AMBULANCE AND PRE-HOSPITAL SERVICES IN RISK SITUATIONS

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

Norwegian **Red Cross**

CRUZ ROJA MEXICANA

ICRC

AMBULANCE AND PRE-HOSPITAL SERVICES IN RISK SITUATIONS

The Seven Fundamental Principles of the Movement

Proclaimed in Vienna in 1965, the seven Fundamental Principles bond together the National Red Cross and Red Crescent Societies, the International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies. They guarantee the continuity of the International Red Cross and Red Crescent Movement and its humanitarian work.

Humanity
The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, 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, cooperation and lasting peace amongst all peoples.

Impartiality
It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality
In order to continue to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence
The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service
It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity
There can be only one Red Cross or one Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality
The International Red Cross and Red Crescent Movement, in which all Societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

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1. FOREWORD

1.1. Fernando Suinaga Cárdenas, President of the Mexican Red Cross

It was an honour for the Mexican Red Cross – together with the regional delegation of the International Committee for the Red Cross (ICRC) for Mexico, Central America and Cuba – to host a workshop for experts in ambulance and pre-hospital care in risk situations at our National Training and Development Centre, in Toluca, Mexico state.

It was important and rewarding for the Mexican Red Cross to contribute, in this way, to the progressive implementation of Resolution 5 of the 31st International Conference of the Red Cross and Red Crescent. We also relished the opportunity to facilitate an exchange of experiences between experts in pre-hospital care and ambulance services, who came from a range of organizations, including more than 20 National Societies from different continents, medical organizations, government agencies and other humanitarian organizations working in this field.

This document compiles the presentations delivered and discussions held during the workshop. The workshop would not have been possible, nor would it have achieved its objectives, without the dedication and hours of preparation of many different people. For this reason, I would like to express my sincerest gratitude to all the volunteers and staff of the Mexican Red Cross who put in effort and offered their support to organize this event, as well as to the staff of the ICRC's regional delegation, who worked together with them to make the event a success.

We hope that the recommendations of this workshop will significantly contribute to fulfilling the humanitarian mission of the International Red Cross and Red Crescent Movement. The Mexican Red Cross would like to reaffirm its commitment to supporting any recommended effort to achieve respect, recognition and acceptance for humanitarian action worldwide.

1.2. Yves Daccord, Director-General of the International Committee of the Red Cross

Violence, both actual and threatened, against health-care workers, facilities and beneficiaries is one of the most serious humanitarian issues at present, but it remains comparatively neglected. Because of it, innumerable vulnerable people are denied the safe access to health care that they need. This violence takes a number of forms – various groups of people are affected by it, either as a matter of policy or accidentally – but ambulance and pre-hospital services are particularly at risk.

Ambulances have come under attack throughout the world in recent years: in Afghanistan, Colombia, Lebanon, the occupied Palestinian territories, Libya, Yemen and Syria. In some cases, they were targeted because they were carrying enemy fighters; in others, because of mistrust created by the deliberate misuse of ambulance services to deceive an adversary. And in some situations, ambulance services were simply caught in the crossfire – Mexico being a prime example. The Mexican Red Cross, the main operator of emergency ambulances in the country, can attest all too well to the heavy toll exacted by drug-related violence.

It is clear that on the whole, *local* workers bear the brunt of the violence against health-care personnel and facilities and medical vehicles. A recent study by the ICRC shows this to be the case in over 90 per cent of the more than 900 incidents recorded in 22 countries. Of the people caught up in those incidents, roughly 25 per cent were wounded or killed. In some cases, those trying to give life-saving assistance to the victims of one explosion were targeted by later explosions – a particularly deplorable practice causing further injury and death and obstructing the provision of care to those who need it urgently.

Violence against health-care facilities and personnel – of any kind – is not only morally reprehensible; it violates international law. The overriding problem is the widespread disregard for the law shown by parties to conflict and armed actors in other emergencies. When protective symbols are brazenly ignored, other measures can offer only limited protection. Ideally, violations must be prevented from happening: the challenge is to find ways of doing so. To begin with, awareness must be raised throughout the world of the terrible human cost of violence against health-care personnel and facilities, and a culture of responsibility established amongst all concerned.

In keeping with the far-reaching resolution on 'health care in danger' that came out of the 31st International Conference of the Red Cross and Red Crescent in 2011, the International Committee of the Red Cross (ICRC) remains committed to tackling both the causes and the consequences of this major humanitarian problem. Partnerships with National Red Cross and Red Crescent Societies is crucial to these efforts.

National Societies have a critical role to play – as first responders and, ultimately, in helping to make access to their services safer. Expert workshops such as the one held in Mexico in May 2013 bring together key stakeholders – from national authorities, security forces, medical associations, non-governmental organizations and numerous National Societies – to exchange ideas and share expertise, and to put forward practical recommendations. This publication reflects a wealth of experience and an extraordinary range of practice; it should serve as a practical tool for bringing about positive change and making the delivery of health-care services and access to them safer for all concerned.

2. EXECUTIVE SUMMARY

This publication summarizes the most significant results of the expert workshop on ambulance and pre-hospital services in risk situations, which was jointly organized by the ICRC and the Mexican Red Cross in Toluca, Mexico, from 20-24 May 2013. Participants included National Red Cross or Red Crescent Societies, national health-care providers, rescue services, universities, militaries and the ICRC.

The focus of the workshop was on understanding the concrete challenges health-care personnel face when providing ambulance and pre-hospital services in risk situations. The pressure on such services in these circumstances is immense: resources and capacity may be exhausted and infrastructure destroyed, impeding the safe delivery of health care. And being a first responder can be fraught with peril, both for the first responders and for the people in their care. Acts, or threats, of violence against health-care personnel are frequent; and indirect or direct attacks against as well as misuse, arbitrary obstruction or looting of medical vehicles are all significant obstacles to the delivery of effective and impartial health care. The opening sections of this publication set out the main challenges for ambulance and pre-hospital services in risk situations: ensuring continuity of service; misuse of ambulances; attacks on health-care personnel and ambulances; and obstruction of ambulances.

More importantly, the expert workshop in Mexico also made a number of recommendations for strengthening security and making access safer for ambulance and pre-hospital services in risk situations. These recommendations applied mainly to three areas: legal initiatives; coordination with stakeholders, including State armed forces; and best practices for ambulance and pre-hospital services. The publication sets out these recommendations together with examples from various contexts.

While some of the challenges brought up during the workshop were widely acknowledged by participants, it must be pointed out that the difficulties ambulance services are facing vary significantly from one country to another. There is no simple, universal solution. It must also be kept in mind that this publication reflects the specific experiences of participants at the workshop, and that the discussions that took place there, as well as the recommendations that were made, are not necessarily pertinent to all contexts. The recommendations set out in the publication could perhaps serve as a point of departure for formulating solutions adapted to specific countries or regions.

3. THE HEALTH CARE IN DANGER PROJECT

Violence, both actual and threatened – during armed conflicts and other emergencies – against health-care personnel and facilities, and medical transports, is widespread and affects individuals, families and communities. It is probably one of the most serious humanitarian issues before us: the number of people affected by it and the effects on chronic and acute needs warrant this conclusion. Yet it remains largely unrecognized.

In November 2011, the 31st International Conference of the Red Cross and Red Crescent asked the ICRC to initiate consultations with experts from States, the International Red Cross and Red Crescent Movement and others in the health-care sector – with a view to making the delivery of health-care services in armed conflicts and other emergencies safer – and to report to the 32nd International Conference in 2015 on the progress made.

The Health Care in Danger project, which was launched in support of this objective, focuses on the illegal and sometimes violent acts that impede or prevent the delivery of health care – attacks, discrimination, armed entry into protected facilities, illegal obstructions, and so on – and their consequences for the wounded and sick, health-care facilities and personnel, and medical transports.
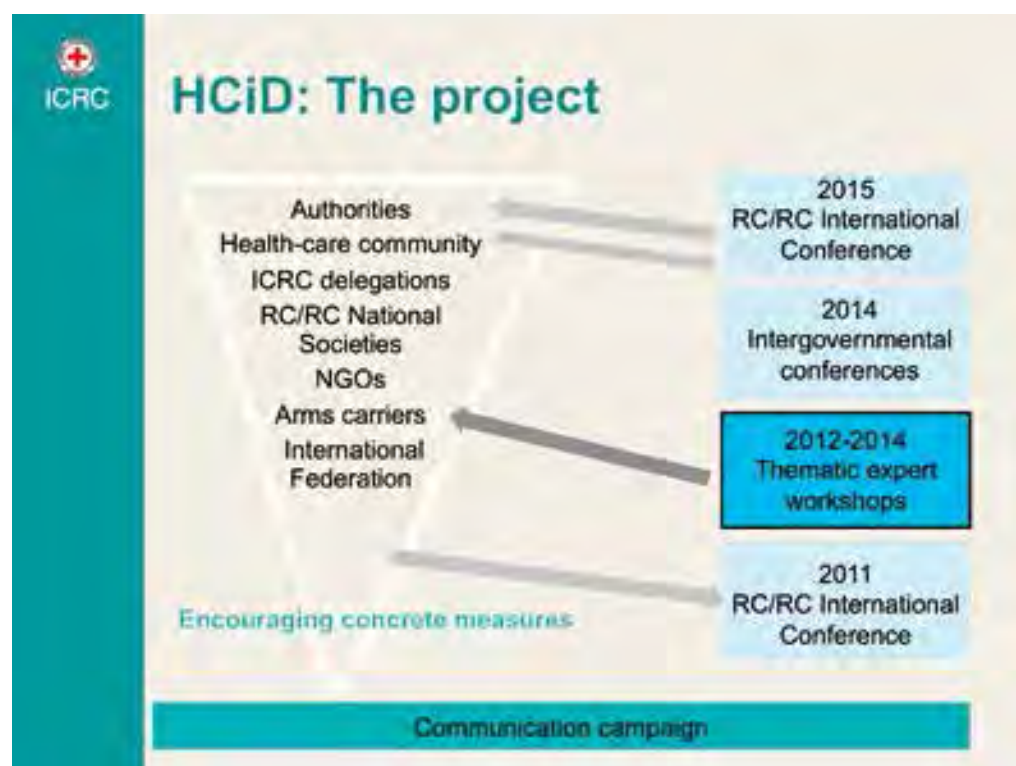
Definitions

As the Health Care in Danger project deals with a number of different situations, the terms used in this publication – for instance, medical personnel, units and transports – should be understood more broadly than they are in international humanitarian law (IHL), which applies during armed conflict. Medical personnel, units and transports fall within the IHL definition when they are "assigned exclusively to medical purposes by a competent authority or party to the conflict." In the context of Health Care in Danger, personnel, units or transports can fall within the scope of the definition even if they have not been assigned by a party to a conflict.

Health-care facilities include hospitals, laboratories, clinics, first-aid posts, blood transfusion centres, and the medical and pharmaceutical stores of these facilities.[a]

Health-care personnel include:[b]

- people with professional health-care qualifications, e.g. doctors, nurses, paramedics, physio-therapists, pharmacists
- people working in hospitals, clinics and first-aid posts, ambulance drivers, administrators of hospitals, or personnel working in the community in their professional capacity
- staff and volunteers of the International Red Cross and Red Crescent Movement involved in delivering health care
- 'medical' personnel of armed forces
- personnel of health-oriented international and non-governmental organizations
- first-aiders.

Medical transports include ambulances, medical ships or aircraft, whether civilian or military; and means of transport conveying the wounded and sick, health-care personnel and medical supplies or equipment. The term includes all vehicles used for health-care purposes, even if not assigned exclusively to medical transportation and under the control of a competent authority of a party to a conflict, such as private cars used to transport the wounded and sick to a health-care facility, transport vehicles for medical supplies and people-carriers transporting medical staff to places of work (e.g. for local vaccinations or to work in mobile clinics).

An **ambulance, for the purposes of this publication**, is a locally available means of transport that carries, as safely and comfortably as possible, wounded and acutely sick persons to a place where they can receive the emergency medical and/or surgical care they need; it is also where the condition of these patients is stabilized. Transportation may be either from the site of an emergency to a health-care facility or between two health-care facilities.

IHL defines "transport," "transportation," "medical vehicles," "medical ships and craft" as well as "medical aircraft" in Article 8 (f) – (j) of 8 June 1977 additional to the Geneva Conventions (Additional Protocol I).

IHL also addresses "transport" or "transportation" in connection with the following:

- the use of the emblem
- the medical purposes listed in Article 8 (e) of Additional Protocol I
- the same protection for medical vehicles as for mobile medical units under Articles 12 and 21 of Additional Protocol I
- the activities of medical personnel in relation to the wounded and sick and the protection of medical transports and of the distinctive emblems under rules 25, 29–30 and 109 of customary IHL equivalent to treaty IHL.[c]

[a] ICRC, *Health Care in Danger: Making the Case,* ICRC, Geneva, 2011.

[b] ICRC, *Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflict and Other Emergencies,* ICRC, Geneva, 2012.

[c] Jean-Marie Henckaerts, Louise Doswald-Beck, *Customary International Humanitarian Law, Volume I: Rules*; and Jean-Marie Henckaerts, Louise Doswald-Beck (eds), *Customary International Humanitarian Law, Volume II: Practice, Parts I and II,* Cambridge University Press, 2005. See also the updated Customary IHL database: http://www.icrc.org/customary-ihl/eng/docs/home

The ICRC brought together National Societies and various external stakeholders in a number of workshops in 2012-2013; experts from approximately 100 countries took part. The workshop in Mexico complements others held on National Societies' response to the issue of 'health care in danger'.[1] Workshops on the following themes have taken place, or will do so in the future:

1. Military practice and operational orders
2. National Society response to 'health care in danger'
3. Responsibilities and rights of health-care personnel
4. Ambulance and pre-hospital services
5. Security of health-care facilities
6. Domestic normative frameworks for the protection of the provision of health care
7. The role of civil society and religious leaders in promoting respect for health care.

The workshop in Mexico was attended by representatives of National Red Cross or Red Crescent Societies, as well as individuals from the armed forces, police medical services, academia and medical organizations such as Médecins Sans Frontières. The publication makes frequent reference to the ambulance services of National Societies because a number of them attended the workshop. However, the discussions in general and the recommendations are of pertinence for any ambulance service. Presentations at the workshop took place both in plenary and during smaller group discussions; the publication reflects this. The publication also contains in-depth and case-specific contributions provided after the workshop. The term 'risk situations' was used for the duration of the workshop: it encompasses armed conflicts and other emergencies addressed by the Health Care in Danger project. It will therefore be used throughout this publication.

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1 Oslo Workshop, 3-5 December 2012, *The role and responsibility of National Societies to deliver safe health care in armed conflicts and other emergencies*. More information available via: http://www.icrc.org/eng/resources/documents/event/2012/health-care-in-danger-expert-workshop-oslo-2012-12-03.htm
Tehran Workshop, 12-14 February 2013, *The role and responsibility of National Societies to deliver safe health care in armed conflicts and other emergencies*. More information available via: http://www.icrc.org/eng/resources/documents/event/2013/02-08-tehran-workshop-health-care-in-danger.htm

4. CHALLENGES FOR AMBULANCE AND PRE-HOSPITAL SERVICES IN RISK SITUATIONS

The International Red Cross and Red Crescent Movement has, since its foundation, been associated with the provision of health-care services. Training volunteers, communities and beneficiaries in matters related to health care and first aid is one of the primary activities undertaken by National Societies around the world. In many contexts, National Societies also operate and maintain ambulance services, either in support of private or government-run services or as the main providers of such services in their countries.

The ways in which ambulance and pre-hospital services are employed in risk situations vary with the security environment, the number and condition of the wounded, access to health-care infrastructure, the resources that can be mobilized for care or transport, access to surgical care, and with the particular health-care facility's capacity to receive and treat patients.

The transportation of the wounded and sick from the spot where they were wounded or became ill to where medical and/or surgical care can be delivered is arranged in a variety of ways, depending on the context – as is also the case with the referral of patients from one health-care facility to another (for instance, to get specialized care after stabilization in a clinic). Private, public or military means of transportation can be used. The extent and the sophistication of medical aid can also vary greatly from country to country. For instance, in some contexts, medical treatment might be available in the ambulance carrying the patient to hospital; elsewhere, ambulances might be no more than a means of evacuating and transporting people.

4.1. Challenge: Ensuring continuity of service

Pre-hospital and ambulance services are under immense strain in risk situations. Maintaining a comprehensive service is a considerable task, requiring a depth of resources, especially if it is a 24-hour service. It also involves a certain amount of risk – for instance, when the service cannot be sustained or when capacities to operate it are limited (shortage of resources, overhelming number of casualties, and so on). The frustrations and misunderstandings engendered by such situations can lead to violence against the remaining service providers or against the organization running the service. These situations can be dangerous, both for first responders and for the people in their care.

The state of infrastructure may also affect service delivery; in some contexts, it can be an impediment to motorized modes of transportation. In mountainous terrain during winter, snowmobiles or low-slung sleds pulled by people or dogs can be used to provide emergency transport. Elsewhere, donkeys or horses may be the most efficient way of transporting the sick and wounded (Chad) or two-wheel drive vehicles (Malawi, Uganda, Zambia) or boats (Colombia, Nigeria). These various means should be taken seriously and studied, as they are sustainable and effective, and give users a sense of ownership.

4.2. Challenge: Misuse of ambulances

Ambulances can be misused in a number of ways. This always has consequences – often severe – for ambulance services, their personnel, the wounded and sick in their care and the integrity of the service. The effects of misuse are seldom confined in space and time. Misusing ambulances – falsely claiming the protection granted to medical personnel – to capture, injure or kill an adversary constitutes perfidy and is prohibited by IHL;[2] it also gravely compromises the neutrality of health-care providers. There are various ways in which an ambulance can be misused; some, not all, amount to perfidy. However, whenever ambulances are misused to facilitate or impede military operations, they lose their protection under IHL (for example, when they are used to transport weapons and fighters or when they are used to launch attacks). In April 2011, an ambulance was used to launch a suicide attack on a regional police training centre on the outskirts of Kandahar in southern Afghanistan: 12 people were killed and several were wounded. The abuse of trust that occurs when protected facilities and transports are misused – as in this instance – can develop into a vicious cycle and undermine the motives for creating neutral entities in armed conflict. The incident in Afghanistan was strongly condemned. But misuse can also take less serious forms and the reasons for it may not always be military: even these form of misuse can have serious consequences in terms of public perceptions, effectiveness and security. For instance, ambulances can be misused as personal vehicles for hospital directors or managers, as taxis, or to carry goods. When that happens, they fall under suspicion and are, at best, subjected to delays and obstructed or, at worst, become objects of attack.[3]

4.3. Challenge: Attacks on ambulances and health-care personnel

Attacks on ambulances and health-care personnel, whether deliberate or not, are a serious obstacle to the safe delivery of health care in risk situations. Attacks on ambulances are frequent and widespread, as examples from Honduras,[4] Libya,[5] Lebanon,[6] and Syria[7] show. Ambulances are attacked for a variety of reasons: for instance, to kill health-care personnel or wounded or sick persons being transported who are regarded as enemies. Health-care personnel may also be targeted because they are from another part of the country, a different ethnic group, or another country. These 'outsiders' can be ostracized for not being part of the community or worse, suspected of being spies. In some contexts, ambulances are attacked by members of the general population who are dissatisfied with the services being provided or with the provider, or because they perceive the sick person's situation to be life-threatening and react violently. First responders may be subjected to threats or demands at the scene of an incident and forced to prioritize the treatment of casualties in a way that is not consistent with medical procedures. These attitudes become hardened, especially in places where an ambulance is considered to be a consumer good or commodity. The ambulance is often regarded, sometimes even presented, as a symbol of immediate and effective assistance in an emergency, and calling an ambulance can become a reflex. People become demanding and frustrated if the service is not delivered in a timely manner (timeliness being defined by those individuals, not by the ambulance service). Any delay where immediate service is expected causes frustration that can turn into aggressive behaviour against the ambulance team when they reach the scene.

Increasingly, ambulances are being targeted in 'follow-up' attacks. In a follow-up attack, the same site is targeted several times to injure or kill first responders assisting and evacuating the victims of a previous attack. An attack of this kind can also be directed against a hospital to which the victims of a previous attack have been taken. This is an especially worrying development because it shows that attacks on ambulances and health-care workers are aspects of a strategy and not collateral damage, as it were. These attacks pose a particularly difficult challenge. Measures to counteract them might, for instance, require ambulances and health-care providers to delay evacuation and treatment of the wounded until the area in question is deemed completely secure – which is likely to have dire consequences for the wounded.

2   Additional Protocol I, Article 37.
3   ICRC, *Health Care in Danger*: *Making the Case,* ICRC, Geneva, 2011.
4   La Prensa, *Acribillan a un hombre dentro de ambulancia en Honduras,* http://www.laprensa.hn/Secciones-Principales/Sucesos/Policiales/Acribillan-a-un-hombre-dentro-de-ambulancia-en-Honduras,20/03/2013
5   "Libya: First-aiders in the line of fire." Available at: http://www.icrc.org/eng/resources/documents/feature/2012/libya-feature-2012-06-11.htm
6   ICRC, *Health Care in Danger*: *Making the Case,* ICRC, Geneva, 2011.
7   UN Human Rights Council, *Publication of the Independent International Commission of Inquiry on the Syrian Arab Republic,* A/HRC/24/46. See also, "Syria: Humanitarian situation catastrophic." Available at: http://www.icrc.org/eng/resources/documents/press-briefing/2013/02-15-syria-humanitarian-situation.htm

The attitudes and/or conduct of ambulance staff can also put them at risk. For instance, their safety can be jeopardized by any or all of the following:
- Being insufficiently informed about methods of self-protection: preparedness, stress management, security management, emergency/ contingency plan, code of conduct, etc.
- Ignorance of or disregard for the elements of the Safer Access Framework[8]
- The wish to be regarded as a hero or as someone capable of dealing with any situation; the wish to save lives; having exceptionally high expectations of oneself; the willingness to sacrifice oneself
- Difficulty in upholding the principles of impartiality and neutrality owing to strong convictions or involvement with parties to a conflict or with political or religious figures
- Employed by a service that acts like a business, one that is accessible only to people who can pay for it.

In 2010, the ICRC conducted a survey in eight countries. It revealed strong agreement in all the countries that health-care personnel and medical transports should be spared from attack and left to do their job.[9] Some respondents noted, however, that attacks were acceptable when health-care personnel were seen to be taking sides and compromising their neutrality or when ambulances were used 'by combatants for hostile purposes'. Under IHL, when ambulances go outside their humanitarian functions and are used to do harm or to express hostility to an enemy, they do in fact lose their protection – after a due warning coupled, whenever appropriate, with a time limit for compliance and if that warning remains unheeded.[10]

4.4. Challenge: Obstruction of ambulances

As *Making the Case* explains, sometimes access to health care is deliberately blocked, but often it is impeded by road closures and delays at checkpoints for security reasons.[11] In 2010, a girl injured by an explosion in the Chahar Dara district of the Kunduz province in Afghanistan died shortly after arriving at a hospital; she had been carried there on foot for an hour because the military had closed the road.[12] There are several reasons why ambulances may be held up or obstructed during armed conflict and other emergencies, such as: administrative procedures (checkpoints), security, coordination measures (with police, military or armed groups), lack of resources (petrol, maintenance service), and bad roads, Impeding timely access for the wounded and sick to health care may delay treatment or even cause death. In various contexts, there may be legitimate security concerns requiring vehicles to be stopped at checkpoints; however, searching and questioning passengers and patients at length can cost lives. It is worth mentioning that, in some cases, first responders might be stopped by people (weapon bearers, demonstrators, members of the community, etc.) who want to protect them from dangers that lie ahead (landmines, snipers, etc.).

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8 The Safer Access Framework, an evidence-based tool developed in 2003 by the ICRC, together with National Societies and the International Federation of Red Cross and Red Crescent Societies, aims to contribute to National Society preparedness for working under uncertain security conditions. The elements of the Safer Access Framework are considered an essential tool that must be used by all National Societies in their efforts to gain safe access to people and communities affected by armed conflict and other emergencies in order to provide protection and assistance.
9 ICRC, *Our World. Views from the Field: Summary Report*, ICRC, Geneva, 2010, p. 58.
10 First Geneva Convention, Art. 21 and Additional Protocol I, Art. 13, para. 1.
11 ICRC, *Health Care in Danger: Making the Case,* ICRC, Geneva, 2011.
12 ICRC, *Health Care in Danger: Making the Case,* ICRC, Geneva, 2011.

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5. RECOMMENDATIONS/DISCUSSION

The presentations and discussions at the workshop produced recommendations in three main areas: legal initiatives; coordination with stakeholders, including State armed forces; and best practices for ambulance and pre-hospital services. The section that follows sets out these recommendations with examples from various contexts. Contributions on other emerging issues, made during presentations and discussions, are also addressed.

5.1. Legal initiatives

During armed conflict, the wounded and sick, and medical personnel, units and transports are afforded specific protection under IHL. In situations that fall below the threshold of armed conflict, health-care personnel enjoy the same rights as any other person under the jurisdiction of a State. In addition, the rights of individuals to non-discriminatory access to health care under human rights law implies that State authorities must permit health-care personnel to treat people and protect them from arbitrary interference with their work.[13] In armed conflict, medical transports must be respected and protected at all times and must not be the object of attack. Medical personnel may not be attacked, and must not be hindered in the performance of their exclusively medical tasks.

The 1949 Geneva Conventions and their 1977 Additional Protocols stipulate a range of domestic measures that States must take in peacetime as much as in times of armed conflict. Some of these measures require legislation while others, depending on the legal system, may be implemented through regulations or administrative provisions. A number of obligations, while strictly applicable only in times of armed conflict require legislative or administrative action that can realistically be undertaken only in peacetime, such as adopting legislation to punish grave breaches of the Geneva Conventions and for preventing and suppressing misuse of the red cross, red crescent and red crystal emblems,[14] disseminating IHL and appointing legally qualified personnel in the armed forces.[15]

To meet these obligations, States have taken a number of steps to incorporate international law in domestic legislation. There are a number of examples – both historical and contemporary – of the incorporation in national military manuals and domestic legislation of international laws on the protection of medical transports.[16] However, with regard to implementation of the law, the stock of examples from domestic case-law is comparatively small. National courts have heard very few cases on the subject.[17] Given the magnitude of the issue – violence affecting health care – this paucity of legal proceedings is striking. Thus, the comparative lack of domestic case-law may be indicative of the problem, forcing us to ponder how to address, judicially at the national level, violent attacks against health-care personnel and facilities, and medical transports.

13 ICRC, *Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflict and Other Emergencies,* ICRC, Geneva, 2012, p. 47.
14 See Section 4.1., recommendation 6, for a further discussion on the emblem.
15 Paul Berman, "The ICRC's advisory service on international humanitarian law: The challenge of national implementation," *International Review of the Red Cross*, Vol. 36, No. 312, May 1996.
16 See United Kingdom, *The Law of War on Land*, part III of the *Manual of Military Law,* The War Office, HMSO, 1958 § 356; United Kingdom, *The Law of War on Land*, part III of the *Manual of Military Law,* The War Office, HMSO, 1958 § 33; United Kingdom, *The Manual of the Law of Armed Conflict*, Ministry of Defence, 1 July 2004, § 15.47; Kenya, *LOAC Manual* (1997), Précis No.3, p. 9; Colombia, *Emblem Decree,* 1998, Article 10; Serbia, *Criminal Code,* 2005, Article 373.
17 See Colombia, Constitutional Court, *Constitutional Case No. C-291/07*, Judgment of 25 April 2007, p. 69 and Israel, High Court of Justice, *Physicians for Human Rights* v. *Commander of IDF Forces in the Gaza Strip*, Judgment, 30 May 2004, § 22-23.

What the law says

International Human Rights Law (IHRL) applies at all times, including in situations of armed conflict. In situations that fall below the threshold of armed conflict, health-care personnel enjoy the same rights as any other person under the jurisdiction of a State. In addition, the rights of individuals to non-discriminatory access to health care under human rights law implies that State authorities must permit health-care personnel to treat people and protect them from arbitrary interference with their work.[a] Among the most relevant of all human rights conventions is the International Covenant on Civil and Political Rights (1966), which includes:

- The right to life[b]
- The right to be free from cruel, degrading and **inhumane** treatment.[c]

In addition, the right to health, which was first formulated in the Constitution of the World Health Organization (1946) and affirmed by the International Covenant on Economic, Social and Cultural Rights (1966),[d] should ensure:

- Availability of health-care services
- Access to these services, i.e. physical access, affordability, information, and lack of discrimination
- Acceptance within the culture of the society concerned
- Health-care services of sufficient quality.

International Humanitarian Law (IHL) is a legal regime that applies specifically in armed conflicts. IHL aims to limit the effects of armed conflict for humanitarian reasons. It aims to protect persons who are not or are no longer taking part in hostilities, the sick and wounded, prisoners and civilians, and to define the rights and obligations of the parties to a conflict in the conduct of hostilities.[e] Both IHRL and IHL apply in armed conflict, though IHL generally prevails over IHRL because it offers more specific protection. For example, in situations of armed conflict, medical personnel, units and transports are afforded specific kinds of protection under IHL. The following are amongst the most important provisions in this regard:

- Medical personnel shall be respected and protected[f]
- Medical transports shall be respected and protected at all times and shall not be the object of attack[g]
- Medical units shall be respected and protected at all times and shall not be the object of attack[h]
- Under no circumstances shall medical units be used in an attempt to shield military objectives from attack[i]
- Medical transports cease to be protected when they are used, outside their humanitarian function, to commit acts harmful to the enemy[j]
- Examples of "acts harmful to the enemy" include the transport of healthy troops, arms or munitions, as well as the collection or transmission of military intelligence[k]
- Examples of acts not harmful to the enemy include the carrying of light individual weapons by medical personnel for use in self-defence or in defence of the wounded and sick in their charge or small arms and ammunition that have just been taken from the wounded and have not yet been handed over to the competent military authority[l]
- Even if acts harmful to the enemy are committed, a warning has to be given, setting, whenever appropriate, a reasonable time limit for compliance. Medical personnel, units and transports lose their protection only when such a warning remains unheeded and an attack is launched against them.[m] Any attack must respect the principles of distinction and proportionality, for the benefit of the wounded and sick.

[a] ICRC, *Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflict and Other Emergencies,* ICRC, Geneva, 2012, p. 47.

[b] See International Covenant on Civil and Political Rights (1966), Art. 6; European Convention for the Protection of Human Rights and Fundamental Freedoms (1953), Art. 2; American Convention on Human Rights (1978), Art. 4; and African Charter on Human and Peoples' Rights (1986), Art. 4.

[c] International Covenant on Civil and Political Rights (1966), Art. 7; European Convention for the Protection of Human Rights and Fundamental Freedoms (1953), Art. 3; American Convention for Human Rights (1978), Art. 5; and African Charter on Human and Peoples' Rights (1986), Art. 5.

[d] Constitution of the World Health Organization (1946); International Covenant on Economic, Social and Cultural Rights (1966), Art. 12.

[e] ICRC, "War and International Humanitarian Law." Available at: http://www.icrc.org/eng/war-and-law/overview-war-and-law.htm

[f] Additional Protocol I, Art. 15; Additional Protocol II, Art. 9.

[g] Additional Protocol I, Art. 21; Additional Protocol II, Art. 11.

[h] Additional Protocol I, Art. 12 (1); Additional Protocol II, Art. 11.

[i] Additional Protocol I, Art. 12 (4).

[j] Additional Protocol I, Art. 13 (1); Additional Protocol II, Art. 11.

[k] ICRC, *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949*, Kluwer,1987 (see the section on Additional Protocol I, Art. 13, paras 1-2).

[l] Additional Protocol I, Art. 13 (2) (a) and (c).

[m] Additional Protocol I, Art. 13 (1); Additional Protocol II, Art. 11(2).

Participants at the workshop discussed how legal initiatives could contribute to strengthening protection for ambulance and pre-hospital services. Discussions revolved around the roles, rights and responsibilities of health-care personnel, advocacy efforts with governments to strengthen the legal framework for protecting health-care personnel, medical ethics for health-care professionals, insurance for health-care workers in risk situations and legal protection for the Movement's emblems and other signs of identification. Participants agreed that practitioners should share information about the legal frameworks in their countries with their colleagues elsewhere. This would help them learn from each other and to consider if what had been done in one context was desirable or feasible in another. Participants also pointed out that the Health Care in Danger project might be a good opportunity to strengthen coordination and communication between the legal and operational departments of National Societies. While drafting domestic legislation, lawyers could use operational information to ensure that the final versions of the regulations or laws reflect operational realities. The recommendations on legal initiatives are listed below.

Domestic legislation should take into account all stakeholders involved in emergency response (including pre-hospital and ambulance workers) to clearly define roles and responsibilities

Participants argued that to ensure an effective response in risk situations, the legal framework should take into account all stakeholders involved in emergency response to clearly define their roles and responsibilities. One of the participants said that a solid legal foundation defining the roles and responsibilities of health-care personnel was useful because it contributed to the possibility of coordination.

Consolidation and coordination of emergency medical services in El Salvador

(Dr Francisco René Hernández, Director of Medical Services, Salvadorean Red Cross Society)

The government of El Salvador has put in place a nationwide medical emergency service. The process began in 2009, when pre-hospital emergency care and rehabilitation services were merged with hospital services, and was supported by the Pan American Health Organization (PAHO), which encouraged the government to include plans to set up a consolidated emergency service in its health-care policy.

The Salvadorean Red Cross Society was invited to draft a reference manual for the emergency medical service. The aim was to establish standards for other Latin American countries to use in setting up an integrated emergency service. The manual was released as a PAHO publication in 2005.*

In 2009, the new government in El Salvador decided to include establishing an emergency medical service among its policies, using the manual as a guide. All organizations that offered pre-hospital care, of which the Salvadorean Red Cross was an important one, as well as hospitals and medical emergency centres were invited to take part in the project.

For efficiency purposes, the manual recommends that emergency services should be consolidated, and coordinated by one emergency response centre (i.e. there should just be one number: 911). The National Directorate of Medical Emergencies, under the supervision of the Health Ministry, is responsible for coordinating the emergency services.

The Medical Emergency Service of Andalusia in Spain provided technical support and donated the software that will be used in the emergency response centre. Implementation of the system is ongoing.

Concluding remarks:
- The PAHO was instrumental in influencing government policy and also provided important technical support for government health programmes.
- The Salvadorean Red Cross, thanks to its leadership and experience, played a very important role in the area of pre-hospital emergency care and in implementing health programmes.

* Dr Francisco Rene Hernández Martínez, *Manual de Normas y Funcionamiento de un Servicio de Emergencias Médicas*, Pan American Health Organization, El Salvador, March 2005.

Domestic legislation could provide for a minimum degree of coordination between the various stake-holders involved in emergency response, including the armed forces. To this end, ensuring that domestic legislation took into account all stakeholders could be a prerequisite in some contexts for effective and clear coordination in risk situations. However, it was also argued, establishing a legal basis for coordination between stakeholders was not necessarily the only way to ensure coordinated action. The experience of some participants showed that in situations or contexts where it was difficult to lobby for the adoption of a legal framework, effective working arrangements could be made. Certain participants gave examples drawn from experience of such arrangements between stakeholders to facilitate the safe passage of the wounded and sick through checkpoints. In El Salvador, a consolidated emergency medical service was established not because a legal basis had been prepared for it, but because the government recognized the critical need for a more integrated system of medical services.

Persuade governments to promote and disseminate the rights and responsibilities of health-care personnel

Participants discussed how the rights and responsibilities of health-care personnel should be reflected or incorporated in domestic legislation. They agreed that the responsibilities of health-care personnel – such as saving lives – were generally very clear, but questions arose about the need for precise definition of 'health-care personnel' and of their 'rights and responsibilities'. This discussion was particularly pertinent to the issue of incorporating the rights and responsibilities of health-care personnel in domestic legislation and other normative frameworks, as that would require a clear definition of 'health-care personnel'. One of the participants mentioned that in his context, only licensed medical practitioners fitted the legal definition of health-care personnel; all others were therefore unable to benefit from the rights afforded to health personnel. In many contexts, individuals who are not licensed medical practitioners, such as volunteers, may perform humanitarian activities that fall within the definition of health-care activities, and that are ultimately of consequence for the sick and wounded. While lobbying for domestic legislation regarding the rights and responsibilities of health-care personnel, it should be borne in mind that the definition of 'health-care personnel' varies greatly from one context to the next. Although domestic normative frameworks on their rights and responsibilities may contribute to strengthening security and protection for health-care personnel, it must be remembered that a law that is too prescriptive may limit protection for those who do not fit the conventional idea of a health-care worker. As participants from the region pointed out, this was of particular relevance to the practice of medicine in South-East Asia, where traditional medicine is considered especially important.

All volunteers and employees working in ambulance and pre-hospital services should have health insurance

The discussion on health insurance also touched on the issue of 'working rights', meaning rights that take effect in the event of accidents, sickness or death while working. Some participants pointed out that this was a sensitive issue in certain contexts. One participant argued that the words "working rights" were generally thought to suggest rights contained in a country's domestic labour laws, and thus implied a relationship with the State. Doctors and nurses working within a public or private health-care system may have a scheme in place that ensures their rights in case of disability, death or sickness, whereas volunteers or employees at other health-care institutions may not. The further point was made that in practice, it can be very difficult to ensure the same rights for the entire community of health-care workers, because the domestic legal definition of 'health-care worker' may be quite narrow.

A 'right' is usually understood to mean something that will ensure *protection* in a particular situation. Though the degree to which workers are protected varies from one country to another, most countries do have domestic rules and regulations that afford rights and protection to workers. However, the rights and the protection granted volunteer health-care workers are defined less precisely and vary greatly. To adopt domestic legislation on the matter would be to acknowledge the crucial role played by volunteers in risk situations. A 2011 publication by the International Federation of Red Cross and Red Crescent Societies on volunteering states that "the laws and policies affecting volunteers are different in almost every country and even in different regions of the same country." It urges governments to do more to "explore the legal mechanisms that protect volunteers in emergencies."[18] More encouragingly,

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18 International Federation, *Protect. Promote. Recognize. Volunteering in Emergencies,* International Federation, Geneva, 2011, p. 16.

Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflict and Other Emergencies – An ICRC publication

Health-care personnel should have a sound grasp of their rights and responsibilities; they should also understand how these may change according to whether or not the situation in question constitutes an armed conflict or one that falls below the threshold of an armed conflict. This publication provides guidance in simple language for health-care personnel, setting out their rights and responsibilities in armed conflicts and other emergencies. It will help them deal with ethical and professional dilemmas they may encounter. It explains how the rights and responsibilities of health-care personnel can be derived from international humanitarian law, human rights law and medical ethics.

The book gives practical advice on a number of subjects:

- Protection of health-care personnel and of the sick and wounded
- Standards of practice
- The health-care needs of particularly vulnerable people
- Handling and sending medical records
- "Imported" health care (including military health care)
- Data gathering
- Witnessing violations of international law
- Working with the media.

It can be downloaded or ordered at: http://www.icrc.org/eng/assets/files/publications/icrc-icrc-002-4104.pdf

it refers to a publication released by the United Nations Volunteers programme in 2009, which found that, since the International Year of Volunteers in 2001, more than 70 domestic laws or policies that encourage or regulate volunteering had been adopted (now more than 80), whereas only a few countries had addressed the issue in a comprehensive way before.[19] Domestic legislation on volunteering can be put in place to resolve issues related to labour and taxation, but might also be necessary to establish protection from the risk of liability for a case of omission (failure to act).[20]

One of the issues that emerged during consultations with health-care experts was the need to consider volunteers' right to insurance. Insurance of this kind does not imply full coverage for all health-related issues; it is restricted to coverage for sickness or accidents that occur because of, or during the course of a volunteer's work. The degree to which volunteers have insurance coverage varies enormously from context to context and is dependent, in large part, on the funds available. Insurance can be very expensive and in some contexts, National Societies are forced to give priority to other matters in order to maintain their humanitarian activities. However, as the International Federation's publication – *Protect. Promote. Recognize. Volunteering in Emergencies* – states, "volunteering should not be at your own risk"[21] and "insurance for volunteers is a collective responsibility."[22] Governments and volunteer organizations should work together to safeguard volunteers.

19 International Federation, *Protect. Promote. Recognize. Volunteering in Emergencies,* International Federation, Geneva, 2011, p. 16.
20 *Ibid.* p. 18. See also example referred to as the Federal Volunteer Protection Act of 1997 in the United States.
21 *Ibid.*
22 *Ibid.*, p. 19.

Colombian Red Cross volunteers: Rights and protection

Law 720 of 2001 in Colombia was an important step in recognizing the significant role of volunteers in the country. The law is intended to recognize, promote, and facilitate voluntary action as an expression of civic participation, solidarity and social responsibility, and to regulate the activities of volunteers in public and private entities. The law defines what volunteering is and sets out a number of principles by which volunteers are guided, such as autonomy from the government and the idea that solidarity is a principle of the common good.

- See http://www.alcaldiabogota.gov.co/sisjur/normas/Norma1.jsp?i=4446 for the full version of Law 720 in Spanish.

Law 1505 of 2012 established a national volunteer system as an integral part of the National System for Disaster Prevention and Response. The purpose of the law is to recognize and encourage the work of volunteers and make it possible for them to enhance their skills. It defines volunteers from the Colombian Red Cross as part of the national volunteer system. Law 1505 grants volunteers priority for housing subsidies and establishes benefits for them related to taxation, education and social security.

The law makes a valuable contribution to the fulfilment of the Colombian Red Cross's mission. The Ministry of the Interior and the National Unit for Disaster Risk Management oversee the implementation of Law 1505, particularly of the article establishing mechanisms for ensuring the benefits granted to volunteers from the Colombian Red Cross, the National Fire Department and the Colombian Civil Defence.

During the drafting of the law, the Colombian Red Cross presented the following as priorities:

i.   The necessity of involving in the Professional Risk System, active volunteers of the National First Responder Volunteers System who were not affiliated to the Contributory Social Security System

ii. The necessity for precise definitions of the following terms: 'active volunteer', 'authorized entity', 'first response', 'emergency' and 'public disaster'

iii. Establishing requirements for affiliation to the Occupational Risks System, as well as the obligations of the volunteering entities and the volunteers themselves before the Occupational Risks System.

The Colombian Red Cross implements Law 1505 so that volunteers can have access to its benefits. The Colombian Red Cross participated fully in drafting, discussing and endorsing the law. The engagement has also promoted a unified position with other national volunteer entities, such as the Fire Department and the Colombian Civil Defence.

- See http://www.secretariasenado.gov.co/senado/basedoc/ley/2012/ley_1505_2012.html for the full version of Law 1505 in Spanish.

International Federation of Red Cross and Red Crescent Societies – Insurance for volunteers

Volunteers are the heart of the International Red Cross and Red Crescent Movement and it is vital that we do all we can to continue to make volunteering safer for our people. National Societies are taking a number of steps in this connection: providing training and safety equipment for volunteers, drawing up pertinent operational policies, and undertaking advocacy.

One of the most pressing concerns is ensuring that all of our volunteers have the necessary insurance.

The International Federation has, for many years now, been offering a very basic insurance option at a cost of one Swiss franc per volunteer per year. This enables National Societies that may not have other options to provide their volunteers with a rudimentary safety net. The policy ensures that in the event of permanent disability or death at least some support is available to the family. Whilst this policy is not intended to replace a full or comprehensive insurance policy that might be negotiated locally, it does provide in the worst circumstances, some element of coverage.

Many National Societies have decided to invest their own resources in insuring volunteers, among them the National Societies of Mongolia, Mali, Togo, Ecuador, Honduras, Nicaragua, Trinidad and Tobago, the Philippines, Sri Lanka, Iraq and Myanmar. We must continue to work together to find ways to improve the working environment for our volunteers, who provide critical service to the most vulnerable people in their communities.

For more information, please contact: volunteering@ifrc.org

The Maurice de Madre French Fund

The **Maurice de Madre** French Fund is an independent fund managed by the ICRC.

It grants financial assistance in the event of an accident or illness to volunteers and staff of the International Red Cross and Red Crescent Movement who are not covered by insurance or social welfare benefits. The injury or illness must be related to work in the service of the Movement.

The assistance provided by the Fund may cover medical expenses or the costs of physical rehabilitation or professional reintegration. The Fund may also award financial or material assistance to the family of a volunteer or staff member who died while carrying out humanitarian tasks.

The Fund is made up of the proceeds from the property left to the ICRC by Count Maurice de Madre, who died in 1970. Its regulations were adopted by the ICRC Assembly on 9 September 1974 and amended on 9 April 1981 and 13 December 1995. The first payment to a beneficiary was made in 1975.

The Fund is administered independently by a board of five members appointed by the ICRC; they represent the ICRC, the International Federation of Red Cross and Red Crescent Societies and the family of Count de Madre. The board always has one non-Movement member. The chairman of the board is from the ICRC, which is also responsible for the Fund's administration, accounts and Secretariat.

The Fund has helped hundreds of Movement volunteers and staff. The money available to it is limited, restricting the amount of assistance that can be distributed, both per case and annually; but even these comparatively small amounts make a lasting impact on vulnerable families and communities.

Since its creation in 1974, the Fund has handled
- **512 requests**
- **817 individual cases**
- **2,066 beneficiaries.**

And made grants totalling 3,571,918 Swiss francs

Advocate the adoption and implementation of domestic laws on the red cross and red crescent emblems, including sanctions for misusing them

The primary purpose of the emblem is to serve as the visible expression of the protection provided under IHL to medical personnel, units and transports during armed conflict. If authorized to do so by the State, other persons or objects may also make use of the emblem for protective purposes in times of war. This is commonly referred to as the "protective use" of the emblem.[23] Those entitled to make *protective* use of the emblem in times of armed conflict include various actors from the medical services of a State's armed forces and from National Societies.[24]

Protection for the emblem (the red cross, red crescent and red crystal emblems) was discussed at the workshop and recommendations for strengthening it, in domestic law, were made. Participants argued vigorously for more effective implementation of domestic laws on misusing the emblem. National Societies contended that challenges, related to security and access, that arose during the delivery of

23 ICRC, *The Domestic Implementation of International Humanitarian Law*: *A Manual*, 2nd ed., ICRC, Geneva, 2011, p. 49.
24 "Those entitled to make *protective* use of the emblem include: *In times of armed conflict*: medical services (personnel, units, such as hospitals, means of transport, etc.) and religious personnel of a State's armed forces; medical personnel, and medical units and transports of National Red Cross, Red Crescent and Red Crystal Societies duly recognized and authorized by their governments to assist the medical services of the armed forces, and thus when employed exclusively for those purposes and subject to military laws and regulations; civilian hospitals (public or private) that are recognized as such by State authorities and are authorized to display the emblem; in occupied territory and in zones of military operations, persons engaged in the operation and administration of such civilian hospitals; all civilian medical and religious personnel either in occupied territory or in areas where fighting is taking place or is likely to take place; all civilian medical units and transports recognized and authorized by the competent authorities to be marked by the emblem; other recognized and authorized voluntary aid societies, subject to the same conditions as National Red Cross, Red Crescent and Red Crystal Societies; the International Federation of Red Cross and Red Crescent Societies; the ICRC." From ICRC, *The Domestic Implementation of International Humanitarian Law*: *A Manual*, 2nd ed., ICRC, Geneva, 2011, p. 49.

> **"Did you know?"**
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> • In 1997, Colombia's Council of State determined that the use of a medical vehicle for military operations was prohibited under IHL. The vehicles had been used to transport troops. The Council referred to the 1949 Geneva Conventions and to both 1977 Additional Protocols.
>
> • In its judgment in the *Emblem* case in 1994, the Federal Court of Justice in Germany stated that there was an essential common interest in protecting the emblems against unauthorized use.
>
> • In the case of *The Public Prosecuting Authority* v. *A Tøyen Tannlegevakt AS*, 2010, the Norwegian Supreme Court affirmed a conviction under the domestic law protecting misuse of the emblem on the basis that the logo used by the dental office in question could "easily be confused" with the logo of the Red Cross. In affirming the conviction it referred to the historical protection the emblem has been afforded in more than one of the Geneva Conventions and their Additional Protocols.

health care in risk situations were closely linked to the misuse of the emblem. In this regard, the term 'misuse' covers: (1) imitation, such as the use of a sign that, owing to its shape and/or colour, may be confused with the emblem; (2) improper use, such as the use of the emblem by people authorized to do so, but in a manner inconsistent with IHL provisions on its use, or the use of the emblem by entities or persons not entitled to do so (commercial enterprises, for instance) or for purposes inconsistent with the Fundamental Principles of the Movement; (3) perfidy.[25] Whether it is intentional or not, the misuse of the emblem severely compromises public perceptions of the neutrality of health-care personnel, and may have grave short- or long-term consequences, for their safety. Under Article 54 of the First Geneva Convention, States are required to include in their domestic legislation all necessary measures to prevent and repress, at all times, the misuse of the emblem referred to under Article 53 of that Convention.[26] In this context, participants at most Health Care in Danger workshops have stressed the importance, where domestic law is inadequate, of advocating the adoption and implementation of domestic red cross and red crescent emblem laws. It was also proposed that, if and when such domestic legal mechanisms are established, there should also be an effective system in place to address and correct mistakes or deliberate misuse. It should be emphasized that the obligation to prevent and repress misuse of the emblem lies with the State, as a party to the Geneva Conventions. However, National Societies should cooperate with the authorities to protect the emblem, and are encouraged to take an active role in this regard.[27]

Protecting the emblem is not a matter for concern only in times of armed conflict; it is an important issue in times of peace as well. Its misuse in peacetime may have adverse consequences for the degree of respect accorded to it during armed conflict. As the ICRC's study on the use of the emblem states, "it must also be borne in mind that failure to suppress misuse during times of peace will contribute to misuse during armed conflict."[28] Ways of dealing with the misuse of the emblem will vary, depending on the context and the severity of the circumstances.

Use of a sign of identification, or the red cross or red crescent emblem, is not sufficient in itself to ensure protection for an organization, which must also undertake awareness raising and trust-building activities

There are a number of signs or emblems that are used throughout the world to indicate the availability of medical assistance. The Movement's emblem has a unique legal status because its use is strictly regulated by international and domestic law. However, the existence on paper of a legal framework for using the Movement's emblem, or other signs of identification, does not automatically provide protection from harm. Though the protection may be well established by law or custom, its practical effect

25 ICRC, *Study on the Use of the Emblems*: *Operational and Commercial and Other Non-Operational Issues,* ICRC, Geneva, 2011, p. 30. Available at http://www.icrc.org/eng/assets/files/publications/icrc-001-4057.pdf
26 Article 54 of the First Geneva Convention states that "The High Contracting Parties shall, if their legislation is not already adequate, take measures necessary for the prevention and repression, at all times, of the abuses referred to under Article 53."
27 See ICRC, *Study on the Use of the Emblems*: *Operational and Commercial and Other Non-Operational Issues,* ICRC, Geneva, 2011, p. 287.
28 ICRC, *Study on the Use of the Emblems*: *Operational and Commercial and Other Non-Operational Issues,* ICRC, Geneva, 2011, p. 281.

the conduct of those it aims to protect, and other trust-building activities. For instance, dissemination activities carried out by National Societies and the ICRC add to what people know about these organizations, the emblem, its value and significance during armed conflict, and the seven Fundamental Principles of the Movement. However, dissemination activities alone are not enough to establish a culture of respect for an organization, its mandate, and the emblem or sign it displays. Participants at the workshop in Mexico noted that the quality of services provided by an organization and the conduct of those delivering these services are essential elements in the creation of a culture of respect for the emblem. As one of the participants said, "the emblem will not protect you if you do not use it properly." Moreover, respect for the emblem is also closely connected to the degree to which the daily activities of the organization, the whole and its constituent parts, are in accordance with the seven Fundamental Principles. The emblem identifies the organization in the field, and thus, the conduct of those displaying it will create positive or negative associations with it. A single instance of conduct inconsistent with any of the Fundamental Principles by a Red Cross/Red Crescent volunteer or employee can have long-term consequences for the safety of other volunteers and employees, and for the organization as a whole.

Some well known symbols

The sign for Médecins Sans Frontières

The Star of Life, known throughout the world as a symbol of emergency medical services

The emblems of the International Red Cross and Red Crescent Movement

The International Federation of Red Cross and Red Crescent Societies

The International Committee of the Red Cross

The Misión Médica symbol in Colombia, the sign for all health-care services in the country – created from Resolution 4481, which adopted the *Manual de Misión Médica*, or the *Medical Services Manual*. In Colombia, health-care personnel and facilities are collectively known as the *misión médica* or the 'medical mission'. The manual is aimed at adopting and implementing a system to strengthen respect and protection for the medical mission in Colombia during armed conflict and in other situations of violence.

A widely used symbol for first aid

The Asociación Nacional de Proteccion Civil is one of the main providers of pre-hospital services in Mexico and other Latin American countries, as well as in other parts of the world. They also play an important role in disaster response. In Mexico they have a mandate to coordinate all activities related to disaster response.

Practitioners should share information on the existing legal frameworks regulating ambulance and pre-hospital services

Participants agreed that practitioners should share information about the legal frameworks in their countries with their colleagues elsewhere. This would help them learn from each other and to consider if what had been done in one context was desirable or feasible in another. The idea of a sharing platform was put forward; it could be used to gather examples from the normative frameworks regulating ambulance and pre-hospital services in various countries. These examples might be illustrative of good practice and could be used to lobby for the adoption of stronger legal frameworks in other countries. Sharing platforms for organizations involved in delivering health care might already exist at national, regional and global levels; this could be looked into.

With regard to National Societies' auxiliary role to the public authorities in the humanitarian field, share standard operating procedures and training curricula and reflect on the need to standardize these procedures

National Societies are auxiliaries to the authorities in the humanitarian field. Participants discussed the need for a sound legal framework to regulate this relationship and procedures to implement the auxiliary role. Having the necessary formal mechanisms in place for coordination between the National Society and authorities does not automatically ensure sound procedures in risk situations. Participants proposed joint training sessions as a measure to strengthen operational cooperation. It was recognized that the way the auxiliary role of the National Society takes effect varies from one country to another. In some countries, it is strong, with a sound legal and practical basis, whereas in others it is not – thus creating opportunities to strengthen the auxiliary role based on existing procedures and training curricula, which could be very useful in many contexts. Although global standardization of this training is unrealistic, one could explore the possibility of developing training modules that can be applicable in similar contexts or regions.

5.2. Coordination with stakeholders, including armed forces

To deliver humanitarian assistance effectively, health-care personnel often have to rely on coordination with a number of different stakeholders, including the armed forces. Thus, well-functioning mechanisms for coordination are essential to ensure that assistance reaches the sick and wounded. Participants at the workshop made two recommendations on coordination with stakeholders:

- There should be a legal framework regulating coordination between persons involved in pre-hospital and emergency health care and the armed forces
- All stakeholders should understand each other's roles and methods of communication and coordination.

Some participants said that to promote the impartial delivery of health care, National Societies should be able to enter into dialogue with non-State actors, when government actors are unable to do so.

The various organizations and actors should – in line with their specific mandates – complement each other's efforts to ensure the safe delivery of health care. There are a number of steps that can be taken in advance of a risk situation to ensure efficient coordination, such as establishing plans, coordination mechanisms, joint exercises, training programmes or simulations with governments, health-care personnel, members of the local community and others involved in providing emergency response.

During the workshop, reference was made to contexts where such coordination mechanisms – for responding to risk situations – were already in existence: Haiti, Mexico, Israel, Palestine, Nepal and the United States, among others. Participants also pointed out that when operating in a risk situation, information on the security situation and plans and procedures with a bearing on humanitarian activities could, when appropriate, be shared with others in the field.

The role and mandate of National Societies have to be firmly established and understood by the authorities in order for the former to discharge their responsibilities effectively: in other words, their role as auxiliaries to the authorities in the humanitarian field must be formally recognized and fully

Colombian Red Cross: Dialogue with non-State actors

The Colombian Red Cross, in its fulfilment of the principles of impartiality and neutrality, has a duty to provide protection and care to all vulnerable people equally – in other words, without discrimination on the basis of any particular characteristic, belief, political opinion, religion, race or sex. We are nevertheless required to make distinctions on the basis of need: we must give priority to protecting, attending to and preventing the suffering of those people most exposed to hardship and risk, without questioning their origins or background.

With this in mind, the Colombian Red Cross works to ensure that the wounded and sick get the assistance they require when conflict or other violence hinders their access to health care. Our efforts are especially important when people are struggling to get the help or humanitarian aid they need on account of their affiliation with non-State armed groups. We must be able to reach those in need safely and this is possible only if we make contact with and obtain security guarantees from all parties to a conflict, or to any other form of violence in which State entities are clashing with opposition groups or groups in breach of the law or social code. Such an approach is outlined in both the International Red Cross and Red Crescent Movement's Safer Access Framework and the Colombian Red Cross's security policy, both of which were developed to make sure we could carry out our work safely and effectively, without putting either our staff and volunteers or our beneficiaries at risk.

It is worth reiterating that the humanitarian work of the Movement does not in any way interfere with the authorities exercising their constitutional and legal powers. With our transparent and safe approach, based on the principles of impartiality and neutrality, we can direct people to State-run centres to get the assistance and care they need, regardless of whether at that point in time they fall within or outside the law. This is in fulfilment of everyone's human right to health. However, the help that we provide in no way prevents the State from enforcing the law if a crime has been committed.

understood. As the ICRC found after consultations with a number of National Societies,[29] if a National Society does not have clearly defined statutes and a strong legal basis, including specific provisions on the delivery of health care in armed conflict and other emergencies, its role as an auxiliary to the public authorities in the humanitarian field may remain unclear. This can affect its access to the victims, especially if the National Society is thought to be a governmental/State organization. Further consultations revealed that one of the requirements for good coordination with the authorities was clear understanding and formal recognition of the National Society's unique auxiliary role to the public authorities in the humanitarian field.[30] However, the mere fact that the auxiliary role has been formalized does not ensure efficient coordination. That requires training and clearly laid out procedures or measures for coordination, of which National Society staff and volunteers and the authorities, such as the military and the police, are all aware. Regular simulation exercises or drills involving all stakeholders (including the population) should also be considered. One practical measure for better coordination might be to establish clear notification procedures between the National Society and the authorities: this will ensure that the National Society's staff and volunteers are afforded security guarantees to operate.

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29 In July 2012, the ICRC sent a questionnaire on the Health Care in Danger campaign to 37 National Societies. The questionnaire asked National Societies to share their experiences in four key aspects of delivering health care during armed conflict and other emergencies: 1) challenges they have encountered; 2) concrete steps they have taken to increase access, acceptance and operational security; 3) the role of National Societies (legal base, statutes) in delivering health care during armed conflict and other emergencies; and 4) the role of National Societies in strengthening protection for the sick and wounded during armed conflict and other emergencies. Supporting data used for this paper were: 1) statistics obtained under an ICRC initiative to collect data on incidents affecting health care in 22 countries, which began in 2012; 2) interviews with ICRC personnel in Geneva and in the field who work with National Societies in operational contexts pertinent to the Health Care in Danger campaign.

30 ICRC and Norwegian Red Cross, Publication from Expert Workshop on Health Care in Danger For National Red Cross and Red Crescent Societies January 2013.

Nødnett – The Norwegian Public Safety Network

Nødnett is a separate digital radio network for police, health services and fire and rescue services that enables communication and coordination between the different actors in emergency situations. In addition, Nødnett can be used by organizations that participate in rescue and emergency work, such as the Norwegian Red Cross. The network is in full operation in parts of Norway and countrywide coverage will be in effect by the end of 2015.

Nødnett is built to be resilient in order to meet the needs of the emergency services. Users must have TETRA radios approved to work with Nødnett. Talk groups are set up internally within the agencies and in groups in common with other emergency services. Only those actively given access to the individual talk groups can listen in. Nødnett radios can also send and receive text messages and can be used to exchange small amounts of data.

TETRA STANDARD

Nødnett is built over the TETRA standard. A TETRA network offers secure, encrypted radio communications in talk groups and in direct one-to-one communications. It is also possible to transfer data at moderate speeds. TETRA technology is in use in many countries throughout the world, both in public security and in businesses with high demands for reliable communication.

Coverage for the Nødnett network is made possible through the use of terrestrial base stations, much like a cellular or mobile network. Nødnett transmits and receives signals between the base stations and the radio terminals used by emergency service workers. Conditions such as topography, distance between radio base stations and coverage from neighbouring base stations are considered in order to find the most effective placement for Nødnett base stations and to provide the best coverage possible.

WORKING TO BECOME PART OF NØDNETT

The Norwegian Red Cross has worked hard to secure that the Red Cross and other volunteer organizations delivering emergency services will be a user of the Nødnett. The over 320 search-and-rescue (SAR) teams in the Norwegian Red Cross are a central element in the Norwegian SAR Service. To secure safe and stable opportunities to communicate with all the other SAR partners it is important for the Red Cross to be a part of and a user of Nødnett.

Since 2012, some SAR teams in the Norwegian Red Cross have been trial users of Nødnett. The Norwegian Parliament confirmed in June 2013 that the Norwegian Red Cross and other voluntary emergency organizations will be users of Nødnett in Norway.

With regard to non-State actors, the Health Care in Danger workshop in Oslo had already emphasized the importance of relying on good practices and approaches developed within the Movement.[31] The ICRC strives to maintain dialogue with non-State actors to enhance the safety of humanitarian workers; gain access to individuals held by armed groups or to people affected by the situation and living in areas controlled by them; assess the willingness and ability of these groups to ensure respect for the law of war; and support to the extent possible their efforts to show more respect for IHL, such as incorporating the law in their codes of conduct.[32]

One of the participants pointed out that her National Society interacts with non-State actors to help them understand that the delivery of health care was governed by the principles of independence and neutrality, and to emphasize that their own families relied on health-care services. It must be kept in mind however that National Societies' ability to maintain contact with non-State armed actors is often limited by law. In some contexts, providing humanitarian assistance to non-State actors may even be criminalized.

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31 Oslo Workshop, 3 – 5 December 2012, *The Role and Responsibility of National Societies to Deliver Safe Health Care in Armed Conflicts and Other Emergencies*. More information available via: http://www.icrc.org/eng/resources/documents/event/2012/health-care-in-danger-expert-workshop-oslo-2012-12-03.htm
32 ICRC, "Building respect for humanitarian action and IHL among 'other' weapon-bearers." Available at: http://www.icrc.org/eng/what-we-do/building-respect-ihl/dialogue-weapon-bearers/other-weapons-bearers/overview-icrc-other-weapon-bearers.htm

5.3. Best practice in the delivery of pre-hospital services

It has become increasingly evident during the various expert workshops conducted within the scope of the Health Care in Danger project, that participants are very keen to learn from the examples of other contexts. Although participants acknowledge that a variety of contexts implies a variety of challenges, they have also pointed out that health-care personnel throughout the world are facing a number of similar challenges. With regard to recommendations, participants have frequently emphasized the importance of sharing best practice on such matters as the Safer Access Framework, health-care ethics, coordination, minimum training requirements, contingency planning and personal protective equipment.

Promote all elements of the Safer Access Framework

In all the Health Care in Danger workshops that took place in 2012 and 2013, health-care personnel highlighted the importance of State authorities, non-State armed groups and the local community accepting and respecting their activities to safeguard the delivery of health care. It has been acknowledged that this was a key factor in ensuring that they had safe access to the sick and wounded during risk situations, including armed conflict and other emergencies. In previous workshops, participants cited the ICRC's Safer Access Framework as an important capacity strengthening tool that National Societies could make use of during armed conflict and other emergencies. The Framework – an evidence-based tool developed in 2003 by the ICRC, together with National Societies and the International Federation – aims to contribute to National Society preparedness for working in sensitive situations under uncertain security conditions, including armed conflicts and internal disturbances and tensions. The elements of the Framework are considered an essential tool that must be used by all National Societies in their efforts to gain safe access to people and communities affected by armed conflict and other emergencies in order to provide protection and assistance. Although the Framework was developed as a capacity building tool for National Societies, other health-care personnel may find certain

Safer Access Framework

Context and risk assessment and analysis: National Societies should have a clear understanding of the interlinked political, social, cultural and economic aspects of the evolving operational environment and the associated risks, which forms the basis for preventing and managing those risks.

Legal and policy base: National Societies have sound legal and statutory instruments and develop policies that provide a basis from which to carry out their humanitarian mandate and roles in conformity with Movement policies, international humanitarian law (IHL), human rights law and domestic legislation.

Acceptance of the organization: National Societies have attained a high degree of acceptance among key stakeholders by providing relevant, context-sensitive humanitarian assistance and protection for people and communities in a manner consistent with the Fundamental Principles and other Movement policies.

Acceptance of the individual: Staff and volunteers have attained a high degree of acceptance among key stakeholders by working in a manner consistent with the Fundamental Principles and other Movement policies.

Identification: National Societies take all necessary steps to protect and promote the organization's visual identity and that of its staff and volunteers.

External communications and coordination: National Societies implement well-developed external communication and coordination strategies and mechanisms, which enhance coordination with external actors.

Internal communications and coordination: National Societies implement well-developed internal communication and coordination strategies and mechanisms, which enhance coordination with other Movement components.

Operational security risk management: National Societies assume responsibility and accountability for the safety and security of staff and volunteers by developing and implementing an operational security risk management system and structure.

Protecting the medical mission of the Lebanese Red Cross

(Georges Kettaneh, Secretary-General of the Lebanese Red Cross)

The Lebanese Red Cross (LRC), and particularly its emergency medical services (EMS), is re-learning the painful lessons of the long and bloody Lebanese civil war of 1975-1990. At the time, the Fundamental Principle of neutrality was also a mode of survival in the midst of religious, sectarian and political turmoil.

During that costly conflict, the LRC was the only organization able to operate throughout the divided country. This was because its volunteers abided by the International Red Cross and Red Crescent Movement's seven Fundamental Principles and because all parties and armed groups perceived them – and subsequently the LRC – as neutral, independent and impartial humanitarian workers.

It took years for the National Society to understand that there is a fine, deadly line between actual neutrality and the perception of this neutrality. It took the death of 12 LRC EMS volunteers before 1987 to realize that it is not enough to actually be neutral but to be *fully perceived* as being neutral. Building this perception with the difficult audiences whose job it is to kill people based on religious differences is actually hard work and requires a deliberate and coherent effort at all levels of the National Society. Being *perceived neutral* required efforts of communications and awareness, and most of all, behaving neutral.

Today, as the Syrian crisis spills over into Lebanon and divides an already fragmented society yet again, the LRC is merely applying the lessons of the past. The LRC prepared for the hard work that has come with the crisis by being rigorously neutral in peacetime and on minor missions. The reward for our hard-won credibility is that now our teams have safe access to the people who need help. In recent years, the LRC has:

1. Actively worked to build a culture of neutrality among its volunteers
2. Actively communicated and disseminated information on the Red Cross to all parties.

ESTABLISHING A CULTURE OF NEUTRALITY

The reality is that no one is or can be really or fully neutral in Lebanon, not even LRC volunteers. Everyone has political opinions, inclinations and preferences. Nothing that the LRC could or would ever try to do would lead to our having thousands of volunteers with no political opinions whatsoever. The LRC does not want its volunteers to shed their opinions; it wants them to act without imposing their opinions on others and to be tolerant of those who think or feel differently.

What the LRC wanted in 1987, and what it wants in 2013, are volunteers who choose every day to place humanitarian action above all other considerations. The LRC wants volunteers who choose to be neutral every day because neutrality eases the approach to people in need. The LRC wants volunteers who are convinced that humanity is more important than politics, who strongly believe that for a society to be able to function, it must contain some people who are able to set their opinions aside and abide by higher principles.

What the LRC wants is an elite group of people, distinguished not only by their skills and knowledge but by their commitment to abiding by a set of principles, an elite that is committed to securing acceptance for their National Society among all parties and communities.

This has been, is now, and will continue to be the daily challenge of our National Society.

NEUTRALITY: PERCEPTIONS AND REALITY

The lesson learnt in 1987, and being re-learnt in even more difficult circumstances today, is that even a group of such neutral volunteers is not guaranteed acceptance. Neutrality in word and deed is a necessary but not a sufficient condition for acceptance. We need to make sure, every day, that the LRC is perceived by everyone in Lebanon and beyond as being completely neutral.

This is a much more difficult task today than it was in 1987. The society is more fragmented, volunteers are younger and some of the experiences of the civil war have been forgotten. Most people now have easy and rapid access to a massive amount of information - some of it accurate and some completely misleading Today, a volunteer with a link to a remotely partisan piece of information on his or her Facebook account can lead to an ambulance being targeted.

It has also become much more difficult to hide the fact that even LRC volunteers have opinions. Achieving and maintaining a perception of neutrality requires more effort, more discipline, stronger control mechanisms, more awareness and more training.

The LRC has unfortunately not yet fully embraced the Information Age. But we know and understand this, have identified it as a priority at the highest levels of the organization, and will work on it so that we can continue to be *the most recognized and widely accepted organization in the country*, and continue also to provide help throughout Lebanon to everyone who needs it.

aspects of it useful for strengthening their security and access. Several sections of a Safer Access Framework Practical Resource Pack for National Societies – based on the Framework and on Resolution 7 of the Council of Delegates in 2011 – will be released in late 2013, with others following in early 2014.

Promote health-care ethics and discussion of ethics in risk situations as part of the curriculum at universities and training institutions

Participants at the Mexico workshop contended that involving universities and training institutions in discussing security and access for health-care personnel was crucial, because they lay the basis for future medical action. Institutions such as the World Medical Association and national medical associations have drawn up sound guidelines on health care and/or medical ethics. These are based on years of case-based discussions about the ethical dilemmas that health-care personnel face in their daily work. While there are clear guidelines on what constitutes ethical conduct in treatment of patients, health-care personnel's ability to act in accordance with them is dependent on the ability to balance rules, principles, results and constraints against each other.[33] In many cases, there are no absolutely right or wrong answers; and training in ethics and in the dilemmas that one might face can contribute to a better understanding of the ethical guidelines one should apply as a health-care worker. Although medical ethics are intended to guide the conduct of health- care personnel such as doctors and nurses, they may also be relevant for others, including volunteers, who carry out health-related activities such as driving ambulances or giving first aid. Ensuring that their training includes the study of codes of ethics, and discussion of the ethical dilemmas that a first responder might encounter (such as choosing which patient to treat first), can make it more likely that volunteers and health-care personnel will reach the right decisions. However, as health-care personnel point out, the realities of the field often pose a formidable challenge to the codes of ethics that may be ingrained in the individual doctor, nurse, driver or first responder: for instance, when they are forced, under threat of personal harm, to treat one patient rather than another.

Make use of the opportunity provided by the Health Care in Danger project to strengthen communication and coordination between the legal and operational departments of your National Society

This recommendation reflects the fact that the emergency response activities of many National Societies may not be integrated with other departments, such as their legal departments. Participants recognized the need – given the cross-cutting nature of the Health Care in Danger project and the challenges already identified – for coordination and communication between departments. It was mentioned during the discussions that operational departments often felt that those responsible for advocating amendments to domestic legislation should seek their advice to ensure that legal initiatives reflect and address operational realities and challenges. This was just as true for efforts to identify gaps or deficiencies in domestic legislation. In certain contexts, people assisting wounded or sick persons defined by the State as criminals or terrorists might be prosecuted for providing impartial medical assistance. In such instances, better communication and coordination between the legal and the operational department might result in a more effective strategy for changing domestic laws that criminalized humanitarian assistance to certain groups or individuals. Using examples from the field that show how domestic legislation hinders or endangers the provision of health care helps to build stronger arguments for advocacy. Participants suggested the creation of national forums or committees for Health Care in Danger, as these might help ensure, when devising domestic strategies and measures, that the various competencies are complementary.

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33 ICRC, *Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflict and Other Emergencies,* ICRC, Geneva, 2012, p. 40.

At a minimum, volunteers should be trained in road safety, ethics, psychosocial support, field safety and security, healthy lifestyles, communication and negotiation skills, cultural knowledge and the Movement Code of Conduct.[34] When appropriate, training may be standardized by region.

A 2011 publication by the International Federation emphasizes the importance of the estimated 13 million people around the world who choose to be volunteers for National Societies.[35] The mobilization and involvement of volunteers is a crucial element in ensuring access and assistance for those in need. In risk situations, volunteers give first aid, ensure transportation, mobilize communities, are involved in vaccination campaigns, and provide treatment to the sick and wounded. Volunteers are involved in every aspect of the chain of care in many contexts and should therefore be trained and prepared for their tasks. Training and preparation is essential for volunteers to cope with the various scenarios that they may face in risk situations; but training is also indispensable for ensuring their personal safety. Health Care in Danger workshops have emphasized this point consistently.

Training should not however be an end in itself; it should be responsive to the needs and the realities of the situation. The need to train volunteers, and the degree to which they must be trained, varies with the situation and their tasks. Minimum training in road safety, for instance, can be very general: it might consist of following certain rules while driving, such as not speeding and always wearing seatbelts. But it can also be very context-specific, such as learning how to conduct oneself at checkpoints (also related to communication and negotiation skills). In some contexts, learning how to give basic first aid may be

Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief

The Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief was developed and agreed upon by eight of the world's largest disaster response agencies in the summer of 1994. It is a voluntary code that lays down ten principles that all humanitarian actors should adhere to while responding to disasters. It also describe the kinds of relationship that agencies working in disasters should seek with donor governments, host governments and the UN system. The code does not concern itself with operational details, such as the calculation of food rations or the setting up of refugee camps. Instead, it seeks to maintain the high standards of independence, effectiveness and impact to which disaster-response NGOs and the International Red Cross and Red Crescent Movement aspire.[a]

1. The humanitarian imperative comes first.
2. Aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone.
3. Aid will not be used to further a particular political or religious standpoint.
4. We shall endeavour not to act as instruments of government foreign policy.
5. We shall respect culture and custom.
6. We shall attempt to build disaster response on local capacities.
7. Ways shall be found to involve programme beneficiaries in the management of relief aid.
8. Relief aid must strive to reduce future vulnerabilities to disaster as well as meeting [*sic*] basic needs.
9. We hold ourselves accountable to both those we seek to assist and those from whom we accept resources.
10. In our information, publicity and advertising activities, we shall recognize disaster victims as dignified human beings, not hopeless objects.

ª See International Federation, "Code of Conduct." Available at: http://www.ifrc.org/en/publications-and-publications/code-of-conduct/. See also: http://www.icrc.org/eng/assets/files/publications/icrc-002-1067.pdf

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34 The full title is *Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief.*
35 International Federation, *Protect. Promote. Recognize. Volunteering in Emergencies,* International Federation, Geneva, 2011.

Emergency vehicle operator course

Besides the part he or she plays in the effectiveness of emergency operations, the driver of an emergency vehicle is also responsible in large measure for the safety of his or her colleagues, the wounded or sick person being transported, and potential bystanders. A course on operating emergency vehicles is likely to vary with the context, but it should typically contain instruction in the following areas:

- Precision driving skills
- Crash-avoidance techniques
- Sending and receiving messages – by radio, for example
- Operating and maintaining vehicles
- Personal safety when driving on bad roads or in rough weather
- Stress management
- Role and responsibilities of the driver
- Navigation and route mapping
- Legal aspects.

a sufficient minimum requirement for volunteers; in other contexts, extensive training programmes might be necessary to ensure continuity and quality of services in the health-care facilities to which casualties are referred. In contexts where the National Society plays a crucial role in delivering health-care services nationwide, the lack of extensive training for volunteers could have a detrimental effect on the standard of care throughout the country. In National Societies working in contexts where there is a great deal of cultural and religious diversity, the training required for volunteers may vary from one area of the country to another. When establishing the minimum level of training, one has to consider the resources available for training, the cooperation and coordination between various stakeholders, the skills required for carrying out the task at hand, the responsibilities the task entails, the community's reliance on volunteers, the context, and the health-care system as a whole. Participants recognized that although regionally standardized training programmes could ensure continuity and quality, there cannot be one universal solution.

The issue of training for ambulance drivers is one that merits more attention. When National Societies were asked about training requirements for ambulance drivers, none reported carrying out specific training for them; they said that the training for driving ambulances was part of the general training that volunteers in the emergency medical services had to undergo. Of course, this may vary with the context. Even so, it may be of value to further assess the need for a specific training regime for ambulance drivers, to ensure their safety as well as access for them, given the importance of their role in emergencies.

The question of personal protective equipment (PPE) should be analysed by country and/or context and proper training provided

The use of PPE has been raised at previous workshops, but the discussion in Mexico took the issue considerably further. Previous discussions had been more polarized: strong opinions were expressed both for and against it. At the workshop in Mexico, where a number of presentations referred to the use of PPE, the discussion was less about whether it should be used but more on the pros and cons of its use and on the ways in which service providers resolved difficult issues about whether to use it and when. Health-care personnel acknowledged that the use of protective equipment in the field created dilemmas. In certain contexts and in certain situations, the use of protective equipment can be encouraged, but in other instances, it could in fact put the team at risk. The difficulty of establishing the causes of security incidents creates yet another problem: it may lead to risk-mitigating actions, such as the use of PPE, that do not address the root cause of the problem, and thus do not really mitigate the risk. During the workshop in Cairo,[36] participants seemed to agree that some kinds of PPE could be

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36 Cairo workshop, 17-19 December 2012, Security of Emergency Health Care in the Field. More information available via http://www.icrc.org/eng/resources/documents/event/2012/12-17-egypt-hcid-workshop.htm

useful in dealing with forseeable risks; and during the workshop discussions and presentations in Mexico, it became evident that PPE was being used extensively by health-care personnel throughout the world.

Health-care personnel have argued that the safety of their first responders and the ability to respond are dependent, although not entirely, on the use of protective equipment; of course, first responders must also be trained in its proper use. During the workshop in Mexico, a number of National Societies and others said that they used PPE during incidents that required first responders and others to be more heavily protected than usual, such as during missile attacks or massive outbreaks of violence. One National Society's emergency medical services said that the use of PPE was essential in its context to protect staff and volunteers from explosive blasts and chemical agents. The National Society said that such incidents "do not allow waiting for the situation to be safe, in order to respond, since by that time the casualties will be dead." In this particular context, therefore, ambulance and health-care personnel have to rely on protective gear to respond effectively and care for the wounded. This is a dilemma faced by many first responders throughout the world. Another National Society reported that owing to the increase in the previously described 'follow-up attacks', staff and volunteers had come to rely on protective equipment. However, personnel may be severely wounded during a follow-up attack even if they are using protective equipment. In certain incidents involving chemical agents, the use of special protective equipment may be essential for the safety of personnel. One National Society reported that it needs increased capacity to provide staff and volunteers with effective protective equipment such as helmets and masks. This National Society said that it had not been able to respond to numerous incidents because the lack of protective equipment would have made it unsafe for staff and volunteers to do so.

Several participants at the expert workshop in Oslo[37] drew attention to the difficulty of determining an acceptable threshold of risk to guide operational decision-making, while remaining vigilant about the safety of National Society staff and volunteers. This has both ethical and legal (duty of care, insurance, etc.) implications for the National Society. The community often expects National Society staff and volunteers to strive to assist people in need, even in the most dangerous circumstances. This is particularly true when the National Society does not explain that it has certain constraints and that there are limits to the emergency assistance that it can provide, even to the wounded. National Society personnel themselves often feel impelled by a duty to assist and are willing to take risks even when that is at odds with established security procedures. Arguably, extensive use of PPE could push the threshold of acceptable risk even lower, because the equipment can give users a false sense of security. Another issue that was raised was the possibility of health-care workers wearing PPE being attacked by individuals who want their equipment. The challenge is to establish standard operating procedures, security guidelines and contingency plans adapted to the circumstances of each context. More broadly, a balance must be struck between responding to humanitarian needs and the safety of staff and volunteers. Health-care personnel have often emphasized the importance of acting only when the authorities provide security guarantees and their formal approval.; others have felt that this was not always possible and that, in some cases, saving lives should take precedence over considerations of personal safety. Developing strategies to resolve this dilemma will ultimately help to provide health care that is more sustainable and needs-based.

The current debate on the use of PPE has not yet produced a solution that everyone can agree upon. Health-care personnel, ambulance drivers and emergency response personnel operate in different contexts, and the necessity of using PPE varies accordingly. Views on the use of PPE could also differ according to whether it is a local/national or international organization providing assistance. Many local or national health-care providers have said that their ability to assist victims is often largely dependent on the availability of protective gear. If local or national health-care providers are unable to assist victims because the lack of PPE made it it unsafe for them to do so, they may incur the disapproval or the distrust of the local community afterwards. National Societies have reported that they may be regarded as weak or as delivering low-quality services if they fail to assist victims, even in a situation that required the

37 Oslo Workshop, 3–5 December 2012, The Role and Responsibility of National Societies to Deliver Safe Health Care in Armed Conflicts and Other Emergencies. More information available via http://www.icrc.org/eng/resources/documents/event/2012/health-care-in-danger-expert-workshop-oslo-2012-12-03.htm

Personal protective equipment (PPE)

PPE is intended to reduce exposure to perceived hazards or risks, and can include, but is not limited to:

- Bullet-proof vests
- Helmets
- Armoured vehicles
- Suits specifically designed for protection against chemicals or hazardous materials
- Gloves (for protection from infectious diseases, for example)
- Glasses
- Masks
- Uniforms (including shoes).

The term 'PPE' does not include armed escorts.

Japanese Red Cross – Chemical, biological, radiological and nuclear (CBRN) decontamination kits

The Japanese Red Cross has CBRN decontamination kits at its prefectural chapters in order to respond to CBRN incidents. In principle, Japanese Red Cross medical teams would not enter a contaminated area ('hot zone'), as it is difficult to treat patients in a contaminated environment. The main role of Japanese Red Cross medical teams is to decontaminate patients evacuated from 'hot zones' and treat them in a safer environment ('warm zone'). The CBRN decontamination kit consists of a decontamination tent with a shower and air filtration system, and protection suits filled with air at positive pressure, masks and other equipment. Cooperation with the rescue and evacuation team – the special response unit of the Japan Self-Defense Forces or the fire department – is an essential while responding to CBRN incidents. It is also necessary to clarify the roles of Red Cross response teams and decide on the equipment necessary. The teams must be properly trained and their conduct in accordance with established standards.

safety of staff and volunteers to be given priority. Such instances could, at best, have short-term repercussions for the image and reputation of the local health-care provider; at worst, it might result in long-term damage to the security of staff and volunteers. Communication campaigns or training courses aimed at the general population, the public authorities, community leaders and the medical community themselves often fail to provide sufficient information about the constraints for responders and the limits to the care that can be given.

The pros and cons identified by the working group during the workshop that ought to be taken into account when deciding upon the use of PPE

PROS
- The gear can give actual protection against dangers.
- When the situation requires, its availability has a significant effect on timely response.
- Staff and volunteers might feel safer.
- We may be able to reach patients in areas that we would not enter without protection.

CONS
- A principal argument against protective equipment is that it is expensive.
- It becomes harder to distinguish between armed forces and security or police forces and ourselves.
- The equipment is often very heavy, making it hard for wearers to move freely.
- It can give a false sense of security, which leads people to take more risks.
- In some cases, the gear may create fear or unease in the patients/population. (Masks hide faces and look frightening; to mitigate this, the colours and signs used on the equipment should be the same as those on the uniforms worn by the organization's staff and volunteers.)

The arguments put forward by the participants highlight the difficulties health-care personnel face when deciding whether or not to use PPE. Participants agreed about the value of further analysing the use of PPE in specific contexts, listing the advantages and the disadvantages. This might help National Societies and others decide whether and when to use the equipment.

Armed escorts for civilian ambulances should always be avoided

The International Red Cross and Red Crescent Movement has a principled stance against the use of any armed protection. It took this position in Resolution 9 of the 1995 Council of Delegates entitled "Armed protection of humanitarian assistance," and reaffirmed it recently in Resolution 7 of the 2005 Council of Delegates entitled "Guidance document on relations between the components of the Movement and military bodies." The reason for this fundamental objection is that armed protection for its components is incompatible with the Movement's Fundamental Principles of humanity, impartiality, independence and neutrality.

However, these Council of Delegates' resolutions, and in particular the publication on the use of armed protection annexed to Resolution 9 of the 1995 Council of Delegates,[38] recognize that there may be exceptional situations in which lives can be saved only by accepting an armed escort, and hence where the principle of humanity requires that the Movement accept changes to its normal operating procedures. The publication lays down certain *minimum* conditions or questions, endorsed by the resolutions mentioned above, that must be fulfilled and answered in the affirmative before a component of the Movement may decide whether to accept an armed escort.

These are given below:
- Are the needs so pressing (e.g. saving lives on a large scale) as to justify an exceptional way of operating and can they be met only with the use of an armed escort?
- Is the Movement's component concerned sure that the use of an armed escort will not have a detrimental effect upon the security of the intended beneficiaries?
- Is the component concerned the most capable of covering the identified needs? Is there no other agency or body external to the Movement that is in a position to carry out the same activities or to cover the same needs?
- Is armed protection being considered primarily for its deterrent value and not for its firepower, recognizing the extreme reluctance with which the Movement would condone the use of violence and the threat of violence to deter attack?
- Has the party or authority controlling the territory through which the convoy will pass and in which the humanitarian assistance will be delivered given its full approval to the principle and modalities of an armed escort? Remember that should this approval be withdrawn, the situation must be reassessed and negotiations must once again take place.
- Is the escort intended to provide protection against bandits and common criminals in situation [*sic*] of general law-and-order breakdown? Remember that there should be no risk of confrontation between the escort and the actual parties to the conflict or organized armed groups which control part of the area through which the humanitarian convoy has to travel.[39]

However, the Movement has to acknowledge that medical transports that are not part of the Movement might operate with military convoys and in some cases be obliged to be part of a military convoy.

During the workshop in Mexico, representatives of military medical services reminded other participants that this recommendation would not be relevant for military medical services whose ambulances are often part of larger military convoys. They indicated however that they understood and appreciated the issues as they pertained to civilian ambulance services operating in high-risk areas.

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38   ICRC, "Publication on the use of armed protection for humanitarian assistance," extracted from "Working paper, Council of Delegates, 1995," presented at the Council of Delegates, Geneva, 1-2 December 1995.
39   Taken from: ICRC, "Publication on the use of armed protection for humanitarian assistance," extracted from "Working paper, Council of Delegates, 1995," presented at the Council of Delegates, Geneva, 1–2 December 1995.

Make sure that contingency plans exist and are implemented in concert with the hospital system

During the discussions in Mexico, participants stressed the need for contingency plans to take into account others playing a role in the response: for instance, the hospital system, the fire and police departments, the public authorities and law enforcement agencies. The objective of any contingency plan should be to ensure effective and safe referral of the wounded and sick. However, in risk situations, humanitarian needs might be so great as to overwhelm the capacity of the ambulance service provided by the National Society, and it may become difficult to meet all the needs. In some contexts, the National Society has a virtual monopoly on ambulance services; in others, the ambulance services of the National Society operate together with private and/or government-run services. In both cases, it is necessary to prepare by making concrete plans of action that can be implemented if and when ambulance capacity is exhausted. One National Society reported that the responsibility for drawing up such plans lay with the government and its national preparedness division. While acting in this capacity the authorities are also able to gather together all the national organizations involved in disaster preparedness and make sure that their roles and responsibilities are defined in advance. This informs the development of organizational procedures and contingency plans.

In certain contexts, the authorities may declare a 'state of emergency'. In such situations, there are generally significant restrictions on movement, except for State security or military forces. There may therefore be a need for health-care personnel and medical transports to obtain special permission or exemptions to be able to assist victims.

For National Societies operating in contexts where they are virtually the sole providers of ambulance services, it may be particularly important to develop adequate contingency plans to maintain the quality and effectiveness of their services. Otherwise, if the National Society is unable to respond because of capacity issues, the community might be left with inadequate or no medical transport. Alternative solutions should be discussed and practised before this exhaustion of National Society becomes a fact. Such contingency plans should be developed with primarily one aim in mind: the transportation of casualties to places where they can receive treatment. Locally available private and public means may be considered in such plans. These means can complement the National Society's capacity; they may even be the only means of access to victims and/or health-care facilities.

Contingency plans should reflect the specific challenges of the context where the service is operating. One should ask what the most likely risks are and how these can be mitigated. This obviously varies greatly from country to country. For instance, a crucial aspect of such plans is ensuring capacity for negotiations and/or notification mechanisms between the parties involved, which depends entirely on the context one is operating in and the parties involved. During the workshop in Mexico, participants gave many examples of such context-specific contingency planning. For example, it was mentioned that 'panic buttons' and cameras had been installed in the reception areas of hospitals where violence or the threat of violence was common. Precautionary measures are implemented both while transporting patients and in areas where they are received. The aim is to reduce the risk of violence against patients and staff. In addition, during the workshop, many National Societies reported that the use of GPS tracking in ambulances had had a positive effect on mitigating the risks that they face in operations. In one context, where the National Society operated an extensive fleet of ambulances, the use of GPS had enabled a more accurate and effective response to emergencies because of a computer system that was able to determine which ambulance was closest to the site of the emergency. Simply clicking on a map would cause the computer system to automatically select the response vehicle. Then the GPS system would automatically plan the best route. Similar systems were in use in other contexts. With regard to security and access for ambulances in risk situations, the use of GPS can also enable the dispatch centre to monitor whether an ambulance is near an area that has not been secured, and also monitor when and for how long the ambulance is halted at a checkpoint. Nonetheless, it was also stated, in some circumstances the use of GPS could raise the suspicions of the parties involved, and thus contribute to compromising security.

The Japanese Red Cross and its minor surgical unit vehicle (MSUV)

In Japan, the National Society responds to natural disasters such as earthquakes, floods or famines. The relief action varies according to the kind of disaster. In the case of an earthquake, immediate action is necessary – the first two weeks for surgical cases, and the following two or more weeks for medical cases. After an earthquake, local medical facilities gradually regain their capacities. The area affected by an earthquake is usually limited and demarcated clearly. Life in non-affected areas continues as before; therefore, the wounded in the disaster areas can be treated at hospitals in the non-affected areas, if the logistical capacity for transporting patients is functioning. The Japanese Red Cross has an MSUV, which was built for providing an immediate response to such situations: its main object is to provide triage and first aid, including minor surgery if necessary. The availability of the MSUV reduces the number of people who have to be transported to hospitals that may be overloaded because of the emergency or disaster. Depending on the situation, the MSUV can serve as anything from a first-aid post to a mobile clinic.

Facts about the MSUV:
- Built to treat the sick or the wounded, not limited to surgery
- Treatment available for both walk-in patients and those transported by ambulances
- Surgical treatment is available, but limited to local anaesthesia
- The vehicle does not have equipment for general anaesthesia
- During emergencies, can deliver sterilized material in excess of its capacity
- Designed for use in initial phase of domestic disaster
- Ready for use in less than thirty minutes after assignment to a disaster spot
- Not suitable for transportation abroad owing to its size
- Certain areas in Japan where it cannot go
- Sometimes requested as stand-by for non-disaster situations such as football matches, concerts, large international conferences, etc.

Communication systems at the Palestine Red Crescent Society (PRCS)

In the past, the PRCS used only mobile phones for communication. However, this was both unreliable and unstable in emergency situations. In order to provide services in a more efficient and reliable way, the PRCS received assistance from local telecom vendors to build its own radio network. The PRCS is now using radio communication (VHF) as the main communication between ambulances, staff and emergency medical service (EMS) stations. The radio network covers most areas in the West Bank and Gaza, but due to some previous damage on the radio network, the PRCS saw it necessary to have other means of communication as backup. Thus, the PRCS also uses mobile repeaters, mobile phones and satellite phones. The means of communication used by the PRCS are:

1. VHF COMMUNICATION NETWORK

a. Fixed sites: MTR2000 repeater fixed in each governorate with certain frequency; each repeater links with the central operation room at PRCS HQ.
b. Mobile repeaters: one mobile repeater located in each governorate to be used as backup in case of any cutoff for the fixed repeater.
c. Mobile repeaters with the disaster response team.

The VHF network covers about 90% of the West Bank and Gaza Strip. In areas such as military zones and areas close to the borders, the VHF signal is blocked by the Israeli military.

2. MOBILE CELLULAR PHONES COMMUNICATION

Closed circle/group mobile phones to be used as a backup system in case of no coverage or complete cut-off of the VHF network (each ambulance is provided with a cellular phone).

3. SATELLITE PHONES

Between the Gaza Strip and West Bank, which can be used in case of communication cut-off between the Gaza Strip and the West Bank. This also enables communication between Palestine and the rest of the world in case of disaster/emergency.

4. GPS TRACKING SYSTEM IN ALL PRCS VEHICLES

Psychosocial support

While no specific recommendations were made about psychosocial support, it was the subject of various presentations and of discussion. There was broad agreement among participants that efforts should be made to provide psychosocial support in risk situations. In addition, previous Health Care in Danger workshops had emphasized the importance of stress-management strategies and techniques for health-care personnel, including ambulance drivers: stress management was thought to be crucial for ensuring the safety of these individuals.

Working in risk situations can be extremely stressful for health-care personnel, regardless of whether they are members of an organization's staff or volunteers, locally employed or expatriates. In an ICRC survey from 2010, some first responders – particularly those who had lost colleagues or were under pressure from their families – said that the risks had made them consider quitting.[40]

Generally, psychosocial support for staff and volunteers is given in three stages: before, during and after assignments. Health-care providers should know how to recognize and deal with the stress experienced by volunteers and staff in all three stages. Procedures should be available for preparing volunteers and staff for the stressful conditions under which they may have to do their work; procedures should also be available for mitigating the stress they may experience after traumatic situations.

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40 ICRC, *Our World. Views from the Field: Summary Report*, ICRC, Geneva, 2010, p. 72.

Israel – Magen David Adom's multi-casualty response vehicle

In order to respond to incidents with a large number of casualties, every region has at least one multi-casualty response vehicle, a mobile depot of supplies for mass-casualty incidents. The supplies include:

- Trauma kit: which enables an advanced life support-certified professional to perform procedures to ensure an open airway, adequate breathing and proper circulation
- First-aid and fluid kits for the use of emergency medical technicians
- Spinal boards, cervical collars and stretchers
- Oxygen
- Identifications vests, body armour, safety helmets.

Spinal boards for moving people with suspected spinal injuries

Equipment bags for emergency medical technicians and paramedics

Equipment and supplies carried by the vehicle

One National Society reported that the psychological well-being of its staff and volunteers was a key responsibility for the organization's management. A specific training programme has been designed to prepare volunteers and staff for what they might face in the field. In addition, management carried out debriefings and follow-up after incidents. Another National Society reported that ambulance personnel were seldom given psychosocial support because they were operating under such time pressure, and needs were so urgent, that this could simply not be prioritized. It was also pointed out that some first responders felt reluctant to accept psychological support because it made them feel weak or fragile.

Furthermore, one National Society said that it had made a strong psyche a precondition for deployment on international missions, and that it had a rigorous screening process for selecting suitable candidates. However, in risk situations, the need for assistance may be so widespread and urgent that it was not possible to exercise the same selectiveness with local health-care personnel. After all, not all ambulance drivers, volunteers, nurses or doctors are psychologically prepared for what they may have to face in the event of armed conflict or national emergencies. Even so, they are expected to respond to the best of their ability.

In addition to the procedures mentioned above, the following may be useful for ensuring that responders are adequately prepared psychologically:
- individual and collective coping mechanisms developed with relatives, friends, colleagues, etc. (including family, peer and community support)
- adequate training (at the beginning and throughout) that simulates, as closely as possible, the realities of the field, especially during exposure to violence in risk situations, including in armed conflicts and other emergencies (to be realistic, practical, pragmatic)
- an effective security management system (i.e. the elements of the Safer Access Framework) that responders are aware of and understand and comply with easily
- sufficient information on the situation, the needs, the roles/tasks and responsibilities, the other players, the security rules, etc.
- minimum level of comfort (food and drink, shelter, boots, equipment, etc.)
- supervision and some support (recognition, rewards, etc.)
- an emergency plan for rescuing injured or sick responders
- insurance coverage or a guarantee that support will be given to responders in case of injury or sickness, and to their families in case of death.

For more detailed information, please see the Inter-Agency Standing Committee's *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*.[41]

41 Inter-Agency Standing Committee, *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva, 2007. Available at: http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

COPENHAGEN CENTRE

Overview

Health-care personnel who work in risk situations are vulnerable to trauma and stress. The Health Care in Danger project emphasizes that psychosocial support must be provided to the workforce prior to and after a mission. This chapter focuses on issues pertaining to psychosocial support issues in the context of health- care delivery in risk situations.

Core principles

The Psychosocial Support (PSS) Centre of the International Federation of Red Cross and Red Crescent Societies has been providing technical support to National Societies to develop and implement psycho-social support programmes in different contexts including support for workers and volunteers. Psychosocial support programmes aim to promote the process of resilience by strengthening inner and external resources. 'Resilience' is the ability of an individual or community to bounce back from an adverse event. Every individual has some level of resilience and psychosocial support strives to identify and enhance that resilience. In emergency settings, the goal of psychosocial support is to assist the survivor to:

- Regain a sense of normality
- Restore hope and dignity
- Improve psychological and social well-being
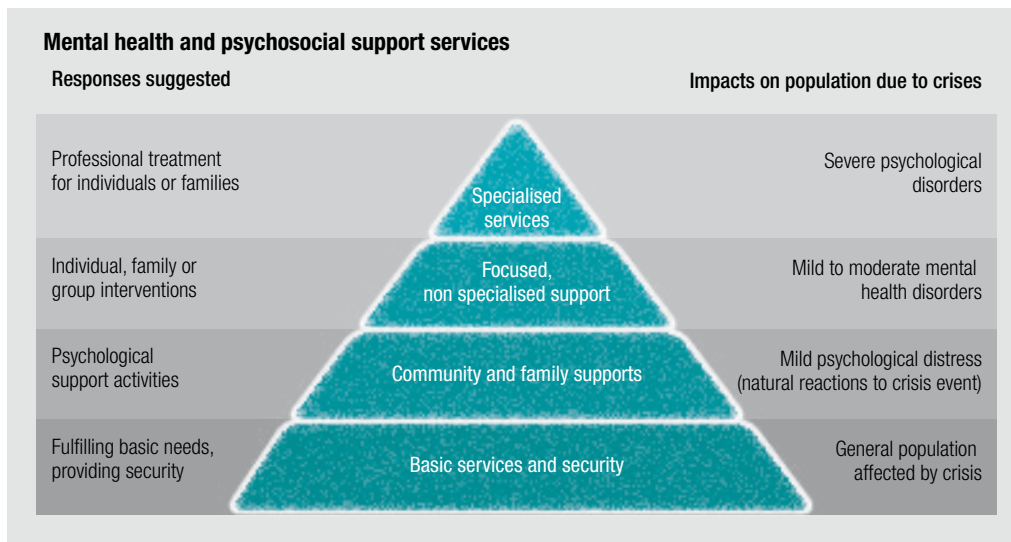- Attain a stable life and integrated functioning.

These programmes are based on lessons learned and best practices from several disaster responses, Sphere Project, and are grounded on the Inter-Agency Standing Committee's *Guidelines on Mental Health and Psychosocial Support in Emergencies* and based on the following principles:

- Assess the situation and the psychosocial needs
- Cooperation/Collaboration
- Relevant information about disaster, services, tracing
- Human rights and equity
- Community-based intervention/Local ownership
- Do no harm
- Ensure protection, special focus on infants and small children
- Building on available resources and capacities
- Integrated support systems
- Multi-layered support (the pyramid)
- Care for staff and volunteers

The PSS Centre recommends multi-sectorial and multi-layered interventions to deal with traumatic and stressful reactions. Most workers will be able to recover from an adverse event with basic support such as psychological first aid. Family, peer and community support combined with self-care would be sufficient to facilitate healing. However, some cases may need more focused and specialized support that may require connecting the worker with mental-health professionals and social workers. The figure on the opposite page illustrates the levels of interventions recommended based on the needs of the individuals and teams.

Not all people react to the same event in the same manner. Some people may react quicker and others may take time to manifest their reactions. Therefore, regular assessment of personnel and their needs is recommended so that timely support can be provided to them. In addition, different people have different coping mechanisms based on their cultural background, belief system, age or gender and hence the interventions need to be flexible and contextual in order to be effective.

The ICRC, the International Federation and some National Societies have developed psychosocial support and mental-health programmes for their staff and volunteers. For example, during the workshop in Mexico, a representative from the Saudi Red Crescent Authority shared that they have developed an assessment system for their workforce. Similarly, the Colombian Red Cross Society has a structured debriefing programme for their health-care staff. These programmes can be documented and adapted in other contexts as well instead of reinventing the wheel every time a new programme is developed.

Mental health and psychosocial support services

Responses suggested   Impacts on population due to crises

Professional treatment for individuals or families	Specialised services	Severe psychological disorders
Individual, family or group interventions	Focused, non specialised support	Mild to moderate mental health disorders
Psychological support activities	Community and family supports	Mild psychological distress (natural reactions to crisis event)
Fulfilling basic needs, providing security	Basic services and security	General population affected by crisis

Source: This illustration is based on the intervention pyramid for mental health and psychosocial support in emergencies in the IASC Guidelines (2207).

Problem: As mentioned, health-care personnel working in risk situations often experience stressful and sometimes traumatic events. These experiences may lead to long-term psychological consequences. In addition, they may cause a decrease in alertness and performance, poor judgement and personal consequences in terms of health and family.

Burnout is another common effect for those who work in stressful situations for a long time without practising self-care. It is an emotional state due to long-term stress, characterized by chronic emotional exhaustion, depleted energy, impaired enthusiasm and motivation to work, reduced work efficiency, diminished sense of personal accomplishment, pessimism and cynicism.

Recommendations: Since traumatic experiences and stress is a reality in health-care work in risk situations, it is recommended to develop a system for psychosocial support for personnel. This system should be a combination of basic and professional support. Each National Society must develop local networks that can provide professional mental-health-care support to their workers, if needed. Secondly, staff must be trained in basic skills such as psychological first aid and self-care. Finally, here are some simple tips for leadership, teams and individuals that can help in dealing with stress reactions:

- *Leadership:* Support starts from commitment from the leadership. It is recommended that there are (a) protocols for screening and orientation before the mission (b) support during and after the mission and (c) training/guidelines for peer support and self-care during the life of the project. However, it is important to note that severe traumatic experiences would require profession mental-health interventions. Here are some tips for supervisors and managers:
- Provide guidance and support to team members
- Conduct pre- and post-mission evaluation/screening of the workforce
- Respect confidentiality so that people can feel safe admitting stress and seeking help
- Emphasize self-care
- Ensure breaks between difficult missions
- Create a peer-support system for sharing experiences
- Provide training to the workforce on psychological first aid and self-care
- Implement safe space for sharing feelings and follow up
- *Teams:* There are many benefits in building a peer-support system. For example, support is provided by someone who knows the situation and assistance can be provided in a short period of time. Prompt peer support may prevent other problems from arising. Peer support helps people to develop their personal coping skills. Teaming of peers helps in forming supportive groups that pool their knowledge, perspectives, and experiences for the benefit of each other. A group of peers can provide:
- An informal support group of people who socialize both during and after work
- A formal framework to discuss work and problem-solve together

- Space to talk to someone with whom you feel at ease, describe your thoughts and feelings
- Opportunity to listen to others and share insights with them. What do they say and think about the event?
- Opportunity to encourage and support your co-workers and be available in a non-intrusive way
- Assistance in establishing self-control – treat the person as a colleague or friend, not as a victim.
- Confidentiality – this is the cornerstone in all support
- Follow up in a non-intrusive way and identify red flags in colleagues and refer. For example, if a person expresses desire to harm himself/herself or someone else.
- *Individuals:* Workers have a big role in dealing with their own stress. Often people do not pay attention to their psychological reactions to stressful situations because of lack of time or knowledge. It is recommended that individuals are trained on simple basic care. Here are some tips for individuals:
- Take special care of yourself, eat well, limit alcohol and tobacco and stay fit
- Do not try to hide feelings
- Defuse briefly whenever you experience troubling incidents and after each work shift
- Do not self-medicate
- Continue to work on routine tasks
- Look for a healthy outlet
- Go easy on yourself
- Seek professional advice
- Openly talk and share your problems without fearing the consequences
- Take a break when you feel your tolerance diminishing
- Stay in touch with family and friends
- Avoid perfectionist expectations; they often lead to disappointment and conflict.

Summary

Health-care providers who work in risk situations are vulnerable to trauma and stress and require appropriate psychological and social support. The International Federation's PSS centre has been providing technical support to National Societies to develop and implement psychosocial support programmes in different contexts including support for workers and volunteers. These programmes aim to facilitate the process of resilience by strengthening inner and external resources. The support system for the workforce must be a combination of basic and professional support. This chapter provides some recommendations for psychosocial support interventions for paid and volunteer staff involved in the Health Care in Danger project.

Psychosocial support: The pilot project in Ciudad Juárez, Mexico →

CONTEXT AND HISTORY

There was a sharp rise in violence in the Mexican state of Chihuahua from 2006 to 2012. This had significantly damaging consequences for the population at every level. During this period, Ciudad Juárez – the city with the largest population in Chihuahua: 1,495,145 in 2012 – became the most violent place in the world: 3,116 homicides were recorded in 2012 alone. The humanitarian consequences were starkly evident: about 210,000 people were displaced; economic productivity fell by about 40% in urban areas and by as much as 80% in rural areas; there was an exodus of medical personnel, mainly from rural areas; and, finally, the mental health of a large number of people was undermined.

Teams from the Ciudad Juárez branch of the Mexican Red Cross were directly affected by this situation. In 2010, its emergency medical technicians (EMT) provided pre-hospital services for 18,582 cases (a daily average of 50) and of these, approximately 30 per day were considered to be "high risk" for the emergency teams or the patients.

Concerned about the physical and mental well-being of its personnel, the Ciudad Juárez branch asked for technical support from the mental health and psychosocial support programme of the ICRC's regional delegation in Mexico.

THEORY AND METHODOLOGY

In the past, the Ciudad Juárez branch had offered members of its emergency teams individual psychological counselling for coping with the consequences of the violence they experienced while on duty. The response to this was unfavourable and very few went to the sessions. Most of them felt that they did not need counselling because they did not think they were "crazy."

The Ciudad Juárez branch has also implemented the Safer Access Framework. To change the behaviour of personnel in high-risk situations, it was necessary to re-emphasize those elements of the Framework that addressed the acceptance of risk and the consequences of violence. This aim was realized, at individual and team levels.

The EMTs' response to the offer of counselling must be taken seriously. Explanations like "resistance to therapy" or "gender issues" (most of the EMTs are male) are superficial and should be avoided. Instead one should ask whether an offer of curative therapy is suitable for situations in which responses should be preventive in character. Patients sometimes oppose overmedication prescribed by physicians. The approach could be the same for rescuers and psychologists.

From this standpoint, we can say that the EMTs were quite right not to consider themselves mad or unbalanced. They had anxieties and conflicts, and were struggling with feelings of heightened aggression, desperation, and so on. These are normal reactions to the experience of facing violent situations every day. What they needed was not individual counselling, which would pathologize and stigmatize them, but something that showed them how to understand and deal with the impact of violence at the individual and the team level.

Therefore, the ICRC's mental health and psychosocial support programme chose to empower EMTs through training and instruction and to transform them into first responders – "helpers." This is preferred over referring them to specialists.

The ICRC's psychosocial team decided to provide responders with better information and stress-management tools related to psychological first aid, psychosocial support and emotional support for individuals and groups facing critical situations. The ICRC team also took into account the fact that the majority of rescuers/EMTs were volunteers and that their primary motive was to help others. The concept of self-help or self-reliance – taking care of oneself first in order to be able to help someone else – is not considered a primary motivation for many volunteers (and not for many psychologists either). Therefore, it was proposed that rescuers/EMTs should be guided by their own basic values and should follow a training programme that allowed them to learn to better assist people affected by violence. The hoped-for result was that helping others would become the main achievement or goal: a wider recognition and acceptance of their own reactions and changes that they experience as a consequence of violence, and at the same time, it would enable them to know how to manage them.   →

Psychosocial support: The pilot project in Ciudad Juárez, Mexico (cont.)

A mixed group was selected, of whom nearly half were psychologists; the rest had other professional backgrounds.

The training took six months and was divided into three phases. Phase A consisted of a three-day seminar, 15% of which was devoted to post-traumatic stress theory and the rest to practical exercises on stress management, assistance during and after critical incidents, psychological first-aid and defusing and emotional-cognitive decoding (in accordance with the trauma model of the Institute Psychotrauma Switzerland). Phase B consisted of monitored practice; responders were supervised at work and provided with constant feedback. In Phase C a three-day seminar took place, during which participants reflected on the work experience of the past few months and reviewed what they had learnt; in addition, group response techniques were expanded.

RESULTS

During the first year of implementation, feedback from responders suggested that the following were some of the results of the pilot project:

- Roughly 80% of the critical incidents dealt with by teams could have been handled by the responders themseves, by putting into practice an immediate defusing response (5-20 minutes).
- Significant improvement could be detected in the relationships between team members (decrease in levels of conflict, higher emotional stability, greater satisfaction while on duty).
- The quality of the services provided improved: for instance, users were shown more warmth and patience.
- Greater responsibility was noticed in the operation and maintenance of equipment (for example, better care was taken care of ambulances by their operators).
- Broader acceptance of psychosocial and psychological methods (counselling). Personnel said that they had lost their fear of psychologists and felt less distant from them. They now felt that they spoke the same language as the psychologists.

RECOMMENDATIONS

- The positive results of the first year notwithstanding, it is necessary to establish a continuous process of evaluation and research that will make it possible to track the impact of the pilot project.
- Volunteers and staff of the Mexican Red Cross, as well as others – for instance, people who have sought their help as a result of the violence – must be guaranteed constant training in mental health and psychosocial support.
- Organizational, or home-grown, capacities should be developed by means of the module on training of trainers (ToT).
- Given the acceptance of psychosocial support by pre-hospital service teams, mental-health professionals should respond positively, with an approach to mental health and psychosocial support that seeks to empower both volunteers and staff.

6. CONCLUDING REMARKS

As mentioned at the beginning of this publication, while some of the challenges and recommendations that emerged during the workshop were widely acknowledged by participants, the solutions to problems must be contextualized. They must be discussed and adapted to prevailing realities by the various stakeholders involved in the provision of ambulance and pre-hospital services in risk situations.

The examples given throughout the text illustrate how some challenges are being dealt with already at the national or the regional level. Here too, one should not underestimate the importance of contextualization. For instance, while high-tech solutions for coordination amongst stakeholders may be effective in dealing with the challenge of sustaining the provision of services in risk situations in one context, field-level agreements and face-to-face dialogue may be the ideal solution in another. One should always keep in mind that the ultimate objective is to transport or evacuate casualties to medical and/or surgical facilities as quickly and efficiently as possible. Methods for realizing this objective may vary greatly from one place to another.

The workshop in Mexico also showed that some principles ought to be applied in any situation:
- Domestic normative frameworks must be adapted to deal with the challenges identified
- Effective mechanisms for coordination, amongst those delivering ambulance and pre-hospital services in risk situations, are indispensable
- Health-care personnel – staff and volunteers – must be given relevant and context-adapted training
- Possibilities for learning about best practices from each other must be explored, and the lessons learnt put into effect.

ICRC