides expanded guidance on:  1. IHL & Core Humanitarian Principles in Action,  2. Safety & Security,  3. Coordination Platforms,  4. Gender Based Violence,  5. Essential Emergency Clinical Care & Rehabilitation  6. Selected Topics in Operations & Logistics    The two documents are designed to be used concurrently by EMTs responding to health emergencies in armed conflict and insecure environments. The classification criteria & processes of the Blue Book are retained and expanded with additional requirements for Red Book contexts (see Annex 1). Chapters are not standalone and need to be read as inter-connected and complementary.  The Red Book is designed to be used alongside and companion to the Blue Book, the Toolkit, and provide practical guidance, advice, and recommendations. Teams and leaders’ actions are required at all times to ensure safety and security for Self, Site, and Survivor (3 S’s). Taking undue risks in war that result in death or injury for team members will not only deny the wounded and sick the medical care they need, but likely result in other teams withdrawn thus severely limiting the entire operation. Positive or negative actions by one team can have repercussions for other teams and/or an entire operation. |

## Why, What, Where, Who, When, and How?

The Red Book extracts, references and summarizes the most relevant sections from existing guidelines, manuals, and recommendations published by medical and humanitarian authorities from around the globe including the WHO, other UN agencies/bodies [[5]](#footnote-5), MSF, ICRC, NGOs[[6]](#footnote-6), agencies/organizations, and Sphere standards. These references, while not exhaustive, will help guide medical teams to make principled patient-focused humanitarian decisions. Most have been cited and posted to the online Toolkit.

### Why?

Medical care for people caught up in conflict saves lives and alleviates suffering. It is one of the most direct needs of an affected population, and is often viewed as a test case for other forms of intervention to serve populations in need. Medical teams working in armed conflict and insecure environments frequently face serious security and safety issues, challenges in access to patients, and possibly limited acceptance by communities and the warring parties to a conflict. Future scenarios anticipate more challenges[[7]](#footnote-7), and therefore a critical need exists to establish contact and a level of trust with all sides to armed conflict and situations of violence. This trust can be achieved if all sides perceive the medical teams as neutral, impartial, and independent; and specifically, not aiding any one party (or appearing to aid) to achieve a military, political or economic advantage. For medical teams that are deploying increasingly closer to the frontlines; the implications and consequences of not being fully prepared and not comprehending context can be severe for staff and patients if these types of operations are hindered or compromised through intentional or unintentional acts and conduct by the teams themselves or the warring parties.

Underpinned by the humanitarian imperative to act, and not delay the provision of medical care, the Red Book offers an important framework to guide and enhance team safety, while diplomatic efforts aimed at finding durable long-term peaceful solutions are pursued by the UN, nations and parties to the conflict.

### What?

The document details a principled and evidence-based practical framework to facilitate safety, access, and acceptance for medical teams in providing quality clinical care, while ensuring respect of core humanitarian principles, and International Humanitarian Law (IHL)[[8]](#footnote-8), as well as ethical conduct within the 'humanitarian space'[[9]](#footnote-9) thus enhancing the safety of teams and the protection of patients.

The document includes practical guidance on key thematic areas with the view that principled and secure medical care in armed conflict requires a holistic 360-degree awareness of an entire operation (not simply within the perimeter of a field hospital or a medical facility). The Red Book includes questions and checklists to aid teams in better preparations and operation in contexts affected by armed conflict, insecurity, and violence.

The patient-focused clinical care chapters include an emphasis on a spectrum of injuries and diseases including trauma care, non-trauma care, infectious disease management, support to outbreak response, burns management, emergency maternal and pediatric care, rehabilitation, and gender-based violence (GBV).

### Where?

Regardless of the legal classification used to define a context or conflict, the impact on patients, facilities, and medical teams has many common aspects and therefore requires the adherence to the precautions and the actions recommended.

“In order for IHL to apply to a situation of violence, that situation must constitute an [armed conflict](https://casebook.icrc.org/glossary/armed-conflict). As different sets of rules apply to international and non-international armed conflicts, it is also important to identify the nature of the conflict. The entirety of the four Geneva Conventions, as well as the rules of Additional Protocol I apply to [international armed conflicts](https://casebook.icrc.org/glossary/international-armed-conflict), while Article 3 Common to the four Geneva Conventions and Additional Protocol II apply to [non-international armed conflicts](https://casebook.icrc.org/glossary/non-international-armed-conflict)” [[10]](#footnote-10)

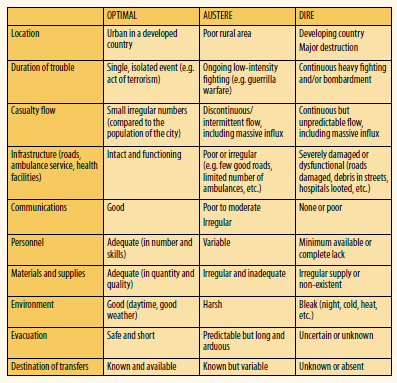
The core standards and guidance are global and applicable to apply to EMTs responding to health emergencies occurring in contexts affected by armed conflict and/or insecurity.

Figure 1: Humanitarian intervention for the wounded and sick, ICRC War Surgery Vol 1, p 148

### Who?

EMTs and a variety of medical teams can benefit from the technical standards and guidance provided in the Blue and Red Books**.** Classified National and International Emergency Medical Teams (EMT), governmental, NGO, private, or military actors, in situations of armed conflict and insecure environments can make use of this document *before, during, and after deployments*. This can also be of use for both state and non-state actors in contexts of armed conflict.

According to the ICRC, the definition of health care personnel encompasses (ref) all those working in the area of health care. This includes those working in: hospitals, clinics, first-aid posts and ambulances; health-care personnel, whether working in medical facilities, in ambulances or as independent practitioners; all persons on the premises of medical facilities, including the wounded and sick and their relatives; Red Cross and Red Crescent staff involved in the delivery of health care, including volunteers; health-oriented NGOs; military health-care facilities and personnel.

This also includes headquarters and field level personnel: management, medical, administrative, communications, logistics, technical and support teams.

### When

The guidance notes, checklists and core standards are intended to be applied along the entire deploying organization strategic and operational management and policy structures as needed spanning headquarters, field offices, operations and return. The guidance is best utilized pre, during and post deployments to better inform the policies, plans and processes required to achieve principled, coordinated, safe, and successful medical missions.

### How?

The guidance is presented as a set of recommendations, guidance notes, technical and core standards. These have been co-authored by experts from multiple agencies/nations and maintained by a community of practice representing stakeholders from a wide representative cross section including NGOs, governments, militaries, UN agencies, ICRC, MSF, DG ECHO, US OFDA, and academics. Verification of EMTs who wish to declare capacity to respond to armed conflict will include additional steps beyond the current Blue Book classification for emergencies. (see Annex 1)

## WHO Policy

WHO has an internal Operations Guidance Paper that outlines how and when the organization will engage in trauma care in situations of armed conflict, and specifies the roles and responsibilities of WHO and its supported partners. (insert ref xx, Jan 2019). The document has several guidance notes and states that (after reminding parties to the conflict of their obligations under International Humanitarian Law – IHL- and discussions with National Authorities, ICRC, MSF, and other humanitarian actors):

|  |
| --- |
| WHO’s *Internal Guidance Note on The Provision of Trauma Care in Conflict Situations*:    “If no organization provides the necessary care to the wounded and sick[[11]](#footnote-11), and WHO has established that there are clear and unmet needs, WHO is within its mandate to provide relevant services.”  “All teams supported by or contracted by WHO must agree to providing services in a principles humanitarian manner, adhere to professional standards and ethical principles, provide quality care services and coordinate with national authorities and coordinating bodies”  WHO will consult with the ICRC, other humanitarian actors and operational partners regarding their capacity and responsibilities. |

# Introduction and Guiding Principles

Under review and edit

Medical Teams (regardless of classification and affiliation) responding to armed conflict and complex emergencies might be called upon to fulfill a patient-focused mission to save lives, alleviate suffering, protect vulnerable populations, and mitigate the impact of war and violence in highly insecure, austere, and resource limited environments, and often spanning a continuum of care.

Therefore, teams require access to the affected population, which requires acceptance from the population and warring parties, which is rooted in some level of *trust*; and this in turn can contribute to enhanced team security.

Teams need to exercise special precautions and ensure their actions respect International Humanitarian Law (IHL), core humanitarian principles, meet core clinical standards of care, and are ethical in conduct as the consequences of their interventions can spread beyond projects. The *perceptions* of the civilian population, authorities and armed actors as to the conduct of medical teams are of paramount importance. Therefore, *all* behavior, conduct, and communications need to strictly aim to enable humanitarian missions and promote trust and access to *all* in need. Seemingly harmless acts like taking photos (with tel, camera or drone), mingling with parties to a conflict, dressing in military style attire, display of national/religious symbols, expressing opinions on social and regular media, and/or operating in close proximity to armed actors can have severe unintended consequences for the team and patients; in fact, an entire operation may be compromised with the negative impact that lasts for years and stigmatizes reputations.

Similar to the Sphere[[12]](#footnote-12) Humanitarian Charter and Minimum Standards in approach, the Red Book affirms the Sphere Commitment:

“By adhering to the Core Humanitarian Standard and the Minimum Standards, we commit to making every effort to ensure that people affected by disasters or conflict have access to at least the minimum requirements for life with dignity and security, including adequate water, sanitation, food, nutrition, shelter and healthcare. To this end, we will continue to advocate that states and other parties meet their moral and legal obligations towards affected populations.”[[13]](#footnote-13)

## Guiding Principles for Blue and Red Books

The Contexts and Guiding Principles for the Blue Book and Red Books:

|  |  |
| --- | --- |
| Blue Book  All EMT types, including specialised care teams, should comply with these guiding principles that govern the practice of teams and individuals  Teams may support existing health facilities, or set up standalone facilities. | Red Book  All EMT types, including specialised care teams, teams should comply with these guiding principles that govern the practice of teams and individuals  Teams may take over existing facilities, set up standalone facilities, or embed/co-locate in existing civilian structures. Distance from frontlines will vary.  (governmental and military teams will often require special considerations as they will face limitations in applying the principles)[[14]](#footnote-14) |
| Contexts  Natural disasters including both slow and sudden onset, disease outbreaks, industrial/technological accidents, refugee and IDP settings, that overwhelm local responders but occur in contexts of a sovereign state without armed conflict or insecurity. | Contexts[[15]](#footnote-15)  Armed conflicts including international and non-international classifications, as well protracted emergencies regions, armed revolts, civil disturbances, and situations of extreme violence and insecurity. Refugee, IDP settings, disasters, and outbreaks in contexts above. |
| 1. Quality Care: The EMT provides safe, timely, effective, efficient, equitable and people centered care | Same principle applies applying core clinical and operational standards |
| 1. Appropriate Response: The EMT offer a “needs driven” response according to the context and type of emergency in the affected nation. | Same principle applies framed in Humanity and Impartiality. Teams to focus on priority needs.  Assumes population has access to the medical team, and vice versa – may not be the case for military and governmental teams, but both can apply same principle in areas they can safely reach |
| 1. Accessible Care: The EMT adopts a human-rights based approach to their response and ensures they are accessible to all sections of the population affected by the emergency, particularly the vulnerable and those requiring protection. | A practical humanitarian approach, framed by International Humanitarian Law (IHL) and core principles is required with a focus on gaining access, acceptance, and security for teams and patients. |
| 1. Ethical Care**:** The EMT undertakes to treat patients in a medically ethical manner at all times. | Same principle applies. War and Chaos cannot be excuses to compromise ethics and the medical principle of “Do No Harm!”. |
| 1. Accountable Care**:** The EMT commits to be accountable to the patients and communities they assist, the host government and MoH, their own organisation and donors. | Accountability to patients is retained, while accountability to the authorities is context specific and needs special considerations. Principle of Neutrality needs to be maintained. Teams to avoid the perception of being parties to a conflict through non-neutral actions. If team is military or governmental, they need to accept government direction and implications. |
| 1. Coordinated Response**:** The EMT commits to a coordinated response under the designated national health emergency management authorities Emergency Operations Centre (EOC) or incident management system equivalent, and collaborate with the national health system, their fellow EMTs, and the international humanitarian response community where relevant | Commitment to coordination with key stakeholders and providers on all sides of a conflict is retained and required. However, principles of Neutrality and Independence need to be maintained. Teams to avoid the perception of being parties if too closely associated with a governmental/military/UN coordination platform.  With context specific exceptions for military, governmental, and some UN teams who would not by designated as humanitarian actors. |

Table 2 Blue & Red Book Contexts, Similarities, and Differences

## Limitations

Medical missions in wars are extremely context-specific and require constant analysis and course adjustments as realities on the ground dictate. Therefore, it is not possible to provide one prescriptive way of doing things.

Humanitarian assistance is often challenged and undermined by the following:

1. Despite the best of efforts by teams and nations, global trends in the conduct of hostilities including the disrespect of IHL may nevertheless limit the acceptance, access, and safety of medical teams
2. National and international medical teams may not have the freedom or space to provide independent, impartial and neutral assistance, and in some cases the work may even by criminalized as it is defined as support to extremism or radical groups.
3. People, authorities, organizations still express opposition to IHL and core humanitarian principles as an ‘External’ or ‘Foreign’ construct,
4. Some State and non-State actors overtly or covertly will instrumentalise (as ‘patriotic’) medical missions that are perceived as supporting the achievement of military/political/economic objectives.
5. The duty of care required when engaging with and/or recruiting local personnel may be difficult and not achievable. For example, out of country evacuations, provision of insurance, and/or protection from armed actors.
6. The differing and often contradictory incentives, motivations, and disincentives facing deploying organizations rooted in donor and organizational agendas that may not promote principled and ethical actions and prioritization.
7. Wide diversity of medical teams with broad and differing standards of practice, definitions of quality, resources, mandates and missions.

## The Red Book Does Not

The Red Book does not replace the critical need for States and non-State Armed Groups, friendly nations, and/or the UN to engage in negotiations and seek diplomatic solutions to end/suspend hostilities.

It also does not replace the need for diplomacy and advocacy to remind parties to a conflict of their obligations towards victims of armed conflict, the laws of war, promote agreements, cease hostilities, and hold parties and individuals accountable to their obligations under both international and domestic laws. Humanitarian aid cannot be a substitute for durable peace agreements.

# The Future of Humanitarian Assistance

Given the very dynamic, fragile, and evolving nature of field and global realities impacting humanitarian operations, it is critical that medical teams regularly scan and anticipate change. Teams need to learn and adapt plans, policies, systems, personnel profiles, and approaches to remain relevant and fit for purpose. Decisions made today are already shaping the future; decisions related to recruitment, equipment, technologies, policies, strategic priorities will ripple for the five to ten years coming

Much has been written about the *future* of the humanitarian landscape[[16]](#footnote-16). The Red Book, where appropriate, incorporates relevant considerations for medical teams given trends in the changing nature of warfare, evolving medical technologies, evolving standards of healthcare delivery in conflict, and geopolitical dynamics. Today’s global phenomena are manifest in increased fragmentation of the political world order, trade wars, cyber-attacks, politicization of aid, and challenges to fundamental accepted global values or lack of adherence to long established treaties. To adapt to such complexity and access people in need, medical teams need enhanced vigilance, partnerships, stronger collaboration: plans for interdependence.

These trends also require teams and organizational leadership to be more agile, flexible, adaptable, and principled to cope with a complex, dynamic and often a confusing operational landscape. Importantly, the ‘soft skills’ associated of good communications, negotiating abilities, humility, meaningful community engagement[[17]](#footnote-17) and acceptance are of importance for current and future missions.

While not exhaustive, the following lists illustrate key issues that continue to be observed and have positive and negative effects on humanitarian action:

Warfare is increasingly asymmetric and trends include siege tactics, urban warfare[[18]](#footnote-18), proxy wars, focus on counterterrorism, cyber wars, more advanced weapons (and injury types), autonomous weapons, attacks on medical facilities and personnel, increased likelihood of CBRN attacks, and the use of rape as a tactic of war. The anticipated trend, as historical evidence suggests, is the continued weaponization of many new technologies[[19]](#footnote-19) (drones, digital, communications, lasers, space, artificial intelligence). Importantly, while guidelines and manuals for Civil-Military Coordination to safely and rapidly reach people in need using deconfliction[[20]](#footnote-20) [[21]](#footnote-21)protocols continue to evolve, but there are no absolute guarantees for safety and security.

The above, combined with severe climate anomalies continue to drive rapid urbanization, rise in disease outbreaks, increased migration/displacement, insecure humanitarian spaces, increased numbers of actors and providers.

A third trend is observed via the influence of emerging medical technologies and diagnostics on digital devices, communications technologies, transportation, tele-medicine and tele-health, mobile platforms, virtual trainings, use of drones, 3-D printing[[22]](#footnote-22), more miniature ruggedized medical devices.

We are witness to a global digital transformation with positive and negative impacts on access to information, confidentiality, viral spread of news and fake news, threats to and manipulation of democracy, polarization in societies, importance and rise of digital identities of refugees/IDPs, digital cash transfers, rapid advances and diffusion of medical technologies and pharmaceuticals; an erosion of trust long established institutions and authorities.

National actors and governments continue to increasingly exert the centrality of local authorities to lead and grant or deny access to responders. And much of the international debate and commitments are driven by the need for policies and practices that ensure accountability to affected populations[[23]](#footnote-23) including highly vulnerable sub-groups.[[24]](#footnote-24)

A recent report called for:

Given the projected level of increasing humanitarian needs and gaps, some have called for a future system with "An effective surge capacity is essential. Despite major access restrictions faced by humanitarian actors, one 'quick fix' for emergency response capacity would be to ensure a minimum number of capable organisations with the capacity, knowledge, readiness and deployability to provide coverage across all lifesaving sectors and deliver reliably in acute crises."[[25]](#footnote-25)

Recent studies and reviews have highlighted the critical need (and provided recommendations) for medical teams to perform better on both the level of the application of humanitarian principles, as well as quality and effectiveness.[[26]](#footnote-26) The report authors call upon all actors "to examine their actions - the end and the means - so that future humanitarian responses will be principled, effective, and accountable to those who need them the most: the victims of war and forced displacement."

In summary, the anticipated future insecurity and fragility requires medical teams to cope with and continually adjust to and with:

* Organizational policies that are updated frequently in dealing with duty of care, risk tolerance, security management, recruitment and personnel profiles, communications with public and authorities, and operational readiness
* Community engagement at both organizational and individual levels in a dignified, respectful, humble, and empathetic approach remains core, regardless of rapidly changing world.
* Policies to guide technology advancements/adoption and adaption[[27]](#footnote-27) [[28]](#footnote-28) .
* More concrete and meaningful sector-wide collaborative and coordination approaches at headquarter and field levels that steer towards increased interdependence, inter-linkages, and complementarity
* Polices and sufficient resources that *invest* in human resources. Enhance knowledge and skill of headquarter management, operational team leaders and team members through practical training, and continuous learning, in more formal association with academic institutions and key regional and global agencies.

CHAPTER 1

International Humanitarian Law (IHL) & Core Humanitarian Principles in Action

“War cannot be Humanized. It can only be Abolished.” Einstein.

But until then, we have

IHL & The Red Book

# International Humanitarian Law (IHL) & Core Humanitarian Principles in Action

Under review and edit

|  |
| --- |
| Chapter Objectives   1. Medical teams have an increased understanding of the relevance of International Humanitarian Law (IHL) and Core Humanitarian Principles to facilitate, support and protect medical teams, patients, and operations in armed conflict. 2. Teams gain increased awareness of the consequences and implications linked to non-adherence to IHL and Core Humanitarian Principles; including implications on security and access. 3. Teams have increased capacity for principled action and critical thinking (decisions & conduct) in making medical and operational decisions at both HQ and Field levels that treat all with respect and dignity. 4. Teams are aware of the importance and fundamentals of meaningful and accountable community engagement. 5. Teams and leaders have easy access to the most relevant key references and manuals at their fingertips. |

Applied IHL & Core Humanitarian Principles enable access to affected populations and help build relationships, trust and confidence crucial to fulfilling and protecting a medical mission.

The humanitarian imperative to provide assistance is shared by all peoples, cultures, religions and humanity at large. Suffering and pain, happiness and joy can be triggered by wars and peace. Throughout the globe, medical teams provide care in all situations and contexts. To continue with the medical mission, teams are increasingly needing to better prepare, train, communicate, manage ethical dilemmas, and make decisions that focus on saving lives; a task more difficult in war situations.

This is not a legal type chapter or text, and it is important for teams to comprehend the abridged frameworks and guidance presented here. The focus is on understanding context, principled decision making, improved self-awareness, mindfulness of consequences, and a pragmatic (not dogmatic) approach. For a truly thorough and deeper understanding of IHL, readers are advised to review “The Practical Guide to Humanitarian Law, 2013” by Françoise Bouchet-Saulnier of MSF[[29]](#footnote-29), ICRC IHL online Database[[30]](#footnote-30), “The Handbook on the Practical Use of IHL by the Danish Red Cross[[31]](#footnote-31), and the ICRC digital App[[32]](#footnote-32)

The medical mission, at its core, remains universal:

“There is considerable merit to the theory that champions the approach that “war is war” regardless of whether an armed conflict is fought in an intra-State, inter-State, or transnational context. This is particularly true regarding humanitarian obligations since human suffering is common to all types of conflict.”[[33]](#footnote-33)

Note that IHL and medical ethics impose obligations and best practices on health-care personnel, which is directly responsible for taking care of the wounded and sick:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **International Humanitarian Law**  **IHL** | **International Human Rights Law**  **IHRL** | **Medical Ethics** |
| **Scope of application** | - International armed conflict  - Non-international armed conflict | - International armed conflict  - Non-international armed conflict  - Other emergencies  - Peacetime | - International armed conflict  - Non-international armed conflict  - Other insecure environments  - Other Emergencies  - Peacetime |
| **Benefi-ciaries** | - Wounded and sick  - Medical personnel | - Wounded and sick  - Medical personnel | - Wounded and sick |
| **Bound by the Law** | - States  - Armed groups  - Individuals  (Medical Personnel/teams) | - States | - Medical personnel |

Figure 2: Laws and Scope of Application, Source ICRC HCiD - <http://healthcareindanger.org/hcid-project/>

## First, Do No Harm![[34]](#footnote-34)

Primum non nocere[[35]](#footnote-35), or ‘first do no harm’, has been central to the concept of good medical practice since the time of Hippocrates: ‘I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing.’

Implicit in this commitment is that a good physician, or indeed any healthcare worker, will practice only within their field of proven competence, and to sue the required equipment to ensure patient safety. A failure by some in the past to recognise the importance of this principle when responding to sudden onset disasters was one of the drivers behind WHO establishing and promoting a set of minimum/core standards for Emergency Medical Teams[[36]](#footnote-36) (EMTs) in the “Blue Book” and its mission to reduce the loss of lives, relieve suffering, and prevent disability in sudden-onset disasters and outbreaks through rapid deployment and coordination of quality-assured EMTs. [[37]](#footnote-37) (insert updated Blue Book reference). While the “do no harm” principle underpins the Blue Book and is directed primarily at the patients we serve, it also applies to the organizations deploying teams “doing no harm” to those they deploy (Duty of care see page xx).

The risks to medical teams in responding to armed conflict are not insignificant and cannot be eliminated; but they can be mitigated by adequate preparation, increased awareness, and training. Teams who lack necessary preparedness, training, supplies, and/or awareness of context, complexity, and importantly conflict sensitivity[[38]](#footnote-38). should consider *not* deploying as they can indeed ‘Do Harm!’ (to patients they seek to treat and to their own staff). Conflict sensitivity merits a deeper understanding by teams and leaders; teams needs to understand the context in which they are operating; understand the interaction between the intervention and the context, and act upon that understanding, in order to avoid negative impacts and maximize positive impacts on the conflict[[39]](#footnote-39).

Civilians caught up in conflict have some of the most complex health needs; needs that can be made only worse by an inappropriate response. Teams and especially team leaders need to pay particular attention and be sensitive to the power dynamics, risk of coercion or intimidation, possible lack of social cohesion, reduced resilience and lack of safety net that affected populations may have compared with other non-conflict populations. In war, more than ever, adherence to the four principles of ethical medical care (respect for autonomy, beneficence, non-maleficence, and justice) [[40]](#footnote-40) will ensure that not only that we do no harm, but recognise and respect the rights of the patient to the best treatment we can give and thereby do justice to the most vulnerable at the time of their greatest need.

The need for core and technical standards and quality assurance of medical teams (now seen in disasters) equally extends to conflicts;[[41]](#footnote-41) a fact recognised by Henri Dunant, the founder of the Red Cross movement, when he published A Memory of Solferino in 1862[[42]](#footnote-42) in which he spoke of the suffering and neglect of the wounded and the need for volunteers that were trained and experienced.

It is recognized and emphasized, that warring factions are required to enhance their medical capacities to enable them to fulfil their legal obligations under the Geneva Conventions (see below). But there will always be times when civilian teams are also asked or indeed required to respond, and in so doing be exposed to a level of ethical and physical risk above and beyond that they will have experienced when responding to sudden onset disasters.

Recent experiences in frontline trauma care provision and coordination have emphasised both the need for EMTs, but also the complex ethical and legal issues that can arise when they are deployed close to the frontline and have access to only one side of the conflict[[43]](#footnote-43). Importantly for medical teams and humanitarian organisations in a conflict zone, is how to adhere to International Humanitarian Law, maintain the first core principle (Humanity) as the over-arching driver of the EMT response, and so address suffering wherever it is found; and still uphold the other principles of neutrality, impartiality and independence. The very concept of humanitarianism itself can be threatened when teams are so close to combatants of a party to the conflict as to be deemed to (and perceived to) be operating as one team and in support of their military objectives (a blurring of the lines) to outside observers. “As emergencies become bigger and more complex, teams are required to protect and strengthen the humanitarian space”[[44]](#footnote-44). EMTs are to be supported and guided by the IHL and Core Humanitarian Principles as they map their path through this difficult moral and legal territory. And teams need to guard against abuses and violations of IHL and the core principles as such an approach will further improve a teams’ protected status, and (through confidential advocacy with warring parties) may limit suffering and the impact of war the population and the wounded and sick.

Insert para and ref (upfront) to highlight the loss of protection for medical personnel and units when they give military advantage to a party or are used to commit act harmful to the enemy

Insert para to address the dual obligations regarding medical confidentiality contained in domestic law in NIAC and violating medical ethics. This is daily practical problem for medical personnel and guidance on this will be key.

## What is International Humanitarian Law (IHL) and Core Humanitarians Principles

IHL[[45]](#footnote-45) is a set of rules with the Geneva Conventions at its core, with the aim to limit the effects of armed conflict. All states in the world are parties to the Geneva Conventions, [[46]](#footnote-46), while non-state parties to armed conflict are still bound by IHL rules. Core humanitarian principles are derived from IHL’s recognition of the role of “impartial humanitarian organizations” (common article 3 and article 9/9/9/10 Geneva Conventions); and both continue to guide humanitarian action across the globe. The battlefield realities however show that signatures and ratification does not necessarily translate into full compliance during armed conflict, and parties to conflict need to be reminded of their obligations[[47]](#footnote-47). Attacks on hospitals and medical teams are commonly observed and reported.[[48]](#footnote-48)

Regardless of national or organizational affiliations, medical teams are required to conduct their mission within the legal frameworks of The Geneva Conventions, and IHL more broadly.[[49]](#footnote-49):

The core humanitarian principles (Humanity, Impartiality, Neutrality, Independence)[[50]](#footnote-50) are a set of values or morals adopted by the UN, and most key humanitarian actors. Together, they have practical operational relevance for medical teams in complex political and militarized environments. Adherence to IHL and the principles is therefore critical in order to distinguish humanitarian action from the activities and objectives of political, military and other actors. Actions and conduct by medical teams that blur those lines can be detrimental.

### IHL

To emphasize again that International Humanitarian Law (IHL)[[51]](#footnote-51), also referred to as the Laws of War or the Law of Armed Conflict is the law that specifically governs armed conflict. Wars are not without rules and the states have agreed, including through international treaties like the Geneva Conventions to impose limits to the way in which warfare is conducted. International humanitarian law is the set of rules which seek, to limit methods of armed conflict and allow humanitarian and medical assistance to the victims of conflict. It protects persons who are not or are no longer participating in the hostilities and restricts the means and methods of warfare. Medical teams in this field, need to be aware of these rules which protect the team, the patients, the medical facilities, and transport. In addition to IHL, medical and humanitarian personnel must respect the domestic laws of the country wherever they are operating.

IHL protection as medical personnel, facility or transport is not absolute. Such persons or objects may lose their IHL protection if they are used for military purposes, and then even direct attacks on such persons and objects are not unlawful. As a result, any perception created (for right or wrong) that medics would serve in reality military purposes will result in security risks for them on the ground

In case of dual conflicting obligations[[52]](#footnote-52) arising from domestic laws, the rules of medical ethic must always prevail.

There are several laws that specifically relate to medical personnel (military and civilian) as well as the provision of assistance and the protection that must be given to those who are wounded and sick. The law states that the parties to the conflict must:

* Not target people who are no longer engaged in the fighting
* Allow for impartial humanitarian assistance to be given to the civilian population
* Not target those who are providing medical or humanitarian assistance.
* Ensure that *all* wounded and sick receive medical care and those who are *entitled[[53]](#footnote-53)* receive humanitarian assistance

Civilians and those who are no longer able to engage in the fighting are entitled to receive medical assistance. These rules within IHL include several obligations on the warring parties. One key obligation is that they themselves, if they can, provide the frontline medical assistance to wounded and sick people who are in their care. Secondly, the parties must allow for others to provide the medical assistance if they themselves cannot. This means that they cannot interrupt, interfere with or prevent the provision of medical assistance from getting to those who are entitled to it. Thirdly, parties must not unlawfully refuse consent to an offer of humanitarian services by impartial humanitarian organizations and once consent is given, allow and facilitate the provision of other humanitarian assistance.

These are all crucial elements for medical teams to be aware of so they can raise these obligations with the parties to the conflict to *remind* them of their obligations and how best to ensure respect for IHL.

Some contexts in which the parties have not been willing and/or have not been able to provide impartial humanitarian, including medical, assistance to the affected population, have called for the support from external and/or humanitarian agencies, and other providers of medical services to address these humanitarian needs. This is legal under IHL.

The Geneva Conventions, their 1977 Additional Protocols as well as customary law IHL[[54]](#footnote-54) clearly enshrine obligations of warring parties (and their affiliates[[55]](#footnote-55)) to provide medical care to *all* wounded and sick. Common Article III states[[56]](#footnote-56): "Each Party to the conflict shall be bound to apply, as a minimum, provisions to collect and care for the wounded and sick". More specifically, IHL states:

“Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed ' hors de combat ' by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.

To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons (article 3 common to the Geneva Conventions):

1. violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
2. taking of hostages;
3. outrages upon personal dignity, in particular humiliating and degrading treatment; and
4. the passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court, affording all the judicial| guarantees which are recognized as indispensable by civilized peoples.

(2) The wounded and sick shall be collected and cared for.

An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict.

The Parties to the conflict should further endeavour to bring into force, by means of special agreements, all or part of the other provisions of the present Convention. The application of the preceding provisions shall not affect the legal status of the Parties to the conflict.”

### Core Humanitarian Principles

Humanitarian action was born not from an abstract idea but on the battlefield. The principles are effective when they are practiced in concrete realities, such as in response to medical needs for the wounded and sick in armed conflict.

These principles of humanity, impartiality, neutrality and independence have been grounded within the humanitarian community as the leading operational principles for any organisation responding to a disaster or armed conflict. what is of the utmost importance for all medical teams to know is that regardless of their independence from governments/public authorities, their provision of assistance must be humanitarian and impartial. For example, military and governmental EMTs, by definition, cannot be expected to be independent.

|  |  |
| --- | --- |
| **Principle** | **In Medical Practice** |
| Humanity is a principle driver for those who endeavor to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, co-operation and lasting peace amongst all peoples Humanitarian assistance is often referred to as assistance which is essential for the survival of the civilian population including food, shelter, water, medical assistance, power/energy and sanitation. | Do no harm! And focus efforts on reaching people in need as quickly as possible and provide assistance as far as practical.  Access is most critical. Do not take undue risk for medical team or patients. Do not work out of scope and competency areas. |
| Impartiality means that the decisions to assist and priority settings are solely driven by need, and do not discriminate based on race, religion, nationality, gender, age, disability, or class. Impartial medical care provides services giving priority to the most urgent cases. | Treat all based on medical need and urgency of the case without discrimination.  A patient is a patient and must be treated with dignity and humanity in all circumstances whatever his/her status as enemy, criminal or any other gender, social, political, religious or ethnic criteria |
| Neutrality means that in order to continue to enjoy the confidence and trust by all, the teams may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.  (However, confidentially raising awareness on violations of IHL by parties to a conflict is not considered a breach of neutrality[[57]](#footnote-57).) | Taking sides will erode trust, limit acceptance by the population to be served and undermine access.  Taking sides will not permit the team to access or communicate with the warring parties  Providing medical care to wounded and sick belonging to the enemy is a duty under IHL and is not to be considered as an act harmful or a material support to the enemy.  A hospital may lose its protected status under IHL if it is used outside its medical function to commit acts harmful to the enemy. Medical teams must retain control over medical facilities and not allow any weapons and military interference with medical care inside medical facilities and transport to retain their status of protection.  With context specific exceptions for military, governmental, and some UN teams. |
| Independence requires teams to always maintain their autonomy from governments and public authorities so that they may always be able to act in accordance with key principles. | Medical actions need to be de-linked from military and governmental agendas.  With context specific exceptions for military, governmental, and some UN teams. |

Table 3 Principles in Medical Contexts

Furthermore, Neutrality requires avoiding interference and manipulation of assistance by any State or non-State party to the conflict.

Neutrality stems from the idea that humanitarians are not engaging in the political or highly controversial topics related to a conflict at the public level so as to remain neutral between the parties to the conflict. How can one side trust that you will treat them with dignity and humanity if you have publicly spoken out in support of their enemy? How can a party to the conflict trust you if your activities are carried out without independence and for the sole advantage of the opposing party to the conflict? While certain extreme situations have seen leading organizations resort to public denunciation, the consequences in the form of reactions from those denounced need to be anticipated and plans put in place to address ensuing denial of access, expulsions, and attacks. Medical teams must focus on responding to the needs of the people who need most urgent assistance, regardless of the affiliations or sympathies of the population. Medical teams ideally need to be able to access all sides (not always possible) and so would be required to navigate the political and controversial aspects in often complex and fragile settings to ensure that they are able to reach and provide the assistance to those who need it the most. To engage in a non-neutral manner, puts the lives of the responders at risk; it puts the lives of those who need the assistance at risk; and it prevents future assistance from getting to where it is most needed. It can impact the entire operation negatively, and not merely the team that engaged in non-neutral actions, conduct, and/or statements

Neutrality is a central principle of engagement with parties to conflict that enables access to affected populations, and operational agreements on legal and ethical framework of medical and humanitarian action. Neutrality and impartiality are often confused to be the same. The two principles differ in that a neutral person does not make judgments related to the conflict. "Neutrality demands self-control and is a form of discipline we impose upon ourselves, a brake applied to the impulsive urges of our feelings[[58]](#footnote-58)". While Neutrality does not impose silence on violations of IHL, teams need to realize the possible consequences if engaged in public statements that negate their neutrality (perceived or real – see section on consequences below)

More on Independence, there may be difficulty of reconciling two things which seem to be mutually exclusive: to enjoy the freedom of autonomous action of a non-governmental entity and to simultaneously seem to submit to the requirements of donors, military discipline, or national laws. However, an ‘operational autonomy’ can be negotiated and accepted for medical teams for it provides an arms-length space without undue influence on medical decisions, allocation of resource, and triage. It is critical, for it counters possible perceptions by communities, warring parties, and stakeholders that a medical mission is biased and partial.

It is also important to note that the principle of independence is not necessarily required for medical personnel to be protected from direct attack. As mentioned above, military and civilian personnel who are providing medical assistance are protected from attack and must be allowed to operate (including agreed by both parties; and a distinctive emblem[[59]](#footnote-59) is used, hospitals used only for medical work, Article 18, GC IV). This applies to both foreign nationals as well as local actors. Again, what is of the utmost importance for all medical teams to know is that regardless of their independence from government, their provision of assistance must be humanitarian and impartial. This of course can be incredibly demanding as the deployment of these teams can be driven by (or perceived to be) politics and/or military objectives. But once deployed and operational, these teams must provide impartial and neutral humanitarian assistance. This operational decision is captured in the rules relating to the use of the protective emblems[[60]](#footnote-60). Regardless of the reason why someone has been deployed into an armed conflict setting, once wearing the emblem or once conducting neutral and impartial medical assistance, a person is protected under IHL from attack. And the parties to the conflict are obligated to respect this.

Therefore, military and governmental medical activities should remain impartial and they should be acutely aware of the importance of independence and neutrality for other humanitarian actors. Hence, they are advised to do their utmost to abstain impacting the perceived neutrality and independence of the whole medical operation.

### Can the Principles be Decoupled?

In the concrete realities of responding to war wounded and needs of civilians caught in armed conflict, the principles should not be viewed as pure moral abstraction, but rather as providing concrete guidance, to support sound judgement and pragmatic decision making.

Medical teams may be forced to deviate and make concessions but must be aware of consequences. Otherwise, poorly thought through decisions can do harm to teams, patients, facilities, and others. The impact of such harm can ripple for years and across the globe. The central mission of medical teams expands the ‘Do no Harm’ of the Hippocratic Oath[[61]](#footnote-61) into relations with populations. Medical ethics[[62]](#footnote-62) provides a strong base for impartial and non-discriminatory care; however, it does not sufficiently address the critical nuances required to access civilian populations in armed conflict, nor does it address the practical and importance of neutrality (and perceived neutrality) in such complex contexts.

Therefore, a ‘de-coupling’ or a compromise would be the result from the circumstance and context, and not a team choice for own bias or agenda. As discussed earlier, military and governmental teams are not expected to be independent and neutral organizations.

For example, a recent report states as pertains to local actors: "In terms of applying the principles, national and local actors may find several of the principles particularly challenging.” As part of their defining characteristics, they are part of the society in which they work and live. Religious, ethnic and political affiliations, as well as economic privilege and power relations, all play a key role in the interaction between local actors and their domestic contexts."[[63]](#footnote-63) Therefore, the report continues: "Some compromises in the application of and adherence to the principles framework may be required but not all compromises are equally acceptable". Therefore, not be separated from the political intent of deployment. These teams are nevertheless bound by the rules of IHL and must provide impartial humanitarian assistance to those who seek it especially if they are wearing one of the protective emblems.

Humanity and Impartiality are non-negotiable principles, Neutrality and Independence are core to all medical teams (with exceptions for some military & governmental teams)

Neutrality and Independence are critical but will not apply for military and governmental teams at the organizational level, however, both principles can be applied at the bed side and clinic levels (i.e. medical care to an individual is neutral and independent even if the politics of being deployed were not).

Additionally, a principled approach to providing medical care can face challenges as some countries criminalize[[64]](#footnote-64) assistance to groups or individuals labelled as “radicals/terrorists” and violent. Blocks of nations (EU parliament resolution[[65]](#footnote-65)) have also advanced resolutions to prevent the criminalization of aid. Teams need to be aware of current legislation and laws pertaining to their organization and nationality[[66]](#footnote-66).

Team leaders, in particular, need to be able to advocate for access and be fully aware of any concessions made that may have consequences on how the medical mission is perceived by the local population, warring parties, and other stakeholders.

## Who can use the Emblem?

In the event of armed conflict, the distinctive protective emblems[[67]](#footnote-67) are a visible sign of the protection conferred by international humanitarian law especially upon medical personnel and equipment. The persons and objects displaying them must (insert conditions) not be attacked, but on the contrary must be respected and protected.

Their use as a protective sign during armed conflict is authorized exclusively for:

* Medical units, transport and personnel, as well as religious personnel, of the armed forces;
* Civilian medical units (including MoH), transport, and personnel, as well as civilian religious personnel, that have received special permission by the competent authorities to use the emblem;
* Medical units, transport and personnel that a Red Cross or Red Crescent National Society has put at the disposal of the medical services of the armed forces

In armed conflicts, the protective emblem must be in red on a white background with no additions. It must be clearly displayed in a large format on protected buildings, such as hospitals, and vehicles. Emblems on armbands and vests for protected personnel must also be clear and stand alone. A deliberate attack on a person, equipment or a building carrying a protective emblem is a war crime under international law.

Insert examples of emblems

|  |  |  |
| --- | --- | --- |
|  | **Protective use** | **Indicative use** |
| **For what purpose?** | Notifying of protection by law | Link to the Red Cross/Crescent Movement |
| **What features?** | Large and visible | Small and unambiguous |
| **Who can use it?** | Persons falling within IHL definitions of medical personnel, units and vehicles:   * armed forces * authorized National Socities * authorized NGOs * authorized hospitals * The ICRC and the IFRC without any further restrictions | National Red Cross and Red Crescent Societies,  authorized ambulances and first-aid stations operated by third parties,  the ICRC and the IFRC. |

Figure 3: Emblems are the visible signs of protection

## Scenarios and Practice

Under review and edit

Applied IHL & Core Humanitarian Principles enable access to affected populations and help build relationships, trust and confidence crucial to fulfilling a medical mission

Section presents scenarios and provides examples when mapping actors and mandates. It is designed to provide teams and leaders with key questions for critical reflections when providing principled care

### Scenario 1: A Generic Conflict Scenario: Mapping Actors and Populations

Figure xx Mapping Medical Teams, People, Access and IHL

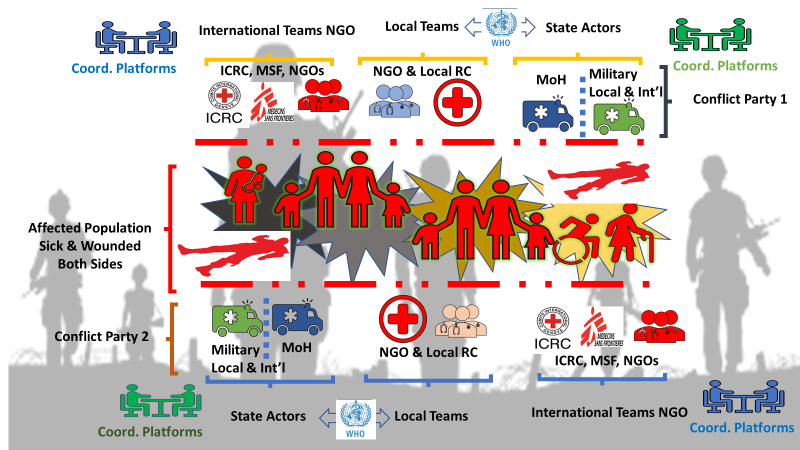


Figure 4 Mapping Medical Teams in Conflict

The Stakeholders: The figure above is designed to illustrate the varied medical actors, affiliations and possible implications on acceptance and access. It depicts two warring parties (top and bottom) and shows the mobilized medical assistance at the state, local and international levels, on both sides. The central part of the illustration shows affected populations from both sides to varied backgrounds which are meant to depict possibly various territories, regions, ethnicities, etc. The State actors shown include MoH and Military medical services. Other local actors may include civil society/ NGOs, local Red Cross/Crescent National Societies which may have level of independence and autonomy from the local authorities (and may not). The International medical actors include ICRC, MSF, and NGOs. This may also include private providers, and depending on the nature of contracts, such providers may be perceived to be linked to State actions or not. Private actors will always be viewed to represent the party funding them (UN, States, etc). This can also apply to local and international NGOs. In peace time, the typical mandate for local Red Crosses/Crescents and many local NGOs is to be auxiliary (complementary) to local authorities in the humanitarian field; often funded by governments and implementing national programs.

Medical teams responding to treat the wounded and sick in situations of armed conflict have differing organizational affiliations. They *all* have important roles to play in saving lives and caring for affected population. They may not *all* gain equal access to the affected regions and population. Such access will be shaped by consent of the warring parties, their affiliates, and the perceptions of the population as to the teams’ intent and safety/protection within or near the facility.

The Sick & Wounded: The civilian population, injured combatants (and their comrades) will most likely not fully comprehend the plethora of actors, logos, affiliations, and agendas. They will observe, view, judge through own values, beliefs, and needs. They will act accordingly in seeking medical care they need, and will likely use very differing terms and labels for the teams based on languages spoken, sings used, how they are treated (respect, dignity), and rumours.

The Principled Framework: Regardless of team’s affiliation or type of organization, all medical services are ideally framed in principles of Humanity and Impartiality at the bedside patient care dictates. Moreover, the actions of all are assumed to be framed by IHL.

The UN: If the UNSC has taken sides in the conflict, and UN agencies and Peace Keepers are deployed, such teams would be perceived as party to the conflict. If States deploy military or civil protection teams to support one side or the other, they would similarly be perceived as party the conflict. Some States may declare their neutrality and deploy teams to serve wounded and sick on both sides. The illustration also shows the WHO (which may be active in coordination in several pillars, deploying EMTs, providing supplies, monitoring mortality/morbidity and causes). The horizontal arrows framing the WHO indicate that the perception of organization’s role can be to side with one of the warring parties (again linked to UN’s stated position vis-à-vis the conflict). Thus although WHO supported teams’ actions will be framed by humanity and impartiality at the bedside within medical facilities, the organization will be viewed through the prism of the UN’s position (with neutrality and independence compromised).

Coordination: The illustration also depicts the varied coordination mechanisms that may exist on both sides including military, civilian, international, UN, within Red Cross Red Crescent Movement, etc. (See chapter xx).

What if this was a Non-International Armed Conflict or Civil War? The illustration would change? However the framework of IHL and core principles would not, especially not when it comes to the obligation and ethical duty to provide impartial medical care. The role of local actors would be further complicated by possible pressures from government and militaries to for example ‘not treat the rebels’ or provide care to civilian sympathizers. This would equally apply to medical teams on rebel held territories. Again, the medical act at the bedside may remain neutral and impartial, but perceptions by the population will impact acceptance and access.

### Scenario 2: In the Emergency Room:

During a medical deployment into a conflict zone with ethnic roots, ER staff are presented with victims of a motor vehicle accident; three seriously injured multiple trauma cases: an adult male in mid-twenties, two children (girl aged approx. 10, and boy aged 16). The children were victims of what appears to have been a reckless driver, who subsequently lost control of the vehicle and crashed. It appears that the driver is from one of the ethnicities fighting each other, the two children from another ethnic background viewed as sympathizing with the opposite warring side. All are in critical situation. Team does not have resources to treat all.

As the physician in charge? Who do you treat first? Why? What principles are implicated?

Think of a similar setting as the scenario above, but the ER team is presented with two severely wounded combatants from opposing sides of the conflict. Both are critical. Team does not have resources to treat both. The facility is located in territories under the control of a non-state armed group. The comrades of the one of the soldiers are the gates of the facility.

As the physician in charge? Who do you treat first? Why? What principles are implicated? What is at risk?

### Scenario 3: Deployment into Internal Conflict

As discussed earlier, principles need to guide actions: The questions for consideration provided in the generic scenario and matrix below are intended to inform organizations, teams and team leaders in navigating the complexity of providing care in armed conflict. They highlight critical practical and principled questions required before, during, and post deployment.

|  |
| --- |
| Your medical team is alerted to a possible deployment into a low-income country in which some districts are experiencing active armed conflict in urban and non-urban areas between government forces and rebels. The ongoing fighting has lasted months and has precipitated a situation of tens of thousands of displaced communities internally (IDPs) and across the border to one neighbor (refugees), as well as many that have remained in their respective communities. Much of the news about the hostilities cite ethnic roots to the conflict. Weapons and tactics used have produced hundreds of casualties and severe injuries and burns. Infrastructure, homes, road networks have been severely damaged. There have been no reports of chemical or biological agents in use. There have been rumors of sexual violence, kidnappings, and general criminality. |

The scenario can be run as a desktop training exercise for teams and team leaders. And depending on the answers provided to each of the questions below: Do you deploy? Where? Do you have a choice? What is your mandate? Who provides authorization? Is there consent to access and work on all sides of the armed conflict? Are there other options? If deployed, what is the scope and region(s) for practice? Will that shift? What are the risks now and anticipated? What are the possible compromises required, why? With what consequences in both the short and long term? Who can you consult before, during, and post deployments to support?

The matrix below captures the inherit dilemmas and critical thinking/questioning required prior to and during deployments. It is designed to ensure that teams have increased awareness of context and pay closer attention and war dynamics and scenarios to protect against unnecessary deployment, harming local efforts, undermining fragile communities, manipulation and perceptions of being party to a conflict, and protect teams and patients from suffering and injury.

| **Core Principle** | **National Team Critical Thinking** | **International Team Critical Thinking** |
| --- | --- | --- |
| Humanity | * Is there a Humanitarian imperative to act? * Are there other means to assist? * Will many suffer and die if we do not respond? | * Is there a Humanitarian imperative to act? * Are there other means to assist? * Will many suffer and die if we do not respond? |
| Do No Harm! | * Are we ready to offer quality care for this scenario with suitable personnel, kits, supplies, skill set, organizational capacities, logistics, funds, etc.? * Do we have relevant experience? * What is the nature of medical services now on both sides? * Can we add value to what already exists? * How will the conflict and needs evolve? Injury types? Outbreaks? Mental health? | * Are we ready to offer quality care for this scenario with suitable personnel, kits, supplies, skill set, organizational capacities, logistics, funds, etc.? * Do we have relevant experience? * What is the nature of medical services now on both sides? * Can we add value to what already exists? * How will the conflict and needs evolve? Injury types? Outbreaks? Mental health? |
| IHL – Acceptance | * Will the affected communities accept treatment from newly deployed teams from other districts? * Will local providers accept teams from other districts operating with and alongside? * Who is collecting & caring for the wounded and sick? Is it with respect and dignity? | * Will the affected communities accept treatment from international teams? * Will local providers accept international teams operating with and alongside? * Will local military commanders accept international teams in areas they control? * Who is collecting & caring for the wounded and sick? Is it with respect and dignity? |
| IHL – Access | * Will the affected communities and military commanders grant the team access to the wounded and sick from both sides without hinderance? * Will the wounded and sick be granted access to the team? By both sides? And if not? Is influence possible? | * Will the affected communities and military commanders grant the team access to the wounded and sick from both sides without hindrance? * Will the wounded and sick be granted access to the team? By both sides? And if not? Are negotiations possible? * Who has authority to grant license for international medical practitioners? |
| IHL – Security | * Will it be safe to operate the mission for the staff and patients? Always? * Will team be viewed as party to the conflict by virtue of ethnicity? * Will local staff have safe access? * Is a secure referral mechanism in place or can it be set up? * Is there a civ-mil coordination mechanism? Other platforms? * Can we evacuate/re-locate if needed? Team and patients? | * Will it be safe to operate the mission for the staff and patients? Always? * Will local staff have safe access? * Is a secure referral mechanism in place or can it be set up? * Will team be viewed as taking sides by virtue of passports and views from deploying nation? * Is there a clear chain of military command on both sides? * Will my nationality, ethnicity, past social media history, government’s position influence the perception by locals? * Is there a civ-mil coordination mechanism? Other platforms? * Can we evacuate/re-locate if needed? Team and patients? |
| Impartiality | * Will we be directed to discriminate and treat one group and not the other? * Can we influence decision makers? * Can we be prosecuted and/or stigmatized in national media for treating all? | * Will we be forced to discriminate and treat one group and not the other by virtue of the location or denial of access to those in need? * Can we influence decision makers? * Can we be prosecuted upon return for aiding those labelled “radicals/extremists/terrorists”? |
| Neutrality | * Do we understand the context? * Are there International Actors present or en route? * What is the nature of medical services now on both sides? * Will we have access to both/all sides of conflict? * Will be forced to make statements and triage preferentially wounded and sick from one side and not the other? * What can and cannot be communicated/shared on this conflict? And with whom? * Will we be perceived as party to the conflict? Is this changeable? * What can and cannot be communicated/shared on this conflict? And with whom? * What are the guidelines as to media and social media? | * Do we understand the context? * What is the nature of medical services now on both sides? * How have others responded? (ICRC, MSF, UN, local NGOs, MoH, etc) * Has the UN formally stated a position in support of either side? * Will we have access to both/all sides of conflict? * Will we be forced to triage preferentially based on uniform from one side and not the other? * Will we be presented with wounded and sick from one side only? Will they be able to reach us voluntarily? * Will my nationality, ethnicity, past social media history, government’s position influence the perception by locals as being party to the conflict? Is this changeable? If not? * What can and cannot be communicated/shared on this conflict? And with whom? * What are the guidelines as to media and social media? |
| Independence | * Is team part of governmental, non-governmental or semi-governmental structures of the state? * Is this alert part of a government or military strategy? * Will we be perceived as party to the conflict? * Who is funding? * What level of operational autonomy will team have over medical decisions, deployment location, mobile/outreach if needed? | * Who is mobilizing? * What is there agenda? * Is this alert part of a government or military strategy? * Who is funding? * What level of operational autonomy will team have over medical decisions, deployment location, mobile/outreach if needed? |
| Special Considerations | * What is the level of GBV? Implications for team skills and kits? * What are the off-limits/taboo topics? * Have atrocities been committed or are probable? By whom? Will team be required to report or provide evidence? | * What is the level of GBV? Implications for team skills and kits? * What are the off-limits/taboo topics? Who can they be discussed with? * Have atrocities been committed or are probable? By whom? Will team be required to report or provide evidence? |

Table 4 A Checklist: IHL & Principles in Action for National and International Teams

## Consequences & Implications when Deviating from Principled Action.

Behaviour and conduct of teams in a principled manner framed by IHL requires deliberate and thoughtful action, as well as constant monitoring of the evolving context within which teams operate. It may also require an advocacy strategy to influence key actors and authorities to ensure safe access to the wounded and sick. The sources to inform this critical thinking can include conversations with locals, authorities, patients, facilities, print/social media, local staff, etc. Team leaders should not dismiss comments and views, but rather actively listen, observe, and reflect. Teams are also not immune to the actions of others or their own from past deployments (reputations follow teams and persist). Populations and communities do not or are not able to distinguish between the various groups and missions, and often tend to generalize (positively or negatively) from what is heard and observed. In many situations, this may require external communications to address rumours and perceptions not reflective of the mission. *All* external communications need to be tightly managed, well-coordinated, and controlled as to avoid mixed or confusing messages that may be misunderstood.

National teams may face additional challenges in being coerced into actions and statements that will be perceived by warring parties as taking sides, deviating from IHL (eg. hospitals used for non-medical functions) and some of the core humanitarian principles. While National teams may have no option but to abide by political and military directives, they also may possess a potential critical advantage in being able to discreetly advocate and influence leaders and military commanders to modify conduct and adhere to IHL, while continuing to negotiate access and some operational autonomy/independence. While teams may not have control as to who can access their facility, they can ensure humanitarian and impartial care upon admission and treatment.

There can also be perceptions of teams not adhering to principles simply due to team’s own nationalities, ethnicities, languages spoken, etc. Such factors need to be accounted for pre-deployment with the recommendation that teams opt out of deployments in which factors beyond their control may pose risks and liabilities in the field of operation.

The above examples help illustrate how principled conduct is of paramount importance to the success of the medical mission and requires pragmatic leadership, flexible thinking, decision making compromise, collaboration, and judgment calls that factor in multiple stakeholder and community perceptions. The decisions may require regular course corrections and frequent, well-coordinated communications to the warring parties, community leaders, local authorities, and others to ensure access and security. The actions of ‘the few’ will affect ‘the many’, and therefore, various medical teams need to act in a principled manner as a community of practice and not merely as individual or solo groups.

The following table, while not exhaustive, aims to guide and support teams in decision making and planning for a deployment into an armed conflict setting, and the engagement with various actors. It is critical to keep in mind that overall awareness of the situation and evolution of conflict is important and a *‘must do’* daily task for the team and team leaders.

Maintaining principled humanitarian action in the face of these pressures is an essential task, but challenging to achieve.

|  |  |  |
| --- | --- | --- |
| Medical Teams are Required to: | Why? | Possible Consequences if not practiced |
| 1. Actively engage in the care for, support to, and referral of patients as medically required | Humanity and Neutrality | Risks categories include loss of protection, security, trust, access, reputation, and increased moral distress:   1. Risk being subjected to direct or indirect attacks on facility, team, and/or patients. 2. Risk loss of acceptance by the wounded and sick not seeking the services, often preferring to suffer or access other forms of care if available 3. Risk loss of access via denial of physical entry to areas where the wounded and sick are present including road blocks to facilities or camps, threats, and coercion. 4. Risk loss of confidential relationships and influence with key actors that can provide access and/or facilitate various aspects of the mission 5. Risk heightened levels of moral distress[[68]](#footnote-68) caused by teams unable to access or care for patients 6. Risk to reputation, both within the area of operations, and possibly globally as the team may develop a reputation or be perceived as an opportunistic/mercenary type organization. 7. Risk stigmatization and generalizations (realities or perceptions) being applied to most teams throughout the operational space. 8. Risk legal prosecution associated with crimes of war and against humanity. |
| 1. Provide medical care and triage as to not favour (or appear to) one group, religion, or ethnicity over another | Impartiality |
| 1. Not restrict access to life saving devices and pharmaceuticals and not prioritize the foreign teams[[69]](#footnote-69) | Impartiality |
| 1. Avoid placing facilities in close proximity to, or co-locating linked to the military of one of the warring sides | Neutrality |
| 1. Avoid Utilizing armed escorts and uniformed/armed guards (see OCHA guidelines[[70]](#footnote-70)) | Neutrality and Independence |
| 1. Avoid expressing opinions and sharing views on the armed conflict actors. This can take many forms: in meetings, in publications, in media interviews, on social media, in conversations with patients/families, with local staff, local authorities, etc | Neutrality |
| 1. Avoid expressing sympathy (or perceived to do so) and solidarity with one side over another via of attire/uniform choices, religious symbols, facility logos/emblems, national flags, and/or socializing | Neutrality |
|  |  |

Table 5 Consequences for non-compliance

In Summary[[71]](#footnote-71):

1. Humanitarian principles govern humanitarian and medical actors’ conduct.

2. Humanitarian actors need to engage in dialogue with all parties to conflict for strictly humanitarian purposes. This includes ongoing liaison and negotiation with non-state armed groups.

3. Compliance with humanitarian principles affects team credibility, and therefore ability to establish safe access to affected people. However, it is not enough to repeatedly recite humanitarian principles. Rhetoric must be matched by leadership and practice.

4. There are multiple pressures on humanitarian actors to compromise humanitarian principles, such as providing humanitarian aid as part of efforts to achieve political ends.

5. Military or Governmental teams contributing to EMTs must provide strictly impartial medical care, in keeping with IHL and medical ethics, and must be aware of the impact their action can have on the perceived neutrality and independence of the broader medical operations.

## Negotiations & Humanitarian Diplomacy

“Out beyond ideas of wrongdoing and right doing, there is a field. I’ll meet you there.”

Jalāl ad-Dīn Muhammad Rūmī Persian poet, Sufi mystic. (AD 1207-1217)

The practice of successful negotiations, in which success is defined as having unhindered *and* safe access to the wounded and sick, requires mature and experienced leadership with skills rooted in conflict resolution and consensus building.

The success of a humanitarian negotiation outcomes is linked to the quality of both the personal relationship established between the leadership and members and the counterparts and the use of the respective networks of influence.

Unlike negotiations during ‘peace’ times or in day to day situations, the context of armed conflict will include additional pressures with high levels of stress, tension, duress, fear, insecurity, risk, and potential for manipulation.

Experience by many suggests that possibilities and opportunities exist in the darkest and most confusing contexts to reach agreement, find acceptable solutions, compromise, and carry on with the mission. The MSF experiences and case studies were published in a book (available in French and English[[72]](#footnote-72)). It states:

“this book sets out to deliberately puncture a number of myths which place humanitarianism above politics. It is a candid examination of the compromises MSF made – some successfully others less so – to try and help the people suffering most in the world today.

Case studies from recent conflicts such as Yemen, Sri Lanka and Afghanistan lay bare the reality of MSF’s efforts to reach the most affected people, and explore just what the limits of compromise should be. There are also a series of thematic essays that explore broader issues, such as the real usefulness of aid responses to natural disasters.”

Team members and leaders require abilities to approach critical situations, diffuse tensions, apply principles to key decisions made, compromise, negotiate with multiple stakeholders, and uphold the centrality of access, quality patient care, protection for the wounded and sick, as well as team safety and security.

The Geneva based Centre of Competence on Humanitarian Negotiation[[73]](#footnote-73) (CCHN), launched by five leading humanitarian organisations, the International Committee of the Red Cross (ICRC), the United Nations High Commissioner for Refugees (UNHCR), the World Food Program (WFP), Médecins sans Frontières (MSF- Switzerland) and the Centre for Humanitarian Dialogue (HD) published a field manual.

In December 2018, the first edition of the CCHN Field Manual on *Frontline Humanitarian Negotiation* was published and be downloaded[[74]](#footnote-74). Drawing on the collective experience and perspective of hundreds of humanitarian practitioners, the Field Manual offers a set of concrete tools and methods to plan and prepare negotiations processes for the purpose of assisting and protecting populations affected by armed conflicts and other forms of violence.

The manual “proposes a comprehensive method to conduct humanitarian negotiation in a systematic and organized manner. It provides a step-by-step pathway to plan and implement a negotiation strategy based on a set of practical tools designed to : Analyze negotiation environments; Assess the position, interests, and motives of all parties; Build networks of influence; Define the terms of the negotiation mandate and clarify negotiation objectives; Set limits (red lines) to these mandates; as well as Enter into transactions in a thoughtful and tactical fashion.”

Humanitarian negotiations are defined as:

“a set of interactions and transactions with parties to a conflict and other relevant actors aimed at establishing the presence of humanitarian agencies in conflict environments, ensuring their access to vulnerable groups, and facilitating the delivery of assistance and protection activities. These negotiations take place at the field level for the most part and involve both state and non-state actors. They include an advocacy component relative to the protection of affected populations as well as a transactional component in setting the logistical and tactical parameters of humanitarian operations.” (CCHN Frontline Negotiations Manual)

It is a central role for team leaders to set the tone, attitude and parameters for the medical mission; communicate the priorities, risks, do’s & don’ts, plans, etc. And while not all team members will be negotiating with lead counterparts, many team members will nevertheless engage in various levels of communicating/negotiating with many actors. It is therefore, imperative that all have a solid grasp on the fundamentals including engaging with locals of all backgrounds and professions.

The Soft skills and competencies required to augment negotiating and communicating are critical to all team members. They include commitment to caring for people, being self-aware, being able to work with others effectively across languages/culture, having leadership skills, being able to follow directives, taking initiative, professionalism, a commitment to ethics, listening skills, good communication skills, and exceptional cultural sensitivity.

It has been said that “Deployment is Diplomacy”[[75]](#footnote-75) and soft skills provide for soft power and influence to achieve mission objectives. While it is challenging to provide a prescriptive or one size fits all approach to the most essential soft skills, experience demonstrates that treating *all* with respect, humility, empathy, patience, and sensitivity will enable better outcomes. This does not mean abandoning principles and mission goals, and can be achieved while being firm, focused, and persistent.

### Community Engagement

Medical teams are usually afforded a high level of trust when responding to health-related emergencies therefore potentially making them key influencers that can encourage healthy behaviors in communities. However, in the context of conflict where violations of international humanitarian law may occur, and a high degree of chaos, suspicions, and confusion can lead to a lack of trust in medical teams and humanitarian action at large. The population will view the medical missions through their own set of values and beliefs, experiences, and rumors, and may have low or high expectations. Thus, active community engagement becomes a critical element in rebuilding trust and acceptance and securing access and managing expectations.

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| Example of importance of Community Engagement in outbreak during acute political violence  Post election violence and criminality that lasted weeks amidst a serious cholera epidemic in a major urban centre resulted in a situation in which the fear of the disease within communities saw patients and medical teams attacked, prevented from setting up, and overall refusal to permit access; meaning no acceptance, no trust, and high level of insecurity. Certain politicians and other religious leaders condemned those with cholera stating that this was “punishment from God” and that “cholera was the work of the devil”. They would travel in convoys with loudspeakers urging the communities to ‘kick out the sick” and “stop medical teams from treating them”.  As the epidemic peaked, with thousands affected, the government sought international assistance (but was unable to force communities to accept the teams). To gain access to one major neighborhood within the big city and set up a cholera treatment centre (CTC), one international team’s approach was to quickly actively engage with over 30 community leaders (political, municipal, religions, schools, women, youth, businesses, local Red Cross, etc). Through meetings convened in place and times of their choice, the team explained the nature of the illness, the causes, the available treatment, the type of field hospital (CTC) and team that would be set up, the duration, the benefits, the need/role for the community to be part of the effort to identify sources and spread the messages on prevention, seeking their assistance to identify a suitable and acceptable location, etc). The meetings dragged on for over 5 days and needed extreme patience and a respectful approach. The team shared epidemiological data with the community throughout the process of dialogue which helped highlight the spread of the disease, locations, the important role they need to play, and urgency needed. The violence continued for weeks, curfews were in place, roadblocks and burning tires were on many street corners.  Once the violence decreased to an acceptable level and most of the community leaders (not all) nodded that the team can set up. There was transparency and agreement as to how to manage the deceased, the waste and the condition of the land upon completion of the operation, training for locals, the support to prevention efforts, etc  The CTC started operating after 8 days from arrival into the country, within the first hours, the 80 beds were fully occupied with women, children, and men. In the next days, many of the leaders were invited to see how cholera is treated and patients are cured. Many seemed pleased and assured.  However, some of the car convoy loud speakers continued to blare against cholera. The team decided to invite the politicians leading the negative campaign (through the local church leaders), and they accepted. Similarly, they were shown the facility and patients and local staff (medical and non-medical) supporting the treatment centre, the training for community members on prevention and hazard identification. The next day, the loud speakers stopped. The team continued treatment for the next 5 months, and upon the decision and close down and handover, the politician who was leading the negative campaign visited the facility and asked the team to please continue: “if you leave, people will die. Please stay” he said. He was assured that the situation is under control and the local community and Red Cross will be able to manage from now on. |

Figure 5 Community Engagement Example

Attacks on medical facilities and personnel also cause communities, community leaders, local health workers, to hesitate in seeking or providing care. This general insecurity creates challenges both for populations trying to access health services and for health actors trying to reach populations in need. A road block, checkpoint or blockades can render the best of efforts to offer medical care not possible. At times, medical missions have been attacked both deliberately and in error[[76]](#footnote-76).   
  
Direct and open engagement with the population, community leaders, local health workers, when providing clinical care will aid in building trust and customizing care to address population specific concerns and morbidities. This may also require competencies in interview techniques, working with interpreters, sensitivity to power/gender dynamics, managing ethical dilemmas, etc. Gauging perceptions and determining how to best gain acceptance into a community entails establishing relationships and frequent communications framed by active listening, soft skills, humility, respect, civility, gender sensitivity, cultural sensitivity, empathy, and transparency. A degree of openness, transparency and a predisposition to learn from local health provider, local community ‘wisdom’, and a willingness to take criticism, reflect, and act can also aid in building trust, preserving *dignity*, and strengthening acceptance.  
  
In the study by the Humanitarian Policy Group[[77]](#footnote-77), it appropriately stated that often in crisis contexts where there has been a rupture of the existing norms and institutions of governance, NGOs claim authority by appealing to impersonal norms such as freedom, equality, health and security: international professionals with expert training descend on a local crisis, imposing values and applying standard procedures to their intervention and, in so doing, denying a state’s sovereignty and depersonalising and decontextualizing social relationships, ‘reducing social agents to human bodies’  
  
Many humanitarian responders today are quite well informed on the core humanitarian principles, their organizations communications strategies which are shaped by mandates, and are often briefed on the context of the operations. However, in the contexts of war, EMTs are often faced with new challenges, dilemmas, and the need to find a delicate balance: Medical teams need to ideally locate services as close as safely possible to a community, however, this may not be possible due to active hostilities and war hazards.   
Where trust and physical interaction between affected populations and responders becomes challenging (e.g. because of access restrictions), or grow too complicated (e.g. because the ability to trust is undermined by perceived bias and/or distance), the resort to “virtual proximity”, including the development of “digital trust”, is one avenue to be explored [[78]](#footnote-78). It can strengthen what was previously discussed on the importance of 'communicating with the population and obtaining feedback.  
  
‘Digitally prepared’ humanitarian responders can deliver better quality and more accountable services to people affected by crises. This also does come with caveats which will require careful consideration linked to data protection and cyber security.   
  
Many organizations are resorting to the use of social media and other digital applications to share message in hard to reach communities. Organizations are creating broadcast lists targeting communities to provide vital information and public health messages. Practical and useful information is shared including drinking safe water, preventing the spread of disease, first aid for wounds, etc.   
For the Toolkit  
Engaging with People Affected by Armed Conflicts and Other Situations of Violence: Recommendations for Humanitarian Organizations and Donors in the Digital Era <https://reliefweb.int/sites/reliefweb.int/files/resources/engaging-with-people-in-armed-conflict-recommendationt.pdf>  
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Sarah Collinson Constructive deconstruction: making sense of the international humanitarian system <https://www.odi.org/sites/odi.org.uk/files/resource-documents/10734.pdf>

## Chapter 1 Guidance Notes

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| *Do No Harm!* | 1. *Medical teams and leaders need to frequently analyze and understand the context and nuances within the areas and territories deployed to through a conflict sensitivity lens to avoid unintentionally Doing Harm.* 2. *Medical teams are required to seriously consider not deploying, and closely examine the location of the deployment when minimum conditions of safety, security, impartiality, and access to wounded and sick cannot be achieved.* 3. *Medical teams need to reach patients through principled conduct. Access requires acceptance by communities and stakeholders. Acceptance is rooted in trust and will provide for improved Security.* 4. *Medical Teams need to be aware and provided with pre-deployment practical training (and field training for local staff) as to applicable International Humanitarian Law (IHL), and the four Core Humanitarian Principles of Humanity, Impartiality, Neutrality and independence.*   *Via practical IHL training modules integrated into existing curricula[[79]](#footnote-79) (and include local staff, and rotating teams)* |
| *IHL and Core Humanitarian Principles in Action* | 1. *Medical teams are required frame operations by IHL and Core Humanitarian Principles through demonstratable actions that ensure they are distinct from military operations; and be able to understand where concessions can and cannot be made while being fully aware of consequences.* 2. *Medical teams, if/when possible and safe, need contact with all parties to the conflict, and treat all wounded and sick without discrimination.* 3. *The realities, complexities and risks associated with operating as a medical team in armed conflict require experienced leadership and resilient teams capable of navigating the landscape with a pragmatic and patient focused approach.* 4. *Team leaders will require special training and guidance to navigate complex and confusing terrains of armed conflict.* 5. *Teams should only consider the use of armed escorts and armed guards only as a last resort* |
| *Humanitarian Negotiations* | 1. *Teams and Leaders require competencies and skills in conflict resolution, consensus building, as well as soft skills applied with humility, respect, patience, and cultural/religious sensitivity as critical enablers to achieve objectives* |
| *Community Engagement* | 1. *Medical teams need to engage with communities with full transparency and openness framed in active listening, extra sensitivity to culture, & gender, respect, and empathy.* 2. *Digital and social media platforms can be considered (with cautions) to communicate with affected populations and other medical professionals, to provide key practical messages and tips on health and hazards.* |

CHAPTER 2

SAFETY & SECURITY

RISK MANAGEMENT

“How very little can be done under the spirit of fear.”

Florence Nightingale

# Safety and Security Risk Management

Under review and edit

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| Objectives:   1. Team have a holistic security risk management approach in place for operations in conflict settings. 2. Teams are able to identify specific security threats associated with armed conflict contexts. 3. Teams have considered particular security measures appropriate for providing care in armed conflict (including CBRNE considerations) 4. Organizations/Agencies better understand the minimum requirements for robust preparedness in terms of workforce mental health. 5. Teams and Leaders have easy access to the most relevant key references and manuals at their fingertips |

## Introduction

To save lives and intervene in a timely manner, medical teams are required to operate in proximity to active hostilities. Such deployments demand a high level of attention to risk management and engagement with stakeholders from all sides.

This chapter will further elaborate the means and measures medical teams are required to undertake to protect the medical mission and respond to deliberate and indirect attacks. It will present and highlight best practices, safe conduct, and specific Do's and Don'ts referencing the work of selected NGOs, ICRC, MSF, WHO on the topic. Many of the key organizations in this field have published guidelines and practical guidance manuals: UN “Security Management System”, ICRC' s "Health Care in Danger"[[80]](#footnote-80), “Safe Access Framework”[[81]](#footnote-81), MSF's "Not a Target"[[82]](#footnote-82), and WHO's "Attacks on Health Care initiative[[83]](#footnote-83))

Organizations deploying medical teams have a legal and moral obligation to strive towards a practical level of judgement and care in safeguarding the safety and wellbeing of deployed team members as well as other stakeholders within the scope of team operations, such as patients and referral cases, their families, local health workers, contractors, and counterparts.

The core question at the heart of the EMT’s approach is: how far is it worth risking a person’s wellbeing – or even life – under specific circumstances in order to achieve organizational objectives? Decisions concerning whether to deploy, how to remain in situ, and whether to continue with a direct field presence in the face of escalating dangers must be placed within a holistic and systematic risk management process.

Armed Conflict contexts evolve rapidly and with little or no early warning, teams need to constantly re-assess, and act.

While the same principles of security risk management apply to all emergency contexts, their application often requires greater care and urgency in situations of armed violence. Without sufficient security, medical response teams cannot (and should not) sustainably access communities in the face of hostilities; without close access, the delivery of meaningful and quality medical care is not possible.

None of these elements – security, access and humanitarian action – is static or stand on their own. This relationship can be illustrated in mechanical terms, as follows[[84]](#footnote-84):



Figure 6 Safety & Security Wheels

In addition, if medical teams fail to deal with security challenges in an ethical and principled way, they may appear biased and even become instrumentalized: seen as giving military or political advantage to one side of a conflict.

The Blue Book (updated 2019 version) and associated EMT Toolkit outline in detail the safety and security risk management considerations for all medical teams, including those operating in conflict settings. A holistic approach requires action at three levels:

* At the institutional level, a security policy, culture and framework should be introduced that demonstrates a clear commitment and division of roles in alignment with the organization’s overall risk appetite. Organizations working in areas of armed violence generally must accept a higher threshold of risk, communicate this openly to their managers and workforce through a dialogue founded on informed consent, and then invest in additional strategies that will enable safe outcomes wherever possible.
* At the field management level, the inter-connected pillars of security risk assessment, security planning and critical incident management should be applied systematically, according to the local context and specific nature of the medical operations. Team leaders must be empowered and resourced to select and implement the most appropriate blend of measures to treat the priority security risks identified. Good practice suggests that specialized support is made available to help team leadership in the form of a dedicated security focal point.
* At the level of individual team members, personnel are trained and briefed in how to reduce risks to physical and mental safety by applying team SOPs and carrying out security contingency plans. Clear parameters for safe behavior on and off duty are followed, including protocols in relation to social media.

Traditionally, aid organizations tend to focus exclusively on the negative impacts of security risks, but a holistic approach to risk management requires teams to consider and utilize the positive impacts too[[85]](#footnote-85). Examples of benefits to EMTs in accepting and managing security risks may include:

* Reputational enhancement;
* Stronger relations and trust with affected communities;
* Building an esprit de corps amongst team members;
* Improved security coordination and response planning;
* Improved conditions for future access.
* Improved organizational resilience;
* Positive media coverage;

## Specific Security Threats

Where health emergencies co-exist with armed violence, there are usually special features relating to the use of weapons, explosives or other means to wage conflict that alter the security environment. Furthermore, with the breakdown of rule of law that often occurs during conflicts, threats from criminality, civil unrest and other types of hazard can increase to levels exceeding those evident prior to the hostilities.

The categorization of threat sources varies according to the assessment methodology used, but typically those within the following broad categories should be considered.

| **Armed conflict** | **Radical Violence** | **Crime** | **Civil unrest** | **Hazards** |
| --- | --- | --- | --- | --- |
| Small arms attack | Improvised explosive device | Kidnapping (economically motivated) | Peaceful protest | Vehicle accident |
| Aerial assault | Kidnapping (politically or militarily motivated) | Sexual assault or gender-based violence | Violent demonstration | Illness / disease (list specifics) |
| Landmine strike (anti-personnel) | Assassination | Car jacking | Looting | Natural disasters (list specifics) |
| Landmine strike (anti-vehicle) | Suicide bomb | Burglary | Patient aggression | Fire in hospital |
| Unexploded ordnance | CBRN(E) attack | Petty theft |  |  |

Table 6 Threat categories (adapted from UN Sec Management System)

As part of their risk management approach, medical teams must weigh their vulnerabilities in relation to each identified threat, including both deliberate attacks on health facilities / team activities as well as indirect dangers caused by virtue of being in the wrong place at the wrong time. Note that decisions should not be made (and security measures should not be introduced) on the basis of “threat,” but on “risk”. In other words, it is entirely possible to be confronted with a high threat level that poses low risk to the EMT in a given area, depending on the EMT’s vulnerability profile.

<https://www.eisf.eu/library/managing-sexual-violence-against-aid-workers/>

## Specific Security Measures

Following a thorough risk assessment and contextual analysis, in addition to routine measures necessary for any type of deployment, special controls designed to reduce exposure of medical teams to some conflict-based threats might include (but are not limited to):

1. Avoid places and times of day where instances of armed violence are more likely;
2. Negotiate and agree safe access protocols with warring parties and arms carriers.
3. Strengthen efforts to demonstrate the medical team’s neutral and impartial position; including careful attention to attire, emblems in use, measured associating with parties to the conflict, personal conduct, restrictions on media and social media statements, treat all with respect.
4. Increased coordination and information sharing with other actors ‘behind the scenes’ on security risks relating to the conflict;
5. Based on risk assessment, consider establishing a hard perimeter around the medical facility or team base;
6. Increasing the stand-off distance separating the perimeter from personnel-heavy areas inside the facility;
7. Enhancing access controls e.g. vehicle chicane, protective features for unarmed guards;
8. Introducing blast protection infrastructure within fixed facilities e.g. designation of hardened walls or rooms;
9. Using blast protected vehicles for transport or staff and patients;
10. Stockpiling personal protective equipment relevant for the armed threat; Inclusion of direct and indirect attacks within the team’s contingency plans and practical rehearsals e.g. medevac, hibernation and relocation / evacuation plans;
11. Incorporating conflict-based threats into the team’s critical incident management system, including specific protocols for high risk scenarios such as kidnap or hostage taking;
12. Instituting team protocols for the medical treatment of war wounded, including separate triage areas for different parties, where appropriate;
13. Establishing a clear “no weapons” policy for the healthcare facility and communicating this clearly to both armed visitors and wounded combatants. Safe storage facilities and protocols should be employed for small arms, ammunition and sharp edged (bladed) weapons – including use of illustrated examples on facilities and vehicles.

|  |  |
| --- | --- |
| No weapon allowed | A black, white and red no gun silhouette sign |

Figure 7 Examples of stickers for facilities and vehicles

Context matters, and it is again stressed that no two situations are the same; a nuanced and informed approach is necessary which balances acceptance, hardening and deterrence measures in degrees proportionate for the threat context and in alignment with the medical team’s internal mandate and capabilities. Although an EMT organization may have a natural leaning towards a soft or hard security profile, those who successfully maintain an operational presence in conflict settings recognize that a mix of methods is needed, and are adept at blending the best available tools for each deployment.

*A nuanced and informed approach is necessary which balances acceptance, hardening and deterrence measures in degrees proportionate for the threat context and in alignment with the medical team’s internal mandate and capabilities.*

Moreover, when introducing a new risk reduction measure, the medical team should take care to monitor how this affects the effectiveness of its other measures. Sometimes, a team that makes itself safer in relation to one threat can unwittingly increase its vulnerability to a different threat.

|  |
| --- |
| **Example 1: Care within Extremist Internal Conflict**  A medical team whose security strategy relies heavily on building trust and positive image engagement with the local communities surrounding its health facility may undergo reduced exposure to threats of criminal intent or localised crowd violence. However, a team that depends solely on acceptance may also be viewed as a ‘soft target’ for potential “extremists” attacks, including those of a criminal nature, which can even put the communities at increased risk due to association with the medical organization.  **Example 2: Care & Armed Escorts**  A medical team in a refugee camp where, for a long period of time, humanitarian road movements were accompanied by police escorts, experienced a reduced vulnerability to car-jacking for criminal purposes. However, travel alongside local security forces actually increased the team’s chances of encountering improvised explosive devices laid by militants who opposed the host government.  **Example 3:** **Care & Transport in Situations of Criminal Violence**  A national organization providing first aid and transport to victims of national severe violence and criminal activity has had personnel face threats and harassment in person and over radio communications.  The organization continues to navigate a delicate balance to position itself as neutral in the ongoing clashes.  The behavior of the gangs has seen the medical personnel taken away from homes and ‘escorted’ to provide care for injured group members.  Similarly, ambulances (with and without physicians) are taken over and diverted to areas in which victims of violence are present.  The organization has resorted to using secure digital radio communications to ensure privacy and confidentiality of ambulance movement and staff locations. The injured were sometimes transported with police escorts.  Despite the hazardous situation, the personnel and ambulances have not been attacked. According to the organization, this is thanks to a long process engaging all the different actors, discussing the nature of the medical mission and the respect it deserves, as well as ensuring transparent, neutral and impartial action of the organization. |

Figure 8 Security Cases & Examples

International guidance for humanitarian actors working in conflict-based emergencies states that armed protection should be considered only a last resort before having to cease life-saving assistance during emergencies. As a general rule, medical facilities and convoys should not use armed escorts for purposes of security. If the use of armed protection is considered to have negative impacts on the perception of humanitarian actors as impartial, the behaviour of each individual humanitarian actor will affect the perception of the whole humanitarian community.

Medical teams should therefore consider the following as preferred alternatives to armed escorts:

* Maintaining a low-profile approach;
* Remote and digital device support type programming options;
* Negotiating access;
* Raise awareness of IHL among armed groups;
* Request area security e.g. ‘clearing’ and patrolling roads, maintaining a presence in the area but not being visible or accompanying the convoy, providing aerial fly-overs;
* De-confliction of military and humanitarian activities, to ensure clear separation of actors co-existing in the same space;
* Humanitarian pauses or corridors (although this is not a favoured option).

The issue of risk sharing, and transference also takes on increased significance for teams working in conflict settings. Transference can occur when:

* Two or more medical teams are co-located or conducting joint operations;
* Local health workers are embedded within the medical team’s facility, or vice versa;
* A medical team conducts a planned handover of its activities to another entity, towards the end of its deployment;
* The security situation deteriorates to a point where a medical team is forced to make a hasty withdrawal, leaving local health workers to continue the service delivery autonomously or with some degree of remote support.

It should be remembered that, while a security threat may remain the same before and after any point of transference, the vulnerabilities to that threat of different teams or health workforces will often vary. For example, depending on a variety of factors, a clinic staffed by local health workers may be assessed as either more, or less, at risk of violent attack than would the same clinic run by an international medical team.

In each case where a medical team opts – through choice or necessity – to transfer risk to another entity, there is a moral as well as practical dimension to consider within the business continuity arrangements. Respective vulnerability profiles should be compared, and expertise shared openly, to ensure that a defendable risk treatment plan is maintained as seamlessly as possible within the constraints being faced.

## Medical Evacuation for Team Members

Insert references

It may be necessary to medically evacuate team members due to injury and other considerations. If the decision is taken that evacuation from a medical point of view is a necessary measure, EMTs need to act quickly and assess risk-benefit for the team member and the team: evacuation is not an end in itself, but a means of achieving the best possible results in a given context.

Evacuation protocols need to be well established, clear, and well communicated to the team, with a designated focal point, and well-coordinated with external stakeholders as required.

Generally, overland transport (ambulances and general-purpose vehicles) is the primary means for the injured evacuation from emergency zones to the nearest and safest point of medical care.

Railway, river and marine transport can be considered and may offer certain advantages over the motor one. Usually the final evacuation steps may require especially equipped civil or military airplanes.

Teams need to ensure adequate medical documents accompany the person(s) evacuated. In cases of infectious diseases, and/or suspected CBRN contamination, special measures must be taken. (insert ref)

*Importantly* key precautions to ensure safety need to be implemented including notification/consent of warring parties, agreed emblem use, coordination with medical providers along the referral pathway,

## Patient Safety

The team needs to consider the safety of the wounded and sick to ensure access and protection for patients and families.[[86]](#footnote-86)

|  |  |
| --- | --- |
| Access, Entry, Referral & Discharge | Consider |
| 1. Prior to Admission:   Do the wounded and sick have free access to the facility? | 1. What are the risks on the roads to the health care facilities? Checkpoints, hazards, threats, etc. 2. What mitigation actions have been taken? 3. Is the transportation to the healthcare facility available and safe for the patients and families? 4. Are the surroundings of the facility safe for the family to stay at? 5. Does the visitor policy account the risks? |
| 1. Care within the Facility   Is the facility protected and marked including consent from warring parties? | 1. Is the medical facility recognized as a protected, impartial and neutral by all parties to the conflict? What are the measures taken to achieve that? Is this coordination periodically visited? 2. What are the agreements with the military / law enforcement on the protection of hospitalized combatants? What are the mechanisms to deal with disputes? |
| 1. The Referral Pathway & Discharge:   Can patients be referred to other facility safely? | 1. Are the medical transports used known to all the parties and respected? What actions are needed to ensure this respect? 2. Is the referral path/discharge for the victim safe (the roads, transportation modes, referral facility)? Is referral considered also in terms of the victim’s safety and security? |
| 1. Overall | 1. Is an ongoing risk assessment in place to monitor the risks to the patients and their relatives? |

Figure 9 Patient Safety Considerations

## Mental Health Considerations

In attempting to care for the wounded and sick in armed conflicts, medical staff (local and international) experience strong emotions, owing to the context of emergency, rapid intervention, and fatigue, but also of fear, and violence in all its forms. The conditions are often hard, as a result of the suffering of victims, and dangerous (due to armed conflicts, undisciplined combatants who have no respect for anything, proliferation of arms and their use in criminal acts, attacks, abductions, outbreaks, and various threats)[[87]](#footnote-87).

In such a chaotic and unpredictable environment, and the affected population will have overwhelming needs. Team members must be able to cope with being away from home and family for extended periods.

Members need to reflect upon[[88]](#footnote-88):

* Having the patience to work through the inevitably frustrating communication breakdowns that occur during cross cultural interactions?
* Being open minded and creative when facing unexpected problems?
* Having constructive and readily available means of coping with stress, anxiety and frustration?
* Being prepared to compromise some of your personal freedom because of security in some areas?
* Considerations for how to respond in the presence of extreme suffering and deprivation, part of the day-to-day reality of many of the people in armed conflict zones?
* Being honest with own motivation for seeking this type of work and realistic in expectations of what it will be like?

See this simple ten question stress self-evaluation and checklist. [[89]](#footnote-89)

## Mental Health & Psycho-Social Support for the Team (MHPSS)

Conflict scenarios pose some specific mental health and psychosocial (MHPSS) challenges, along with those who are common also to large scale disasters.

Disaster settings are highly stressful; grave human suffering, overwhelming needs, shortage of supplies, long working hours and not enough rest, harsh physical conditions, being away from friends and family with often poor communication opportunities, are just some of the hardships encountered that will have an impact on the responder’s emotional wellbeing. Some of the additional characteristics of conflict settings, that can have a great and severe impact on the responders include:

* Cruelty (including the use of gender-based violence as a weapon of war).
* Attacks and violations targeting the most vulnerable (children, women, elderly, sick persons)
* Direct threats against the health care personnel, or physical aggression against them or against the health care facility.
* Direct threats or violence against the local staff and their relatives (mainly around “treating the opposing side of the conflict”).
* Armed actors denying care for certain groups and/or hindering access.
* In order to mitigate the adverse effects of the situation on the EMT personnel, and prevent long term consequences on the team members emotional wellbeing, all EMT deployed to a conflict environment should:
* Have a comprehensive MHPSS plan in place. The plan should include among other components; initial screening of the delegates, risk analysis and mitigation actions, definition of “critical incidents” and actions following a critical incident (e.g. injury or death of a colleague due to violence), referral path for personnel including – medevac and long term follow up, after mission MHPSS plan.
* Train all personnel in personal stress management and Psychological First Aid.
* Train the team leaders (or designated focal points) in psychosocial care for their team.
* Ensure personnel work shifts allow appropriate time for rest and leisure activities, and that living conditions (to the extent possible) allow rest and time off.
* Ensure that the set up allows for peer support, and group dynamics as culturally appropriate.
* Have a mechanism in place that allows a team member to “step down” if feeling “overwhelmed” and ensure that this is well known and accepted by the team.
* Ensure that appropriate MHPSS support is available for the local staff and volunteers as culturally acceptable in the setting.

Ref RFL <http://pscentre.org/?resource=broken-links-psychosocial-support-for-people-separated-from-family-members-a-field-guide-english>

For the Toolkit

1. MHPSS for Delegates deployed to a violence setting:

a. Mental Health and Psychosocial Support in Emergencies – Delegate Handbook: http://pscentre.org/?resource=mental-health-and-psychosocial-support-in-emergencies-delegate-handbook

b. Monitoring and Evaluation Framework for MHPSS Programmes in Emergencies: http://pscentre.org/?resource=emergency-me-framework

c. Caring for Volunteers A Psychosocial Support toolkit & Training materials: http://pscentre.org/?resource=caring-for-volunteers-a-training-manual and http://pscentre.org/?resource=caring-for-volunteers-a-psychosocial-support-toolkit-english

d. Psychological First Aid Module 2 (1-day training): http://pscentre.org/?resource=powerpoint-psychological-first-aid-module-2-basic-pfa

e. Psychological First Aid for Children Module 3 (2-3 days training): http://pscentre.org/?resource=psychological-first-aid-for-red-cross-red-crescent-module-3-children

f. Psychological First Aid for Groups: Support to teams (Module 4): http://pscentre.org/?resource=training-in-pfa-for-red-cross-red-crescent-pfa-in-groups-support-to-teams

g. Child Friendly Spaces in Humanitarian Settings Guidance Manual: http://pscentre.org/?resource=operational-guidance-for-child-friendly-spaces-in-humanitarian-settings and training:http://pscentre.org/?resource=child-friendly-spaces-tool-kit

h. Child Friendly Spaces in Humanitarian Settings Activity Catalogue: http://pscentre.org/?resource=activity-catalogue-for-child-friendly-spaces-in-humanitarian-settings

i. Assessing MHPSS Needs and Resources in Humanitarian Contexts: http://pscentre.org/?resource=assessing-mental-health-and-psychosocial-needs-and-resources-toolkit-for-humanitarian-settings-who-unhcr-2012

2. MHPSS for local staff working in international healthcare facilities:

a. Caring for Volunteers: A Psychosocial Support toolkit: http://pscentre.org/?resource=caring-for-volunteers-a-psychosocial-support-toolkit-english

b. Assessing MHPSS Needs and Resources in Humanitarian Contexts (see tools specifically for healthcare facilities pp42-55): http://pscentre.org/?resource=assessing-mental-health-and-psychosocial-needs-and-resources-toolkit-for-humanitarian-settings-who-unhcr-2012

c. Psychological First Aid Guide: http://pscentre.org/?resource=a-guide-to-psychological-first-aid-for-red-cross-red-crescent-societies

d. Psychological First Aid Module 1 (4-hour training): http://pscentre.org/?resource=pfa-module-1-introduction

3. Victims of violence (including victims of gender-based violence as a weapon of war):

a. SGBV Manual and Training, IFRC PS Centre: http://pscentre.org/?resource=sexual-and-gender-based-violence-training,

b. Psychosocial Social Support for Youth in Post-Conflict Settings: http://pscentre.org/?resource=psychosocial-support-for-youth-in-post-conflict-situations-manual

c. Loss and grief section and crisis events of the CBHFA programme: http://ifrc-ecbhfa.org/guides-and-tools/ (see the MHPSS chapter under the Primary Prevention modules)

4. Relatives and communities affected by the violence

a. Loss and grief section and crisis events of the CBHFA programme: http://ifrc-ecbhfa.org/guides-and-tools/ (see the MHPSS chapter under the Primary Prevention modules)

b. Broken Links: Psychosocial Support for People Separated from Family Members: A Field Guide: http://pscentre.org/?resource=broken-links-psychosocial-support-for-people-separated-from-family-members-a-field-guide-english

c. Psychosocial Support in Emergencies Brochures, Handouts and IEC materials: http://pscentre.org/?resource=psychosocial-support-in-emergencies-brochures-handouts-english andhttp://pscentre.org/?resource=iec-material-arabic-and-english

 The Psychological First Aid for Groups: Support to teams (Module 4):<http://pscentre.org/?resource=training-in-pfa-for-red-cross-red-crescent-pfa-in-groups-support-to-teams> may be of particular use for Managers.

And yes, I absolutely support your suggestion to make references to restoring family links on the ‘victims’ section of the Red Book.  The following publication would fit here (along with the section on families & relatives):

Broken Links: Psychosocial Support for People Separated from Family Members: A Field Guide:<http://pscentre.org/?resource=broken-links-psychosocial-support-for-people-separated-from-family-members-a-field-guide-english>

## Chemical, Biological, Radiological, Nuclear and Explosive Threats (CBRN-E)

Under Review

CBRNE hazards or attacks are serious and potential threats to medical teams deployed into situations of wide spread armed conflict.

The ICRC states

“Mounting an effective international humanitarian response to a chemical, biological, radiological or nuclear (CBRN) event, especially if the response is undertaken on an ad hoc basis, would be extremely difficult and would pose many risks to the responders. The International Committee of the Red Cross (ICRC) has created a competency-based capacity to respond to at least small-scale CBRN events, including a deployable capability to undertake operational activities.”[[90]](#footnote-90)

Explosives are considered as (E), as by the nature of armed violence explosives are used (either as ammunition of firearms, or as charges detonated). This section will address the management of patients with explosives and firearms injuries (dealt with in chapter 5) but with special situations involving the use of explosives.

This document will refer to several scenarios associated with the use of CBRN(E) agents during their deployment:

1. As result of the hostilities a container holding Chemical, Biological, Radiological material (either in a fixed facility or during transportation) is breeched resulting in the possible release / verified release of the contaminant (either to the air / water sources / soil).
2. Deliberate release of Chemical, Biological and Radiological agents against armed groups, civilians or both.   
   (The detonation of a nuclear device and its impact are beyond the scope of this book, but not beyond the scope of medical teams.. They will be needed, it’s a matter of where they are deployed; post decontamination zones and in the zones of either survivability or on the edge of the zone separating those likely to need palliation and those with a chance of survival with supportive measures). (insert ref)
3. In a complex emergency, EMTs dealing with casualties in an area affected by an outbreak.
4. In a complex emergency, EMT dealing with casualties in an area affected by environmental long-term contamination.
5. Threats to use CBR agents.
6. Rumours on the use of CBR agents during the violent incidents.
7. Treating patients with unexploded ordnance wedged in the patient’s body.

All the above scenarios can take place before and during the EMT deployment cycle.

Working assumptions for medical teams working with the potential CBRN(E) risk:

1. CBRN(E) risks exist in every wide spread violence scenarios.
2. Chemical contamination can be caused by:
   1. Toxic Industrial Compounds (TIC)
   2. Chemical warfare agents  
      Those compounds can be in the forms of solid, vapours, or a mist of droplets (“fog like”)
3. Detection of possible chemical contamination will be based on signs and symptoms of the victims. Protection and decontamination measures will be conducted following a decision of the team leader, without waiting for technical confirmation from technical detectors.
4. Treatment of patients with suspected chemical intoxication will be based on their signs and symptoms (toxidrome[[91]](#footnote-91)), as this is a time dependent pathology, thus treatment should not be delayed, waiting for laboratory results (laboratories that require specific equipment and technical expertise of the technicians, capacity that normally does not exist within or near the EMT operation), nor to the results and analysis of the technical detectors readings.
5. Detection of Radioactive particles on patients can be achieved only following the use appropriate detectors used by trained personnel. In case a patient suffers from a life-threatening injury, and the possible presence of radioactive contamination is suspected, the treatment of the life-threatening condition comes first (see below).
6. Presence of a biological contaminant can be confirmed only by appropriate laboratories and competent public health authorities.  
   Until such declarations are made, the personnel in the EMT will use personal protective equipment (PPE), according to WHO guidelines[[92]](#footnote-92) [[93]](#footnote-93)
7. In the case of a patient presenting with unexploded ordnance wedged in their body, the safety of the personnel and the facility, are as important as the life of the patient.
8. All EMTs will have a SOPs and protocols to ensure that no patient is admitted into the EMT facility with weapons and or ammunition.

**All EMTs** deployed to a wide-spread insecure environment should be capable of:

1. Conduct a risk assessment, specifically addressing the CBRN(E) threats. This capacity includes access to remote expert advice.
2. Share with the local coordination mechanisms to ensure the distribution of real time information on the possible use of CBRN agents, threats or rumors on the possible use to key actors.
3. Have a procedure in place that will ensure that all victims are searched for the presence of weapons and or ammunition before entering the EMT facility, and that and weapons / ammunition found are disposed/handed over safely.
4. Have a procedure to deal with patients and dead bodies arriving with unexploded ordnance wedged in their body, including their placement is a safe and dignified place, safety perimeters, access to bomb disposal or other relevant experts who will support the safe removal on the ammunition, personal protective equipment for the treating personnel (if deemed appropriate), medical treatment protocol (including dignified end of life if this is the clinical situation).
5. Have a contingency plan for the eventuality that the EMT facility is threatened by a possible toxic plume. This contingency will include as a minimum:
   1. Decision making processes.
   2. Notification (internal and external)
   3. Shut down of the facility
   4. Evacuation: shelter in place of patients and local staff
   5. Evacuation: shelter in place for international staff
   6. Emergency decontamination for personnel / patients within the EMT facility
   7. Emergency treatment for victims within the EMT facility
   8. Management of victims, suspected as chemically contaminated, brought to the EMT facility.
   9. Management of dead bodies[[94]](#footnote-94) suspected as chemically contaminated.
   10. Assessment for the re-opening of the facility.
   11. Debriefing of the team and psychosocial support, lessons learned and reporting.
6. Have a contingency for the treatment of a patient in a life-threatening injury, with suspected radiological contamination (specifically dealing with – PPE to be used by the personnel, containment of the patient clothing and belonging and all the equipment used to treat the patient).  
   The treatment of a patient suspected as being contaminated with radioactive particles, implies the shutdown of the EMT facility, until further assessment of the personnel, equipment and facility by radiation experts.
7. Need to be able to protect their staff and decontaminate patient. And to handle potentially multiple casualties at once with these symptoms.
8. Have all personnel participating in the EMT activities (international and local staff) trained in the procedures as well as the use of the relevant equipment.
9. Ensure appropriate hand-over to other rotations and knowledge sharing with other EMT’s deployed.
10. Have a risk assessment for the implications of running a disease outbreak EMT in an insecure environment

**EMT may opt to be recognized as “CBRN EMT”.**

All EMTs deployed in a conflict area with threats of CBRN attacks need to have minimum standards (staff PPE and decontamination capacity) while others may be specialist in the area. Such capacity would require extensive investment and preparations. It is more appropriate for military and/or governmental teams if mandated to do so

In order to meet this level, the EMT will have to demonstrate the following capacities (insert ref) (in addition to existing EMT classification):

1. Have appropriate personal protective equipment (PPE) for all the personnel expected to treat and decontaminate patients. The equipment should include as a minimum – face mask test fitted to the user including eye-glasses if those are used (or a solution like – powered air purifying respirator that ensures the seal without fit testing and allows for the use of glasses) with appropriate chemical canisters, protective garments, gloves (including inner cotton gloves), boots or shoe coveralls – all those meeting an internationally recognized chemical protection standard (e.g. NIOSH/NFPA).  
   The equipment should be sufficient to treat / decontaminate 50 patients and allow for the team members to work 4 hours with protection.  
   It is the responsibility of the EMT deploying organization, that all the (origin) national standards with regards to the use of PPE are met.
2. Have the set up (infra-structure, personnel and procedures) that will allow for the safe simultaneous decontamination of 2 non-ambulant and 6 ambulant victims (considering gender issues for the ambulant patients), with a total of 20 non-ambulant and 30 ambulant patients.
3. Have the treatment protocols and equipment to treat 50 patients with chemical intoxication, (20 non-ambulant, 30 ambulant, among them 10% children), specifically with medications to treat: organophosphate intoxication, respiratory mucus membranes irritation, eye irritation.
4. Have a supply chain for the replenishment of the equipment and supplies used.
5. Have at least 1 physician and 1 nurse / paramedic, with specific CBRN training.
6. Have all the personnel expected to wear PPE medically checked and approved to use PPE (also considering climate where the PPE is to be used).
7. Have all the personnel trained in the CBRN procedures, and specifically, all the personnel expected to use PPE practically trained in the use of PPE (Donning / doffing the PPE).
8. Have a procedure for proper decontamination of the facility and safe disposal of contaminated equipment and supplies.
9. Have a clear procedure for the resumption of ‘normal’ operations following the treatment of contaminated patients.
10. If the EMT opts to use technical detectors, have the personnel duly trained to provide maintenance, use the devices during the incident and interpret the readings to the EMT management.

## Chapter 2 Guidance Notes

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| 1. Medical teams need to ensure safety for self, site, and survivors (3 S’s) 2. Medical teams deployed into armed conflict are required to have safety and security risk management plans that are context and area specific with training provided pre and during deployment including all staff, local staff, and rotating teams. 3. Medical team organizations have a duty of care and legal obligations that ensure the safety and wellbeing of teams including mental health, medical evacuation plans, and informed consent, 4. Special considerations, protocols, kits, training and plans are required for CBRN scenarios |

**General Reading Links: for the toolkit**

From Governments:

* ISO 31,000 International Risk Management Standard – <https://www.iso.org/obp/ui/#iso:std:iso:31000:ed-1:v1:en>
* Handbook 167 Security Risk Management – <https://infostore.saiglobal.com/en-au/Standards/HB-167-2006-568733/>
* Voluntary Guidelines on the Duty of Care to Seconded Personnel, 2017

<https://www.zif-berlin.org/fileadmin/uploads/experten-einsaetze/Voluntary_Guidelines_on_the_Duty_of_Care_to_Seconded_Civilian_Personnel_Final_170420.pdf>

From ICRC:

* Safer access framework <http://saferaccess.icrc.org/overview/>
* Dead Body Management <https://shop.icrc.org/gestion-des-depouilles-mortelles-lors-de-catastrophes-manuel-pratique-a-l-usage-des-premiers-intervenants-669.html>
* Chemical, biological, radiological or nuclear events: The Humanitarian, response framework, of the International Committee of the Red Cross

<https://www.icrc.org/en/download/file/24540/irc97_9.pdf>

From United Nations:

* UN Security Management System Overview
* Programming in Access Constrained Environments (Health Cluster)

<https://www.alnap.org/system/files/content/resource/files/main/9789241513722-eng.pdf>

* Humanitarian Programming and monitoring in inaccessible conflict settings: a literature review  
  <https://www.who.int/health-cluster/resources/publications/remote-lit-review.pdf?ua=1>

From NGOs:

* Links to EISF/InterAction Frameworks e.g. Good Practice Review on Operational Security in Violent Environments
  + <https://odihpn.org/wp-content/uploads/2010/11/GPR_8_revised2.pdf>
  + <https://www.eisf.eu/library/security-risk-management-a-basic-guide-for-smaller-ngos/>
  + <https://www.eisf.eu/library/managing-sexual-violence-against-aid-workers/>
* IASC Non-binding Guidelines on the Use of Armed Escorts for Humanitarian Convoys

<https://www.unocha.org/sites/unocha/files/Armed%20Escort%20Guidelines%20-%20Final_1.pdf>

CHAPTER 3

COORDINATION PLATFORMS & MODALITIES

"It is the long history of humankind (and animal kind, too) that those who learned to collaborate and improvise most effectively have prevailed." – Charles Darwin

# Coordination Platforms and Modalities

Under review and edit

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| Chapter Objectives   1. Teams and leaders have increased understanding as to the importance, platforms and modalities for coordination in armed conflict and complex emergencies. 2. Teams better grasp own roles and responsibilities to engage and contribute to coordination platforms. 3. Team leadership can put into practice functional liaison with other providers, military actors, UN peace keepers, and/or key stakeholders present 4. Teams have increased familiarity and understanding as to existing coordination published guidelines and manuals 5. Teams and Leaders have easy access to the most relevant key references and manuals at their fingertips |

Contexts of conflict can present significant challenges to the delivery of humanitarian assistance. Frequently humanitarian and other actors may find their motivations, purpose and methodology subject to positive or negative perceptions by parties to a conflict and by a recipient population.

The objective of international humanitarian action, and the purpose of its coordination, is to meet the needs of the affected people by means that are reliable, safe, effective, inclusive and respect humanitarian principles. This will also enable better quality patient care including referral chains, continuity of care, sharing of resources, protection, and standardized data.

As stated in chapter 2 on IHL and core principles within contexts of armed conflict:

* Governments and their militaries (in conflict scenarios) have clear obligations under IHL to provide medical care for the wounded and sick.
* Perceptions of political bias are especially difficult to prevent and to reverse. Parties to a conflict will often view local and external actors through the lens of the current political situation and may well view humanitarian interventions as overtly political acts.

In such a context, it is particularly important to maintain close coordination between humanitarian actors (and other medical actors) to ensure alignment of interventions and clarity of collective voice.

Maintaining a robust framework of *principled* collective humanitarian action ensures that medical teams (non-military) remain perceived by all as truly humanitarian and therefore as legitimate and duly entitled to access affected communities.

The composition and background of a medical team and/or classified EMT, or their method of operating can impact positively or negatively on themselves and the wider humanitarian community in a given context.

## Pre-Deployment Considerations

An in-depth conflict analysis prior to deployment should involve contact with some of the coordination groups in order to better understand the environment.

In Red Book contexts, medical teams also need to consider carefully which of the many coordination mechanisms they need to engage with and to what extent they should engage once deployed. EMTs should ask questions of themselves and the various coordination mechanisms within contexts:

* Does engagement with a given coordination mechanism enable us to access affected populations in a *principled* manner (and throughout the deployment timeframe)
* Does engagement with a given coordination mechanism involve *compromise* to humanitarian principles (which ones?) or allow others to perceive us as a biased and an unprincipled actor (and throughout the deployment timeframe)

## Types of Deploying Teams & Coordination Mechanisms

Medical teams will have different affiliations, nationalities, capacities, and deploying organizations. Regardless, it is critical to *coordinate* and be aware of overall existing capacities/resources, skills, facility locations, plans, referral arrangements, and disease/injury types and caseloads. This type of critical information can only be achieved if teams report on a regular basis and engage with the coordination platform(s). As described in the Chapter 1, not all teams can be independent and or be perceived as neutral, however, all national and international teams have important roles to fulfill. This is particularly the case for some military and governmental teams. For a thorough commentary on definitions of impartial organizations and actors, refer to IHL database.[[95]](#footnote-95)

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| **Team Type** | **Blue Book:**  **Natural Disasters/Emergencies/Outbreak**  **Humanity & Impartiality apply to all** | **Red Book:**  **Health Emergencies in Armed Conflict & Insecure Environments**  **IHL, Humanity & Impartiality apply to all** |
| 1. EMT – Classified  Civilian NGO – Classified  National or International | -Standards Apply  -WHO coordinated deployments | -Standards Apply  -WHO coordinated deployments  -If Local NGO:  Neutrality & Independence an issue |
| 2. EMT – Classified MoH/Governmental | -Standards Apply  -MoH, WHO supported deployments | -Select Standards Apply  -Neutrality & Independence an issue |
| 3. EMT – Classified  Private | -Standards Apply | -Neutrality & Independence an issue |
| 4.EMT – Classified  Military  National or International | -Standards Apply  -WHO coordinated deployments | -Bilateral Deployments  -Neutrality & Independence an issue |
| 5.Civilian Medical Team  National or International | -Standards Apply | -Select Standards Apply |
| 6.Red Cross Red Crescent Medical Teams  National Society or International Deployment | -Classified via Movement Channels and Standards by IFRC (standards aligned with EMT) | -Classified via Movement Channels and Standards by ICRC  -Select Standards Apply |
| 7.Private Medical Teams | -Standards Apply | -Standards Apply  -Contracting party agenda an issue  -Neutrality & Independence an issue |
| 8.Military Medical Team  National or International | -Bilateral Deployments  -Standards Apply | -Bilateral Deployments  -Neutrality & Independence an issue  -Select Standards Apply |

Figure 10 Typology of Teams and Special Considerations

### National & International Military EMTs

* National Military EMTs

In many States, national military or civil defence units are part of or even leading national responses to disasters and crises on their territory. Affected States have the responsibility to use whatever means at their disposal to respond to the needs of their citizens. Their militaries can often be the most appropriately equipped and best positioned to respond. The ‘FMA’[[96]](#footnote-96) or ‘MCDA Guidelines’ and, therefore, the principle of ‘last resort’ are *not* intended to apply in the case of national militaries and/or civil defence units responding to a disaster or crisis within its own territory.

Military EMTs will likely *not* be perceived as independent and neutral by the some of the recipient populations and the warring parties. They should ideally seek to ask themselves the following questions prior to deployment:

* Are they the option of last resort, indispensable and appropriate to treat civilian casualties (often mostly women and children)?
* Should the mission be restricted to support injured combatants?
* How long will they be needed for? And how may the conflict evolve?
* Can they be deployed without weapons or additional security forces?
* What are the optimal coordination platforms?
* How and when will an exit plan or transition back to civilian responsibility be achieved?
* What are the consequences for the population, other humanitarian actors, and humanitarian operations is perceptions of that the team is party to the war effort in the mid to long term?
* Bilateral military deployment

Many requests for assistance by States, civilian or military, start as bilateral requests, often at the regional or “neighbouring” level, with (in some cases pre-existing) agreements between the affected and assisting States on the type of assistance. In such circumstances, however, the assisting State(s) and the affected State(s) are encouraged to use the principles and procedures provided in the MCDA guidelines.

* International military EMTs

Military EMTs may be mandated by their governments, as per obligations under IHL, to provide medical care for the wounded and sick (including frontline care). Internationally deployed military teams which are to be considered as Military and Civil Defense Assets (MCDA) may face challenges when deploying into conflict settings (MCDA guidelines apply only to foreign military and civil defence assets). Affected States may, nonetheless, find some of the principles and concepts provided in these Guidelines useful in managing the use of those assets. Questions will be raised as to how far they are able to adhere fully to humanitarian principles; particularly the principle of independence, but also potentially of neutrality. This may also impact the perception and reality as to neutrality and impartiality of the wider humanitarian response as populations (and warring parties) may not make distinctions between various teams and should not be expected to fully comprehend who’s who given the many, emblems, logos, (see emblem use section xx) and affiliations that are often observed. In order to avoid confusion, military EMTs may want to consider the method and location of their deployment and therefore how they should best coordinate.

International military EMTs will also *not* be perceived as independent and neutral by the some of the recipient populations and the warring parties. They should ideally seek to ask themselves the following questions prior to deployment:

* Are they the option of last resort, indispensable and appropriate to treat civilian casualties (often mostly women and children)?
* Should the mission be restricted to support injured combatants?
* Are the countries offering MCDA or Government EMTs also parties to the conflict?
* Based on the need, is a MCDA or Government EMTs capable of the task?
* How long will they be needed for? And how may the conflict evolve?
* Can they be deployed without weapons or additional security forces?
* How will governmental affiliation impact the security of UN personnel and other humanitarian workers?
* How will this impact the perceptions of UN neutrality and/or impartiality?
* What are the optimal coordination platforms?
* How and when will an exit plan or transition back to civilian responsibility be achieved?
* What are the consequences for the population, other humanitarian actors, and humanitarian operations is perceptions of that the team is party to the war effort in the mid to long term?

### Government/MOH EMTs

Governmental and MoH EMTs are often the first to deploy. EMTs that are established and operationally managed directly by their governments may also wish to consider their method of coordination and location of their deployment within a conflict setting. Such medical teams (national or international) may also find it a challenge to realize adherence to all humanitarian principles, especially the principles of independence and neutrality.

Government medical teams further need to consider whether their deployment will involve direct risk to them or negatively affect other humanitarian actors. For example, operating under the banner/emblem of a deploying government, the team may face potential risks of direct targeting in certain circumstances, specifically contexts in which:

* + That deploying government is understood/suspected to have a strong strategic interest in the outcome of a conflict or historical links that may have generated adverse perceptions
  + Presence of armed actors directly targeting the deploying government’s interests
  + The deploying government’s military is an active participant in a conflict or a vocal supporter.

In such circumstances an EMT may want to consider not deploying or deploying to locations in which access to the wounded and sick, and safety can be attained, otherwise the underlying perceptions of that EMT may carry threats to the humanitarian response as a whole.

### Local NGOs/Local Actors

Local NGO medical teams are ideally suited for rapid surge, access to population in need, advise to international groups, and possibly full acceptance by the population. However, in situations of internal conflict, trust and acceptance may erode if the NGO team is viewed as partial and not independent or not neutral of parties to the conflict. And the local NGO/actor has a history/reputation in being viewed as allied with the government or other parties. As outlined in chapter 2, the challenges need to be addressed upfront and appropriate decisions made to ensure safe access and acceptance by communities and authorities. Coordination is still required within platform(s) that operate. The NGO/actor may opt to self-impose limits on locations it can access safely.

### Private Contractors

Private or corporate medical teams established and operationally managed by a private for-profit organisation should consider to what extent they are able or willing to fully adopt humanitarian principles. If it is the case that the private contractor is able to operate within humanitarian principles, they would be considered to be a humanitarian actor (not organization) and expected to fully engage with coordination mechanisms. This may represent an additional cost and additional training of staff and these factors need to be taken on board by the contracting entity.

It also needs to be kept in mind that private contractors may find it challenging to operate completely independently of the contracting entities agenda. The private contractor will be perceived to act as an agent of the contracting party. For NGOs and INGOs joint action and frequent informal group engagement is a core component of working within conflicts and this will be just as essential for private contractors.

### International NGO (INGO) Medical Teams

International NGO EMTs should already be aware of coordination methodology and be fully prepared to operate under humanitarian principles. Many such organisations have operated within numerous conflict contexts and are highly experienced. For those that have yet to operate within conflicts a period of engagement with peer INGOs will prove informative and help to establish relationships. Extensive experience in response to natural disasters and domestic emergencies is *insufficient* preparation for conflict response.

### Red Cross Red Crescent Teams

International teams can also Red Cross Red Crescent teams deploying across borders which are to abide by rules and regulations of the Movement (including additional principles of Voluntary Service, Unity, and Universality[[97]](#footnote-97). They are mandated to coordinated with the Red Cross Red Crescent National Society in the affected country(s). Such medical teams are called Emergency Response Units, but can also have other configurations. (see ERUs reference and types[[98]](#footnote-98))- Local National Societies are most often the first responders and engage with the many actors and communities. Their staff and volunteers are at the frontlines, embedded in communities, and coordinate with many stakeholders. They are often tasked to support communities and lead with first aid and dignified and safe burials.

## Objectives of Humanitarian Coordination in Conflict Settings

There are clear motives to coordinate in any humanitarian context to ensure effective action, avoiding gaps, duplications, wasted efforts and inappropriate interventions. Coordination is of even more paramount importance for medical teams. In conflict, coordination carries additional weight and specific purpose:

### Robust Principled Framework for Action

Coordination within conflict contexts should guide collective engagement with principled action. Adherence to humanitarian principles is a key responsibility of individual groups/organizations, however coordination allows discussion and collective examination and interpretation of highly complex issues. This brings a greater weight of understanding and analysis and crucially ensures a degree of alignment

### Collective Impartiality & Neutrality

Maintaining organizational impartiality and neutrality can be an exceptional challenge within a conflict. The nuances and perceptions of political bias are an ever-present challenge for humanitarian actors and it is only through coordination platforms that humanitarians can discuss and collectively establish clear positions.

The collective nature of coordination bodies prevents an undermining of individual positions and interventions. However, this may come with some cost. Coordination needs to be entered into fully and interventions must be considered carefully through the prism of their impact on the impartiality and neutrality of the humanitarian response as a whole and not just for an individual actor.

### Impartial Access & Care

Coordination mechanisms should be able to identify and highlight difficulties of access across a context. This is particularly important in contexts in which marginalised groups can lack access to even the most basic services by due to physical and psychological obstacles (real and perceived). In such circumstances collective positions and collective support are essential.

The arguments of individual agencies acting alone stand slimmer chances of success in dealing with parties to a conflict than do collective positions backed by humanitarian principles. This is especially true when parties to a conflict view assistance provided to certain communities as a hostile act and part of the war effort.

### Collective Security

Coordination mechanisms also provide an essential forum for collective security. The information, analysis and solidarity afforded by good coordination can maintain the safety of teams working in some of the most challenging environments.

Coordination mechanisms allow for a collective voice and collective action. This could involve speaking with one voice to parties to a conflict, advocating for additional security arrangements/funding, or agreement on joint methodologies to improve security, such as convoy systems, joint operations, or in extreme circumstances joint evacuations or withdrawal of services to certain areas.

Such unity of action in support of principled access is crucial to maintaining humanitarian interventions in highly insecure areas.

It is important to note that security coordination can also take place “behind the scenes” and does not necessarily need to compromise a medical team’s independence.

### Protection

Protection issues are some of the foremost challenges of humanitarian response within a conflict setting. These are often complex and politicised. Bringing attention to challenges of protection or difficulties of vulnerable groups or individuals is a significant component of any principled response. However, within the highly charged environment of a conflict raising protection issues publicly can carry a level of risk and precipitate counter actions from the warring parties.

Coordination mechanisms can support the humanitarian imperative crucial for the protection of the most vulnerable by providing a critical platform and framework for clarifying and highlighting protection priorities, identifying the ‘invisible’ and highly exposed population groups, adding collective weight and voice.

### Advocacy

Advocacy can take on multiple forms and form a component for any of the above issues. Advocacy is generally to address either difficulties of principled access to affected communities or to highlight the difficulties faced by affected communities. Playing the part of advocate (publicly or privately) can also lead to accusations and suspicions of political bias, lack of neutrality, etc. And may affect the advocate and the humanitarian field as a whole. Therefore, such efforts need to well-thought through and carefully considered. Coordination platforms can be ideal setting for subtle advocacy and consensus building.

While individual actors can and do speak out on specific issues, a collective voice can carry more weight and profile when emanating from a coordination body of humanitarian actors and framed within the context of humanitarian principles. It can also inform the statements of key organizations and governments aiming for diplomatic solutions, expansion of humanitarian action, and influence key decision makers.

## Types of Humanitarian Coordination Mechanisms

Many factors are at play to determine which coordination platforms are activated and where. Regardless, medical teams are required to scan the operational environment and engage in a principled manner as articulated above. Some coordination platforms can exist in capitals, in the field of operations, in neighboring nations and/or across the globe. They will serve to address various issues and functions that may deal with funding, strategic directions, alignment of positions, operational considerations, etc. Medical team engagement in coordination needs to prioritize population needs, access, healthcare, safety, security and protection. Teams may also witness tensions and disagreements between the various mechanisms. The focus needs to be kept on the *principled* humanitarian mission, quality patient care, and safe access to the wounded and sick.

### Global Levels

The Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator (USG/ERC) is responsible for the oversight of all emergencies requiring United Nations humanitarian assistance. He/she also acts as the central focal point for governmental, intergovernmental and non-governmental relief activities. The ERC also leads the Inter-Agency Standing Committee (IASC), an interagency forum for coordination, policy development and decision making involving key UN and non-UN humanitarian partners. The ERC chairs the IASC. Most humanitarian coordination tools and many humanitarian guidelines are developed at the global level through the IASC.

Insert updated diagram from OCHA

### National Levels

The Humanitarian Country Team (HCT) is chaired by the Humanitarian Coordinator (HC) and is composed of a limited number of humanitarian organizations to enable effective decision-making. The main membership criterion is operational relevance. Members represent their respective organizations at the highest level (country representative or equivalent), as well as the thematic sectors/clusters their agency may be leading.

At country level, the humanitarian coordination architecture can be summarized as follows:

• Strategic level: HCT, led by the HC

• Operational level: Inter-Cluster Coordination Group (ICCG)

• Technical level: Sectors/Clusters

In the humanitarian coordination architecture, ICRC has an official observer status and MSF usually engages as an observer.

If a UN Mission is deployed to a country, the highest representative of the UN is the Special Representative of the Secretary-General (SRSG). The RC in that case is often the Deputy Special Representative of the Secretary-General (DSRSG). Apart from being the DSRSG and RC, the same official is also often designated as the HC, thereby creating a triple-hatted DSRSG/RC/HC function.

### UN Cluster System

Clusters support the delivery of humanitarian assistance by coordinating, implementing and monitoring projects, and conducting joint needs assessments and gap analyses in the field. They also inform strategic decision-making of the HC/HCT, through sectoral planning and strategy development. There are 11 global clusters (see diagram below). Clusters are groups of humanitarian organizations, both UN and non-UN, in each of the main sectors of humanitarian action, e.g. water, health and logistics. Clusters support the delivery of humanitarian assistance by coordinating, implementing and monitoring projects, and conducting joint needs assessments and gap analyses in the field. They are designated by the Inter-Agency Standing Committee (IASC) and have clear responsibilities for coordination. Up to eleven thematic clusters (see diagram below) may be set up in response to emergencies. Each has a designated UN lead agency (WHO for health). It is important to note that the Cluster System is designed to partner with local government (and authorities in non-government controlled areas) counter parts. In context of armed conflict, especially civil wars/rebellion, the cluster focus may be with a limited focus on group or region.

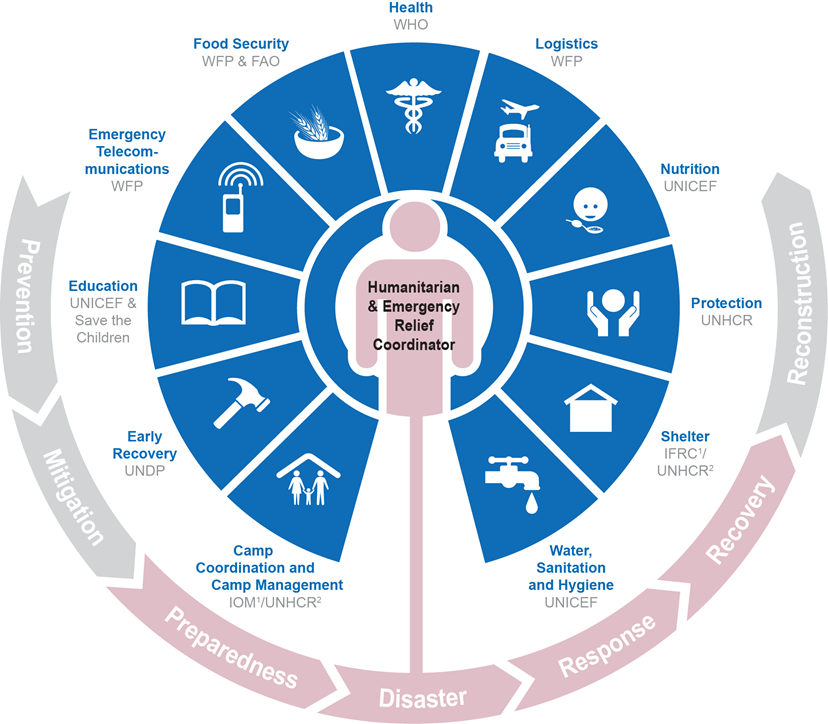


Figure 11 UN Clusters & Leads

The Health Cluster Guide suggests how the Health Cluster lead agency, coordinator and partners can work together during a humanitarian crisis to achieve the aims of reducing avoidable mortality, morbidity and disability, and restoring the delivery of and equitable access to preventive and curative health care as quickly as possible. It highlights key principles of humanitarian health action and how coordination and joint efforts among health sector actors working in partnership can increase the effectiveness and efficiency of health interventions. It draws on Inter-Agency Standing Committee (IASC) and other documents but also includes lessons from field experience.

The Health Cluster Guide is currently in revision. The 2009 version can be downloaded and provides detailed practical guidance to teams[[99]](#footnote-99). Importantly the Global Cluster IASC has published a position paper on ‘Civil-Military Coordination[[100]](#footnote-100) During Humanitarian Health Action’. The paper provides a risk assessment matrix linked to the military involvement in humanitarian action. The matrix is organized based on two assumptions: (1) as a general rule, direct health assistance shall be carried out only by civilian humanitarian health agencies; and (2) the more military actors are entrenched in the conflict dynamics, the more the two worlds – military and humanitarian – should be kept separate in order to safeguard the actual and perceived impartiality of humanitarian actions.

### EMT Coordination Cell (EMTCC)

While EMT Coordination normally sits with the Health EOC of an affected country in non-conflict (Blue Book) contexts, in cases of active conflict, EMT coordination will often be through a clinical case management or trauma working group acting under the Health Cluster or another independent coordination platform, such as the On-Site Operations Coordination Centre (OSOCC).

The Blue Book Coordination approach for EMTs (insert ref) states that “EMT coordination should occur within existing emergency response frameworks and if possible be led by the clinical care or emergency response sections of the MoH, within the Health Operations pillar of the Health EOC. This EMT function may require WHO experts to support , arriving EMTs, UNDAC team members or direct bilateral expert deployments from neighboring countries. Some international agencies and INGOs may deploy EMTs and other health and thematic expertise in WASH, Shelter, GBV, etc. It is critical that the various coordination platforms communicate closely and coordinate internally. EMT Coordination is a specialized field and requires training, ideally through the WHO EMT-CC course. If a national focal point is not available, then a MoH emergency officer should be designated EMT coordinator but strongly supported by an EMT expert coordinator from WHO or through the channels above.

### Civil-Military Coordination (UN-CMCoord)

Teams will require a good understanding of the importance and the mechanisms in place, provided for some by UN OCHA, to liaise with military personnel (e.g. Operational Commanders, others). Humanitarian Civil-Military coordination (CMCoord) has evolved over the years and clear coordination platforms, under UN OCHA's lead, may be in place to engage with. Depending on the context, this may involve focus on patient care and protection, alleviation of suffering, access to communities & vulnerable groups, etc. as well as specific provisions concerning the safety and security of the medical mission. A Field Handbook [[101]](#footnote-101) provides extensive guidance on the topic. The Manual defines UN-CMCoord as “the essential dialogue and interaction between civilian and foreign military actors in humanitarian emergencies that is necessary to protect and promote humanitarian principles, avoid competition, minimize inconsistency and, when appropriate, pursue common goals. Basic strategies range from cooperation to co-existence. Coordination is a shared responsibility facilitated by liaison and common training”.

Humanitarian civil-military coordination is one of OCHA’s core functions. CMCoord facilitates a coherent and consistent humanitarian approach to interaction with military and other armed actors, enhancing understanding and respect of humanitarian action. OCHA is the custodian of UN-CMCoord Guidelines and related documents. The scope and character of interaction between humanitarian actors and military and other armed actors is always context-dependent.

A key principle of the UN-CMCoord guidelines is the principle of last resort applied to foreign military teams. In disasters in peacetime, Foreign Military Assets (MCDA or FMA ) should be utilized where there is no comparable civilian alternative in terms of time and/or capability, to meet a critical humanitarian need. In complex emergencies, the concept is even more important: Foreign Military assets, which includes EMT , should be used only if they are the last resort to respond to a critical life-threatening situation, i.e. the need cannot be met with available civilian assets, and there are no alternatives to the activity. As a matter of principle, FMA of belligerent forces or of units actively engaged in combat shall not be used to support humanitarian activities. Decision-makers must weigh the risk to relief workers and their ability to operate effectively at the moment and in the future, against the immediacy of the needs of the affected population and the need for the use of FMA.

As a general rule, humanitarian actors will not use armed escorts. There may be exceptional circumstances in which the use of armed escorts is necessary as a last resort to enable humanitarian action. Before deciding on such exceptions, the consequences and possible alternatives to the use of armed escorts must be considered. Potential consequences of the use of armed escorts include (perceived) cooperation with an armed actor which can undermine actual and perceived neutrality, impartiality and independence of the organization or humanitarian community. Cooperation, or perceived cooperation, with an armed actor can increase convoy vulnerability to attack by opposing armed actors. The use of armed escorts by one humanitarian actor can negatively affect the security of others that do not use them. Dependence on an armed actor undermines sustainability of the humanitarian operation. Cooperation with one armed actor can make it impossible or unsafe to operate in a territory controlled by another armed actor.

Basic CMCoord strategies range from co-existence to cooperation. Cooperation is a form of Humanitarian Civil-Military Coordination that strives to ensure complementarity and coherence of efforts between humanitarian and military actors. Co-existence is a form of humanitarian Civil-Military coordination that aims at de-conflicting humanitarian and military activities; actors merely operate in the same space albeit largely independently. In this instance, humanitarian Civil-Military coordination focuses on minimising competition to enable different actors to work in the same geographical area with minimum disruption to each other’s activities. It is often observed in man-made hazards and complex emergencies.

Coordination and liaison with UN peace keepers and other security actors, if present, would be ensured through UN OCHA's Civil Military Coordination Service (CMCS)[[102]](#footnote-102) (check if CMCS still exists after the re-org) and directly with the dedicated deployed CMCoord on the ground.[[103]](#footnote-103)

Deconfliction[[104]](#footnote-104) efforts are required, where deconfliction is defined as the exchange of information and planning advisories by humanitarian actors with military actors in order to prevent or resolve conflicts between the two sets [of] objectives, remove obstacles to humanitarian action, and avoid potential hazards for humanitarian personnel. This may include the negotiation of military pauses, temporary cessation of hostilities or ceasefires, or safe corridors for aid delivery.

### Host Governments

Engagement with the Host Government is essential but does need to be viewed through the lens of a sound context analysis especially linked to perceptions of independence and neutrality.

Implementing agencies need to be aware that all conflict contexts differ, and this extends to the attitude of Host Governments towards in-coming international actors. It is almost inevitable that the national Host Government will be an actor in the conflict and will therefore have an established point of view, political and military positions and established vested interests.

The above factors need to be understood and kept in mind while also remembering that the Host Government remains the duty bearer, responsible for meeting the basic needs of its citizens. However, Host Governments may be either unable or unwilling to provide access to the most vulnerable people within its borders. It may then be incumbent upon international principled humanitarian assistance to bridge the gap.

### Host Ministry of Health (MoH)

The MoH will naturally take the lead in coordinating health activities. Implementing organisations should make themselves known to the MoH. Appropriate permissions and authorization for medical staff to operate will need to be obtained and medical teams will need to familiarise themselves with the appropriate coordinating staff, processes and meetings. Teams need to be sensitive to appearing to be directed or manipulated in those contexts.

### Military to Military Coordination

Military to military coordination mechanisms will also be established. It may be that military EMTs should properly coordinate through both a Civ-Mil and Mil-Mil coordination platform as outlined in *The Guidelines on the Use of Military and Civil Defence Assets (MCDA) to Support UN Humanitarian Activities in Complex Emergencies[[105]](#footnote-105)*

### National Disaster Agency / National Humanitarian Coordination

As in any humanitarian emergency the National Disaster Agency (if existing) will very likely be a leading actor as part of national Government coordination of agencies. Implementing international agencies will be expected to coordinate or at least to make themselves known to such an agency. Teams need to be sensitive to appearing to be directed or manipulated in those contexts.

### Non-State Actors

Non-state actors can take many forms[[106]](#footnote-106). It is a feature of modern conflicts to see a proliferation of non-state actors controlling territory and therefore access to populations. Great care needs to be taken to undertake and maintain a sound context analysis in order for medical teams to engage safely, gain/maintain access, avoid manipulation, diffuse tensions, and retain a principled approach.

### ICRC and Red Cross Red Crescent Movement

In the context of armed conflict, the International Committee of the Red Cross (ICRC) is the lead and overall coordinator for medical teams deploying internationally from Red Cross and Red Crescent National Societies (via Movement existing mechanisms). The ICRC will typically have such medical teams (see ERUs reference and types[[107]](#footnote-107)) embedded within its own operations and will coordinate such deployments with the National Society in the affected country(s). The ICRC has the special mandate that gives the organization an international legal status, distinct from that of NGOs and akin to that of international intergovernmental organizations such as the UN. Through status agreements with governments, ICRC is granted certain legal protections. For example, immunity from legal process and the protection of its premises, documents and data from being accessed.

The International Federation of Red Cross and Red Crescent Societies (IFRC) is the lead for natural disaster coordination. The two may operate in proximity and in close coordination in context where they co-exist (e.g. ICRC leading within areas/countries affected by war, IFRC in leading in neighboring countries addressing refugee crises).

## Chapter 3 Guidance Notes

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| 1. All deploying teams have an obligation contribute and participate in coordination of medical care in a *principled* and *IHL* rooted approach 2. Teams need enhanced sensitivity and strategies in contexts in which coordination mechanisms may be perceived as party to a war effort. Such considerations may require aborting deployments and/or change of location. 3. National and International teams need to coordinate but be aware of *perceptions* as to independence and neutrality to inform decisions. 4. Communicate and coordinate with all parties to the conflict when and if possible 5. Medical teams need to invest and train pre-deployment on coordination mechanisms 6. Deconfliction, when activated, can provide an additional layer of security. However, it cannot not guarantee team or patient safety 7. Teams to aware of the key elements within the UN-CIMCoord manual and challenges 8. Governmental and Military teams may need to self-impose limits as to locations and population areas that can be safely accessed. |

CHAPTER 4

GENDER BASED VIOLENCE

&

PROTECTION

# Gender Based Violence & Protection – GBV

Under review and edit

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| Chapter Objectives:   1. Highlight the importance and specific roles for medical teams 2. Outline specific measures required for prevention, protection, and care, including national and organisational legal obligations related to preventing, reporting and responding to SGBV. 3. Provide concrete examples including advocacy measures 4. Teams integrate a capacity strengthening approach as a pillar of support 5. Teams and Leaders have easy access to the most relevant key references and manuals at their fingertips |

Gender-based violence is a widespread public health problem and human rights violation that primarily affects women and girls but is also used to describe gendered violence against men and boys, and individuals from sexual and gender minorities.[[108]](#footnote-108) Conflict and complex humanitarian emergencies are likely to increase risks of sexual violence and intimate partner violence (IPV) due to breakdowns of family and social structures, increased militarization, impunity of perpetrators, displacement, lack of community and State protections, scarcity of resources, changing cultural and gender norms, disruption of services, and weakened infrastructure. Sexual violence is recognized as a tactic of war primarily targeting women and girls and also men and boys. [[109]](#footnote-109)[[110]](#footnote-110) During conflict, there are often ongoing threats to the physical safety and security of GBV survivors due to restrictions on movement, presence of armed actors and threats of retaliation by perpetrators. As such, medical teams need to provide accessible, safe, competent and confidential health services for gender-based violence survivors as part of the emergency response to address physical, reproductive and mental health. Medical teams should be ready to treat or appropriately refer urgent unintended pregnancy and pregnancy complications, sexually transmitted infections (STIs) including HIV, pelvic pain, urinary tract infections, fistula and chronic conditions. Medical teams should also respond to mental health impacts including acute stress reactions, post-traumatic stress disorder (PTSD), depression, anxiety, sleep disturbances, self-harm and suicidal behaviour. Confidential documentation is vital to the safety of patients experiencing violence and health systems must follow strict privacy, confidentiality and safety principles.[[111]](#footnote-111) These are critical to protect the patient from further harm including stigma, discrimination or retaliation by the perpetrator.

## What Medical Teams Need to Know Before Providing Services?

In setting up a service for survivors of gender-based violence and developing a treatment protocol, the following questions and issues need to be addressed, and standard procedures developed for implementation within the local context. Treatment options (e.g. provision of emergency contraception or safe abortion) and legal obligations and requirements (e.g. for documentation) will be determined by national laws and policies, where they exist. In the absence of national policies or protocols, medical teams should refer to WHO guidelines and treatment recommendations

### Relevant Laws & Policies

* What forms of sexual violence and intimate partner/domestic violence are considered crimes under the applicable law?
* Are same-sex relationships criminalized?
* What are the national laws, and community practices, relevant to the management of the possible consequences of rape (e.g. emergency contraception, abortion, testing and prevention of HIV infection)?
* What are the legal requirements for health-care providers about reporting cases of sexual violence or partner violence to authorities?
* Does the law have requirements about who may provide clinical care to survivors? For example, if the person wishes to report the rape officially to the authorities, the country’s laws may require that a certified, accredited or licensed medical doctor provide the care and complete the official documentation.
* What are the legal requirements with regard to forensic evidence? Who may collect it? Are laboratories for testing forensic evidence available and accessible?[[112]](#footnote-112)

### Available Resources & Services

* Do national or sub-national protocols for managing care for survivors of sexual violence already exist?
* Is there a national STI treatment protocol, a post-exposure prophylaxis (PEP) protocol and/or a vaccination schedule? Which vaccines are available? Is emergency contraception available? Is comprehensive abortion care available, and for which indications?
* What psychological or psychosocial support services are available?
* What possibilities are there for referral to a secondary health-care facility, a specialized service provider, or to another deployed medical team that can provide needed care (e.g. gynaecology/obstetrics, counselling, surgery, paediatrics, GBV specialized service)?
* What facilities exist for testing for sexually transmitted infections (STIs, including HIV)?
* Is there equipment for documenting and for collecting and storing forensic evidence? What laboratory facilities are available for forensic testing (e.g. DNA analysis, acid phosphatase)?

### Essential equipment, medicines and other supplies for examination

Medical teams will also need to ensure that they have all core requirements for examination and treatment. Below is a checklist of these essential items (those with an asterisk are minimum requirements).

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| **Checklist of requirements for providing quality clinical care for survivors of rape and intimate partner violence (IPV)** | |
| **1. Protocol** | **Available?** |
| Written medical protocol in the language of the provider\* |  |
| **2. Personnel (pay attention to gender)** | **Available?** |
| Trained (local) health-care professionals (where possible, it is ideal to have an on-call system 24 hours a day, 7 days a week)\* |  |
| A female health-care provider who speaks the same language as the survivor is optimal. If this is not possible, a companion of choice or another female health/social worker should be in the room during the examination.\* (male survivors may prefer male professional) |  |
| **3. Furniture/setting** | **Available?** |
| A clean, quiet, child-friendly, accessible consultation room, with access to a toilet or latrine, and with a door, curtain or screen for visual privacy\* |  |
| An examination table\* |  |
| Light, preferably fixed (a torch may be threatening for children)\* |  |
| A magnifying glass (or colposcope) |  |
| Access to an autoclave to sterilize equipment\* |  |
| Access to laboratory facilities/microscope and a trained technician |  |
| Weighing scales and a height chart for children |  |
| **4. Supplies** | **Available** |
| Speculums\* (only adult sizes) |  |
| Tape measure or ruler for measuring the size of bruises, lacerations, etc.\* |  |
| Syringes/needles\* (butterfly type for children) and tubes for collecting blood |  |
| Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)\* |  |
| Resuscitation equipment\* |  |
| Sterile medical instruments (kit) for repair of tears, and suture material\* |  |
| Tongue depressor (for inspection of oral frenulum and injury) |  |
| Cover (gown, cloth, sheet) to cover the survivor during the examination\* |  |
| Spare items of clothing to replace those that are torn or taken for evidence |  |
| Sanitary supplies (disposable or cloth pads)\* |  |
| Pregnancy tests |  |
| Pregnancy calculator disk to determine the age of a pregnancy |  |
| Additional supplies that may be needed for forensic evidence collection/documentation |  |
| Comb for collecting foreign matter in pubic hair |  |
| Cotton-tipped swabs/applicators/gauze compresses for collecting samples |  |
| Glass slides for preparing wet and/or dry mounts (for sperm) |  |
| Laboratory containers for transporting swabs |  |
| Paper sheet for collecting debris as the survivor undresses |  |
| Paper bags for collection of evidence |  |
| Paper tape for sealing and labelling containers/bags |  |
| **5. Drugs (with age-appropriate dosages)** | **Available** |
| For treatment of STIs as per country protocol\* |  |
| For post-exposure prophylaxis of HIV transmission (PEP)\* |  |
| Emergency contraceptive (EC) pills\* and/or copper-bearing intrauterine device (IUD) |  |
| Tetanus toxoid, tetanus immunoglobulin\* |  |
| Hepatitis B vaccine\* |  |
| Pain relief\* (e.g. paracetamol) |  |
| Anxiolytic (e.g. diazepam) |  |
| Sedative for children (e.g. diazepam) |  |
| Local anaesthetic for use when suturing\* |  |
| Antibiotics for wound care\* |  |
| **6. Administrative supplies** | **Available** |
| Medical consultation form including chart with pictograms\* |  |
| Medical certificate/medico-legal forms |  |
| Referral directory |  |
| Job aids in the language of the provider (e.g. care/treatment algorithm, referral flow chart) |  |
| Consent forms\* |  |
| Information pamphlets for post-rape care (for the survivor)\* |  |
| Safe and locked filing space to keep records confidential, or password-protected computer for electronic files\* |  |

### Staff Training

* Ensure that medical team members and local health providers (doctors, medical assistants, nurses, midwives, etc.) are trained to provide appropriate care, including first-line support (LIVES) and to refer as feasible and that they have the necessary medicines and medical supplies.
* Female (and male) health-care providers should be trained as a priority, but a lack of trained female health workers should not prevent the health service from providing care for survivors; if a male health-care provider conducts the examination, a female chaperone should be present.
* All other health-care facility staff, such as cleaners and administrators, should also receive awareness training, including on how to respect confidentiality and communicate with survivors compassionately, without discrimination.

### Coordination with Other Service Providers

* Referrals are essential for meeting the full range of survivor needs and for ensuring that your own medical team’s health providers are not overwhelmed when presented with a GBV case. This is particularly true in conflict contexts where medical team members’ time is constrained and survivor safety and psychosocial needs are more complex.
* Ensure you are able to refer survivors to other needed services, according to their needs and with their consent. This includes mental health and psychosocial support, safety/security and legal services/justice services.
* Develop or obtain a copy of a referral directory with the clear focal points and contacts for each service provider, locations, procedures for making a referral and sharing information with another service provider. This process should also identify referral options that address the specific needs of male, child and other survivors (e.g. People with disabilities, sexual and gender minorities).
* In humanitarian settings, there may be a GBV sub-cluster/working group (see chapter 3 on Coordination Platforms and Modalities) or other relevant coordinating body that has an active referral pathway that you can be part of and consult.

## The Components of a Medical Response to GBV

Medical teams and local health care providers may be the first and sometimes only point of contact for GBV survivors. During conflict, a minimum package of health services[[113]](#footnote-113) for GBV should be provided at all levels: emergency mobile teams; primary health clinics; secondary and referral hospitals and should be integrated into existing health services. [[114]](#footnote-114) Patients/survivors presenting with life-threatening or severe conditions should be referred immediately to specialist facilities for more complex care or surgery.

Health facilities and field hospitals should be equipped with appropriate infrastructure, equipment and commodities to provide quality GBV care. This will include private spaces for consultation (this is critical for safety and comfort), protocols for provision of health care to survivors, essential medicines and supplies and confidential mechanisms for documentation and referrals.[[115]](#footnote-115) Identify a focal point within your team (e.g., doctor, nurse or midwife), ideally female, who is trained to provide clinical care to GBV survivors.[[116]](#footnote-116) Always obtain consent from the survivor.

### Survivor-Centred Care & First-Line Support

(note that reference to she/he or persons, is deliberate to indicate that both females and males can be survivors of GBV)

When addressing the health needs of survivors of sexual violence and IPV, medical teams need to deliver care in a confidential, non-judgmental and non-discriminatory manner that respects the survivor’s decision-making role and considers the patient/survivor’s sex, age and their specific needs, regardless of the medical team’s own beliefs or organizational values. Medical teams must address immediate and ongoing emotional/psychological health needs; physical health needs and safety needs. **First-line support** is an essential part of the care provided and involves responding to a person who discloses violence in a way that is supportive, helps to meet her/his needs, and prioritizes their continued safety without intruding on her privacy.[[117]](#footnote-117)

First line support (represented by the acronym LIVES) includes:

* **L**istening to the survivor closely, with empathy, and without judging. Don’t pressure her/him to tell her story or judge what she has done or how she is feeling.
* **I**nquiring about needs and concerns. Assess and respond to the survivor’s various needs and concerns – emotional, physical, social and practical. Ask open ended questions such as “Could you tell me more about that?”
* **V**alidating. Show her/his that you understand and believe her. Assure them that they are not to blame. Tell her that it is not her/his fault and that she is not to blame for the violence she experienced.
* Enhancing safety. Discuss a plan to protect them from further harm if violence occurs again.
* **S**upport them by helping her access information, services and social support. You may see if she has a trusted person she can talk with for support. You should also see if she needs other services by asking “What would help most if we could do it right away?”

### Clinical management of rape

Rape survivors require urgent medical care that should begin with first-line support and be accompanied by the following steps after obtaining informed consent (for the history, physical examination and for obtaining forensic evidence, if applicable). [[118]](#footnote-118)

* **Taking the history:** This includes four parts: (a) general medical information (current or past health problems, allergies, medications the survivor is taking); (b) talking about the rape incident(s) (politely asking the survivor to briefly describe events, explaining that she/he does not have to tell you anything that she/he does not want to); (c) gynecological/anal/rectal history as applicable; and (d) assessment of mental state. It is important to limit questions to what is required.
* **Perform the physical and genito-anal examinations:** Examinations are carried out to determine what medical care is needed. Women/men who do not consent to a physical examination, or who are not able to complete the examination, should still be offered treatment based on a thorough history. [[119]](#footnote-119) For a head to toe physical exam, please see the post-rape physical examination checklist in Annex. Survivors may be very sensitive to being examined or touched, particularly for the genito-anal exam, so proceed slowly, explain what you are doing next and ask them if she is ok to proceed throughout.
* **Treatment:** Treatment will depend on how soon after the incident the survivor presents.

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|  | **Treatment** | **Timeline and specifics** |
| **Priority within 72 hours** | **Treatment of physical injuries** | **Immediately** refer the survivor to emergency care for life-threatening conditions. Clean and treat less severe injuries on-site. |
| **Post-exposure prophylaxis (PEP) for HIV infection** | Provide PEP **as soon as possible and within 72 hours of possible exposure**. Provide the full 28-day course at first visit as survivors may not be able to return. If after 72 hours, provide the range of other essential interventions and referrals for HIV testing and treatment |
| **Emergency contraception (EC)** | Provide EC **as soon as possible and for up to 120 hours** (5 days). Levonorgestrel-only regimens work better and cause less nausea and vomiting than combined regimens. Provide 1.5mg levonorgestrel in a single dose. Any woman can take EC pills. There is no need to screen for health conditions or test for pregnancy. |
| **Presumptive treatment of sexually transmitted infections (STIs)** | **As soon as possible,** provide presumptive treatment for gonorrhoea and chlamydial infection. Give the shortest course available according to the local or national protocol. If survivor presents after a few weeks, treat according to syndromic model or lab testing. |
|  | **Tetanus prophylaxis** | Provide according to risk and pre-exposure vaccination status. |
|  | **Hepatitis B prophylaxis** | Vaccinate according to protocol, unless already vaccinated. |
|  | **Management of unintended/unwanted pregnancy** | Provide counselling and discuss options with the survivor. Offer safe abortion, where legal, or refer to other support services, such as adoption, if available. |

* **Follow-up visits**. During conflict, follow-up may not be feasible and therefore providers should aim to provide essential information and care during the first visit. Ask the survivor if she has a trusted friend or family member who can provide support following the initial visit. Keep in mind that family members may not be supportive and may be the perpetrators of violence, and therefore it is important to let the survivor determine who to involve in her care. Set up a 2-week follow up appointment to continue first line support and assess emotional state, check that any treatment given was taken for the full course, test for pregnancy and evaluate for STIs and treat as appropriate.
* **Referrals for specialist care and/or mental health:** According to your referral pathway, ensure the survivor has access to safety, protection and psychosocial services. Life-threatening injuries or those necessitating surgical intervention should be referred to a specialist facility.

### Special Considerations when Dealing with IPV

Women (and other minatory groups - ref) who have experienced IPV may have physical injuries or other health conditions that require medical treatment. Often, they will not disclose the violence due to shame, fear of being judged, or fear of her partner. Regardless of disclosure, it is important to address the survivor’s health needs while asking about suspected violence and providing first-line support.

### Special Considerations for Children

For children, attention to the best interests of child, safety, privacy and confidentiality are critical. Medical teams need to be trained in providing sensitive care to children who may have been abused and be able to adapt procedures for obtaining informed consent; preparing the child for the physical examination; conducting the examination and providing treatment according to age, sex and stage of development.[[120]](#footnote-120), [[121]](#footnote-121) Medical teams should be aware of international standards on children’s rights to protection, privacy, participation and health as well as how these standards are translated into national law and applied in the local context. [[122]](#footnote-122)

### Self-Care for Medical Teams Dealing with GBV

Working with survivors of GBV can be deeply rewarding, particularly when one sees a positive impact from the assistance provided. At the same time, GBV cases can be difficult, demanding, and emotionally exhausting. Seeing survivors in distress and hearing disturbing details of traumatic events can be upsetting and can sometimes bring up memories of personal experiences of violence. If the emotional demands of this work are not addressed, medical teams are at risk of developing stress-related conditions such as burnout, compassion fatigue, or vicarious trauma. Medical teams should be aware of these risks and establish standard and routine mechanisms for supporting staff well-being and safety. Examples include: (ref needed)

* Being aware of workload and ensuring that sufficient time is given to handle complex cases, such as GBV.
* Providing supervision to medical team members working directly with survivors to ensure they have the support and information needed to handle these cases.
* Sharing information about stress reduction exercises such as slow breathing, grounding, or progressive muscle relaxation.
* Ensuring medical teams have time for relaxing activities and are able to engage in physical activity and maintain a regular sleep schedule.

Self-care can be challenging in conflict contexts, but even small actions can reduce the risk of developing stress-related conditions when working with survivors.

## Protection, Risk Mitigation, & Advocacy

### Security Risks to GBV Survivors

There are often on-going and life-threatening risks to the safety of survivors from the perpetrator, family, community or armed actors. During conflict and complex emergencies, protection, legal and security services may be limited, and family and community support reduced. A ‘survivor-centred approach’, which prioritizes the rights, choices and needs of the victim, is an essential component of ensuring protection and promoting recovery and is enhanced by well-coordinated responses. Health staff need to help the survivor assess any immediate risk of violence, identify and take steps to make herself safe, and access support. Key questions to ask include:

* Does the survivor have a safe place to go when she leaves?
* Does she have children or other dependents and is she able to continue to provide care to them (some survivors may be unable to carry out day to day activities following an experience of violence)?
* Does she have support from family, friends or relatives to help with childcare, accompaniment to appointments for follow up, other? Some survivors can face rejection from their families after experiencing GBV and will have material and emotional needs that need to be met.

If the survivor is not safe to go home, or if she is struggling to carry out day to day activities, consult referral pathways so find her a focal point within a protection or psychosocial service who can help.

### Risk Mitigation & GBV

**Health staff have a responsibility to guarantee privacy and confidentiality.[[123]](#footnote-123)** During conflict, health staff must take extra measures to avoid any harm to patients/survivors. Privacy, confidentiality and safety are key principles[[124]](#footnote-124) that should inform the development of health information and surveillance systems for documenting reports of violence and for programme monitoring. A privacy and confidentiality policy[[125]](#footnote-125) should be established at the start of an intervention and data security procedures must be put in place to avoid putting survivors (and potentially health care providers) at risk if confidentiality is breached.

During conflict, even if a survivor wishes to report to the authorities, she may not be able to report due to breakdowns in State legal systems, insecurity, risks to the life of the survivor, impunity of perpetrators or if the survivor is unable to identify the perpetrator. However, if needed, physical examinations may be used to complete any legal documentation. Regardless of any legal redress or mandatory reporting requirements, the priority should always be on the provision of life-saving health care to survivors of violence.

Guidelines for ensuring the confidentiality, safety and privacy of the survivor[[126]](#footnote-126):

* Always obtain the survivor’s consent before sharing any information about them. If mandatory reporting is applicable, ensure the survivor is aware of the limits of confidentiality so that she can choose what to disclose.
* Decide who will be responsible for collecting and recording information
* Determine where and how information will be collected, recorded and stored.
* Maintain the confidentiality of health records by using anonymizing coding systems and by keeping paper-based in a safe and secure location, such as a locked filing cabinet or electronic files password-protected.
* In situations deemed too risky or insecure for paper files, consent can be obtained verbally, examinations and treatments provided with accompaniment for referrals offered if possible.
* If women are given medical records to take home, information about their experience of violence should not be mentioned.

### Advocacy

Medical teams may have opportunities for advocacy and access to decision-makers (e.g. local leaders, government officials, military leaders) that can be used to strengthen responses to gender-based violence.

Examples of advocacy could include:

* Highlighting the needs around GBV within the health sector to ensure that quality services are available to survivors.
* Speaking with community members, local leaders, and NGOs working in the area to determine if things can be done to promote a more protective environment for women and girls or to support survivors returning to their communities.
* Speaking with government officials to raise awareness of GBV and build political will for a stronger response to it.

Medical teams can convey key messages around GBV as a preventable health problem that seriously affects women’s health, using both global data and information gathered from their own service delivery (ensuring no survivor information is ever disclosed). Medical team leads should consider when and if advocacy may be needed, carefully weighing the risks that could follow if they speak out on gender-based violence. Survivor and medical team safety are paramount and should always be at the center of any advocacy decisions.

## Media & GBV

There is often media interest about stories of gender-based violence during emergencies. While media reporting can play a vital role in advocacy, if it fails to consider basic ethical and safety principles, it can put survivors at risk.

* All media requests should be coordinated and authorized by medical team leads or leading agency. Medical team members should never accept requests from the media, without prior authorization from their lead. Media and advocacy strategies and determinations are the role of the team lead, not individual members.
* Ensure that informed consent is obtained from survivors for any media story about their experience. It is important that survivors understand the full implications of their involvement in a media story.
* Ensure that details, such as names, photographs, or other identifying information about survivors, family members or even sometimes those providing assistance are not used, unless informed consent is given. Make sure that survivors are not pressured and understand the potential risks.
* If you are considering contributing information and analysis on GBV to the media, carefully consider the risks and benefits. Advocacy on GBV is important and media can be a key way to raise awareness that such violence is occurring. However, it can also compromise perceived neutrality and independence and jeopardize security. It can put services and service providers at risk, particularly if it becomes known that your facility or team is treating survivors of GBV (and therefore might have information about alleged perpetrators). Weigh carefully the risks that this will bring to your services and if you decide to proceed, plan for any potential security issues that could arise (demands for information and files, closure of services, etc).

## Legal & Security Frameworks

Sexual violence can constitute a war crime under the Rome Statute and is addressed in seven UN Security Council Resolutions (1820, 1888, 1960, 2106, 2122, 2242, and 2247), which call for services for survivors and establish tools to combat impunity, including through monitoring mechanisms. In addition, sexual violence, rape, intimate partner violence are criminalized to some degree in most national legal frameworks.

Because of the increased focus on ending impunity for conflict-related sexual violence, in particular, medical teams should be aware of their role in the collection of forensic or medico-legal evidence (even if forensic evidence cannot be collected, providers have a responsibility to ensure proper documentation of GBV cases). This includes thorough and complete documentation of the survivor’s account, any injuries, physical exam findings, and collection of blood and DNA evidence. Only medico-legal evidence that can be collected, stored, analysed and used should be gathered, and only if a survivor wishes for it to be collected and has given full informed consent. Ideally, the forensic medical examination should be done at the same time as the provision of medical care. Health workers must be specifically trained and have supervised experience in order to conduct forensic medical examinations. Even when forensic evidence collection is not feasible, medical teams should ensure the exam findings and treatment are well documented. The examination documentation itself can be useful if a woman decides to pursue a legal case.

In cases of rape medical care of a survivor includes preparing a medical certificate, which is a legal requirement in most countries. The medical team member who examines the survivor must make sure a certificate is completed. The medical certificate is a confidential medical document that the health-care provider must hand over to the survivor, while keeping a copy on file. The medical certificate constitutes an element of proof and is often the only material evidence available, apart from the survivor’s own story. The medical certificate should be available for free; survivors should not be charged for it.

### Tips for GBV Documentation

* Record the interview and your examination findings in a clear, complete, objective, non-judgmental way.
* It is not the responsibility of medical teams and local health providers to determine whether or not a woman has been raped. Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.
* Completely assess and document the physical and emotional state of the survivor.
* Document all injuries clearly and systematically, using standard terminology and describing the characteristics of the wounds. Record your findings on pictograms. Health workers who have not been trained in injury interpretation should limit their role to describing injuries in as much detail as possible, without speculating about the cause, as this can have profound consequences for the survivor and accused attacker.
* Record precisely, in the survivor's own words, important statements made by her, such as reports of threats made by the assailant. Do not be afraid to include the name of the assailant, but use qualifying statements, such as "patient states" or "patient reports".
* Avoid the use of the term "alleged", as it can be interpreted as meaning that the survivor exaggerated or lied.
* Make note of any sample collected as evidence

Medical teams should also be aware of their responsibility to safeguard survivor information and ensure confidentiality. Medical teams should never share information about a survivor with officials from UN agencies or bodies, monitoring mechanisms, or the national legal and security sector without the consent of the survivor. Sharing information without consent is a breach of confidentiality and can entail serious safety risks to the survivor.

## Chapter 4 Guidance Notes

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| 1. Teams need to be trained, prepared and equipped to manage clinical, security, protection, and advocacy components of GBV at the operational level. 2. Teams need to be aware of the confidentiality and risk mitigation methods with special considerations for children. 3. Teams need to be aware means for self-care when managing GBV. 4. Teams integrate a capacity strengthening approach in when working with local providers and team 5. Teams and Leaders have easy access to the most relevant key references and manuals at their fingertips |

**GBV Resources to be move references section of Red Book**

IASC (2015) Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action Reducing risk, promoting resilience and aiding recovery <https://gbvguidelines.org/en/>

WHO, UN Women and UNFPA (2014). *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.* Geneva: WHO.

https://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/.

WHO, UNPFA, and UNHCR (2019). *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings* (2019),

Inter-agency Working Group on Reproductive Health in Crises (2011), *Minimum Initial Service Package (MISP)* (2011).

WHO, UNODC. Strengthening the medico-legal response to sexual violence. Geneva: World Health Organization; 2015 ( http://apps.who.int/iris/bitstream/10665/197498/1/WHO\_RHR\_15.24\_eng.pdf?ua=1 ).

UNFPA, Managing Gender Based Violence Programs in Emergencies, eLearning <https://www.unfpa.org/sites/default/files/pub-pdf/GBV%20E-Learning%20Companion%20Guide_ENGLISH.pdf>

GBV Annex: to be moved to Annex section of Red Book

**Post-Rape Physical Examination checklist**

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| Look at all the following | Look for and record |
| Physical examination checklist | |
| * General appearance * Hands and wrists, forearms, inner surfaces of upper arms, armpits * Face, including inside of mouth * Ears, including inside and behind ears * Head * Neck * Chest, including breasts * Abdomen * Buttocks, thighs (including inner thighs), legs, feet | * Active bleeding or fresh wounds * Bruising * Redness or swelling * Cuts or abrasions * Evidence that hair has been recently pulled out, and evidence of recent loss of teeth * Injuries such as bite marks, or stabbing or gunshot wounds * Evidence of internal, traumatic injuries to the abdomen * Ruptured ear drum |
| Genito-anal examination checklist | |
| * Genitals (external) * Genitals (internal examination, using a speculum) * Anal region (external) | * Active bleeding or fresh wounds * Bruising * Redness or swelling * Cuts or abrasions * Foreign body presence |

CHAPTER 5

ESSENTIAL EMERGENCY CLINICAL CARE

&

REHABILIATION

“the very first requirement in a hospital is that it should do the sick no harm.”

Florence Nightingale

# Essential Emergency Clinical Care & Rehabilitation

A principled medical response is comprised of both operational and clinical interventions that are guided by and adhere core standards and a patient focus on quality, safety, and protection.

ICRC War Surgery Vol 1 and 2

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| Chapter Objective  1. Provide insights in how the burden of clinical presentations varies between responses to emergencies and outbreaks in non-conflicts and armed conflict areas  2. Acquire knowledge on how conflict and complex emergencies impact health service provision to and access for patients  3. Prepare teams to adapt their care, team composition and equipment for acute presentations of non-communicable, communicable as well maternal health conditions  4. Ensure awareness of the skills and protocols needed to manage acute and complex injuries, outbreaks, CBRN threats, burns, mass casualty incidents |

## Introduction & Setting

This chapter outlines best practices of clinical care for health problems that medical teams will encounter in armed conflicts and complex emergencies. It sets guidance notes for clinical care provision that has a principled humanitarian approach and focuses on the civilian population. It has a patient- centered perspective and includes medical, nursing as well as rehabilitation guidance for community, pre-hospital, hospital, referral and rehabilitation care. It is not a “stand alone” chapter but serves as a compliment to the clinical chapters in the “Blue Book” and the “toolkit” adding specific clinical care considerations in armed conflicts & complex emergencies.

Armed conflicts and complex emergencies create unique health care needs that require additional services and expanded skill sets of responders compared to disasters and outbreaks in non-conflict settings. Key differences between the two contexts regarding clinical care needs, presentations and operational aspects are highlighted in Table below.

## What Type of Health Care Needs should Medical Teams be able to Manage?

In addition to conflict-related injuries, patients will also present with conditions which are prevalent in the area pre-event. These will vary depending on the socioeconomic situation of the affected area. For example, the disease burden in middle income countries is more dominated by non-communicable diseases compared to low income countries. However, conflicts may cause re-remerge of communicable diseases. The crises (length and intensity) may have impacted health system functions and disrupted routine public health services such as vaccination and preventive programs as well as water and sanitation, shelter, access to food etc, causing health problems that was not an issue prior to the conflict. With particular relevance to clinical care in armed conflict and complex emergencies; access to patients by teams or services for patients is often severely impaired due to insecurity, health facilities closure and targeting or fear among national and international health staff. It is essential for any medical team to before deployment, critically assess the health care need by analyzing the context and its development and direct and indirect health effects as well as the areas current (i.e. the conflict period) demographics, death and birth rates, vaccination coverage, malnutrition level, burden of disease, as well as existing health system capacity and coverage, (see toolkit for a full checklist). The results will prepare and guide the deployment design, operational strategy, set up, staff qualification and equipment. For better clinical outcomes deployment time for EMTs in Red book context is considerably longer compared to Blue book context and should be at least 3 months, preferably longer. It is required that any medical team should be able to manage injuries and also provide care for acute presentations of maternal and child conditions, communicable and non-communicable disease presentations. It should not come as a surprise that acute asthma patients and women in labor show up at the facility.

The pattern of presentations at health facilities will vary depending on time of transport. Tranfer time is critical and will not only depend on distance from the conflict but as well on availability of transport, security as well as road conditions. Time to treatment is particularly important for emergency conditions such as trauma. Trauma presentations in armed conflicts will be cyclical depending on conflict intensity and access. During response to recent conflicts trauma care was provided in much closer proximity to the frontline by a wider range of actors compared to previous conflicts, yet transportation times remained long. Some data suggest that the response closer to the conflict led to survival to clinical care of more severe and acute complex penetrating polytrauma from ordnance, bullets and blasts. The complex referral pathway system that was set up, involved more levels of care shared between more actors, has been praised but its set up and value needs to be critically evaluated. Recent conflicts have highlighted new and different challenges to trauma response that call for adaptation of old paradigms including type and level of trauma services provided as well as systems for referrals. Recent conflict experience marks a new era for advanced civilian trauma care in resource limited settings that has brought in new actors and strategies that may have contributed towards more saved lives[[127]](#footnote-127).

Preparedness and previous exercise are necessary to manage different types of mass casualty incidents (MCI). Armed conflict often produces multiple “pulses” of large and small numbers of patients from MCIs due to explosions, escalations within a specific conflict zone, or due to building collapse or other secondary event. To add to the complexity, it is possible that patients with CBRN exposure could present during an MCI. A significant number of contaminated with or without symptoms may arrive simultaneously overwhelming the medical teams and exposing them to risks of contamination. MCI preparedness for sudden influx of significant number of injured must also be in place including practiced trauma triage protocols and dedicated roles and responsibilities of all staff. Triage protocols for identification and initial sorting must also be available as well as protective gear and antidotes for the staff for CBRN events. Space and equipment for safe decontamination outside the facility should be readily available (consider the appropriate removal of clothing, water supply etc. See the toolkit for more information)

Outbreaks in armed conflict and complex emergencies pose significant and complex challenges. Recent examples in Central Africa of high consequence pathogen outbreaks, and in the Middle East with very high case numbers of Cholera and diarrheal disease during active armed conflicts have severely impacted the ability of local health authorities and international actors to mount a “normal” clinical and public health approach to the response. Outbreak response requires a multi/pillar response with equal weighting given to public health measures such as surveillance and active case finding, safe and dignified burials, Public health messaging and community engagement along with the more clinical focused laboratory services and treatment and isolation of patients, infection prevention and control in health facilities and continuity of access to health services such as safe births, NCD and other communicable disease care not related to the specific outbreak. Traditional use of IHL dealing with the care of injured among civilians by parties to the conflict is well covered elsewhere in the chapter, but the specific role of parties to the conflict responding to an outbreak is not as well covered. While many read into the wording of IHL that “providing care” to the civilian population should also include response to outbreak this does not seem to be the interpretation of militaries in current conflict examples above. Intra-state violence which involves the Governmental forces against non-state actors and the additional complexity of UN peace keeper direct action makes other UN agency action more complex, especially when completely aligned with the Government side. Effective clinical and public health outbreak response more than any other form of health intervention requires an approach that ensures the population believe it is neutral and impartial, or they may disregard or not believe the public health messages, hide love ones for fear of aligning with opposition forces, and may well fear violent reprisals more than they fear the outbreak. Trauma care (Surgery, wound management and airway control procedures) and operative or invasive reproductive services in an area affected by outbreak are particularly high risk for personnel. The chaotic moments of MCI during conflict are risky for staff due to bodily fluid and sharps exposure. Add to this response in an area affected by high-consequence pathogens such as Ebola and the complexity multiplies tenfold. New advances in better PPE, immunization of health workers against pathogens such as Ebola and new designs of operating theatres for use during Ebola response have helped partially mitigate these risks.

## What are the Special Operational Issues?

The insecure and dynamic environment impacts all aspects of clinical care including, but not limited to, care site set up, referral pathways, medical supplies and critical medications, surgical case planning and its implementation. For example, in the high-threat environment, health facilities may need to be moved closer or further from the conflict areas based upon both patient need and responder safety. Continuity of care must be secured, and standards of care should remain on equal levels throughout the referral chain including transfers and rehabilitation. As a guiding principle, the level of care provided during transport must aim to at least equal that at the point of referral and must prepare the patient for admission to the receiving service. Additionally, teams may need more robust security at the treatment site to protect against antagonistic attack or be cautious of secondary devices aimed at injuring responders (see safety and security chapter). Preparation for and surveillance of communicable diseases and outbreaks such as epidemic diarrheal diseases, highly contagious diseases including viral hemorrhagic fever, and influenzas is a must. A critical issue is maintenance and storage of patient files that in a conflict constitute a potential security threat to patients. As per the Blue Book, patients deserve a copy of their medical record or in cases of complex care, a discharge summary. Other hospital identification such as wrist bands should generally be removed prior to discharge in case presence of these is a risk to the patient from armed groups later. Patients records in armed conflict areas are a potential source of information for one or other party to the conflict. Medical teams should ensure that identifiable data always is confidential and should not be shared with any side without very careful consideration on the implication for patients who may later suffer reprisals of many kinds (direct and indirect). This is a clear difference with the Blue Book context. It is important that continuity of care at the individual patient level is ensured, so if patients agree to be transferred to another facility their medical record and notes should accompany them. Copies held by the original treating medical team for all cases should be securely stored. Any digital records should be de-identified, and daily surveillance reports and MDS (Minimum Data Set) reporting should all be anonymized. Hard drives and passwords for secure computers should be carefully managed, and contingencies for urgent evacuation by a medical team should also include plans for securing medical records and hard drives containing sensitive information.

## Clinical guidance per Level of Care

Successful management of patients with acute conditions require a chain of health services with different capacities and services that are interlinked. All levels serve a purpose and are important and should be recognized. This means ensuring an understanding of what health services and referral pathways are available in the area you have set up. Every facility should understand the capacity and capability of the facilities from which they refer from and those which they refer to! Just as in the Blue Book context, response in armed conflict is often first carried out by untrained bystanders and family/survivors, first aid trained rescue staff and occasionally by pre-hospital ambulance medics. The types of EMT (1 mobile, 1 fixed, type 2 and type 3) as well as context adapted specialized teams all have a place in armed conflict, though not all patients will be seen in each level (some only need basic care, others may bypass a level depending on local context). The section below describes any adaptations required for armed conflict setting to the normal typology of medical teams, but all should ensure that IHL principles and medical ethics are respected and followed.

The design, staffing, equipment and focus of medical teams deployed to armed conflict and complex emergencies may vary depending on the context and distance to the frontline. Nevertheless, management ofemergency presentations *of non-communicable and communicable disease, injuries* as well as *maternal health conditions* including acute deliveries should be readily available at an any outpatient health facility, especially when referrals are difficult and long, and should follow the standards defined in the Blue book.

### Community, first responders

It must be acknowledged that most injured are first treated and potentially saved by by-standers such as neighbors and family members. Injured may be dragged out of direct danger and provided with basic care before being transported. At this stage the principle of three SSS’s should guide responders, with the first S more important than the second, and finally the third (Table below).

Transportation from site of injury to pre-hospital care will vary and be defined by the type of conflict, security and distance. Time to evacuation and transportation time is critical. Essential first aid guidelines are available[[128]](#footnote-128) and depending on context and actors in the field, ambulances and trained pre-hospital care providers/paramedics may be present that should without delaying transport perform initial stabilization including compressive dressing and ensure that the injured can breathe (Stanford paper).

### Prehospital Outpatient Care, (EMT -1, Mobile & Fixed)

Outpatient clinical care can be provided through fixed or mobile clinics. The need for either and their limitation should be carefully assessed prior to deployment.

EMT Type 1 mobile teams

Mobile teams have shown value in Blue and Red Book contexts recently, they have in recent conflicts been labelled “trauma stabilization points” (TSP) and form the first level of the trauma care chain. Their overall impact on effectively addressing health needs remains largely undocumented. The strategy of sporadic and irregular visits by mobile teams in underserved areas can be effective but rarely has lasting effects. Coverage remains limited, especially for acute emergencies given the short time on location. Efforts should be made to ensure regular services that is well accepted by the local community. Mobile clinics should be seen as a strategy of last resort to reach population groups cut off from health services[[129]](#footnote-129).

In conflict we have recently seen and increasing use of labelled mobile clinics from various organizations and health authorities. It is important than a degree of coordination occurs through the prevalent medical coordination system(s) so that communities receive equitable coverage, and no communities are un-served, and that one community is not over-burdened with multiple and potentially contradictory medical visits.

EMT Type 1- fixed teams

These clinics are relatively stable, e.g. in an established IDP or refugee camp or as a trauma stabilization point, but in contexts of armed conflict we need to remember that Type 1 mobile and fixed teams may both be required to evacuate quickly, in case of change in security threats or population movement. Type 1 fixed may state they have a focus on trauma stabilization and even call themselves a “trauma stabilization point” (TSP), yet these facilities MUST be able to manage acute presentations of non-trauma emergencies, as they are often close to an extremely vulnerable population with multiple unmet medical needs, and with potential for morbidity and mortality from emergency presentations of these illnesses. Presentations and severity of cases will vary as laid out in Table below. It is critical to take into consideration the evacuation time to definitive facility and level of services available there. Rapid arrival (without pre-hospital delay) to hospital with trauma care capacities will determine if the bleeding patient will survive or not. This will require that clinical protocols are adapted to capacities along the referral line. Location of operation and mobility of clinical teams must be addressed pre-emptively in order to balance security and patient access (See safety and security chapter). Set up should include a sufficiently spaced area to allow triage and acute management of injuries.

### Clinical Considerations Pre-Hospital

#### Trauma care

Ensure a well-known and practiced Triage system to sort and prioritize among injured. Assessment and stabilization should follow ABCDE principles[[130]](#footnote-130) and should include acute hemorrhage control (pressure bandage or tourniquets if necessary), basic airway management (such as nasopharyngeal tube), recovery position, infusion (limited to crystalloids and well as preventing hypothermia by keeping patient warm). Advanced initial trauma care, including intubation and chest tube insertion should be used only as temporary measure to stabilize the critically during ambulance transfer to higher level of care (Type 2 or 3) that is reachable within an acceptable time limit: if advanced-life saving procedure has been carried out, the patient must be accompanied during transfer by sufficiently trained medical staff. Remember, invasive procedures can only be provided by professionals with license to practice it in the affected country and require acting under medical doctor authority. Avoid “heroic” and futile interventions but ensure availability to sufficient end of life care that is ethically acceptable to all.

Ensure clear and exercised ABCDE protocols adapted to the context. Resuscitation level may need to be adapted based on what level of services are available at referral unit, time and referral quality and capacities as well as for MCI versus individual patient scenarios. Special considerations must be made before attempting to resuscitate severely injured, futile patients and those with complex brain injuries. For the bleeding patient rapid and basic stabilization of vital functions according to ABCDE principles should be quickly executed before transportation without delay. Remember that the internally bleeding patient is saved by surgery at hospitals. Don’t delay transport to hospital with unnecessary interventions! Tourniquets should only be applied when all other alternatives fail to control the bleeding. It remains a controversial tool that is extremely painful and if applied too long, can cause significant harm leading to unnecessary amputations. If applied, there should always be an accompanying person that when (within 2 hours) it must be removed. Careful considerations, clear plans and protocols including responsible during transfers and when it must be released (within 3-4 hours) should be in place, especially when transfers are expected to be long.

Uncomplicated minor injuries can be fully managed in pre-hospital medical facilities. Ensure that established protocols for this level of care are followed including wound management, pain control, follow up and rehabilitation[[131]](#footnote-131),[[132]](#footnote-132),. Additional considerations for trauma care are highlighted in table below for Q/A.

*Burns* may be a substantial problem requiring special considerations. They may present individually or a part of MCI. Initial care for burns may be basic in the pre-hospital (rescue) phase. New guidance on Burns MCI has clarified the value of basic pain relief and coverage of burns pre-hospital, and NO FLUID administration, while the care at a Type 1 mobile or fixed should be equally basic[[133]](#footnote-133). Burns estimation in the field is very difficult and often incorrect, and may under or over-estimate severity by 10-20%. Burns over an estimated 5% should be referred to a Type 2 for definitive cleaning, fluid therapy and further care.

#### CBRN .WILL BE ADDED

#### Outbreak

Any EMT should have capacity to identify potential communicable disease and protocols to manage infectious patients including IPC/PPE and well as separate space for waiting areas, treatment, isolation and ensure surveillance and reporting. Type 1 mobile and fixed are expected to be able to manage basic communicable disease cases. They may become valuable in treatment of outbreaks (eg Cholera) acting as a Cholera treatment unit or an oral re-hydration point depending on the skills of staff.

#### MCI

It is essential to have a well exercised triage system in place. Several triage systems to sort and prioritize injured patients before onward transfer patients exists. Teams should choose one and ensure that it is well known by all and exercised. Teams should have a well exercised MCI and contingency plan with clear designated roles and responsibilities for all staff as well as pre-defined designated space for triage and initial resuscitation. Basic ABCD principles to stabilize the injured according to triage category should be followed. Onward transportation may be a significant bottleneck and careful planning is needed to identify alternative transport when possible.

#### Referrals

EMT 1 teams are the first link in the trauma care chain of survival and must ensure that a robust patient evacuation system is in place to support clinical operations.  The continuity of care is essential, and the referral is a critical component. Experiences in recent armed conflicts and complex emergencies has highlighted the role of referrals and its limiting effects on survival. Ambulance transport has taken more time than expected and levels of care provided during transport has been low. Before referring injured patients, considerations must be made for referrals and if possible and secure trained staff may accompany the injured to definitive care. As in non-conflict settings, the clinical team sending the patient is responsible for the patient until they arrive at the next level of care. Accordingly, evacuation capacity and capabilities shape clinical interventions in the pre-hospital setting. Only patients requiring a higher level of care should be transferred to the definitive facility. Experience from recent conflicts is that referrals between EMT 1 and 2 can be significantly improved by the installment of specific coordination teams including “hot lines” to call and availability ambulances to send. Experience has also shown that referrals may take hours rather than minutes even if distances are short. This highlight that careful considerations must be made when tourniquets are applied and that responsible are assigned and tasked to remove the tourniquet if too long time has elapsed. Similar considerations should be used in use of advanced airway techniques with long transfer times. Key considerations for transport of critically ill patients is available[[134]](#footnote-134).

### Hospital (EMT-2 & EMT-3)

The main role of first hospital in the trauma referral chain (EMT 2) and referral hospital (EMT 3) is to ensure capabilities to manage penetrating, complex poly-trauma patients, providing stabilizing or definitive surgical care in emergency general surgery cases, treatment and stabilization of acute medical emergencies, and care for subspecialty emergencies such as, orthopedics and burns. The difference between EMT 2 and 3 is the level of service provided (see Blue book). In an armed conflict setting it is likely that EMT 2 will be closer to the frontline and receive fresh injuries and will once surgically stabilized will refer complicated cases to EMT 3 that are better resourced. It may also be that EMT 2 need to refer due to lack of bed capacities or due to security concerns. Such referrals can be to local hospitals with capacities further away from the frontline. Experience from recent conflicts showed that frontline EMT 2 at times did not have space and capacity to provide definitive surgical care. Newly operated patients had to be referred demanding acute referrals of critically ill, putting significant pressure on transportation and receiving hospitals that sometimes received freshly operated patients without prior notice.

A main reason to refer patients, whether trauma or other sever condition, to higher care will be the need for surgery. The surgical care needs in conflicts includes acute injuries as well as the baseline emergency surgical needs such as C-section, appendicitis and other acute surgical emergencies. The surgical services provided should be adapted to the context, meaning that careful considerations should be made not to introduce treatment practices including elective surgery, that are beyond the existing health system’s ability. Specialized care (teams) may provide specific reconstructive services to manage trauma complications including, non-unions, malunions and infections considering the challenges these types of services need including long time on ground and specific rehabilitation. Teams must possess the capability to manage the complications and post- surgical care of patients that they treat. Importantly, the EMT 2/ EMT 3 efforts should support the pre-hospital efforts and align with rehabilitation capabilities in order to ensure continuity of care and appropriate referrals. There are significant ethical and cultural considerations to be taken into account before commencing advanced treatments of severely injured patients. Besides consent and culturally appropriate information to the patient, futile interventions should be avoided. Careful adaptation to the context and available health system resources including rehabilitation must be made. At time this may challenge the ethos of individual staff that are used to providing maximum care for any patient without consideration to available resources and future destiny of the patient. A more holistic perspective is needed to adapt the approach and care provided. Nevertheless, despite the contextual challenges, teams should strive for maximum quality of the services. The technical standards and capacities for EMT 2/3 are defined in the Blue book

#### Clinical Considerations - Hospital

Any hospital (EMT 2 and 3) must have medical, nursing and rehabilitation services available and protocols in place to manage acute presentation of non-communicable, communicable diseases as well as obstetric emergencies. Training in mental health/psychological first aid is also a must. More comprehensive description of standards for such care is available in the Blue book. The Red book context may affect how and when patients with these condition present at the hospital. In table below some of the main operational concerns are highlighted.

#### Trauma Care

Clinical considerations focus on management of penetrating injuries due to bullets, blasts and ordnance. Teams should have knowledge of ballistics and the type and complexity of organ injury and have clinical experience of managing penetrating injuries. Basic principles for treatment of such injuries have been outlined in ICRC and partner manuals[[135]](#footnote-135)[[136]](#footnote-136) but should be complemented by more modern yet adapted resource adapted strategies including damage control resuscitation principles and strategies. This approach has been successfully implemented in high resource settings to improve survival of the critically injured patient. It builds on a system approach and includes aggressive mechanical hemorrhage control, limited crystalloid resuscitation, early balanced blood product administration, hypothermia prevention, utilization of hemostatic adjuncts (e.g. tranexamic acid), and early movement to damage control surgery. To what extent this advanced and resource demanding strategy can be implemented depend on several aspects including availability of resources such as trained and dedicated staff, equipment, medications, blood products, ICU as well as early rehabilitation. Surgical teams operating in a conflict zone should expect to manage large volumes of life- threatening trauma and should strive to apply as many components of damage control principles as possible in their treatment guidelines while taking the context and continued care including referrals and rehabilitation into considerations[[137]](#footnote-137).

Hemorrhage is the leading cause of potentially preventable death in trauma. Efforts must be made to rapidly and safely administer life- saving blood transfusions.  However reliable access to blood products is a major logistical, administrative and clinical challenge in conflict settings. Teams must work with partners to ensure a safe and reliable blood resource process accessible to facilities.

Extensive work exists on clinical standards for the full spectrum management of acute penetrating injuries in resource poor conflict zones including wound care, ortho-plastics[[138]](#footnote-138),[[139]](#footnote-139) as well as essential management of neuro and spinal injuries. Teams should ensure a collection of guidelines and protocols for managing complex penetrating multi-trauma including rehabilitation that are based on updated best practices appropriate for the context.

In 2018 a group of experienced trauma experts (Stanford summit) convened to compile best practices for civilian trauma care in armed conflict and complex emergencies and set minimum services that should be available at first receiving hospital. In table below these recommendations are summarized and used as guidance for EMT 2 and 3.

Burns may be cause significant health service in armed conflicts and complex emergencies. Burn care is resource intense. (see WHO Specialist Cell Burn care). Depending on severity of burn patients should be referred to specialized unit where care is provided based on best practices protocols. EMT Protocols for burn management is available (REF), but it is expected that all Type 2 and 3 EMTs must have the ability to manage Burns presentations including MCIs with Burns victims. This will include secondary triage, stabilization and resuscitation, wound scrubbing and dressings with tertiary triage and definitive percentage burn estimation allowing appropriate distribution of patients to other Burns centers, treatment of minor Burns up to 20%, and care for patients requiring palliation due to survivable Burns.

#### CBRN WILL BE ADDED

#### Outbreak

As in the Blue Book situation, all Type 2 and 3 facilities need to be able to triage and recognize highly infectious patient presentations (e.g. TB, Diphtheria, Cholera etc.), separate triage areas and wards that can manage communicable disease presentations along with appropriate PPE for staff. Referral of patients to appropriate specialist facilities may or may not be possible depending on context. Specific Outbreak treatment centers e.g. Ebola or Cholera Treatment centers are termed specialist teams for outbreak and have the same standards as Blue Book contexts but with additional requirements for community engagement as per earlier in this chapter. *MCI* Any medical facility providing care in conflicts and complex emergencies should have defined and exercised plans for MCI events. Unlike sudden onset natural disasters, in conflict zones MCI’s are more frequent, generate more high acuity patients, and are cyclical.  At the EMT 2/ EMT3 level, teams must be prepared to manage patient surge from point of entry into the facility through damage control surgery into post- surgical care and evacuation. EMT 2/EMT 3 should work in coordination with other advanced resources to develop mutual aid plans and strategies for rapid evacuation of patients.

### Specialized Care Cells

Deployment of specialized care cells to armed conflict and complex emergencies should be done based on request and special needs. Specialized care cells that are particularly relevant are ortho-plastics, maternal and child health, rehabilitation, burns, outbreak care teams. Such teams should not be stand-alone but set up in combination and as addition to an EMT 2 or 3 or may be embedded in to a local hospital. More information about clinical considerations for specialized care teams are available XYZ

Outbreak specialist teams (eg Ebola or Cholera treatment centres) WILL BE ADDED

### Rehabilitation

Rehabilitation is an essential component of clinical care in armed conflict and complex emergency response, particularly with the considerable legacy of disability that a massive surge in traumatic injuries and the exacerbation of chronic medical conditions create [[140]](#footnote-140),[[141]](#footnote-141), [[142]](#footnote-142), Previous armed conflict and complex emergency responses have clearly demonstrated the devastating consequences for affected individuals, families and communities that results from insufficient access to rehabilitation [[143]](#footnote-143),[[144]](#footnote-144). Rehabilitation is now recognised as an integral part of emergency response by the World Health Organisation (WHO) and partners [[145]](#footnote-145).

Specific challenges are faced by EMTs providing rehabilitation in this context including; a broad range of conditions (physical as well as mental health) requiring rehabilitation, limited national rehabilitation capacity, damaged infrastructure, reduced workforce, disrupted services, and compromised procurement and coordination pathways. The provision of rehabilitation by EMTs in armed conflict and complex emergencies may take place within an EMT facility (type 1-3) or as part of an EMT specialist care team embedded into a host facility and commence as early as possible. Due to the differing mechanisms of injury sustained in conflict, adapted surgical and rehabilitation practice and protocols may be required. Clear operation notes and early patient education is essential to managing expectations, encouraging participation and optimising outcomes. Dependent on accessibility to limb reconstruction, rehabilitation staff should be prepared to manage the expectations of the patient and to consider necessary interventions to maintain tissue quality and mobility whilst awaiting definitive surgery. Amputations are maiming operations that should be limited, and rehabilitation advice should be sought before surgery to ensure optimal results and rehabilitation. Standards for rehabilitation is available [[146]](#footnote-146). More comprehensive information on how to set up rehabilitation services in the context of armed conflict and complex emergencies including technical guidance and operational issues are available in the Toolkit.

### Recent Case Study Experience

Mosul, Raqqa, contracting health service, more advanced care close to the fighting, problems with long referrals

## Chapter 5 Guidance Notes

|  |  |
| --- | --- |
|  |  |
| Get to know the context before deployment | 1. Medical teams and leaders must critically analyze and understand the context including burden of disease and what type of other conditions to manage as well as IHL |
| Trauma care | 1. Follow existing ABCD principles and adapt to available resources 2. Provide services that is adapted to what level of care in available further down the trauma referral chain 3. Early rehabilitation is essential on all levels |
|  | 1. Ensure triage system and MCI plan that is well exercised 2. Security for the staff including protective gear |
|  | 1. Ensure importance of all disciplines including medical, nursing as well as rehabilitation services |

For Toolkit

Additional reading

Husum H, Gilbert M, Wisborg T et al. Rural Prehospital Trauma Systems Improve Trauma Outcome in Low-Income Countries: A Prospective Study from North Iraq and Cambodia. J Trauma 2003;54:1188-1196

WHO/ICRC Technical Meeting for Global Consensus on Triage. (2017). Available at: <https://www.humanitarianresponse.info/en/operations/stima/document/guidance-triage>.

<https://extranet.who.int/emt/content/management-limb-injuries-during-disasters-and-conflicts>

The Mosul Trauma response <http://hopkinshumanitarianhealth.org/assets/documents/Mosul_Report_FINAL_Feb_14_2018.pdf>

Table 7 Key clinical service needs differences in Blue and Red book context

|  |  |  |  |
| --- | --- | --- | --- |
|  | | **Blue book** | **Red book** |
|  | |  |  |
| **General context** | | Relatively stable and disaster impact has already occurred, potentially damaged health infra-structure | Unstable, moving frontlines, cyclical violence and MCIs, access limitations, health system degradation and health facilities may be damaged |
| **Clinical care needs** | *Non Communicable diseases* | * Significant and varies depending on context, conditions may be worsened due to disaster | * Same as Blue book but context dependent, with some patients with NCD lacking care for years |
| *Communicable diseases* | * Significant and acute if lack of WASH and poor living conditions | * Significant and Chronic due to long term degradation of WASH and bad living condition and collapsed preventive public health programs and vaccinations |
| *Injuries* | * Mainly “old” blunt, closed fractures affecting mainly limbs and crush injuries and minor open often infected wounds | * Mainly “fresh” (i.e. in minutes to hours) often severe penetrating complex polytrauma affecting mainly limbs caused by bullets, blast, bombs and ordnance. Wounds infection prone |
| *Maternal and child health* | * Continuous and depend on birth rate | * Continuous and depend on birth rate and function of programs |
| *CBRN* | * Not likely | * Potential need especially if combined with MCI. |
| *Outbreaks* | * Rare and unlikely | * May be common and need special consideration |
| **Presentation pattern** | *Timing* | * Medical teams arrive hours to days post disaster and will treat “old” injuries and manage acute presentations of other conditions. | * Medical teams will be in a setting with ongoing violence and cyclical presentations of fresh injuries and acute presentations of other conditions. Access may be a critical issue stopping people from arriving early |
| *Severity* | * Mainly old cases | * Will depend on distance from frontline, the closer the more severe injuries will be seen requiring advanced management |
| *Multiple Casualty Incident (MCI)* | * Rare | * Primarily injuries but may also include CBRN |
| **Operational issues** | *Rehabilitation* | * Difficult follow up | * Difficult follow up, insecurity Movement restrictions |
| *Referral chain* | * Infrastructure problems | * Insecurity, lack of transport, capacity and movement restrictions |
| *Patient records* | * Follow Blue book standards | * Security issue for patient! store locked and don’t hand out. Bring with you if evacuated. Only hand out anonymous compiled data |
| *Surveillance* | * Report outbreaks and data | * Report outbreaks and data but with concern |

Table 8 First Responder Guidance

|  |  |
| --- | --- |
| Self | Without PPE and correct training, you are in danger of becoming another casualty and worsening the situation. The injury or death of a medical team member has the possibility of the ending the entire mission. Put your own safety and that of your team above everything else. Are you trained to work in this forward position? |
| Scene | Is the scene safe? Are there secondary devices and IEDs waiting? Are there active shooters, snipers or residual CBRNe contaminants? Is there structural instability of the buildings? Contrary to the natural instinct of many responders, as long as there are ongoing threats, it remains a security situation rather than a medical situation. The injury or death of a medical team member has the possibility of ending the entire mission. |
| Survivors | Now patients and survivors can be brought to safety and treatment instigated. First stand at a safe distance and call survivors out and to safety. If they obey commands it tells you they are still perfusing their brain and able to mobilize, this is a vital first observation contributing to triage. Those who remain lying down may be dead or badly injured. |



Figure 12 Health care needs difference blue and red book context

Table 9 Minimum Hospital Services at Type 2 and 3 facilities (Stanford Summit proposal)

|  |
| --- |
| Type 2 hospital: Definitive or provisional facility |
| * Imaging: Ultrasound * Diagnostic peritoneal lavage/aspiration * Closed fracture management * Conservative management of spinal cord/column injuries * Emergency burn escharotomy and acute burn management * Basic neck exploration * Suprapubic tube placement * Temporary vascular stabilization including shunt * Operative treatment of abdominal and obstetrical surgical emergencies * Open skull fracture management * Amputation * Fasciotomy * Surgical treatment of wounds and infection * Regional, spinal, and general anesthesia with intubation * Post-anesthesia recovery unit in operating suite * Basic transfusion services * Pain management * Intermediate level of care above ward (HDU/SDU) |
| * Imaging: X-Ray * Operative fracture management * Definitive/surgical burn care * Herniorrhaphy (non-elective, primary tissue) * Emergency GU procedures * Complex wound closure and skin graft * Enucleation * Operative management of fractured mandible * Local or rotational flap * Definitive vascular reconstruction * Expectant/palliative care for high mortality burns |
| Type 3-Referral facility |
| Medical   * Ventilators * ICU nursing staff * Central venous catheters * Cardiac Monitoring * IV inotropes   Surgical   * Cardiothoracic * Neurosurgical * Reconstructive |
|

Table 10 Clinical Considerations & Questions

|  |  |
| --- | --- |
| **Question/statements** | **Answer** |
| Should blood transfusion be available in the pre-hospital setting? | For bleeding patients’ blood transfusions save lives. However, blood transfusions in the pre-hospital setting is complex and risky. If it can be done safely and rapid transfer is available to higher care may be considered |
| What about pre hospital Tranexamic acid? | Current research indicates that for the bleeding patient early tranexamic acid provision save lives. However, timing is critical and extra doses may be needed. Tranexamic acid protocols must be accepted throughout the referral system before being provided |
| Should emergency thoracotomies be done? | Due to poor long-term prognosis and high risks resuscitation of pulseless patients and emergency resuscitative thoracotomy should not be performed. |
| Should thoracis drains be inserted in the pre hospital setting? | In general No. Invasive procedures such as thoracic drains are filled with significant risks and may ONLY be considered if directly lifesaving in a otherwise stable patient and if safe and rapid referral is available to a facility with more advanced services |
| Our team is a trauma stabilization point and only provides trauma care | Any medical team deployed to conflict areas must be able to manage all acute medical conditions |
| We are paramedics that deploy without medical doctors | Any medical teams must have a medical doctor responsible for the care provided and care should only be provided based on license to practice. Paramedics is a diverse group of professionals that in some countries have limited training and no license to practice. |
| What about internal fixation? | Carries significant risks in the field setting for complex and open fractures see |
| CONTINUE |  |
|  |  |

CHAPTER 6

SELECTED TOPICS

IN

OPERATIONS

“By failing to prepare, you are preparing to fail.”  
― Benjamin Franklin

# Selected Topics in Operations: Logistics and Information Management

Pending: awaiting Input from sub-working group and Blue Book

Objectives:

* Teams understand the preparedness and deployment requirements for organizational systems/processes in logistics, administration, human resources, team well-being, information management, monitoring & evaluation
* Teams can integrate capacity strengthening approaches as a pillar of support

Key Reference Documents and existing Policy Frameworks: [To be added here]

Below from the Blue Book draft – to be adapted to Red Book contexts:

|  |
| --- |
| • EMT Guiding Standards (Summary Table)  • All EMTs (Type 1, 2, 3 and specialised care teams), must comply with the guiding standards.  • Administration & Organizational Management: EMTs will maintain administrative and finance systems that allows them to rapidly and safely deploy teams, and maintain Headquarters office support from their home base throughout missions.  • Human Resources: EMTs have a system in place to ensure staff are readily deployable and are recruited, screened and have access to preventative measures to decrease risk of ill health on deployment and have arrangements in place for care of team members during deployment and for their repatriation and after care if required. It also must ensure its policies regarding human resource management promote protection of the vulnerable through adequate police checks and other measures.  • Training of teams: EMTs will ensure they have a training and learning programme in place either by directly training staff or combined with out-sourcing to training providers and recognizing prior learning. EMTs must also have a system to provide mentoring to those identified as future leaders of the team or sections of the response in their roles of escalating complexity and seniority.  • Professional Conduct: EMTs should have in place systems to ensure all staff are licensed for the practice they will undertake while deployed and to have an ability to accept complaints, investigate and correct the outcomes of such complaints and a medical indemnity system for all clinical staff.  • Team Field Management & Operations: EMTs must be able to manage their day to day operations while deployed including managing their own safety and security, critical incident management and liaison with relevant local authorities and the media.  • Records & Reporting: EMTs will keep confidential patient records of interventions, clinical monitoring and possible complications of care received, with a copy available to the patient, as well as to report regularly and prior to departure, to the relevant local health authorities using national reporting forms or if not available the agreed EMT minimum data set (MDS). Teams undertake not to conduct research without appropriate consent of the patient and of national authorities.  • Support to National Clinical System/Patient Referral: EMTs will support and be part of the health referral system and depending on Type of EMT, offer to accept, and/or refer patients to other health facilities or EMTs.  • Self-Sufficiency: EMTs should be self-sufficient through either direct supply or local organization of support that does not undermine or detract from the ability of the local community to respond.  • Administration & organizational management: EMTs will maintain administrative and finance systems that allows them to rapidly and safely deploy teams, and maintain headquarters office support from their home base throughout missions. |

# 

## Team Classification for Armed Conflict & Complex Emergencies

Current processes within the Blue Book of engaging with EMTs involves robust pre-verification, verification and classification components.

However, Red Book contexts of insecurity and fragility will require additional preparedness steps.

The level of effort and processes involved in preparing for, deploying to, and returning from missions are complex, demanding and require a high level of attention to detail, as well as both awareness of multiple internal and external parameters. Conflicts and complex emergencies, by definition, are dynamic, unpredictable, complicated, often with many local, regional and international stakeholders with varying interests and agendas.

Operating successfully in such contexts requires a deep understanding or a 360 degree holistic awareness of the nature and dynamics at play. Well prepared teams need both solid foundational trainings into the evolving nature of conflict and best methods for coping and delivering.

See Annex 1

|  |  |
| --- | --- |
| Blue Book | Red Book |
|  |  |
| Administration & Organizational Management: EMTs will maintain administrative and finance systems that allows them to rapidly and safely deploy teams, and maintain Headquarters office support from their home base throughout missions. | Applicable to Red Book context  Special considerations may be required for cash handling, cash amounts, currencies, and confidentiality. |
| Human Resources: EMTs have a system in place to ensure staff are readily deployable and are recruited, screened and have access to preventative measures to decrease risk of ill health on deployment and have arrangements in place for care of team members during deployment and for their repatriation and after care if required. It also must ensure its policies regarding human resource management promote protection of the vulnerable through adequate police checks and other measures. | Applicable to Red Book context  Also need to consider:  -Nationalities and ethnicities of the team, regardless of passport  -Abilities for the management and coping with extreme stress. See chapter 2  -Duration of deployments depending on the hardship anticipated.  -regular monitoring of conditions and hazards |
| Training of teams: EMTs will ensure they have a training and learning program in place either by directly training staff or combined with out-sourcing to training providers and recognizing prior learning. EMTs must also have a system to provide mentoring to those identified as future leaders of the team or sections of the response in their roles of escalating complexity and seniority. | Practical team leader and member trainings related to the 5 chapters   1. IHL & Core Humanitarian Principles 2. Safety & Security Risk Management including self-care 3. Coordination 4. Gender Based Violence and Protection 5. Clinical Care for war wounded 6. Special considerations for logistics and re-supply |
| Professional Conduct: EMTs should have in place systems to ensure all staff are licensed for the practice they will undertake while deployed and to have an ability to accept complaints, investigate and correct the outcomes of such complaints and a medical indemnity system for all clinical staff. | Applicable to Red Book contexts |
| Team Field Management & Operations: EMTs must be able to manage their day to day operations while deployed including managing their own safety and security, critical incident management and liaison with relevant local authorities and the media. | -Applicable to Red Book and must be enhanced.  -Hazards and dangers associated with direct or indirect attach, looting, and CBRN must be considered and plans made accordingly.  -See chapter 2 |
| Records & Reporting: EMTs will keep confidential patient records of interventions, clinical monitoring and possible complications of care received, with a copy available to the patient, as well as to report regularly and prior to departure, to the relevant local health authorities using national reporting forms or if not available the agreed EMT minimum data set (MDS). Teams undertake not to conduct research without appropriate consent of the patient and of national authorities. | -Maintaining the confidentiality of health records by using anonymizing coding systems and by keeping paper-based and electronic files in a safe and secure location, such as a locked filing cabinet)  -Need to be aware for "special / VIP" patient like one of the local conflict leaders and/or wanted persons, etc. |
| Self-Sufficiency: EMTs should be self-sufficient through either direct supply or local organization of support that does not undermine or detract from the ability of the local community to respond. | Hiring of local staff and use of local contractors needs to be viewed via the IHL and Humanitarian Principles lens; will such actions be perceived as taking sides?  Local staff need rapid on-the-job training on the principled approach, security measures, GBV, and context specific topics. |
| Administration & organizational management: EMTs will maintain administrative and finance systems that allows them to rapidly and safely deploy teams, and maintain headquarters office support from their home base throughout missions. | Applicable to Red Book contexts. |

## Human Resources & Training

Objectives:

1. Organizations/agencies comprehend the minimum pre-deployment skill/competency requirements for team members and profiles
2. Organizations/agencies' human resources and training units/departments gain an understanding for personnel training and briefing requirements pre, during, and post missions.
3. Suggest a list of key recognized existing trainings (online and practical) that can benefit various groups and individuals

Key Reference Documents and existing Policy Frameworks:

The success of operations hinges on the ability of the team to function in harmony, provide quality care, and be safe/secure. Different team member profiles (beyond standard accredited certifications they present) may require special induction, refresher, orientation, practical trainings/updates just-in-time or on an annual or semi-regular basis. This includes management, medical practitioners, support teams and technicians, security personnel, etc. This also includes cultural sensitivity and exposure to the nature and complexity of IHL, and the humanitarian/aid landscape.

CHAPTER 7

THE TOOLKIT

“Perfect is the Enemy of Good.” –Voltaire

# The Tool Kit

Pending

A specific section in being planned to contain (online) top practical references as a readily accessible tool kit elaborating to the various above core standards and recommendations

RESPECTING AND PROTECTING HEALTH CARE IN ARMED CONFLICT AND OTHER EMERGENCIES – PowerPoint, 35 Slides, Health Care in Danger 9HCiD) with scenarios and guidance for instructors. <https://slideplayer.com/slide/12443221/>

CHAPTER 8

ANNEXES

REFERENCES

& CONTRIBUTORS

INSERT QUOTE

# Annexes, References & Contributors

Pending

## Annex 1: Readiness Checklist for Armed Conflict

This chapter builds upon and extends the Blue Book: Classification checklist.

EMT Checklist for Deployment into Armed Conflict

List incomplete and in progress

***Important Note:***

*1. This is not a stand-alone check list, as it builds on the Blue Book verification checklist.*

*2. reference to trainings below does not necessarily mean sperate courses, but rather modules to be embedded within existing training, online e-learning, and/or specialized courses. This to be determined by the background and skill/knowledge baseline for the target audience.*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Category | Check | CheckmarkClose |
| 1 | Duty of Care | For the Organization   1. Adopted specific policies for the legal aspect of duty of care including safety, protection, and health measures, and related insurance policies 2. Informed Consent forms for armed conflict are in place with full transparency and clear accountability frameworks. 3. Care and Support before, during and after deployment 4. Team leader and team member rosters have training for armed conflict contexts including select topics from the chapters of the Red Book. 5. Team leaders and members have training on self-care and stress management 6. Stated policy on prevention of sexual exploitation and abuse, including confidential reporting 7. Stated policy on reporting of breaches in conduct and abuse in the field 8. Profile for leaders and members stated and communicated 9. If needed, arrangements with peer groups that have experience in conflict documented pre and during deployments 10. A code of conduct is in place and signed by team members 11. Team evacuation protocols and plans are drafted and communicated (then customized for each deployment) 12. Protocols for family/significant other protocols are in place in case of harm, death, kidnap, disappearance, loss of communications, and other severe circumstance. 13. Post deployment medical and relevant psycho-social support are in place 14. Written policy as to duty of care towards local staff including protection, pay, insurance, and training   For the Team   1. Team leaders and members apply the duty of care principles during operations – field checklist |  |
| 2 | IHL & Principles | For the Organization   1. Stated policy in compliance with IHL 2. Stated policy on Core Humanitarian Principles (Humanity, Impartiality, Neutrality, Independence) 3. Team leaders and members have received practical IHL training 4. Team branding: Logos, Attire, Emblems for facility, personnel, vehicles are pre-agreed and printed with clear instructions to team leaders and team on proper use 5. Communications protocols (internal and external) are stated and agreed upon 6. Team leaders and members have training on Community Engagement techniques and approaches. 7. Team leaders have training in humanitarian negotiations.   For the Team   1. Team leaders and members commit to compliance with IHL and Core Humanitarian Principles 2. Team leaders to act as guardians, implementers, and influencers related to policies and approaches in this list. |  |
| 3 | Safety & Security | For the Organization   1. SOPs and Protocols for safety and risk management in the field including Critical Incident Management (CIM) 2. Team leaders and members have received armed conflict focused safety and security risk management training. 3. See item above on team branding 4. Measures and supplies are in place for protection of the facility (fencing, fire extinguishers, sand bags, lighting, communications equipment, etc) 5. Signage – “no weapons” or facility and vehicles 6. Written policy on use of armed escorts and armed guards as option of last resort. (does not apply for military or civil defence teams) 7. CBRN precautions…   For the Team   1. Commit to adhere to security protocols. Breaches will result in termination field assignment and disciplinary action. 2. CBRN precautions … |  |
| 4 | Coordination | For the Organization   1. Team leaders and team members have received specific training on the importance and methods of coordination in armed conflict.   For the Team   1. Mechanism to ensure contributions to coordination mechanisms, representation, and compliance when indicated. |  |
| 5 | GBV & Protection | For the Organization   1. Stated and communicated policy on GBV in the field 2. Team leaders and members have received training to care for GBV survivors including special approach to children. 3. GBV and post rape medical kit and supplies 4. Confidential documentation policy and field arrangement including consent forms 5. Team leaders and members have training on confidential advocacy and protection, including how to manage media   For the Team   1. Assure own and local compliance with GBV approaches with sensitivity to confidentiality, protection and local laws. |  |
| 6 | Clinical Care | For the Organization   1. War wounded medical kit and supplies 2. Experience? 3. Arrangements for Access to remote and tele-consultations and advice 4. ……   Rehabilitation…  To be added  For the Team   1. On Scope and competency 2. On local standards and protocols 3. Use of remote and tele-consultations and advice |  |
| 7 | Operations | For the Organization   1. Capacity to analyze and assess context of deployment, own readiness and fit, risk appetite, legal implications, funding and resources. 2. Kits and supplies for self-sufficiency up to xx weeks 3. Special patient documentation kits (that allows confidentiality and anonymity) 4. Medical Evacuation protocols are in place and team understands how to activate (including HQ staff) 5. Team composition plans account for gender sensitivity 6. Policy on rotations written and communicated 7. Check readiness on: power, light, water, sanitation, shelter, waste, IT, kitchen, laundry, climate control, cold chain, sterilization 8. Policy and mechanisms for re-supply 9. Dead body management training and kits 10. Policy and training on forensics   For the Team   1. Familiarity with the relevant kits and supplies 2. Conduct and behavior to treat all locals with dignity, respect, civility, and empathy. 3. Managing conflict and ethical dilemmas within the team, and with other teams |  |
| 8 | Other Considerations | For the Organization   1. …Media & social media …   For the Team   1. Media and social media… |  |

## Annex 2: Summary Guide to Deployment & Operations[[147]](#footnote-147)

For Organizational and Field Team Leaders to consider:

|  |
| --- |
| 1. Assess the conflict context and situation (and evolution): Draw on assessment data, which is often openly shared through humanitarian coordination and information portals, tools. If not, contact trusted focal points associated with the potential deployment. 2. Be principled: Political and media pressure to act quickly must be balanced against the need to provide safe targeted and quality medical care to *all* sides, which will have a greater impact. 3. Follow core standards: The chaos of war cannot be an excuse to not provide quality and ethical care, seek consent from all side, and work within scope and mandate of practice. 4. Coordinate: Coordination with local, national and international actors helps to fill gaps and avoid duplication and ensure wider coverage. 5. Assess the local safety and Security situation, local hazards, establish and communicate plans, modify as needed. 6. Establish referral mechanisms with other teams and ensure follow up. 7. Engage with Communities: local community leaders (municipal, religious, women, education, business, and youth groups, etc), understand the local situation and can close information gaps, provide sound advice, help avoid costly errors, etc. 8. Communicate: People need to be informed about when and where to expect medical assistance. Communicate with local organizations, community leaders, and governments who can then directly communicate with affected people. 9. Train and Learn: Local medical workers can provide valuable knowledge and skills on local practices. Integrate local capacity strengthening and training for local workers 10. Protect: Every society has vulnerable groups and wars expose people further to higher levels of suffering and cruelty. Medical teams can provide some level of protection, advocacy, and support to minimize impact. |

## Annex 3: References

Pending

Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies- <https://www.wma.net/policies-post/ethical-principles-of-health-care-in-times-of-armed-conflict-and-other-emergencies/>

Summary and categorization of footnotes

## Annex 4: Contributors

Pending

1. <https://journals.sagepub.com/doi/full/10.1177/1609406915621381> [↑](#footnote-ref-1)
2. [https://www.who.int/hac/global health cluster/fmt guidelines september2013.pdf?ua=1](https://www.who.int/hac/global_health_cluster/fmt_guidelines_september2013.pdf?ua=1) [↑](#footnote-ref-2)
3. Blue Book, developed post 2010 Haiti Earthquake published standards of care, and expanded upon the 2003 [WHO-PAHO Guidelines for the Use of Foreign Field Hospitals:](https://www.paho.org/disasters/newsletter/index.php?option=com_content&view=article&id=404:who-paho-guidelines-for-the-use-of-foreign-field-hospitals&catid=189&Itemid=242&lang=en) [https://www.paho.org/disasters/index.php?option=com docman&view=download&category slug=books&alias=3](https://www.paho.org/disasters/index.php?option=com%20docman&view=download&category%20slug=books&alias=3)[0-who-paho-guidelines-for-the-use-of-foreign-field-hospitals-in-the-aftermath-of-sudden-impact-disaste&Itemid=1179&lang=en](https://www.paho.org/disasters/index.php?option=com_docman&view=download&category_slug=books&alias=30-who-paho-guidelines-for-the-use-of-foreign-field-hospitals-in-the-aftermath-of-sudden-impact-disaste&Itemid=1179&lang=en) [↑](#footnote-ref-3)
4. <https://extranet.who.int/emt/emt-classification> [↑](#footnote-ref-4)
5. For example, UNSC Resolution 2286; demanding that all parties to armed conflict fully comply with IHL and protection of medial and humanitarian workers [↑](#footnote-ref-5)
6. Term ‘NGO’ in this document also includes Civil Society Organizations (CSO), and Private Voluntary Groups (PVO) [↑](#footnote-ref-6)
7. [In militarised Mali, humanitarian responders say aid is an afterthought](https://www.irinnews.org/news-feature/2019/03/11/militarised-mali-humanitarian-responders-say-aid-afterthought?utm_source=IRIN+-+the+inside+story+on+emergencies&utm_campaign=a9aa86598c-EMAIL_CAMPAIGN_2018_12_03_05_37_COPY_01&utm_medium=email&utm_term=0_d842d98289-a9aa86598c-15734829) [↑](#footnote-ref-7)
8. International humanitarian law (IHL) is the law that regulates the conduct of war. It is the branch of international law which seeks to limit the effects of armed conflict by protecting persons who are not or are no longer participating in hostilities, and by restricting and regulating the means and methods of warfare. In addition to IHL, other legal frameworks apply including but not limited to domestic and international human rights, domestic and international criminal law, and domestic and international refugee law. [↑](#footnote-ref-8)
9. Humanitarian space denotes the protected physical or symbolic space which humanitarian agencies need to deliver their services according to the principles they uphold. [↑](#footnote-ref-9)
10. <https://casebook.icrc.org/glossary/classification-conflict> [↑](#footnote-ref-10)
11. defined as Persons, whether military or civilians, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility.Medical units and personnel [PI Art. 8(c, e)]: [↑](#footnote-ref-11)
12. The Sphere Standards: <https://www.spherestandards.org/> [↑](#footnote-ref-12)
13. Sphere 2018, <https://handbook.spherestandards.org/en/sphere/#ch003> [↑](#footnote-ref-13)
14. <https://www.who.int/hac/global_health_cluster/about/policy_strategy/ghc_position_paper_civil_military_coord_2_feb2011.pdf> [↑](#footnote-ref-14)
15. For details: See Annex 6c – pages 146-150, <https://www.icrc.org/en/doc/assets/files/other/icrc-002-0973.pdf> [↑](#footnote-ref-15)
16. See ODI’s <https://www.odi.org/publications/10694-planning-future-humanitarian-system-fit-purpose> and ALNAP - The State of the Humanitarian System 2018 - Summary <https://sohs.alnap.org/system/files/content/resource/files/main/SOHS%202018%20Summary%20online_2.pdf> [↑](#footnote-ref-16)
17. Engaging with People Affected by Armed Conflict

    <https://www.icrc.org/en/download/file/69676/engaging-with-people-in-armed-conflict-recommendationt.pdf> [↑](#footnote-ref-17)
18. Watkins, K. Medical Care in Urban Warfare. <https://digital-commons.usnwc.edu/cgi/viewcontent.cgi?article=1729&context=ils> [↑](#footnote-ref-18)
19. <https://www.techworld.com/security/future-of-technology-in-warfare-3652885/> [↑](#footnote-ref-19)
20. Deconfliction: The exchange of information and planning advisories by humanitarian actors with military actors in order to prevent or resolve conflicts between the two sets objectives, remove obstacles to humanitarian action, and avoid potential hazards for humanitarian personnel. This may include the negotiation of military pauses, temporary cessation of hostilities or ceasefires, or safe corridors for aid delivery. [https://www.unocha.org/sites/unocha/files/Stay and Deliver.pdf](https://www.unocha.org/sites/unocha/files/Stay_and_Deliver.pdf)

    [https://www.humanitarianresponse.info/en/operations/stima/document/turkevsvria-humanitarian-deconfliction-mechanism-humanitarian](https://www.humanitarianresponse.info/en/operations/stima/document/turkeysyria-humanitarian-deconfliction-mechanism-humanitarian) [↑](#footnote-ref-20)
21. With the caveat that “de-confliction” as a general solution, comes with certain challenges, including 1) shifting the burden away from parties to armed conflicts to live up to their own obligations towards humanitarians to contribute to “de-confliction”; and 2) creating a false dichotomy between “de-conflicted” and “non-deconflicted” persons or objects, while not just “de-conflicted” persons or objects will be protected under IHL, just to name two concerns. [↑](#footnote-ref-21)
22. On Drones:

    <https://www.swissinfo.ch/eng/sci-tech/-dronefrontier_how-drones-are-transforming-humanitarian-aid/44141254> and 3D printing in Humanitarian Aid <https://odihpn.org/magazine/3d-printing-humanitarian-supplies-in-the-field/> [↑](#footnote-ref-22)
23. World Humanitarian Summit Commitments: <https://www.agendaforhumanity.org/core-commitments> [↑](#footnote-ref-23)
24. <https://www.irinnews.org/feature/2019/01/02/ten-humanitarian-crises-and-trends-watch-2019> [↑](#footnote-ref-24)
25. MSF, Bridging the Emergency Gap: Reflections and a call for action after a two-year exploration

    of emergency response in acute conflict, April 2018<https://arhp.msf.es/sites/default/files/BRIDGING-THE-EMERGENCY-GAP-FULL-REPORT.pdf> [↑](#footnote-ref-25)
26. Johns Hopkins Mosul Trauma Case Study, Spiegel et al, Feb 2018

    [http://hopkinshumanitarianhealth.org/assets/documents/Mosul Report FINAL Feb 14 2018.pdf](http://hopkinshumanitarianhealth.org/assets/documents/Mosul_Report_FINAL_Feb_14_2018.pdf) [↑](#footnote-ref-26)
27. For details: See Annex 1a, <https://www.icrc.org/en/doc/assets/files/other/icrc-002-0973.pdf> [↑](#footnote-ref-27)
28. See the New Humanitarian <https://www.thenewhumanitarian.org/in-depth/humanitarian-technology> and <https://www.irinnews.org/opinion/2019/01/07/humanitarianism-crisis-digital-innovation-won-t-fix-it> [↑](#footnote-ref-28)
29. <https://guide-humanitarian-law.org/content/index/> [↑](#footnote-ref-29)
30. <https://ihl-databases.icrc.org/applic/ihl/ihl-search.nsf/content.xsp?key=intro> <https://www.icrc.org/en/document/ihl-digital-app> [↑](#footnote-ref-30)
31. <https://www.rodekors.dk/sites/rodekors.dk/files/2018-03/handbook_on_ihl.pdf> [↑](#footnote-ref-31)
32. <https://www.icrc.org/en/document/ihl-digital-app> [↑](#footnote-ref-32)
33. Watkins, K. Medical Care in Urban Warfare. <https://digital-commons.usnwc.edu/cgi/viewcontent.cgi?article=1729&context=ils> [↑](#footnote-ref-33)
34. Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies <https://pdf-it.dev.acw.website/please-and-thank-you?url=https://www.wma.net/policies-post/ethical-principles-of-health-care-in-times-of-armed-conflict-and-other-emergencies/&pdfName=ethical-principles-of-health-care-in-times-of-armed-conflict-and-other-emergencies> [↑](#footnote-ref-34)
35. **Non-maleficence**, another way to state it is that, "given an existing problem, it may be better not to do something, or even to do nothing, than to risk causing more harm than good." It reminds physicians to consider the possible harm that any intervention might do. It is invoked when debating the use of an intervention that carries an obvious risk of harm but a less certain chance of benefit. [↑](#footnote-ref-35)
36. <https://extranet.who.int/emt/> [↑](#footnote-ref-36)
37. <https://www.who.int/hac/techguidance/preparedness/emergency_medical_teams/en/> [↑](#footnote-ref-37)
38. Reychler, L. (2006). Humanitarian aid for sustainable peace building. In P. Gibbons & B. Piquard (Eds.), Working in conflict - Working on conflict: Humanitarian dilemmas and challenges (pp. 135-154). Bilbao: University of Deusto. - Conflict sensitivity means the ability to: 1. understand the context in which you operate; 2. understand the interaction between your intervention and the context (how the context affects the intervention and how the intervention affects the context); and 3. act upon the understanding of this interaction, in order to avoid negative impacts and maximise positive impacts. <http://www.deusto-publicaciones.es/deusto/pdfs/hnet/hnet17.pdf> [↑](#footnote-ref-38)
39. see <http://conflictsensitivity.org/> [↑](#footnote-ref-39)
40. <https://www.bmj.com/content/309/6948/184> [↑](#footnote-ref-40)
41. <https://www.icrc.org/en/document/common-ethical-principles-health-care-conflict-and-other-emergencies> [↑](#footnote-ref-41)
42. <https://www.icrc.org/en/publication/0361-memory-solferino> [↑](#footnote-ref-42)
43. <http://hopkinshumanitarianhealth.org/assets/documents/Mosul_Report_FINAL_Feb_14_2018.pdf> [↑](#footnote-ref-43)
44. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/67579/HERR.pdf> [↑](#footnote-ref-44)
45. <https://www.icrc.org/en/doc/assets/files/other/what_is_ihl.pdf> [↑](#footnote-ref-45)
46. Map of Signatories 2017 <http://ihl-databases.icrc.org/applic/ihl/dihl_setup.nsf/xsp/.ibmmodres/domino/OpenAttachment/applic/ihl/dihl_setup.nsf/58068F6508A7EE86C1257DF1004C2463/%24File/icrc-annual-report-2017-A3.pdf?Open> [↑](#footnote-ref-46)
47. Typically by ICRC, UN, other Nations, NGOs, Media, etc. [↑](#footnote-ref-47)
48. <http://healthcareindanger.org/the-issue/> [↑](#footnote-ref-48)
49. For a guidance on this framework, please refer to ICRC’s Customary Law Database. <https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul> [↑](#footnote-ref-49)
50. Adopted by UN, and based on Red Cross Red Crescent Principles <https://www.unocha.org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf> [↑](#footnote-ref-50)
51. For detailed references and readings, see ICRC online Database <https://www.icrc.org/en/icrc-databases-international-humanitarian-law> and the ICRC App at <https://www.icrc.org/en/document/ihl-digital-app> and MSF <https://guide-humanitarian-law.org/content/index/> [↑](#footnote-ref-51)
52. This is often the case in NIAC with regard to the medical confidentiality and the duty to report certain types of patients to authorities. (see reference to the practical guide to humanitarian law at medical ethic <https://guide-humanitarian-law.org/content/index/>) [↑](#footnote-ref-52)
53. It is important to make a difference between humanitarian and medical assistance because there must be not discussion on who is” entitled “to medical care while there is one regarding humanitarian assistance. Only medical personnel can decide who is entitle to medical care.

    The word “entitle” refers to specific legal categories of protected person under IHL that are decided by the parties to the conflict. [↑](#footnote-ref-53)
54. The Geneva Conventions and their Additional Protocols are international treaties that contain many of the rules of IHL. [https://www.icrc.org/en/doc/war-and-law/treaties-customary-law/geneva-conventions/overview-geneva-](https://www.icrc.org/en/doc/war-and-law/treaties-customary-law/geneva-conventions/overview-geneva-conventions.htm)

    [conventions.htm](https://www.icrc.org/en/doc/war-and-law/treaties-customary-law/geneva-conventions/overview-geneva-conventions.htm) [↑](#footnote-ref-54)
55. Common article 1, Geneva Conventions.. [https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1 cha](https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_cha_chapter40_rule139)  [↑](#footnote-ref-55)
56. Common Article III <https://ihl-databases.icrc.org/ihl/WebART/375-590006> [↑](#footnote-ref-56)
57. Update from the ICRC doctrine [↑](#footnote-ref-57)
58. [Jean Pictet, Commentary on the Fundamental Principles, 1979](https://www.icrc.org/en/doc/resources/documents/misc/fundamental-principles-commentary-010179.htm) [↑](#footnote-ref-58)
59. <https://guide-humanitarian-law.org/content/article/3/distinctive-or-protective-emblems-signs-and-signals/> [↑](#footnote-ref-59)
60. See rules of emblem use: <https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule59> and

    <https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_cha_chapter7_rule30> [↑](#footnote-ref-60)
61. The Hippocratic Oath and the Ethics of Medicine, Steven H. Miles. Oxford University Press, 2004 [https://books.google.ca/books?id=ONXlXfeaO70C&printsec=frontcover#v=onepage&q&f=false](https://books.google.ca/books?id=ONXlXfeaO70C&printsec=frontcover%23v=onepage&q&f=false) [↑](#footnote-ref-61)
62. "Ethical principles of health care do not change in times of armed conflict and other emergencies and are the same as the ethical principles of health care in times of peace." [https://www.icrc.org/en/download/file/9567/ethical principles of health care.pdf](https://www.icrc.org/en/download/file/9567/ethical_principles_of_health_care.pdf) [↑](#footnote-ref-62)
63. MSF, [The Challenges of Localized Humanitarian Aid in Armed Conflict, 2016](https://arhp.msf.es/sites/default/files/MSF_EGS03_The%20challenges%20of%20localised%20humanitarian%20aid%20in%20armed%20conflict_november%202016_0_0.pdf) [↑](#footnote-ref-63)
64. <https://www.odi.org/blogs/10709-uk-counterterrorism-travel-ban-could-criminalise-humanitarian-assistance> [↑](#footnote-ref-64)
65. <http://www.europarl.europa.eu/doceo/document/TA-8-2018-0314_EN.html> [↑](#footnote-ref-65)
66. UNSC resolution 2462 uses decisive and mandatory language in OPs 5 and 6 to request that States comply with IHL when adopting or adapting CT measures, and pressing language in OP 24 to take into account CT measures’ impact on impartial and neutral humanitarian activities. This language means that UN members States will be obliged to domesticate these OP 5 & 6. <https://undocs.org/en/S/RES/2462(2019)> [↑](#footnote-ref-66)
67. See rules of emblem use: <https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_cha_chapter7_rule30> and <https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule59> [↑](#footnote-ref-67)
68. <https://odihpn.org/magazine/the-psychological-health-of-relief-workers-some-practical-suggestions/> [↑](#footnote-ref-68)
69. While valid practical and other reasons can justify this action, and such policies often exist due to various organizational duty of care and insurance requirements, it is critical that this is not openly advertised and expressed. [↑](#footnote-ref-69)
70. <https://www.unocha.org/sites/unocha/files/Armed%20Escort%20Guidelines%20-%20Final_1.pdf> [↑](#footnote-ref-70)
71. <https://www.unocha.org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf> [↑](#footnote-ref-71)
72. <https://www.msf-crash.org/en/publications/humanitarian-negotiations-revealed-msf-experience> [↑](#footnote-ref-72)
73. <https://frontline-negotiations.org/> [↑](#footnote-ref-73)
74. <https://frontline-negotiations.org/field-manual/> [↑](#footnote-ref-74)
75. <https://www.nationaltraumacentre.nt.gov.au/system/files/publications/TQ%202018%20DEC%20Final_0.pdf> [↑](#footnote-ref-75)
76. <https://www.who.int/emergencies/attacks-on-health-care/attacks-dashboard-2018-full.pdf?ua=1> [↑](#footnote-ref-76)
77. <https://www.odi.org/sites/odi.org.uk/files/resource-documents/10734.pdf> [↑](#footnote-ref-77)
78. Engaging with People Affected by Armed Conflicts and Other Situations of Violence: Recommendations for Humanitarian Organizations and Donors in the Digital Era <https://www.icrc.org/en/download/file/69676/engaging-with-people-in-armed-conflict-recommendationt.pdf> [↑](#footnote-ref-78)
79. As example, see online training by PHAP on IHL and Core Humanitarian Principles: Humanity, Neutrality, Impartiality and Independence

    <https://www.alnap.org/help-library/ihl-and-core-humanitarian-principles-humanity-neutrality-impartiality-and-independence> [↑](#footnote-ref-79)
80. <http://healthcareindanger.org/resource-centre/> [↑](#footnote-ref-80)
81. <https://www.icrc.org/en/doc/assets/files/2013/safer-access-a-guide-for-all-national-societies.pdf> [↑](#footnote-ref-81)
82. <https://www.msf.org/saving-lives-and-staying-alive> [↑](#footnote-ref-82)
83. <https://www.who.int/emergencies/attacks-on-health-care/attacks-on-health-care-28November2018.pdf?ua=1> [↑](#footnote-ref-83)
84. From Security Management to Risk Management: Critical Reflections on Aid Agency Security Management and the ISO Risk Management Guidelines, Merkelbach and Daudin, 2011. [↑](#footnote-ref-84)
85. <https://www.eisf.eu/news/iso-31000-the-next-step-in-the-evolution-of-humanitarian-security-risk-management/> [↑](#footnote-ref-85)
86. <http://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4208-promoting-military-op-practice-ensures-safe-access-health-care.pdf> [↑](#footnote-ref-86)
87. Adapted from ICRC’s <https://shop.icrc.org/engagement-humanitaire-et-conflits-armes-le-facteur-stress-2603.html> [↑](#footnote-ref-87)
88. Adapted from MSF’s <https://www.msf.org.au/join-our-team/work-overseas/essential-criteria> [↑](#footnote-ref-88)
89. See page 26 <https://shop.icrc.org/engagement-humanitaire-et-conflits-armes-le-facteur-stress-2603.html> [↑](#footnote-ref-89)
90. <https://www.icrc.org/en/download/file/24540/irc97_9.pdf> [↑](#footnote-ref-90)
91. is a syndrome caused by a dangerous level of toxins in the body.  [↑](#footnote-ref-91)
92. <https://www.who.int/medical_devices/meddev_ppe/en/> [↑](#footnote-ref-92)
93. <https://www.cdc.gov/vhf/ebola/healthcare-us/ppe/index.html?deliveryName=DM7557> [↑](#footnote-ref-93)
94. <https://shop.icrc.org/gestion-des-depouilles-mortelles-lors-de-catastrophes-manuel-pratique-a-l-usage-des-premiers-intervenants-669.html> and <https://apps.who.int/iris/bitstream/handle/10665/137379/WHO_EVD_GUIDANCE_Burials_14.2_eng.pdf?sequence=1> [↑](#footnote-ref-94)
95. Commentary of 2016 Article 9: Activities of the ICRC and other impartial humanitarian organizations <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?documentId=3074EE1C685CFDBDC1257F7D00360B7B&action=OpenDocument> [↑](#footnote-ref-95)
96. <https://cms.emergency.unhcr.org/documents/11982/48574/Recommended+Practices+for+Effective+Humanitarian+Civil-Military+Coordination+of+Foreign+Military+Assets+in+Natural+and+Man-Made+Disasters/b6c934f0-1dec-42ea-9396-5313e3e2f2d3> [↑](#footnote-ref-96)
97. <https://www.icrc.org/en/document/fundamental-principles-red-cross-and-red-crescent> [↑](#footnote-ref-97)
98. Emergency Response Units (ERUs) will deploy under ICRC in armed conflict, and under IFRC in natural disasters. <https://www.ifrc.org/en/what-we-do/disaster-management/responding/disaster-response-system/dr-tools-and-systems/eru/types-of-eru/> [↑](#footnote-ref-98)
99. <https://apps.who.int/iris/bitstream/handle/10665/70128/WHO_HAC_MAN_2009.7_eng.pdf;jsessionid=0A72F5D9AFAF764BDB1F62EA8F97E7A1?sequence=1> [↑](#footnote-ref-99)
100. <https://www.who.int/hac/global_health_cluster/about/policy_strategy/ghc_position_paper_civil_military_coord_2_feb2011.pdf> [↑](#footnote-ref-100)
101. UN-CMCoord Field Handbook, Version 2.0, <https://www.unocha.org/sites/unocha/files/%5BE-Version%5D%20UNCMCoord%20Field%20Handbook%202.0%20%282018%29.pdf>

     [↑](#footnote-ref-101)
102. CMCS is the designated focal point in the UN system for humanitarian civil-military coordination, supporting relevant field and headquarter level activities and operations. [↑](#footnote-ref-102)
103. <https://cms.emergency.unhcr.org/documents/11982/48574/Recommended+Practices+for+Effective+Humanitarian+Civil-Military+Coordination+of+Foreign+Military+Assets+in+Natural+and+Man-Made+Disasters/b6c934f0-1dec-42ea-9396-5313e3e2f2d3> [↑](#footnote-ref-103)
104. [https://www.unocha.org/sites/unocha/files/Stay and Deliver.pdf](https://www.unocha.org/sites/unocha/files/Stay_and_Deliver.pdf)

     [https://www.humanitarianresponse.info/en/operations/stima/document/turkevsvria-humanitarian-deconfliction-mechanism-humanitarian](https://www.humanitarianresponse.info/en/operations/stima/document/turkeysyria-humanitarian-deconfliction-mechanism-humanitarian) [↑](#footnote-ref-104)
105. MCDA Guidelines, rev. 2006 <https://www.unocha.org/sites/unocha/files/01.%20MCDA%20Guidelines%20March%2003%20Rev1%20Jan06_0.pdf> [↑](#footnote-ref-105)
106. See ICRC The Roots of Restraint in War <https://shop.icrc.org/the-roots-of-restraint-in-war.html?___store=fr&_ga=2.184693481.1559149783.1566643057-1429221013.1540831685> [↑](#footnote-ref-106)
107. Emergency Response Units (ERUs) will deploy under ICRC in armed conflict, and under IFRC in natural disasters. <https://www.ifrc.org/en/what-we-do/disaster-management/responding/disaster-response-system/dr-tools-and-systems/eru/types-of-eru/> [↑](#footnote-ref-107)
108. *I*nter-Agency Standing Committee (IASC) (2015) *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* GBV is “an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.” Women and girls are disproportionately affected by GBV due to the systemic inequality between males and females globally. However, the term GBV may also be used to describe gendered violence against men and boys, and individuals from sexual and gender minority groups. <https://gbvguidelines.org/wp/wp-content/uploads/2015/09/TAG-health-08_26_2015.pdf> [↑](#footnote-ref-108)
109. IASC (2015) *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery*. The term ‘GBV’ is also increasingly used by some actors to highlight the gendered dimensions of certain forms of violence against men and boys—particularly some forms of sexual violence committed with the explicit purpose of reinforcing gender inequitable norms of masculinity and femininity (e.g. sexual violence committed in armed conflict aimed at emasculating or feminizing the enemy). This violence against males is based on socially constructed ideas of what it means to be a man and exercise male power <https://gbvguidelines.org/wp/wp-content/uploads/2015/09/TAG-health-08_26_2015.pdf> [↑](#footnote-ref-109)
110. Because of GBV’s disproportionate impact on women, the starting point for service delivery is care for women, and female pronouns are used throughout when referring to a survivor. However, much of the advice is also relevant to sexual violence against men, and where special considerations are needed for male survivors, or other vulnerable groups, they are noted. [↑](#footnote-ref-110)
111. See Annex 11 Privacy and confidentiality in documentation WHO (2017:55) *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence. A manual for health managers* <https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/> [↑](#footnote-ref-111)
112. In conflict contexts, the ability to collect and process forensic evidence is often extremely limited. The primary purpose of an examination is to determine the required medical care. [↑](#footnote-ref-112)
113. Essential drugs and supplies for managing the consequences of sexual violence are available through the Inter-Agency Reproductive Health Kit 3 (IARH Kit 3 available at https://www.unfpa.org/resources/emergency-reproductive-health-kits) and the Interagency Emergency Health Kit (IEHK) 2017 additional module for PEP (available at https://www.who.int/emergencies/kits/iehk/en/). [↑](#footnote-ref-113)
114. Many women suffering health consequences of violence, particularly IPV, are first seen in primary health care services. They are seen particularly in departments or services that serve women and children (for example, antenatal or postnatal care, family planning or HIV clinics), although they may not disclose their experience of violence. Emergency departments are also frequent entry points, particularly for women with injuries and for survivors of sexual assault. WHO (2017:55) *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence. A manual for health managers* <https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/> [↑](#footnote-ref-114)
115. Job Aid 1: Checklist of requirements for providing quality clinical care for survivors of rape and IPV in WHO (2019) *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings* [upcoming} [↑](#footnote-ref-115)
116. Female health care providers should be trained as a priority, but a lack of trained female health workers should not prevent the health service from providing care for survivors; if a male health care provider conducts the examination, a female chaperone should be present. Male survivors should also be offered a choice of a male or female provider. It should be noted, however, that male survivors often also prefer to see a female provider. [↑](#footnote-ref-116)
117. The steps in providing first-line support are to **L**isten to her; **I**nquire about her needs and concerns: **V**alidate her feelings and experiences; **E**nhance safety concerns and **S**upport her by helping her connecting to information, further services and social support. For more information on first-line support and the LIVES approach, see WHO (2014) *Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook* <https://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/> [↑](#footnote-ref-117)
118. Informed consent is required for examination, treatment and for the release of information to third parties, such as the police and the courts, as relevant. WHO (2019) *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings* [upcoming} [↑](#footnote-ref-118)
119. While the health care provider may document the examination and care they provide, it is NOT their job to determine whether a rape has occurred. Rape is a legal definition and it is not necessary to make this determination in order to provide appropriate care. For further details on forensic examinations, see Annex 4 in WHO (2019) *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings* [upcoming}

     <https://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/> [↑](#footnote-ref-119)
120. Guidance on providing health care to child survivors of sexual violence is included in the updated WHO (2019) *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings* [upcoming} [↑](#footnote-ref-120)
121. WHO (2017) *Responding to children and adolescents who have been sexually abused: WHO clinical guidelines* based on the United Nations CRC and other human rights standards <https://www.who.int/reproductivehealth/publications/violence/clinical-response-csa/en/> [↑](#footnote-ref-121)
122. Idem. More information can be found in these guidelines on international standards and guiding principles applicable to children. [↑](#footnote-ref-122)
123. WHO (2014) *Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook* <https://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/> [↑](#footnote-ref-123)
124. See Annex 11 Privacy and confidentiality in documentation WHO (2017:55) *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence. A manual for health managers* <https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/> [↑](#footnote-ref-124)
125. More guidance on developing a privacy and confidentiality policy is included on page 108 and in annex 11, page 55 WHO (2017) *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence. A manual for health managers* <https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/> [↑](#footnote-ref-125)
126. Guidance on providing health care to child survivors of sexual violence is included in the updated WHO (2019) *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings* [upcoming} [↑](#footnote-ref-126)
127. <http://hopkinshumanitarianhealth.org/assets/documents/Mosul_Report_FINAL_Feb_14_2018.pdf> [↑](#footnote-ref-127)
128. https://www.icrc.org/en/doc/assets/files/other/icrc-002-0870.pdf [↑](#footnote-ref-128)
129. https://www.icrc.org/en/doc/assets/files/other/icrc\_002\_0886.pdf [↑](#footnote-ref-129)
130. https://www.resus.org.uk/resuscitation-guidelines/abcde-approach/ [↑](#footnote-ref-130)
131. https://icrc.aoeducation.org/files/downloads/A\_Field\_Guide\_Low\_res.pdf [↑](#footnote-ref-131)
132. https://www.icrc.org/en/doc/assets/files/other/icrc-002-0973.pdf [↑](#footnote-ref-132)
133. https://www.euroburn.org/wp-content/uploads/Draft-EBA-guidelines-for-transportation-of-patients.pdf [↑](#footnote-ref-133)
134. https://www.cicm.org.au/CICM\_Media/CICMSite/CICM-Website/Resources/Professional%20Documents/IC-10-Guidelines-for-Transport-of-Critically-Ill-Patients.pdf [↑](#footnote-ref-134)
135. https://www.icrc.org/en/doc/assets/files/other/icrc-002-0973.pdf [↑](#footnote-ref-135)
136. https://icrc.aoeducation.org/files/downloads/A\_Field\_Guide\_Low\_res.pdf [↑](#footnote-ref-136)
137. https://iatsic.org/DSTC/ [↑](#footnote-ref-137)
138. https://www.springer.com/gp/book/9783319291208 [↑](#footnote-ref-138)
139. https://icrc.aoeducation.org/files/downloads/A\_Field\_Guide\_Low\_res.pdf [↑](#footnote-ref-139)
140. World report on disability. Geneva: World Health Organization and World Bank; 2011. [↑](#footnote-ref-140)
141. Rehabilitation in Health Systems; a guide for action. World Health Organisation. 2019. <https://www.who.int/rehabilitation/rehabilitation-guide-for-action/en> [↑](#footnote-ref-141)
142. World Health Statistics 2016. Monitoring health for the SDGs. Geneva: World Health Organization; 2016 [↑](#footnote-ref-142)
143. World report on disability. Geneva: World Health Organization and World Bank; 2011 [↑](#footnote-ref-143)
144. The Mosul Trauma response: A case study. John Hopkins Center for Humanitarian Health, 2018 [↑](#footnote-ref-144)
145. Minimum Technical Standards and Recommendations for Rehabilitation. WHO, 2016 <https://extranet.who.int/emt/sites/default/files/MINIMUM%20TECHNICAL%20STANDARDS.pdf?ua=1> [↑](#footnote-ref-145)
146. https://extranet.who.int/emt/sites/default/files/MINIMUM%20TECHNICAL%20STANDARDS.pdf [↑](#footnote-ref-146)
147. adapted from <https://www.unocha.org/sites/dms/Documents/UN%20OCHA%20Guide%20for%20the%20Military%20v%201.0.pdf>) [↑](#footnote-ref-147)