LAUREA
UNIVERSITY OF APPLIED SCIENCES
Prime Mover

Attacks on humanitarians

-Identifying causes of increased violation

Hirvonen, Minna

2013 Otaniemi

Laurea University of Applied Sciences
Otaniemi

Attacks on humanitarians
–Identifying causes of increased violation

Minna Hirvonen
Degree Programme in Nursing
Bachelor's Thesis
January, 2013

Laurea University of Applied Sciences **Abstract**
Otaniemi
Degree Programme in Nursing

Hirvonen Minna

Attacks on humanitarians – Identifying causes of increased violation

Year 2013 Pages 52

The purpose of this thesis is to describe what might have caused the increased attacks on health care professionals and medical facilities under humanitarian status in conflict zones. The thesis aims to promote conversation and answer the following research question: What are the possible causes of increased attacks on humanitarians in conflict zones?

The research method was an integrative literature review. Three different databases were used for data search: the International Committee of Red Cross (ICRC), Médecins San Frontières (MSF), and Google Scholar. The style of the research is descriptive; it aims to identify causality of effects. Appendices 2 – 4 are included to provide additional information for readers who are not familiar with International Humanitarian Law, and how the law should be applied in conflict situations.

Through a categorised data analysis, three main causes of increased attacks were identified. Political intervention compromises the access to populations, independence, and neutrality of humanitarian organisations. Moreover, direct targeting, criminality, and involvement of armed forces causes insecurity for the whole humanitarian community. Use of native workers in extreme cases has been seen as ineffective in the most violent areas, since these workers face security threats as international workers. Blurring distinctions of what is humanitarian aid together with the Western background has caused problems for humanitarians in new types of warfare. Respect towards medical freedom and ethics seems to have lost its meaning.

Violence against humanitarians has severely increased. Long term conflicts are increasing the needs of people in distress. Medical humanitarians are needed in these conflict zones to provide safe and continuous health care. It is a question of the whole health care community to promote the safety of global health care and those providing it. There is a clear need for evidence-based research.

Key words: Humanitarian aid, security, conflict zones

Laurea-ammattikorkeakoulu **Tiivistelmä**
Otaniemi
Degree Programme in Nursing

Hirvonen Minna

Humanitaariset työntekijät lisääntyneiden hyökkäyksien kohteena – Syiden ja aiheuttajien tunnistaminen

Vuosi 2013 Sivumäärä 52

Opinnäytetyön tarkoituksena on kuvailla, mitkä syyt ovat mahdollisesti aiheuttaneet lisääntyneet hyökkäykset terveydenhuollon henkilöstöä ja omaisuutta kohtaan humanitaarisen avun alaisuudessa konfliktialueilla. Opinnäytetyön tavoitteena on keskustelun herättäminen ja vastaaminen tutkimuskysymykseen: Mistä mahdollisesti johtuvat lisääntyneet hyökkäykset humanitaarisia työntekijöitä kohtaan konfliktialueilla?

Tutkimusmenetelmänä on käytetty integroivaa kirjallisuuskatsausta. Tiedonhaussa käytettiin kolmea erilaista tietokantaa. Nämä olivat Punaisen Ristin kansainvälinen komitea (ICRC), Lääkärit ilman Rajoja (MSF) ja Google Scholar. Tutkimuksen lähestymistapa on kuvaileva, sillä tässä opinnäytetyössä pyritään tunnistamaan syy-seuraussuhteita. Liitteet 2 – 4 on lisätty antamaan lisätietoa lukijoille, joille Kansainvälinen humanitaarinen oikeus ja sen soveltaminen konfliktitilanteissa ei ole ennestään tuttua.

Kolme keskeistä aiheuttajaa lisääntyneille hyökkäyksille tunnistettiin ryhmitellyn aineiston analyysin avulla. Poliittinen väliintulo hankaloittaa organisaatioden pääsyä kansan keskuuteen ja kyseenalaistaa humanitaaristen järjestöjen toiminnan itsenäisyyden ja neutraliteetin. Lisäksi suorat hyökkäykset, kriminaalisuus ja aseellinen voimankäyttö aiheuttaa turvattomuutta koko humanitaariselle yhteisölle. Organisaation paikallisten työntekijöiden hyödyntäminen kansainvälisten sijasta vaativimissa tilanteissa on osoittautunut tehottomaksi kaikista vaarallisimilla alueilla. Länsimaalaisuus sekä humanitaarisen avun väärinymmärtäminen on aiheuttanut ongelmia, samalla kuin sodan luonne vaikuttaa muuttuneen. Kunnioitus terveydenhuollon puolueettomuutta ja etiikka kohtaan näyttänee unohtuvan.

Väkivaltaisuus humanitaarisia työntekijöitä kohtaan on lisääntynyt huomattavasti. Pitkäaikaiset konfliktit kasvattavat hädässä olevien ihmisten avun tarvetta. Terveydenhuoltoa jakavia humanitaarisia työntekijöitä tarvitaan näillä alueilla takaamaan potilasturvaa ja hoidon jatkuvuutta. Koko terveydenhuollon yhteisöllä on vastuu edistää globaalin terveydenhuollon turvallisuutta. On selvää, että näyttöön perustuvalle tutkimukselle on tarvetta.

Asiasanat: Humanitaarinen apu, turvallisuus, konfliktialueet

Table of Contents

1 Introduction

Violence against humanitarians has dramatically increased. The safety of 260 humanitarian workers was violated during the year 2008, whilst they were performing their duties in conflict areas. This year has been the most violent ever recorded, showing a three times higher increases in statistics (Stoddard, Harmer & DiDomenico 2009, 1). A humanitarian worker/humanitarian discussed in this thesis is a health care professional delivering medical assistance in response to a violent conflict in areas affected by emergencies. An emergency is a life-threatening situation in which daily mortality rate is higher than one death per 10,000 people (Grearson, Schultz, Jacob & Ozcivi 2010, 5).

The curious question is what has happened? Ever since humanitarian organisations have existed, humanitarians have been working in extremely dangerous settings and exposed to the effects of military attacks. Now the organisations are being targeted by opposition groups or the local military itself. The Geneva Conventions and their Additional Protocols (partly in appendices 2 - 4) have been implemented to secure civilian population and health care in war (ICRC 2011c). Moreover, Human Rights are continuously applied. The delivery of health care is hindered as the local health care personnel and facilities are used as part of warfare. Thus, cooperation with humanitarian organisations and their international health care personnel is compromised.

Even though fewer incidences were recorded during 2010, violence, in terms of kidnapping, death, and serious injuries against humanitarians has still been the major issue in the discussion of humanitarian workers' security in conflict zones (Stoddard, Harmer & Haver 2011). Especially in the three most violent settings, security issues have brought humanitarian organisations into a difficult situation. In Afghanistan, Somalia, and Sudan, which account for 60 % of the attacks, the changing nature of warfare, Western politics, and influence of local governments have been challenging humanitarian operations. Of course, the humanitarian movement has also been steadily increasing as organisations receive more funds and volunteers. However, this alone is not a reason for the higher number of victims (Stoddard et al 2009).

As global conflicts continue and increase the needs of people in distress, humanitarian organisations have been balancing between different authorities, time, and security concerns to make their mission possible. Humanitarian organisations are, by International law, bound to assist in the delivery of health care, when a state in question is not able to conduct responsibility alone (ICRC 2011b, 23). Operations have been suspended and cancelled due to security concerns, which has left many people without access to health care.

During 2011 the non-governmental organisation Médecins Sans Frontières (MSF) performed 8,300,000 out-patient consultations (MSF 2012a, 9). According to MSF's Activity Report 2011, 39,7% of their work was performed in areas affected by violent conflicts (MSF 2012a, 8). This means that approximately 3,259,100 patients received care in these areas. What if there would be no space for such an intervention?

By definite, health care is being attacked (Elder 2012). Humanitarian relief is an evident part of nursing and health care in general. In the London Symposium 2012, an organised meeting for health experts and humanitarian professionals, the responsibility of health care community to raise awareness of global health insecurity was emphasised. In this meeting, health care institutions were encouraged to produce valid research and prompt communication about the current security concerns of doctors and nurses on a global basis (ICRC, British Red Cross, British Medical Association & World Medical Association 2012). Thus, the purpose of this thesis is to describe what might have caused the increased attacks on health care professionals and medical facilities under humanitarian status in conflict zones. The thesis aims to promote conversation and answer the following research question: What are the possible causes of increased attacks on humanitarians in conflict zones?

2 Literature review

The topic of the thesis is the compromised security of medical humanitarian aid in conflict zones. The style of research is descriptive; it aims at identifying causality of effects (Hirsjärvi, Remes & Sajavaara 2006, 128). As the International Committee of Red Cross (ICRC) launched a campaign promoting security of health care a few years ago, it was discovered that there is a lack of evidence-based knowledge and theories surrounding the topic (ICRC 2011c). Moreover, the violation rates started to increase from 2006 onwards implicating a new trend. Thus, the method chosen for this thesis is an integrative literature review, since it aims to retrieve and analyse the problems of existing material, suggest further areas of research, and focus on recently emerged topics (Salminen 2011, 3; Torraco 2005). This method has also been chosen because of the further aims of a literature review: to create new knowledge through previous studies, evoke conversation, and build a holistic picture of the problem in question (Salminen 2011, 3).

The integrative review is more flexible, but less analogical than systematic, since it allows the use of diverse data sources (Salminen 2011). As the problem for finding material had been acknowledged prior the research process, there needed to be a possibility to combine information from various articles, publications, conferences, and researches to produce sufficient findings. Nevertheless, the integrative method is critical, trustworthy, and the process steps of review do not differ greatly from the systematic method (Salminen 2011).

2.1 Research purpose, aim, and question

The purpose of this thesis is to describe, what might have caused the increased attacks on health care professionals and medical facilities under humanitarian status in conflict zones. The thesis aims to promote conversation and answer the following research question: What are the possible causes of increased attacks on humanitarians in conflict zones?

2.2 Data

One of the databases chosen for the review is the publications of ICRC. The organisation founded in 1863, is "an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance" (ICRC 2011c, 23).

The second database selected was the publications of Médecins Sans Frontières (MSF), also known as Doctors without Borders. MSF is a private international association applying universal medical ethics to its missions. The members consist mostly of doctors and nurses. Similar to ICRC, MSF is a neutral and impartial organisation helping victims of armed conflicts (MSF 2012a, 2). Since MSF guarantees its neutrality from political, economic and religious influences, the association was included in this thesis to represent the policy and view of medical humanitarian workers.

To have different perspective, and prevent excluding any other useful material, Google Scholar has also been used. This database was chosen instead of "Nelli", a commonly used database for Bachelor's thesis writing in Laurea University of Applied Sciences. "Nelli" had to be excluded due to several unsuccessful searches that resulted in irrelevant, out-dated, and inaccessible material.

2.3 Use of key words and data search

The key words used in this thesis have been chosen according to the topic of the thesis. Humanitarian aid in this thesis means medical care delivered by international or national humanitarian organisations, whose workers consist of health care professionals and assistants. Security means the possibility of these organisations to fulfil their mission without being harassed, violated, or threatened. It includes the safety of both national and international workers following appropriate measures without compromising the humanitarian principles of neutrality, independence and impartiality. Conflict zones are considered as areas affected by any kind of armed conflict exposing civilians to its effects. These conflicts can be either

international or national. The former meaning conflicts between the states and the latter within a state (ICRC 2011b, 7).

Data was searched for using the three decided key words: humanitarian aid, security and conflict zones. For combining key words, appropriate prepositions and conjunctions were implemented. These were “and”, “of”, and “in”. The most successful combination was “security of humanitarian aid in conflict zones”. This combination brought useful sources from Google Scholar, whereas “security of humanitarian aid” was more effective in organisational publications.

The data search had to be done three times, since three different databases were used for data collection. Under the following subheadings, each process of data search is explained. Using the key words alone, “security”, “humanitarian aid” and “conflict zones”, was implemented in unofficial trial prior research process. Since the search was not successful, and this was excluded from the actual research process, data selection and screening is not explained in this thesis. On the same occasion the previously mentioned “Nelli” data base was searched. No data has been taken from the trial search.

2.3.1 ICRC

Data was searched for using the combination of the key words. As mentioned, “security of humanitarian aid” was highly successful. With this combination 2,587 articles were found. After specifying the search with “health care” and “conflict zones” by using the option provided in the database, the number of articles reduced to 1,587. Articles were set to be sorted automatically by relevance and displaying hundred in one page. This gave sixteen pages of results.

2.3.2 MSF

The data search was completed with the same key word combination as with ICRC. 270 pages of articles were found with the combination “security of humanitarian aid”. Since the MSF database used number of pages, instead of number of articles for calculating the amount of data, it was not possible to count the exact number of articles that came out in the search. Again, the articles were set to be sorted automatically by relevance.

2.3.3 Google Scholar

Total number of pages was an enormous 33,000, when “security of humanitarian aid in conflict zones” was used. The time frame was set to 2006 - 2012 and articles were automatically set to be sorted by relevance to the key words. This reduced the number of pages only to 25,800. As it was the case with MSF, also the total number of articles was not possible to count since the data was listed in pages.

2.4 Data selection and screening

Research purpose and research question have been influencing the exclusion and inclusion criteria. As the focus in this thesis is on humanitarian organisations that deliver medical care, data was selected according to its relevance in the field of health care. The relevance to health care has been estimated on the titles of articles and on the content of abstracts, if the abstract was available. Besides relevance, the date of publication, accessibility, and the authority of the author and/or publisher have been part of the selection criteria (Hirsjärvi et al 2006). The year 2006 has been set as the time limit; No articles older than this have been used in the review. This year was decided based on the statistics showing increase in violations from 2006 onwards (Stoddard et al 2009).

The table of this page shows the selection criteria and the data selection. The screening process is described in table 2. The steps 1 – 4 in table 2 are given to help understanding. The articles selected for the actual review are listed in table 3. The reason for only these being listed in the table is that the remaining articles can be found in the list of reference and from appendix 1. The articles of data analysis are categorised in appendix 4.

INCLUSION	EXCLUSION
RELEVANCE TO HEALTH CARE	CANNOT BE USED IN HEALTH CARE CONTEXT
DATE OF PUBLICATION 2006-2012	DATE OF PUBLICATION OLDER THAN 2006
ACCESSIBLE TO PUBLIC	NO ACCESS AT ALL, ACCESS ONLY WITH MEMBERSHIP, or PAYMENT
TRUSTWORTHY and TRACEABLE PUBLISHER and/or AUTHOR **One or more of the following: medical journal, humanitarian organisation, university, United Nations and its offices of Humanitarian Affairs**	SUSPICIOUS and UNTRACEABLE PUBLISHER and/or AUTHOR None of the following: medical journal, humanitarian organisation, university, United Nations and its offices of Humanitarian Affairs
ONLY FOR MSF and GOOGLE SCHOLAR: **Came before five following pages of irrelevant material**	ONLY FOR MSF and GOOGLE SCHOLAR: Would have come after five following pages of irrelevant material

Table 1: Selection criteria

2.4.1 ICRC

All of the sixteen pages of data were searched thoroughly. Based on the title, ten articles, and four videoed interviews were selected for further study. Each piece of data was read in the beginning to estimate the relevance of the actual contents. Five articles were finally selected for comprehensive study; two of which ended up into the review. The remaining four had a little relevant material. However, these were useful for other purposes, thus the articles remained as general references.

2.4.2 MSF

Since the number of pages retrieved was 270, it was decided that after five pages of irrelevant material the data search would be stopped. From all articles, releases, and publications sixteen articles passing the inclusion criteria were selected for the first round. Six of these remained for further study, and finally four were included in the review. Each piece of data that had been found provided some information. However, only the most relevant and useful pieces were finally selected. Again, the remaining two articles have been used as general references.

2.4.3 Google Scholar

Besides relevance, the authority of the publisher and author excluded most of the articles in this database. The data had to be published in medical journals, webpages of humanitarian organisations, by a university, or United Nations (UN). Also, the official webpages of the organisation in question had to be searched, found and checked to prove authority. The material from ICRC and MSF are already proven by the organisations themselves, and published under the name of organisation in question. Thus, data from these databases was automatically assumed to have valid authority. This was not the case was with Google Scholar.

After the search and first round of selection, twenty one articles were chosen for further reading. Eight of these passed the criteria for comprehensive reading, and six of these were chosen for the review. Also, as the case had been with the other remaining articles, the remaining two have been used as general references.

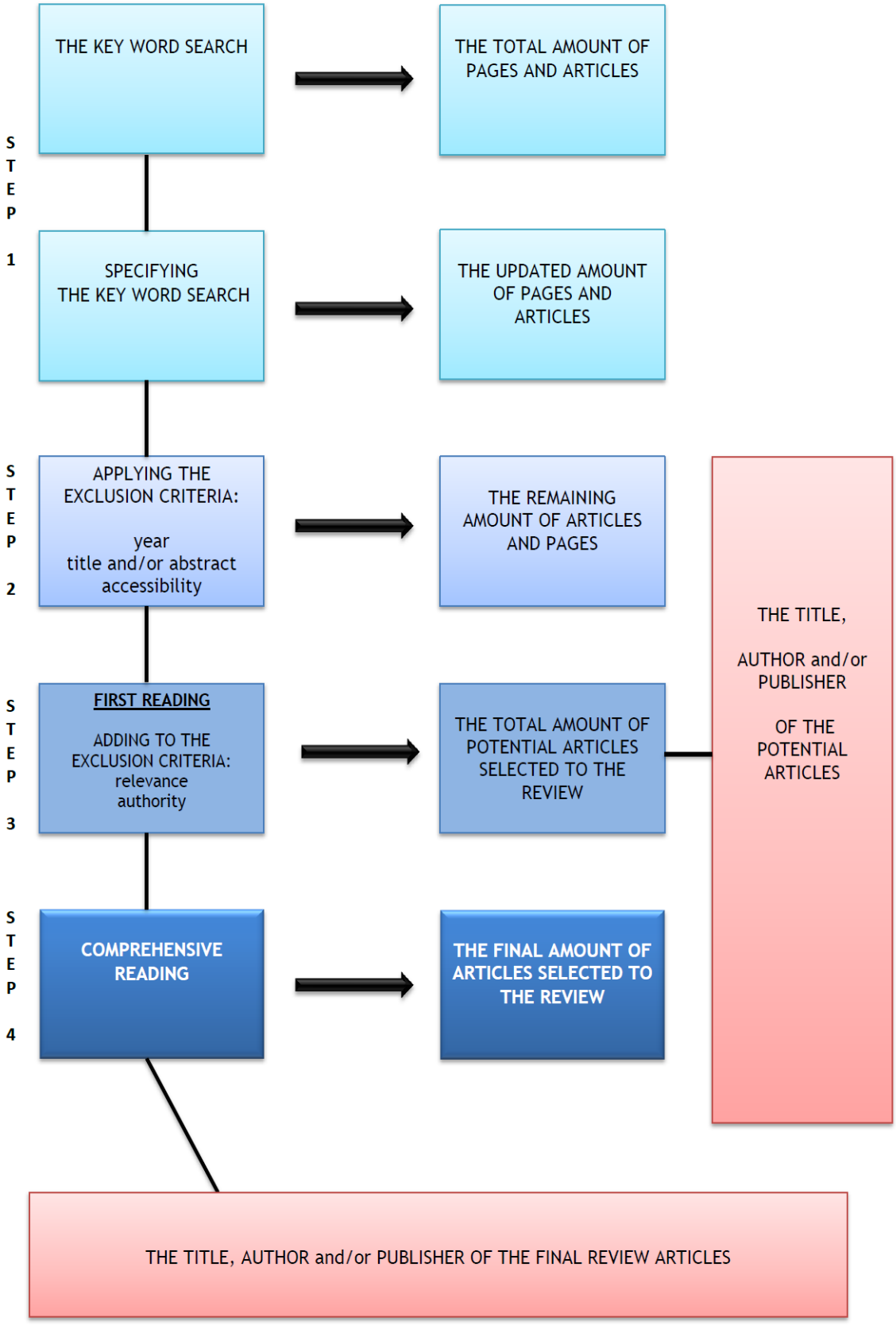


Table 2: Data selection and screening processes

ICRC

TITLE	PUBLISHED
✓ International Humanitarian law and the challenges of Contemporary armed conflicts. 31st International Conference of the Red Cross and Red Crescent	2011
✓ Health Care in Danger. Making the case	2011

MSF

✓ Darfur: Humanitarian Aid Held Hostage	2006
✓ Health Services Paralyzed: Bahrain's Military Crackdown on Patients. An MSF Public Briefing Paper	2011
✓ Activity Report 2011	2012
✓ Syria: Safety of Wounded and Medical Workers Must Be Prioritized	2012

GOOGLE SCHOLAR

	PUBLISHER	
✓ Providing aid in insecure environments: 2009 Update	Humanitarian Policy Group	2009
✓ A Grave New World	Merlin	2010
✓ Responsibility for protection of medical workers and facilities in armed conflicts	Health Policy	2010
✓ To stay and deliver: Good practice for humanitarians in complex security environments	OCHA/UN	2011
✓ Aid Worker Security Report 2011. Spotlight on security for national aid workers: Issues and perspectives	Humanitarian Outcomes	2011
✓ Keeping health workers and facilities safe in war	The Bulletin/WHO	2012

Table 3: Articles on literature review

2.5 Data analysis

The review articles, given in table 3, were read comprehensively. The articles were first read by focusing on the main points of each article. The most important points of the text were underlined and the key points were written down. The point of this content analysis was to identify similarities, categorise findings, and draw a conclusion to the causality of effects (Hirsjärvi et al 2006). Whilst reading, the research question was aimed at being answered.

After all the articles were read and important points underlined, the evident causes to increased attacks started to become clear. From the underlined test, findings with similarities were all highlighted with same colour. Finally, findings were categorised under the main topics from the colour-highlighted text. This is how the main causes (political intervention, use of natives in extreme cases, and changing nature of warfare) were identified. Table 4 gives an example of this categorisation.

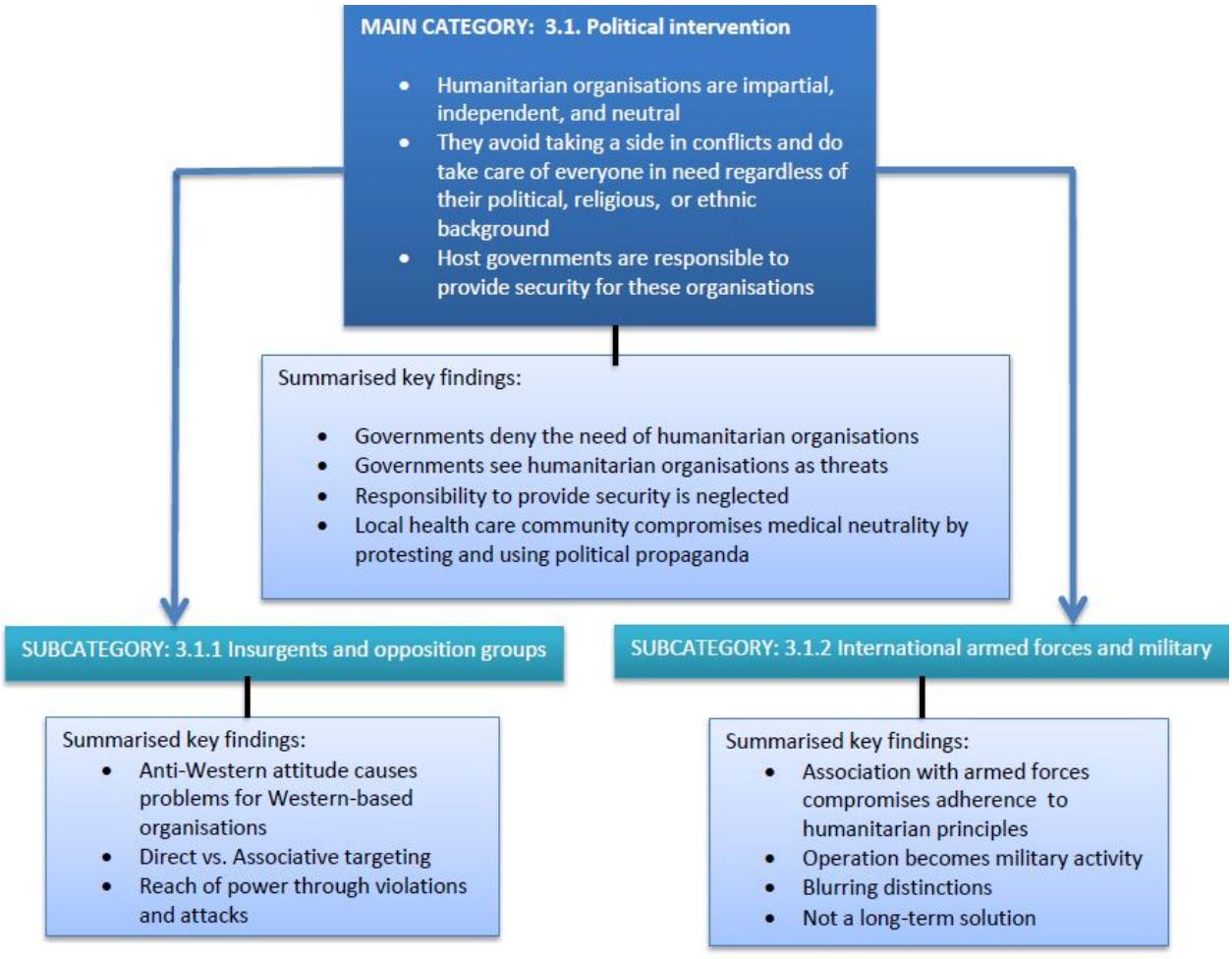


Table 4: Example of data analysis

3 Findings

3.1 Political intervention

Attacks in the highest incident areas have been politically motivated and planned against the humanitarian community rather than a specific organisation (Stoddard et al 2009). In some cases, it is a question of how authorities see the humanitarian mission. There have been occasions in which local governments have denied the need for international organisations and justified this by appealing to Western propaganda, or even terrorism (ICRC 2011b). If the local government sees the organisations as a threat to the state authority, the violation might be allowed either actively or passively (Stoddard et al 2009, 6).

As the humanitarian organisations do not differentiate between the patients and people in need, they can be exposed to violation and be left between the fights of political parties (Serle & Fleck, 2012). For example, in areas held by the Sudanese government MSF had reported brutal violations, death threats and sexual attacks, against its workers by rebels and the military. This resulted in the suspension of the operation leaving 100,000 people without care (Weissman 2006, 1). MSF considers that the Sudanese government neglected its responsibility to provide security. Thus, allowing these violations to happen, and at the same time threatening international intervention in the state (Weissman 2006, 2).

It is possible that in some circumstances the local governments are associated with politically motivated attacks and the restraining of humanitarian assistance. During 2008 – 2009 MSF was forced to leave the northern part of Sudan, because the local authorities issued the organisation with suspension and deportation (MSF 2012a, 14). Moreover, humanitarian organisations have had limited access to populations and possibilities to negotiate with all parties in the conflict to ensure their security (Egeland, Harmer & Haver 2011, 4). For example in Syria in May 2012, MSF reported that the association had been seeking approval to work with the local medical community in the most conflict-affected areas. By the time of publication of the MSF report, access had not been granted. For this same instance, MSF had announced increased need for securing the safety of its workers (MSF 2012b). There is a definite possibility that the most dangerous and vulnerable situations for humanitarian organisations is when their presence is not wanted (Egeland et al 2011).

In Bahrain MSF had witnessed local health care professionals themselves compromising the neutrality of health care; the hospital grounds were used for protesting and political propaganda. Resulting from this act, the hospital was declared as military target affecting cooperation with humanitarian organisations (MSF 2011, 2). The necessary medical neutrality was no longer provided. MSF was not capable working in its full capacity in the area and was

now faced with increased security risk. Also, ICRC found in their Health Care in Danger project that sometimes the local health care personnel in conflict zones do work against the medical ethics and base their care on ethnicity, religious beliefs, and politics (2011c, 12). Thus, they are taking a side in the conflict and are possibly targets of attacks. It is likely that association with the affected health facilities can partly expose the humanitarians to attacks and violations.

3.1.1 Insurgents and opposition groups

Another crucial point in political intervention is the Western ideology. One area of research showed that even though the Islamic culture is more communal than Western culture, the humanitarian movement can be misunderstood as "a tool of Western political and cultural power" (Egeland et al 2011, 16). Thus, just the fact that an organisation is originally Western can expose the humanitarians to violent attacks. This presents a difficult threat for humanitarian community to overcome. Moreover, it is possible that humanitarian organisations are no longer seen as exclusively humanitarian, since they are being mixed with international agencies, military, and armed forces (Merlin 2010, 20; ICRC 2011b, 23). It was reported from Afghanistan a few years before 2009 that the Afghan community classified humanitarian organisations and judged the organisations, besides ICRC, by its origin. This possibly caused insecurity for the other Western humanitarian organisation working in the area (Stoddard et al 2009, 6).

The question of being Western is more concerning when humanitarian organisations are dealing with rebel insurgent and opposition groups in national armed conflicts. These groups do not necessarily respect, or are aware of, the International law (appendices 2 – 4) providing security of medical activities (Serle & Fleck 2012, 8). The actions of these groups can be either associative or direct. The former meaning that violation is caused because the organisation is working together or with assistance of the enemy of the group. The reason for the latter one is simply the organisation itself, its mission, or statement; the group aims directly at civilians (Stoddard et al 2009, 5).

It was found in a few review articles that these groups see humanitarian organisations as targets to receive economic or political gain, control, and publicity (Egeland et al 2011; Merlin 2010; Rubenstein & Bitte 2010; Stoddard et al 2009 & Stoddard et al 2011). Humanitarians are perceived as an easy and in some cases the only target for attacks (Stoddard et al 2009, 4). The vehicles of humanitarian organisation are packed with essential medicines, equipment, and health care professionals that might have great value on the black market (ICRC 2011c). As the on-going conflict isolates communities and dislocates patients, humanitarian organisations have to move further in order to deliver the care and help the people in need. As the humanitarians are working in remote areas where the rebel groups can

have more authority and possibilities to neglect the law, it is more likely for humanitarian organisations to be exposed to violation (ICRC 2011c).

3.1.2 International armed forces and military

In MSF Activity Report from 2011, the organisation expressed concern of the current image of humanitarian aid: "Since 1990 the revival of Western military interventionism, development of international criminal justice and integration of aid and politics in UN have all contributed to a blurring of distinctions between what is military and political and what is humanitarian" (2012a, 14). It has been estimated that part of the violations against humanitarians could be a result of organisations' association with military and political campaigns (Stoddard et al 2011, 2).

A very basic point considering association with military is to realise that as soon as the troops are involved the operation becomes part of military activity; the operation becomes a possible target for the opposition (Egeland et al 2011, 13). The problem with this is also that the opposition does not necessarily differentiate between the troops and civilians. According to the International law, civilians should be distinguished (appendix 4). Thus, the presence of and cooperating with armed forces either military or international armed forces, can cause exposure to attacks. The problem with the security of humanitarian organisations would become evident when the troops are leaving. If the forces have secured the humanitarian mission, how can the security be guaranteed in the future if it has been dependent on the additional armed forces? It seems that particularly for United Nations (UN) it has been challenging to establish a neutral image in anti-Western societies due to its political activity (Egeland et al 2011, 16).

Because adherence to humanitarian morals has come as second for some organisations in the most vulnerable areas, it has been challenging for the others to negotiate with different parties of conflict and gain acceptance. The security of humanitarian workers is thought be dependent particularly on acceptance and how the organisation is seen in the community (ICRC 2011b, 26). Presence of armed forces complicates the negotiations and judgements with the opposition (Weissman 2006). Without gaining such option, humanitarians cannot explain their mission, activities, and reason for being present in the zone. Thus, they might not be able to gain the needed trust from all parties in the conflict to be granted their neutral and secure space in the conflict (MSF 2012a).

3.2 Use of natives in extreme cases

In their research, Stoddard et al found that native workers receive less security training than international workers of an organisation. This was especially the case with local non-

governmental organisations working in conflict zones (2011). In addition, the natives felt more exposed to violent threats, since they live in the country without additional security precautions, travel constantly, and are present in the most extreme situations. In fact, most of the attacks have happened on the road, and even 90% of the field staff might consist of native workers (Stoddard et al 2009, 8 & 10).

In the same research survey, the native workers ranked their work as "somewhat" or "highly" dangerous (Stoddard et al 2011, 10). First aiders and medics are in the most dangerous positions, since they work on the frontline of conflicts (ICRC 2011c). Stoddard et al followed the number of field victims from 1997 to 2008 and found an upward trend in the native victim numbers (figure 1). Nevertheless, international workers are still considered to be most likely the victims and targets of the attacks aimed at humanitarian community

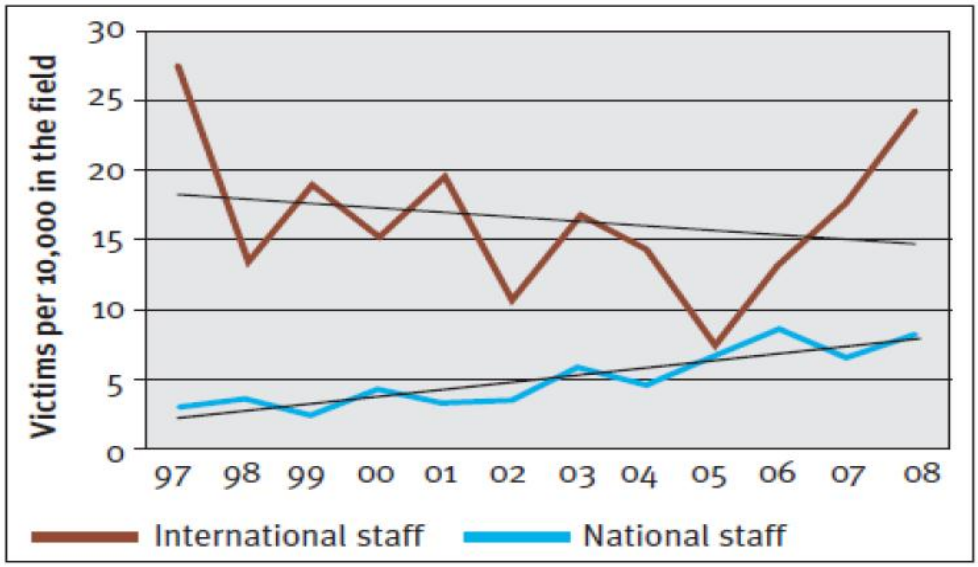


Figure 1: Comparing the amount of international and national victims (Stoddard et al 2009, 3)

One of the general safety principles applied in conflict areas is to withdraw the international workers and recruit more native workers. The international workers do remain, if possible, but they are not on the frontline; they might remain in the neighbour state, for instance (Stoddard et al 2011). This tactic has remained in the humanitarian community as "remote management" (Stoddard et al 2009, 9). Besides possibly increasing the risk of native victims, this approach can have negative long-term effects. In Somalia, where remote management had been used, the number of attacks towards humanitarian community had increased after the humanitarians returned (Stoddard et al 2009, 9). Moreover, the remote management has been considered to put more pressure on the native staff as they try to negotiate for security.

As mentioned, the case is quite difficult for Western-based organisations. Even if the field staff consisted of native workers, the Western background still remains (Stoddard et al 2011).

Ethnic and religious backgrounds can expose native workers to violation. This can be crucial in national armed conflicts, when two or more groups are fighting within one state aiming at specific political, ethnic, or religious groups. Merlin found in its campaign "Hands up for health workers" that the native health care personnel working for non-governmental organisations are being threatened and harassed (2010). Thus, in extreme cases they are forced to seek asylum (Merlin 2010). Also, as mentioned in the case of kidnappings, insurgent groups are considered to use humanitarians for means of propaganda, power, and money. Some native workers can possess economic value that is more evident in the local community than the statuses of international worker. Unfortunately, it has been found that the families of these workers are also threatened due to ransom demands (Egeland et al 2011, 39).

Even though it is quite likely that natives do face threats just as international workers, using natives in extreme situations has been supported in humanitarian community by relying on acceptance. It is considered that native workers would not dramatically stand out, thus being more widely accepted and secured by the local community itself (Egeland et al 2011). However, when humanitarian organisations rely too naively on acceptance approach, the workers are exposed to threats. It should not be assumed without valid evidence that the organisation and its workers are secure and accepted in the conflict zone.

The problem with the native workers is also the fact that they do not necessarily report the violations, since they want to secure their vacancies (Merlin 2010). Moreover, the security incidents causing death and severe injuries to native workers might go undocumented since there is no need to inform embassies and insurance companies, as the case would be with international workers (Stoddard et al 2009). This results in lack of evidence-based knowledge and compromises the security management. When there is little evidence, it is difficult to analyse trends and improve the general condition. Thus, lack of evidence-based research and improper security protocols can also expose humanitarians to attacks and violations (Stoddard et al 2011).

3.3 Changing nature of warfare

After the attacks of 9/11, there have been international conflicts in which the humanitarian community has not been as prepared for. Attacks in conflict zones have become more complex due to armed terrorist groups that have caused the humanitarian community to seek and demand special security attention. Moreover, conflicts are long-lasting, international, and more political without clear solutions to peace; conflicts can also involve high levels of

criminality (ICRC 2011b, 6; Egeland et al 2011). For example, in Afghanistan, Somalia and Iraq terrorist groups are compromising humanitarian missions (Egeland et al 2011, 12-13). For groups like these, it is quite ineffective to emphasise the independence of humanitarian aid from all political influences, since they do rarely aim at a general communal good, or obey the International law (Stoddard et al 2009). The security protocols already used seem somewhat ineffective in the most violent conflict zones affected by terrorism. This is also likely to be causing vulnerability for humanitarian organisations.

What is common in the most violent conflict areas is that these areas are run by a weak state, where formation of terrorist-supportive communities has been made possible. There has been a long and active conflict phase in which criminal behaviour has become a powerful tool for these terrorist groups (ICRC 2011b). ICRC reported that the fourth most common reason endangering humanitarians and local health care professionals is increased criminality. Attacks towards the medical community have increased and stealing of medicines and medical equipment is quite common (2011c, 9).

Also problematic is the lack of respect towards medical freedom. Medical vehicles are misused by politicians to move faster, for fooling enemies, and to support military operations (ICRC 2011c, 19). Health care personnel are threatened for their lives by enemy combats and military, when hospitals are occupied. Health care personnel are challenged to work according to their medical ethics as parties of conflict are depriving patients from receiving care, or trying to affect the patient triage (ICRC 2011c). Moreover, hospitals have been used to store weapons, hunt enemies, and launch attacks. These acts combined greatly compromise the neutral status of medical care (ICRC 2011c, 9).

Militarised and armed health care facilities are endangering the local medical community as well as the humanitarian organisations which are cooperating with that community, since these facilities are becoming targets of attacks (MSF 2012b). Also, the humanitarian community can be misunderstood as taking a part in conflict, when the organisation associates with the affected units (MSF 2011). It seems that in the most challenging conflicts just by trying to fulfil its mission, the humanitarian community is exposed to violation and attacks. As MSF reported from Syria in 2012: “being caught with a patient is like being caught with a weapon” (2012, 1).

4 Discussion

International law protects health care in conflict (appendix 2 - 4). Attacks aimed at the medical community are punished unless the neutrality of the community in question is compromised (ICRC 2011c, 5). This neutrality and independence are seen as necessities for

humanitarian organisations to be able to fulfil their mission in peace. Together with humanity these create the base for acceptance of humanitarians in the local community. The acceptance is well needed in conflict zones (Egeland et al 2011, 4). The humanitarian community needs to remain neutral so the access to affected populations can be guaranteed. This is also a question of their safety (Stoddard et al 2009).

Humanitarian organisations somewhat share a clear consensus that working with armed forces is not necessarily the best option when the security is tried to be gained through promoting the humanitarian principles: neutrality, impartiality, and independence. However, some organisations have announced that there are few options left besides cancelling or suspending operations in the most violent conflict areas (Stoddard et al 2009). ICRC admits that international fora is essential in promoting the humanitarian principles, but also emphasises that organisations need to be careful where and when additional armed protection is used (ICRC 2012a, 51 & 81); Sometimes it is a question of the safety of the whole humanitarian community rather than a specific organisation. Unfortunately, some humanitarian organisations have been noticed to neglect the main humanitarian principles as these organisations have been cooperating with military and political factors. This is mostly the case with smaller organisations that used additional protection in areas, where other organisations did not (ICRC 2012a).

Moreover, both ICRC and MSF have been clear about their interdependence in the discussion of using private military in aid operations (ICRC 2011b, 35; MSF 2012a). It is not a question of gaining total freedom from all political influences, but rather about possibility to choose. By choosing, with whom to associate, humanitarians can identify and negotiate the "humanitarian moment": when it is safe to continue the work (MSF 2012a, 15). If these organisations are bound to political and military forces, the organisations might not be seen objectively by the local community and the conflicting parties. These security issues create a dilemma, since apparently joining with additional security forces seems to expose humanitarians to attacks. Unfortunately, it also seems quite evident that relying only on acceptance and promotion of humanitarian principles are not enough in the most dangerous areas. Suspension and cancelling of operations also have negative long-term effects on the security; a vicious circle is created.

However, the case seems to be different for ICRC. In Afghanistan ICRC was able to carry out its mission, whereas other Western organisations were faced with security risks. For example, MSF decided to leave the country after five of its workers were killed. ICRC has been able to stand out and create a special identity (Stoddard et al 2009). As an example for other organisations, ICRC highly emphasises neutrality and important meaning of active negotiation with combats. ICRC has also decreased its field staff, made improvements in security

management, and continues to prompt humanitarian principles in its activities (Stoddard et al 2009, 3).Nevertheless, it should be remembered that ICRC has been functioning since 1863 and is well established in the humanitarian field. It definitely takes time to establish such a status; there are newer organisations in the field that are struggling with the security.

Medical humanitarian organisations are needed to guarantee safety and continuity of health care. As stated by ICRC, "violence disrupts health care services at the moment when they are needed most" (2011c, 6). Also during the time of a conflict, there are patients with chronic conditions who need continuous care. Moreover, conflict forces people to move to safer areas resulting in an evident lack of local health care staff (ICRC 2011c). Besides, the new nature of warfare is demanding humanitarians to guarantee that people do receive care regardless of their ethnicity, religious, or political status. The occupied health care facilities have become places to be feared, since military and opposition groups have been known to seek wounded enemies (ICRC 2011c). For example, during the recent case in Syria in spring 2012, MSF witnessed that medical care in a few facilities depended on which side of the party the patient represented (MSF 2012b). Moreover, the year before in Bahrain the opposition used special bullets in guns to make the enemies easier to identify when the troops would return to seek them from the hospitals (MSF 2011).

Bombing and fighting in urban areas already causes unavoidable security risks for humanitarian workers, and now the whole community is under attack. It is a responsibility of the whole health care community to participate in the discussion as to how the security of these colleagues could be improved. In most cases humanitarians are normal doctors and nurses, who voluntarily participate in relief operations. They might also have a regular job and use their vacations for these missions. No one is forced to take apart in humanitarian missions; it is a personal choice. However, these colleagues do work according to the same medical ethics. Regardless of their own lives, they are carrying out one of the main principles of health care: helping those in need.

4.1 Ethics and trustworthiness

The ethical process of research already begins when the topic will be chosen (Hirsjärvi et al 2006, 26). It was acknowledged prior the data search that material might be challenging to find. Regardless of this, the topic was chosen due to its importance and current need for research in this area. Also, it was estimated that the amount of material applicable to medical care could be limited to only a few, thus affecting the validity of the research (O'Leary 2004, 61). However, authenticity is guaranteed by strictly following the chosen research method (O'Leary 2004).

Some of the review articles do discuss humanitarian workers on a general basis without specifying the actual profession of the worker. Of course, when talking about wide topics such as security in this research, it is quite challenging to focus on specific profession in the whole community. However, the review articles and example cases were selected to suit the medical context. It is worth mentioning that the exact amount of health care professionals cannot be estimated in the numbers and statistics given in this thesis. More likely, these indicate the victim numbers of the whole humanitarian community. When considering generalizability of research, this permits the applicability of research in other fields, too. (O´Leary 2004).

In discussion of war, ethnicity, and cultures, it is necessary to understand that these are likely to change over the time and affect each other (Reed 2002). The research material is collected from data published between 2006 and 2012. This is explained in the section discussing methodology of the research. Unfortunately, the material collected from this time frame pointed out specific ethnicities that are likely causing insecurity for humanitarian organisations; No harm was intended to cause. The International Humanitarian Law is partly included in the appendices 2 - 4 to reflect the appropriate code of conduct in conflict situations and provide information for those readers, who are unfamiliar with the subject. Also, appendix 2 shows states party to the law. In research like this, the complexity of war and conflict situations has to be taken into consideration (Reed 2002). Thus, it should not be assumed that the situation in the most violent settings will always stay the same. Moreover, behaviour of a group should not be assumed to defame the whole population.

The data search was done according to the literature review guidelines of Salminen, Torraco, and Hirsjärvi et al. An integrative review was best suited, since trustworthy, updated, and relevant results from modified data sources needed to be used. It has been questioned, whether it is ethical to use non-governmental organisations' internal material in research or not (Reed 2002). All the data used in this research have had public access, which was one of the data selection criteria (table 1). The researcher had no access to internal data that would have not been provided in the public search. Moreover, this data is in the form of public briefing papers, press releases, campaign brochures, or research articles (appendix 5).

Transferability of research is one of the necessary ethical criteria (O'Leary 2004, 62 – 63). Thus, the steps of the research process are explained in detail. For clarification and auditability, articles of data analysis are listed in the appendix 5. Also, the three data selection and screening processes are provided in appendix 1. By reading the section 2 Literature review and familiarising with these appendices, readers can follow the review process (O'Leary 2004).

The objectivity of research "implies distance between the researcher and researched" (O'Leary 2004, 57). Even though this would probably be more evident in research that uses humans as resources, it is a point to consider in this thesis as well, since two specific organisations were chosen as databases from various medical humanitarian organisations. ICRC and MSF were selected because of their visibility in the media. It was also assumed that these two organisations would have been more commonly recognised among the readers. Most importantly, it was known that these organisations do have ethical board for their published research. The objectivity of the research is also guaranteed by the fact that the researcher has not been working for these organisations at the time of research, has not been given the topic, or sponsored by the organisations. Thus, the acknowledgements are added.

Trustworthiness of the research has been promoted by selecting reliable data that show authority. The databases were planned carefully before hand and an unofficial trial data search was implemented. The findings strictly follow the material of review articles and consist only of the articles given in table 3. The text is also referenced according to the resources, which are listed under references. Other opinions and ideas, such as personal conclusion, are only included to discussion part. The research follows its purpose. The answer to the research question is found, and three main causes of increased attacks are identified. The research was successful, even though the relevant material was quite limited resulting to challenging data analysis process. Hopefully, this research has also something new to give for this current and challenging issue in global health care.

4.2 Recommendations for further research

- How insecurity of humanitarian health care impacts on the patients and wounded in conflict areas?

- What is the current image of the humanitarian community in the most violent areas and how are humanitarian organisations perceived in local communities?

- What would be the most convenient way to evoke conversation and raise awareness concerning the insecurity of humanitarian health care?

Acknowledgements

The findings and opinions expressed in this thesis do not necessarily reflect the policy and attitude of ICRC, MSF or other humanitarian organisations used as references.

The interpretations are based on the reviewed articles and listed references. Possible errors in interpretation of used data remain my own.

References

Bauer, N. 2009. The Dangerous Business of Aid: A Report on the Risks to Aid Workers in the Field. Washington D.C.: The Johns Hopkins University & The Paul H. Nitze School of Advanced International Studies (SAIS).

Elder, G. 2012. A Doctor's protests. Alert vol.13 no.3, spring 2012. New York: Médecins Sans Frontières, 7.

Egeland, J., Harmer, A. & Stoddard, A. 2011. To stay and deliver: Good practice for humanitarians in complex security environments. Policy and Studies Series. Office for Coordination of Humanitarian Affairs (OCHA). Policy Development and Studies Branch. United Nations (UN).

Grearson, R., Schultz, C., Jacob, S. & Ozcivi, A. 2010. Working with humanitarian organisations: a guide for nurses, midwives and health care professionals. London: Royal College of Nursing/RDNDIRECT.

Hirsjärvi, S., Remes, P. & Sajavaara, P. 2006. Tutki ja kirjoita. 12th edition. Jyväskylä: Gummerus Kirjapaino OY.

International Committee of the Red Cross (ICRC). Reference on 1st August 2012. http://www.icrc.org/eng

International Committee of the Red Cross (ICRC). 2011a. Millions affected by violence against health-care personnel and facilities. Reference on 12th November 2012. http://www.icrc.org/eng/resources/documents/news-release/2011/health-care-in-danger-news-2011-08-10.htm

International Committee of the Red Cross (ICRC). 2011b. International Humanitarian Law and the challenges of contemporary armed conflicts. 31st International conference of the Red Cross and Red Cresent, 28th November – 1st December 2011. October 2011, Geneva. Reference on 14th November 2012. http://www.icrc.org/eng/resources/documents/report/31-international-conference-ihl-challenges-report-2011-10-31.htm

International Committee of the Red Cross (ICRC). 2011c. Health Care in Danger: Making the Case. Reference on 17th October 2012. http://www.icrc.org/eng/assets/files/publications/icrc-002-4072.pdf
International Committee of the Red Cross (ICRC). 2012a. Annual Report 2011. Geneva: ICRC.

International Committee of the Red Cross (ICRC). 2012b. Health care in danger: first steps at London Symposium. Reference on 14th November 2012. http://www.icrc.org/eng/resources/documents/feature/2012/health-care-in-danger-feature-2012-04-25.htm

International Committee of the Red Cross (ICRC), British Red Cross, British Medical Association & World Medical Association. 2012. Report. Health Care in Danger. The London Symposium. 23rd April 2012. Reference on 7th November 2012. https://docs.google.com/viewer?a=v&q=cache:1LTudAasRFkJ:www.wma.net/en/20activities/20humanrights/20distress/London_HCiDsymposiumReport8May.doc+MASTER+FOR+CHANGES+as+of+4.5.2012+Report+Health+Care+in+Danger+The+London+Symposium&hl=fi&gl=fi&pid=bl&srcid=ADGEESgG3spbPkl-R8j_H5nMjVYJyb64qyXlAF78dBi_p9JtRqN_TKLIVFFqPejGU052ZnqdBEPyZhVKn8Vue8uIw2Yz6aEVoWwczipWar-koAjqbSx5mkN7pBPwScRhTE7l11loQ0fJZ&sig=AHIEtbRY7uAXBtXplhCTx7qeFH3pnoRDiw

Marko, S. & Vuorela, K. 2008. Laurean opinnäytetöiden lähdeviitteiden ja lähteiden merkintätavat. Laurea ammattikorkeakoulu.

Merlin. 2010. A grave new world. Hands up for health workers. London. Reference on 17th October 2012. http://www.who.int/workforcealliance/news/agravenewworld_report.pdf

Médecins Sans Frontières / Doctors Without Borders (MSF). Reference on 1st August 2010. http://www.msf.org/msf

Médecins Sans Frontières/ Doctors Without Borders (MSF). 2009. Growing Insecurity Forces MSF to Leave its Largest Health Center in Somalia. Reference on 26th October 2012. http://www.doctorswithoutborders.org/press/release.cfm?id=3670

Médecins Sans Frontières/ Doctors Without Borders (MSF). 2011. Health Services Paralyzed: Bahrain's Military Crackdown on Patients – An MSF Public Briefing Paper. Reference on 26th October 2012. http://www.doctorswithoutborders.org/publications/reports/2011/Bahrain_BP_Final_06042011_2106_FR-EN%20LOGO.pdf

Médecins Sans Frontières/ Doctors Without Borders (MSF). 2012a. Activity Report 2011. London: ACW.
Médecins Sans Frontières/ Doctors Without Borders (MSF). 2012b. Syria: Safety of Wounded and Medical Workers Must Be Prioritized. Reference on 26th October 2012. http://www.doctorswithoutborders.org/press/release.cfm?id=6012&cat=press-release

O'Leary, Z. 2004. The Essential Guide to Doing Research. London: SAGE Publications Ltd.

Reed, H. 2002. Research Ethics in Complex Humanitarian Emergencies: Summary of a workshop. National Research Council. Washington, DC: National Academy Press.

Rubenstein, L.S. & Bitte, M.D. 2010. Responsibility for protection of medical workers and facilities in armed conflict. Health Policy vol. 375, 23rd October 2010, 329 – 340.

Salminen, A. 2011. Mikä kirjallisuuskatsaus? Johdatus kirjallisuuskatsauksen tyyppeihin ja hallintotieteellisiin sovelluksiin. Vaasan yliopiston julkaisuja. Opetusjulkaisuja 62, Julkisjohtaminen 4. Vaasa: Vaasan yliopisto.

Serle, J. & Fleck, F. 2012. Keeping health workers and facilities safe in war. The Bulletin vol.90 no.1, January 2012. Bulletin of World Health Organization. World Health Organization (WHO).

Stoddard, A., Harmer, A. & DiDomenico, V. 2009. Providing aid in insecure environments: 2009 Update. Trends in violence against aid workers and the operational response. HPG Policy Bried 34, April 2009. London: Overseas Development Institute (ODI).

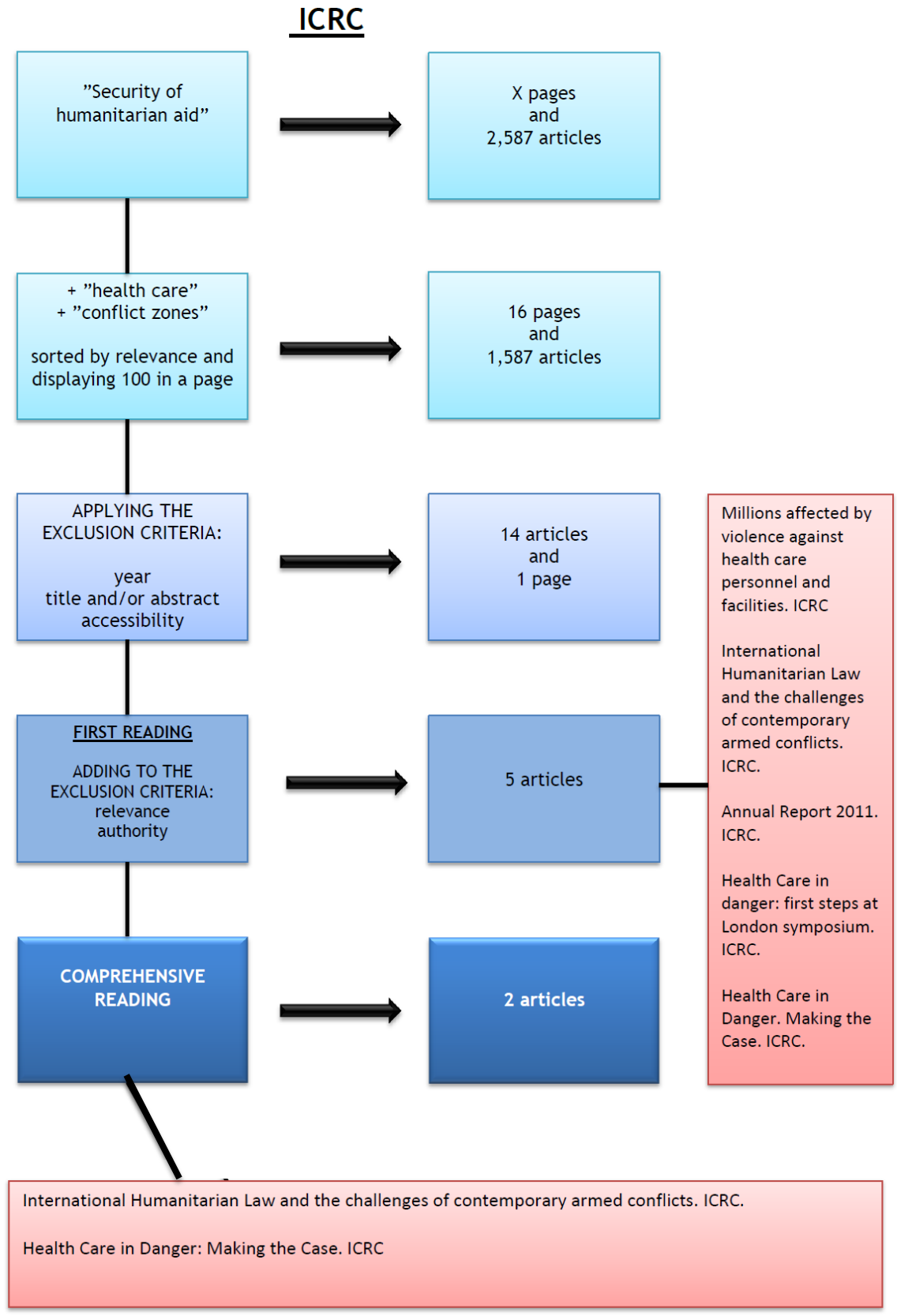
Stoddard, A., Harmer, A. & Haver, K. 2011. Aid Worker Security Report 2011. Spotlight on security for national aid workers: Issues and perspectives. Humanitarian Outcomes. Reference on 12th November 2012. http://humanitarianoutcomes.org/resources/AidWorkerSecurityReport20112.pdf

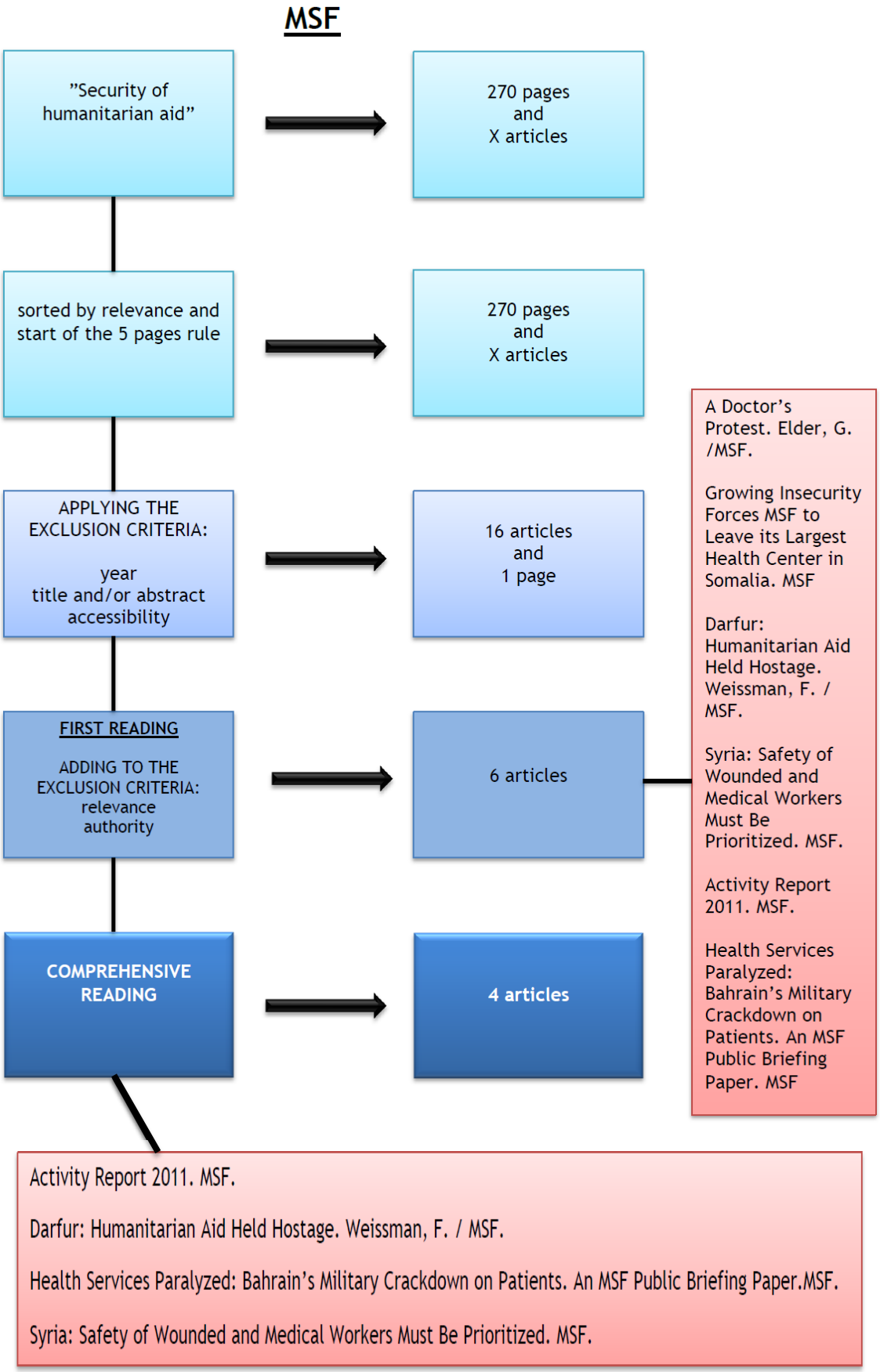
Torraco, R.J. 2005. Writing Integrative Literature Reviews: Guidelines and Examples. Human Resource Development Review vol 4. no.3, September 2005. Sage on behalf of Academy of Human Resource Development (AHRD), 356-367. Reference on 12th November 2012. http://www.sagepub.com/gray/Website%20material/Journals/hrd_torraco.pdf

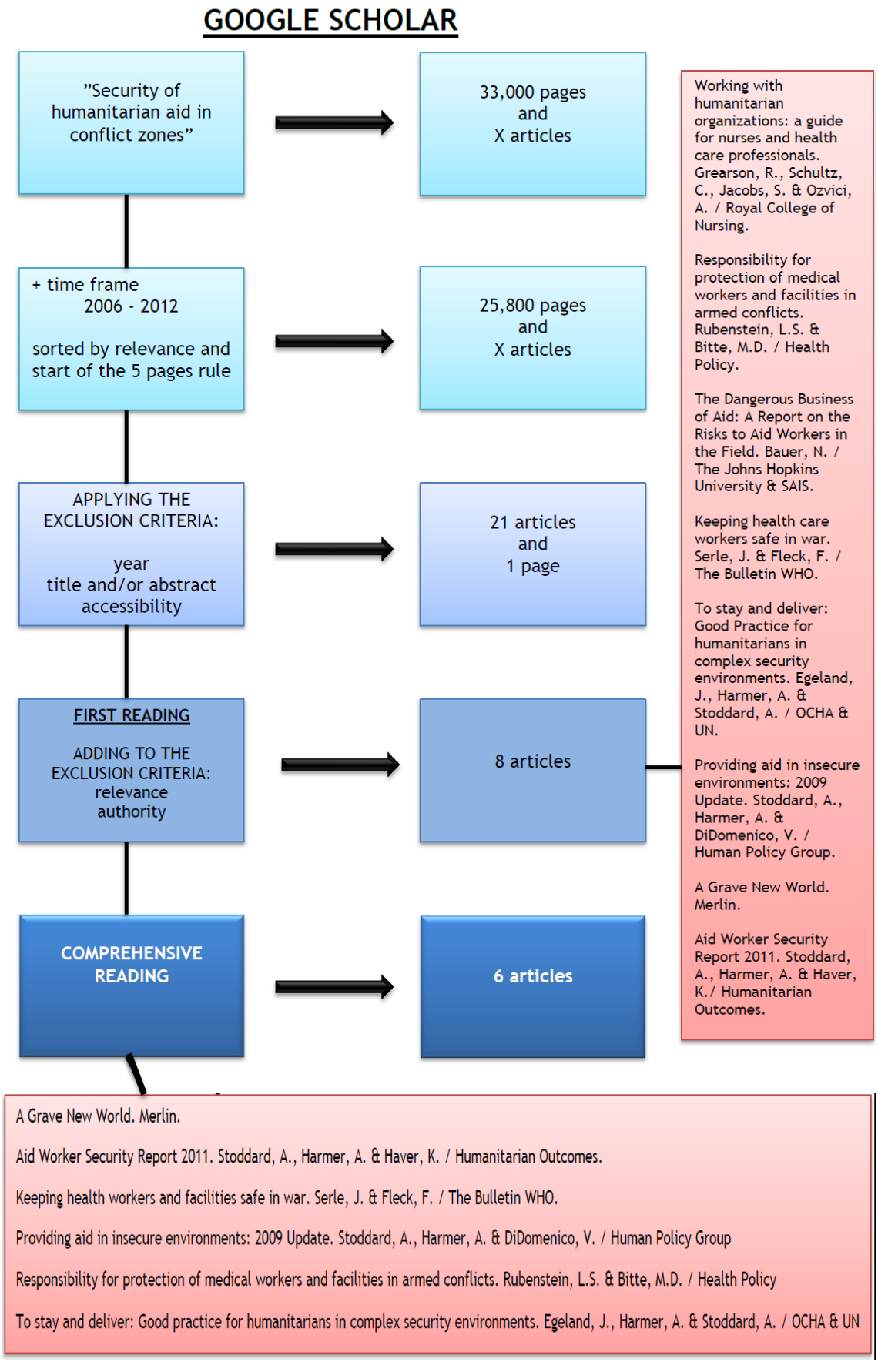
Weissman, F. 2006. Darfur: Humanitarian Aid Held Hostage. Médecins San Frontières/ Doctors Without Borders (MSF). Reference on 26th October 2012. http://www.doctorswithoutborders.org/publications/article.cfm?id=1893&car=ideas-opinions

Appendices

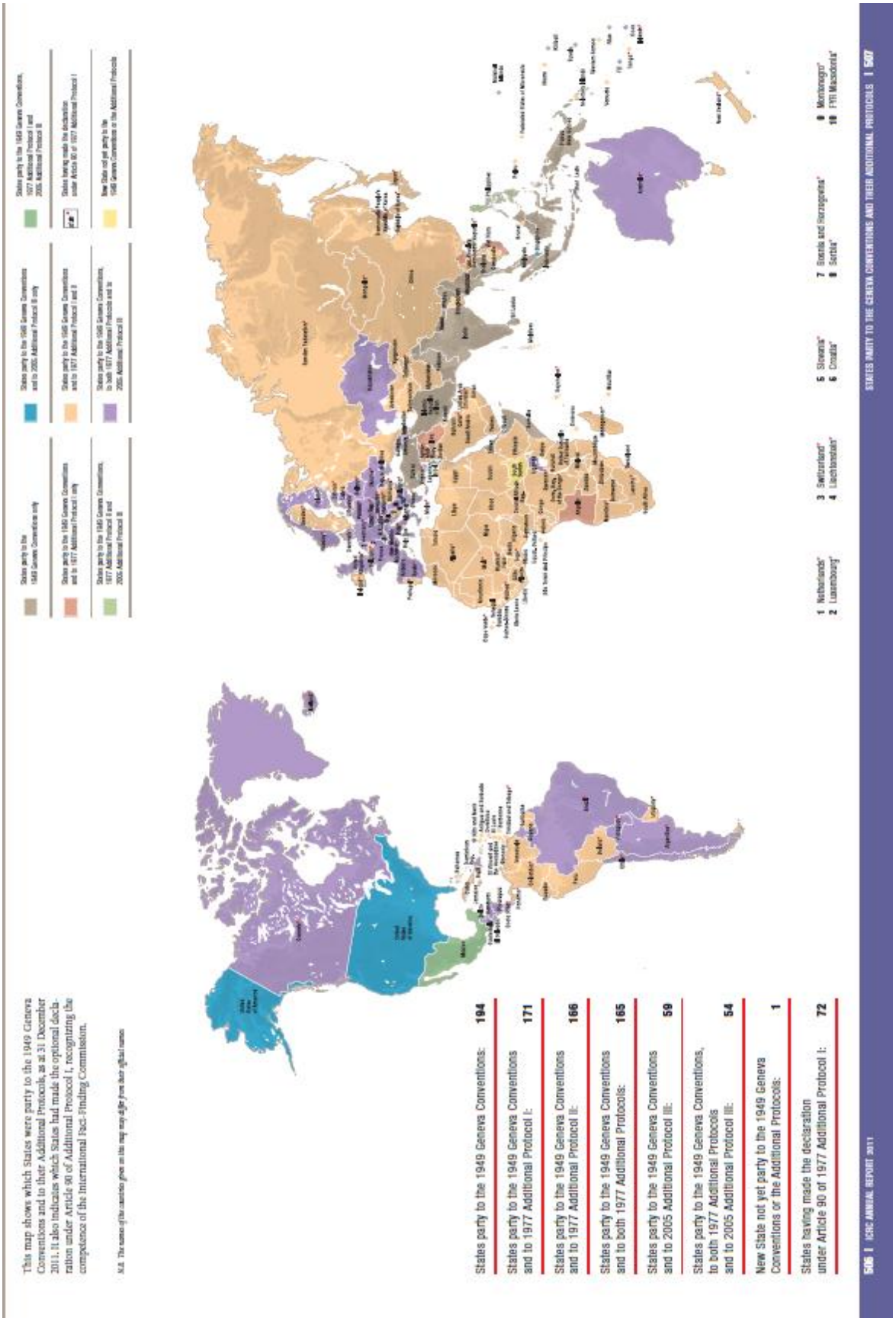
Appendix 1 Data selection and screening processes




MSF
"Security of humanitarian aid"
270 pages and X articles
sorted by relevance and start of the 5 pages rule
270 pages and X articles
APPLYING THE EXCLUSION CRITERIA:
year
title and/or abstract
accessibility
16 articles and 1 page
FIRST READING
ADDING TO THE EXCLUSION CRITERIA:
relevance
authority
6 articles
COMPREHENSIVE READING
4 articles
A Doctor's Protest. Elder, G. /MSF.
Growing Insecurity Forces MSF to Leave its Largest Health Center in Somalia. MSF
Darfur: Humanitarian Aid Held Hostage. Weissman, F. / MSF.
Syria: Safety of Wounded and Medical Workers Must Be Prioritized. MSF.
Activity Report 2011. MSF.
Health Services Paralyzed: Bahrain's Military Crackdown on Patients. An MSF Public Briefing Paper. MSF
Activity Report 2011. MSF.
Darfur: Humanitarian Aid Held Hostage. Weissman, F. / MSF.
Health Services Paralyzed: Bahrain's Military Crackdown on Patients. An MSF Public Briefing Paper.MSF.
Syria: Safety of Wounded and Medical Workers Must Be Prioritized. MSF.


GOOGLE SCHOLAR
"Security of humanitarian aid in conflict zones"
33,000 pages and X articles
+ time frame 2006 - 2012
sorted by relevance and start of the 5 pages rule
25,800 pages and X articles
APPLYING THE EXCLUSION CRITERIA:
year
title and/or abstract
accessibility
21 articles and 1 page
FIRST READING
ADDING TO THE EXCLUSION CRITERIA:
relevance
authority
8 articles
COMPREHENSIVE READING
6 articles
Working with humanitarian organizations: a guide for nurses and health care professionals. Grearson, R., Schultz, C., Jacobs, S. & Ozvici, A. / Royal College of Nursing.
Responsibility for protection of medical workers and facilities in armed conflicts. Rubenstein, L.S. & Bitte, M.D. / Health Policy.
The Dangerous Business of Aid: A Report on the Risks to Aid Workers in the Field. Bauer, N. / The Johns Hopkins University & SAIS.
Keeping health care workers safe in war. Serle, J. & Fleck, F. / The Bulletin WHO.
To stay and deliver: Good Practice for humanitarians in complex security environments. Egeland, J., Harmer, A. & Stoddard, A. / OCHA & UN.
Providing aid in insecure environments: 2009 Update. Stoddard, A., Harmer, A. & DiDomenico, V. / Human Policy Group.
A Grave New World. Merlin.
Aid Worker Security Report 2011. Stoddard, A., Harmer, A. & Haver, K./ Humanitarian Outcomes.
A Grave New World. Merlin.
Aid Worker Security Report 2011. Stoddard, A., Harmer, A. & Haver, K. / Humanitarian Outcomes.
Keeping health workers and facilities safe in war. Serle, J. & Fleck, F. / The Bulletin WHO.
Providing aid in insecure environments: 2009 Update. Stoddard, A., Harmer, A. & DiDomenico, V. / Human Policy Group
Responsibility for protection of medical workers and facilities in armed conflicts. Rubenstein, L.S. & Bitte, M.D. / Health Policy
To stay and deliver: Good practice for humanitarians in complex security environments. Egeland, J., Harmer, A. & Stoddard, A. / OCHA & UN

Appendix 2 States party to the Geneva Conventions and Their Additional Protocols



States party to the
1949 Geneva Conventions only

States party to the 1949 Geneva Conventions
and to 1977 Additional Protocol I only

States party to the 1949 Geneva Conventions,
1977 Additional Protocol II and
2005 Additional Protocol III

States party to the 1949 Geneva Conventions
and to 2005 Additional Protocol III only

States party to the 1949 Geneva Conventions
and to 1977 Additional Protocol I and II

States party to the 1949 Geneva Conventions,
to both 1977 Additional Protocols and to
2005 Additional Protocol III

States party to the 1949 Geneva Conventions,
1977 Additional Protocol I and
2005 Additional Protocol III

State* States having made the declaration
under Article 90 of 1977 Additional Protocol I

New State not yet party to the
1949 Geneva Conventions or the Additional Protocols

Appendix 3 ICRC: Advisory service on International Humanitarian Law

ICRC

ADVISORY SERVICE
ON INTERNATIONAL HUMANITARIAN LAW

Respecting and Protecting Health Care in Armed Conflicts and in Situations Not Covered by International Humanitarian Law

In times of armed conflict, international humanitarian law (IHL) provides rules to protect access to health care. These rules bind States and non-State armed groups. In situations that do not reach the threshold of armed conflict only international human rights law (IHRL) and domestic law apply. In principle, IHRL applies at all times, unless States decide to derogate from it. Though less specific than IHL, IHRL contains several rules protecting access to health care.

International and Non-International Armed Conflict

The wounded and sick

Attacking, harming or killing
The rights of the wounded and sick must be respected in all circumstances; attempts upon their lives and violence against their person are strictly prohibited. Wilfully killing them or causing great suffering or serious injury to their bodies or to their health constitutes war crimes as grave breaches of the Geneva Conventions.

In certain circumstances, the denial of medical treatment may constitute cruel or inhuman treatment, an outrage upon human dignity, in particular humiliating and degrading treatment, or even torture if the necessary criteria are met.

Searching for and collecting
Parties to an armed conflict must take all possible measures to search for and collect the wounded and sick without delay. If circumstances permit, parties must make arrangements for the removal or exchange of the wounded and sick.

Protection and care
All parties to an armed conflict must protect the wounded and sick from pillage and ill-treatment. They must also ensure that adequate medical care is provided to them as far as practicable and with the least possible delay.

Treatment without discrimination
The wounded and sick must be treated without discrimination. If distinctions are to be made among them, it can be only on the basis of their medical condition.

Medical personnel

Protecting and respecting
Personnel engaging in medical tasks must always be respected and protected, unless they commit, outside of their humanitarian function, acts that are harmful to the enemy. When they carry and use weapons to defend themselves or to protect the wounded and sick in their charge, medical personnel do not lose the protection to which they are entitled. The wounded and sick under their care remain protected even if the medical personnel themselves lose their protection.

Provision of care
Parties to an armed conflict may not impede the provision of care by preventing the passage of medical personnel. They must facilitate access to the wounded and sick, and provide the necessary assistance and protection to medical personnel.

Impartial care
Medical personnel may not be punished for providing impartial care.

Medical ethics
Some medical professionals, such as physicians, have certain ethical duties to fulfil. These duties are protected by various provisions of IHL. Parties to an armed conflict should not compel medical professionals to carry out activities that are contrary to medical ethics or prevent them from fulfilling their ethical duties. Further, parties should not prosecute medical professionals for acting in accordance with medical ethics.

Medical professionals must protect the confidentiality of information obtained in connection with the treatment of patients: this is one of the most important principles of medical ethics. Under Protocols I and II of 8 June 1977 additional to the Geneva Conventions, persons engaged in medical activities may not, unless required to do so by law, be compelled to give information concerning the wounded and sick who are or have been under their care either to their own party or to an adverse party, if this information would prove harmful to the patients or their families.

The World Medical Association is of the view that medical ethics remain the same during armed conflict and in peacetime.

Medical units and transports

Medical units
Medical units, such as hospitals and other facilities that have been set up for medical purposes, must be respected and protected in all circumstances. Medical units may not be attacked and access to them may not be limited. Parties to an armed conflict must take measures to protect medical units from attacks, such as ensuring that they are not situated in the vicinity of military objectives.

Medical units will lose the protection to which they are entitled if they are used, outside their humanitarian function, to

commit acts harmful to the enemy, such as sheltering able-bodied combatants or storing arms and ammunition. However, this protection can be withdrawn only after due warning has been given with a reasonable time limit and only after that warning has gone unheeded.

Medical transports
Any means of transportation that is assigned exclusively to the conveyance of the wounded and sick, medical personnel and/or medical equipment or supplies must be respected and protected in the same way as medical units. If medical transports fall into the hands of an adverse party, that party becomes responsible for ensuring that the wounded and sick in their charge are cared for.

Perfidy
Parties to an armed conflict who use medical units or transports with the intent of leading the opposing parties to believe they are protected, while using them to launch attacks or carry out other acts harmful to the enemy, commit acts of perfidy. If such an act of perfidy results in death or injury to individuals belonging to an adverse party, it constitutes a war crime.

Use of the distinctive emblems protected under the Geneva Conventions and their Additional Protocols

When used as a protective device, the emblem – the red cross, the red crescent or the red crystal – is the visible sign of the protection conferred by the Geneva Conventions and their Additional Protocols on medical personnel, medical units and medical transports. During an armed conflict, this includes military medical personnel, units and transports; National Red Cross and Red Crescent Societies' medical personnel, units and transports that have been recognized by the State and authorized to assist the medical services of the armed forces; State-certified civilian medical units authorized to display the emblem; and medical personnel in occupied territory. To secure the best protection, the emblem used as a protective device should be large enough to ensure visibility. Medical units and transports may also use distinctive signals (such as light and radio signals).

When used as an indicative device, the emblem links the person or object displaying it to an institution of the International Red Cross and Red Crescent Movement. In this case, the sign should be relatively small.

Attacking buildings, material, medical units and transports or personnel displaying the distinctive emblems is a war crime.

Misuse of the emblem
Any use of the emblem not prescribed by IHL is considered to be improper. Perfidious use of the emblem – to protect or hide combatants, for example – constitutes a war crime when it results in death or serious injury.

Situations Other than Armed Conflicts

Under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), States must take steps to ensure the right of everyone to enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of physical and mental health (the right to health).

General Comment No. 14 of the United Nations Economic and Social Council (General Comment No. 14) states that the right to health contains the core obligations to maintain essential primary health care, access to minimum essential food, basic shelter, housing and sanitation, and an adequate supply of safe and potable water, as well as the obligation to provide essential drugs. These core obligations are non-derogable and require States to respect, protect and ensure the right to health.

The right to medical care is also provided under Article 25 of the Universal Declaration of Human Rights, an instrument accepted by most as international customary law.

Access to health care is also articulated in several other important instruments of international human rights law.[1]

The wounded and sick

Attacking, harming or killing
The wounded and sick are protected under IHRL from attempts upon their lives or violence against their person. Under Article 6 of the International Covenant on Civil and Political Rights (ICCPR), States have a non-derogable obligation not to subject any individuals under their jurisdiction or control to arbitrary deprivation of life. Individuals also have a right to personal security under Article 9 of the ICCPR.

The use of force against an individual may be justifiable in certain cases where it is absolutely necessary. The United Nations' Basic Principles on the Use of Force and Firearms by Law Enforcement Officials sets out the situations in which the use of force is permissible. However, the lethal use of force is justified only when protecting life. A warning must be given prior to the use of force, and sufficient time allowed for it to be observed.

Under the Rome Statute of the International Criminal Court, the murder of wounded and sick people, as well as other inhumane acts of a similar character intentionally causing great suffering or serious injury to body or to mental or physical health, may amount to crimes against humanity.

In certain circumstances, the denial of medical treatment may constitute cruel, inhuman and degrading treatment, or even torture if the necessary criteria are met.

Protection
States have an obligation to protect the wounded and sick from ill-treatment; they must also protect the right to health of the wounded and sick. The Human Rights Committee of the United Nations has stated on many occasions that States have an obligation under the right to security to take the necessary measures to protect individuals under their jurisdiction, even protecting them from private individuals. The right to health also requires that States take all necessary measures to "safeguard individuals within their jurisdiction from infringements of the

[1] See Art. 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (1965); Arts 11 (1) (f), 12 and 14 (2) (b) of the Convention on the Elimination of All Forms of Discrimination against Women (1979); Art. 24 of the Convention on the Rights of the Child (1989); Arts 28, 43 (e) and 45 (c) of the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families 1990; and Art. 25. of the Convention on the Rights of Persons with Disabilities (2006).

right to health by third parties" (General Comment No. 14)

Searching for, collecting, and providing care
Under the right to health, States have a non-derogable obligation to "ensure the right of access to health facilities, goods and services" (General Comment No. 14). When individuals are unable to realize this right by themselves, as may be the case for the wounded and sick, States must take the necessary measures to provide this access, which may entail searching for and collecting the wounded and sick.

General Comment No. 6 of the Human Rights Committee of the United Nations states that the right to life in the ICCPR also contains the obligation for States to take positive measures, which include measures to ensure health care, especially in life-threatening-circumstances.

Treatment without discrimination
Under Articles 2.2 and 3 of the ICESCR, the right to health must be exercised without discrimination. Access to health care for the wounded and sick must be equitable. This obligation is immediate and non-derogable. Under Article 4 of the ICESCR, States are entitled to place restrictions on the right to health. However, this must be done in accordance with the law, including human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society (General Comment No. 14).

Medical personnel

Protecting and respecting
Medical personnel have the right to protection against arbitrary deprivation of life and the right to security in the same way as the wounded and sick.

Provision of care
States must not prevent medical personnel from treating the wounded and sick. Under the right to health, States have an obligation to "refrain from interfering directly or indirectly with the enjoyment of the right to health" (General Comment No. 14).

Arresting medical personnel for providing care may amount to a violation of the protection against arbitrary arrest and detention, even if it is done lawfully under national law. The Human Rights Committee of the United Nations has stated that inappropriateness and injustice in legislation can amount to arbitrariness.

Medical ethics
Resolution 37/194 of the UN General Assembly on the Principles of Medical Ethics states that in these situations as in times of armed conflict, States should not punish medical personnel for carrying out medical activities compatible with medical ethics or compel them to undertake actions that contravene these standards.

Medical units and transports

Under the right to health, States have a non-derogable obligation to ensure access to health infrastructure. They must therefore respect medical units and transports. States may not target them or use them to launch law enforcement operations or to carry out other similar measures. States must also take measures to protect medical units and transports from attacks or misuse by third parties.

Use of the distinctive emblems protected under the Geneva Conventions and their Additional Protocols

During situations other than armed conflicts, the use of the emblem is restricted. Under Article 44, Para. 1 of the First Geneva Convention, military medical personnel, units and transports can use the emblem as a protective device in time of peace, and in situations of violence other than armed conflict. National Societies' medical units and transports, whose assignment to medical duties in the event of an armed conflict has been decided, can also use the emblem as a protective device, as long as they have been authorized to do so by the appropriate authority. Finally, in certain cases, civilian medical units may be authorized to use the emblem as a protective device. This requires the medical units to have been recognized as such by the State and the State to allow this use of the emblem. However, this use should be limited to the preparation of medical units for an eventual armed conflict: for example, painting the emblem on the roof of a hospital.

The emblem may also be used as an indicative device by ambulances and first-aid stations, when they are exclusively assigned to provide free treatment to the wounded and sick. In this case, the use must be in conformity with national legislation and authorized by the National Society.

Maintaining health-care systems during armed conflicts and in situations not covered by IHL

In all circumstances, in times of peace and during conflict, States have an obligation to maintain a functioning health-care system. They must maintain essential primary health care, access to minimum essential food, basic shelter, housing and sanitation, and an adequate supply of safe and potable water, as well as provide essential drugs, while respecting the principles of non-discrimination and equitable access. States must also design and implement public health strategies. (General Comment No. 14) Similar provisions exist in IHL that require States to provide food and medical supplies to the population. In occupied territory, pursuant to Article 56 of the Fourth Geneva Convention, the Occupying Power (with the cooperation of national and local authorities) must, to the fullest extent of the means available, ensure and maintain medical and hospital establishments and services and public health and hygiene, and adopt the prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics. Though both IHL and IHRL allow States to predicate their obligations on the resources available to them, a lack of resources does not justify inaction. Even in cases where resources are extremely limited, States should adopt low-cost programmes that target the most disadvantaged and marginalized members of the population.

Humanitarian relief

Under IHL, if a civilian population lacks essential supplies, the party concerned has the obligation to ensure that humanitarian assistance is provided. It may therefore have to allow an organization or a third State to enter its territory to provide humanitarian assistance or even to request it. This obligation is circumscribed by the requirement to secure the consent of the receiving party; however, to justify its refusal, the receiving party must produce reasons whose validity cannot be

contested. In occupied territory, the Occupying Power does not have the option to refuse.

All States and all parties to an armed conflict must allow and facilitate the unimpeded passage of humanitarian relief on their territories to populations in need, subject to their right of control. This obligation is not limited to parties to the conflict; it also applies to third States through which relief consignments must pass in order to reach populations in need.

Under the right to health, States have an obligation to take all necessary steps and use their resources to the maximum extent available, which includes available humanitarian relief.

Domestic normative and practical measures

Dissemination

To ensure protection of access to health care, States need to disseminate the content of both IHL and IHRL obligations at all levels. This information should be provided to the armed forces and to civil defence and law enforcement officials, as well as to medical personnel and civilians in general.[2] Dissemination may require the translation of legal texts.

States must provide military commanders and law enforcement officials with legal advisers to help them apply and teach IHL and IHRL.[3]

Use of the distinctive emblems protected under the Geneva Conventions and their Additional Protocols[4]

The responsibility for authorizing the use of the red cross, red crescent and red crystal emblems, and for suppressing misuse and abuse, rests with the State, which must regulate their use in accordance with the terms of the Geneva Conventions and their Additional Protocols.

States should therefore adopt internal measures to: identify and define the emblems that have been recognized and are protected by the State; determine which national authorities are competent to regulate and monitor the use of the emblems; decide which entities are entitled to use the emblem; and identify the uses for which permission is required.

States must enact domestic legislation prohibiting and punishing unauthorized use of the distinctive emblems and their denominations at all times, for any form of personal or commercial use, and prohibit imitations or designs that could be mistaken for the emblems.

States should also take measures to prevent the misuse of the emblems by the armed forces.

Medical personnel
In times of armed conflict, medical personnel should wear armlets and carry identity cards displaying the emblem.

Medical units and transports
In times of armed conflict, parties should use the emblem to clearly mark their medical units and transports on the ground, at sea and in the air.

Repression of violations[5]

Measures should be implemented at the national level to ensure an effective system for fixing individual criminal responsibility and for suppressing crimes against the wounded and sick, medical personnel, medical units and medical transports.

Under Article 2 of the ICCPR, States have an obligation to enact legislation to give effect to the rights contained in the Covenant and to provide effective remedy. This might require States to enact criminal sanctions for certain violations, such as torture.

Other measures[6]

Parties to an armed conflict should do everything feasible to verify that the objectives to be attacked are neither civilians nor civilian objects and are not subject to special protection (as is the case for medical personnel, units and transports) but are military objectives.

When targeting military objectives or choosing means and methods of attack, parties to an armed conflict must take all feasible precautionary measures to avoid harming, or at least to minimize the danger to, medical personnel, units and transports.

This requires: choosing means and methods of attack that inflict the least incidental injuries to the wounded and sick and to medical personnel; cancelling attacks where it becomes apparent that they could result in excessive injury or damage, that the objectives are not military in character or that these objectives enjoy special protection; and giving effective advance warning of attacks that might affect the civilian population.

Parties to an armed conflict must also, to the greatest extent possible, limit the effects of attacks by removing the wounded and sick, medical personnel and medical units and transports from the vicinity of military objectives.

When planning the occupation of a territory, Occupying States should include provisions on public health in their standard operating procedures.

03/2012

[2] For more information on dissemination, please refer to the fact sheet prepared by the Advisory Service of the ICRC and titled *The Obligation to Disseminate International Humanitarian Law*.

[3] For more information on legal advisers in armed forces, please refer to the fact sheet prepared by the Advisory Service of the ICRC and titled *Legal Advisers in Armed Forces*.

[4] For more information on the use of the emblem, please refer to the fact sheet prepared by the Advisory Service of the ICRC and titled *The Protection of the Red Cross/Red Crescent Emblems*.

[5] For more information on the repression of violations, please refer to the fact sheet prepared by the Advisory Service of the ICRC and titled *Penal Repression: Punishing War Crimes*.

[6] For more information on the implementation of IHL, please refer to the fact sheet prepared by the Advisory Service of the ICRC and titled *Implementing International Humanitarian Law: From Law to Action*.

Appendix 4 International Humanitarian law: Protocol I, Part II and III

Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I), 8 June 1977.

Full text

Part. II WOUNDED, SICK AND SHIPWRECKED

Section I : General Protection

Art 8. Terminology

For the purposes of this Protocol:
a) "Wounded" and "sick" mean persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility. These terms also cover maternity cases, new-born babies and other persons who may be in need of immediate medical assistance or care, such as the infirm or expectant mothers, and who refrain from any act of hostility;

b) "Shipwrecked" means persons, whether military or civilian, who are in peril at sea or in other waters as a result of misfortune affecting them or the vessel or aircraft carrying them and who refrain from any act of hostility. These persons, provided that they continue to refrain from any act of hostility, shall continue to be considered shipwrecked during their rescue until they acquire another status under the Conventions or this Protocol;

c) "Medical personnel" means those persons assigned, by a Party to the conflict, exclusively to the medical purposes enumerated under e) or to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either permanent or temporary. The term includes:

i) medical personnel of a Party to the conflict, whether military or civilian, including those described in the First and Second Conventions, and those assigned to civil defence organizations;

ii) medical personnel of national Red Cross (Red Crescent, Red Lion and Sun) Societies and other national voluntary aid societies duly recognized and authorized by a Party to the conflict;

iii) medical personnel or medical units or medical transports described in Article 9, paragraph 2.

d) "Religious personnel" means military or civilian persons, such as chaplains, who are exclusively engaged in the work of their ministry and attached:

i) to the armed forces of a Party to the conflict;
ii) to medical units or medical transports of a Party to the conflict;
iii) to medical units or medical transports described in Article 9, Paragraph 2; or
iv) to civil defence organizations of a Party to the conflict.

The attachment of religious personnel may be either permanent or temporary, and the relevant provisions mentioned under k) apply to them;

e) "Medical units" means establishments and other units, whether military or civilian, organized for medical purposes, namely the search for, collection, transportation, diagnosis or treatment - including first-aid treatment - of the wounded, sick and shipwrecked, or for the prevention of disease. The term includes for example, hospitals and other similar units, blood transfusion centres, preventive medicine centres and institutes, medical depots and the medical and pharmaceutical stores of such units. Medical units may be fixed or mobile, permanent or temporary;

f) "Medical transportation" means the conveyance by land, water or air of the wounded, sick, shipwrecked, medical personnel, religious personnel, medical equipment or medical supplies protected by the Conventions and by this Protocol;

g) "Medical transports" means any means of transportation, whether military or civilian, permanent or temporary, assigned exclusively to medical transportation and under the control of a competent authority of a Party to the conflict;

h) "Medical vehicles" means any medical transports by land;

i) "Medical ships and craft" means any medical transports by water;

j) "Medical aircraft" means any medical transports by air;

k) "Permanent medical personnel", "permanent medical units" and "permanent medical transports" mean those assigned exclusively to medical purposes for an indeterminate period. "Temporary medical personnel" "temporary medical-units" and "temporary medical transports" mean those devoted exclusively to medical purposes for limited periods during the whole of such periods. Unless otherwise specified, the terms "medical personnel", "medical units" and "medical transports" cover both permanent and temporary categories;

l) "Distinctive emblem" means the distinctive emblem of the red cross, red crescent or red lion and sun on a white ground when used for the protection of medical units and transports, or medical and religious personnel, equipment or supplies;

m) "Distinctive signal" means any signal or message specified for the identification exclusively of medical units or transports in Chapter III of Annex I to this Protocol.

Art 9. Field of application

1. This Part, the provisions of which are intended to ameliorate the condition of the wounded, sick and shipwrecked, shall apply to all those affected by a situation referred to in Article 1, without any adverse distinction founded on race, colour, sex, language, religion or belief political or other opinion, national or social origin, wealth, birth or other status, or on any other similar criteria.

2. The relevant provisions of Articles 27 and 32 of the First Convention shall apply to permanent medical units and transports (other than hospital ships, to which Article 25 of the Second Convention applies) and their personnel made available to a Party to the conflict for humanitarian
purposes:
(a) by a neutral or other State which is not a Party to that conflict;
(b) by a recognized and authorized aid society of such a State;
(c) by an impartial international humanitarian organization.

Art 10 Protection and care

1. All the wounded, sick and shipwrecked, to whichever Party they belong, shall be respected and protected.

2. In all circumstances they shall be treated humanely and shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones.

Article 11 - Protection of persons

1. The physical or mental health and integrity of persons who are in the power of the adverse Party or who are interned, detained or otherwise deprived of liberty as a result of a situation referred to in Article 1 shall not be endangered by any unjustified act or omission. Accordingly, it is prohibited to subject the persons described in this Article to any medical procedure which is not indicated by the state of health of the person concerned and which is not consistent with generally accepted medical standards which would be applied under similar medical circumstances to persons who are nationals of the Party conducting the procedure and who are in no way deprived of liberty.

2. It is, in particular, prohibited to carry out on such persons, even with their consent:
(a) physical mutilations;
(b) medical or scientific experiments;
(c) removal of tissue or organs for transplantation, except where these acts are justified in conformity with the conditions provided for in paragraph 1.

3. Exceptions to the prohibition in paragraph 2 (c) may be made only in the case of donations of blood for transfusion or of skin for grafting, provided that they are given voluntarily and without any coercion or inducement, and then only for therapeutic purposes, under conditions consistent with generally accepted medical standards and controls designed for the benefit of both the donor and the recipient.

4. Any wilful act or omission which seriously endangers the physical or mental health or integrity of any person who is in the power of a Party other than the one on which he depends and which either violates any of the prohibitions in paragraphs 1 and 2 or fails to comply with the requirements of paragraph 3 shall be a grave breach of this Protocol.

5. The persons described in paragraph 1 have the right to refuse any surgical operation. In case of refusal, medical personnel shall endeavour to obtain a written statement to that effect, signed or acknowledged by the patient.

6. Each Party to the conflict shall keep a medical record for every donation of blood for transfusion or skin for grafting by persons referred to in paragraph 1, if that donation is made under the responsibility of that Party. In addition, each Party to the conflict shall endeavour to keep a record of all medical procedures undertaken with respect to any person who is interned, detained or otherwise deprived of liberty as a result of a situation referred to in Article 1. These records shall be available at all times for inspection by the Protecting Power.

Art 12 Protection of medical units

1. Medical units shall be respected and protected at all times and shall not be the object of attack.

2. Paragraph 1 shall apply to civilian medical units, provided that they:
(a) belong to one of the Parties to the conflict;
(b) are recognized and authorized by the competent authority of one of the Parties to the conflict; or
(c) are authorized in conformity with Article 9, paragraph 2, of this Protocol or Article 27 of the First Convention.

3. The Parties to the conflict are invited to notify each other of the location of their fixed medical units. The absence of such notification shall not exempt any of the Parties from the obligation to comply with the provisions of paragraph 1.

4. Under no circumstances shall medical units be used in an attempt to shield military objectives from attack. Whenever possible, the Parties to the conflict shall ensure that medical units are so sited that attacks against military objectives do not imperil their safety.

Art 13. Discontinuance of protection of civilian medical units

1. The protection to which civilian medical units are entitled shall not cease unless they are used to commit, outside their humanitarian function, acts harmful to the enemy. Protection may, however, cease only after a warning has been given setting, whenever appropriate, a reasonable time-limit, and after such warning has remained unheeded.

2. The following shall not be considered as acts harmful to the enemy:

(a) that the personnel of the unit are equipped with light individual weapons for their own defence or for that of the wounded and sick in their charge;
(b) that the unit is guarded by a picket or by sentries or by an escort;
(c) that small arms and ammunition taken from the wounded and sick, and not yet handed to the proper service, are found in the units;
(d) that members of the armed forces or other combatants are in the unit for medical reasons.

Art 14 - Limitations on requisition of civilian medical units

1. The Occupying Power has the duty to ensure that the medical needs of the civilian population in occupied territory continue to be satisfied.

2. The Occupying Power shall not, therefore, requisition civilian medical units, their equipment, their materiel or the services of their personnel, so long as these resources are necessary for the provision of adequate medical services for the civilian population and for the continuing medical care of any wounded and sick already under treatment.

3. Provided that the general rule in paragraph 2 continues to be observed, the Occupying Power may requisition the said resources, subject to the following particular conditions:
(a) that the resources are necessary for the adequate and immediate medical treatment of the wounded and sick members of the armed forces of the Occupying Power or of prisoners of war;
(b) that the requisition continues only while such necessity exists; and
(c) that immediate arrangements are made to ensure that the medical needs of the civilian population, as well as those of any wounded and sick under treatment who are affected by the requisition, continue to be satisfied.

Art 15. Protection of civilian medical and religious personnel

1. Civilian medical personnel shall be respected and protected.

2. If needed, all available help shall be afforded to civilian medical personnel in an area where civilian medical services are disrupted by reason of combat activity.

3. The Occupying Power shall afford civilian medical personnel in occupied territories every assistance to enable them to perform, to the best of their ability, their humanitarian functions. The Occupying Power may not require that, in the performance of those functions, such personnel shall give priority to the treatment of any person except on medical grounds. They shall not be compelled to carry out tasks which are not compatible with their humanitarian mission.

4. Civilian medical personnel shall have access to any place where their services are essential, subject to such supervisory and safety measures as the relevant Party to the conflict may deem necessary.

5. Civilian religious personnel shall be respected and protected. The provisions of the Conventions and of this Protocol concerning the protection and identification of medical personnel shall apply equally to such persons.

Art 16. General protection of medical duties

1. Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.

2. Persons engaged in medical activities shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics or to other medical rules designed for the benefit of the wounded and sick or to the provisions of the Conventions or of this Protocol, or to refrain from performing acts or from carrying out work required by those rules and provisions.

3. No person engaged in medical activities shall be compelled to give to anyone belonging either to an adverse Party, or to his own Party except as required by the law of the latter Party, any information concerning the wounded and sick who are, or who have been, under his care, if such information would, in his opinion, prove harmful to the patients concerned or to their families. Regulations for the compulsory notification of communicable diseases shall, however, be respected.

Art 17. Role of the civilian population and of aid societies

1. The civilian population shall respect the wounded, sick and shipwrecked, even if they belong to the adverse Party, and shall commit no act of violence against them. The civilian population and aid societies, such as national Red Cross (Red Crescent, Red Lion and Sun) Societies, shall be permitted, even on their own initiative, to collect and care for the wounded, sick and shipwrecked, even in invaded or occupied areas. No one shall be harmed, prosecuted, convicted or punished for such humanitarian acts.

2. The Parties to the conflict may appeal to the civilian population and the aid societies referred to in paragraph 1 to collect and care for the wounded, sick and shipwrecked, and to search for the dead and report their location; they shall grant both protection and the necessary facilities to those who respond to this appeal. If the adverse Party gains or regains control of the area, that Party also shall afford the same protection and facilities for as long as they are needed.

Art 18. Identification

1. Each Party to the conflict shall endeavour to ensure that medical and religious personnel and medical units and transports are identifiable.

2. Each Party to the conflict shall also endeavour to adopt and to implement methods and procedures which will make it possible to recognize medical units and transports which use the distinctive emblem and distinctive signals.

3. In occupied territory and in areas where fighting is taking place or is likely to take place, civilian medical personnel and civilian religious personnel should be recognizable by the distinctive emblem and an identity card certifying their status.

4. With the consent of the competent authority, medical units and transports shall be marked by the distinctive emblem. The ships and craft referred to in Article 22 of this Protocol shall be marked in accordance with the provisions of the Second Convention.

5. In addition to the distinctive emblem, a Party to the conflict may, as provided in Chapter III of Annex I to this Protocol, authorize the use of distinctive signals to identify medical units and transports. Exceptionally, in the special cases covered in that Chapter, medical transports may use distinctive signals without displaying the distinctive emblem.

6. The application of the provisions of paragraphs 1 to 5 of this article is governed by Chapters I to III of Annex I to this Protocol. Signals designated in Chapter III of the Annex for the exclusive use of medical units and transports shall not, except as provided therein, be used for any purpose other than to identify the medical units and transports specified in that Chapter.

7. This article does not authorize any wider use of the distinctive emblem in peacetime than is prescribed in Article 44 of the First Convention.

8. The provisions of the Conventions and of this Protocol relating to supervision of the use of the distinctive emblem and to the prevention and repression of any misuse thereof shall be applicable to distinctive signals.

Art 19. Neutral and other States not Parties to the conflict

Neutral and other States not Parties to the conflict shall apply the relevant provisions of this Protocol to persons protected by this Part who may be received or interned within their territory, and to any dead of the Parties to that conflict whom they may find.

Art 20. - Prohibition of reprisals

Reprisals against the persons and objects protected by this Part are prohibited.

SECTION II. MEDICAL TRANSPORTATION

Art 21. Medical vehicles

Medical vehicles shall be respected and protected in the same way as mobile medical units under the Conventions and this Protocol.

Art 22. Hospital ships and coastal rescue craft

1. The provisions of the Conventions relating to:
(a) vessels described in Articles 22, 24, 25 and 27 of the Second Convention,
(b) their lifeboats and small craft,
(c) their personnel and crews, and
(d) the wounded; sick and shipwrecked on board.

shall also apply where these vessels carry civilian wounded, sick and shipwrecked who do not belong to any of the categories mentioned in Article 13 of the Second Convention. Such civilians shall not, however, be subject to surrender to any Party which is not their own, or to capture at sea. If they find themselves in the power of a Party to the conflict other than their own they shall be covered by the Fourth Convention and by this Protocol.

2. The protection provided by the Conventions to vessels described in Article 25 of the Second Convention shall extend to hospital ships made available for humanitarian purposes to a Party to the conflict:
(a) by a neutral or other State which is not a Party to that conflict; or
(b) by an impartial international humanitarian organization,

provided that, in either case, the requirements set out in that Article are complied with.

3. Small craft described in Article 27 of the Second Convention shall be protected, even if the notification envisaged by that Article has not been made. The Parties to the conflict are, nevertheless, invited to inform each other of any details of such craft which will facilitate their identification and recognition.

Art 23. Other medical ships and craft

1. Medical ships and craft other than those referred to in Article 22 of this Protocol and Article 38 of the Second Convention shall, whether at sea or in other waters, be respected and protected in the same way as mobile medical units under the Conventions and this Protocol. Since this protection can only be effective if they can be identified and recognized as medical ships or craft, such vessels should be marked with the distinctive emblem and as far as possible comply with the second paragraph of Article 43 of the Second Convention.

2. The ships and craft referred to in paragraph 1 shall remain subject to the laws of war. Any warship on the surface able immediately to enforce its command may order them to stop, order them off, or make them take a certain course, and they shall obey every such command. Such ships and craft may not in any other way be diverted from their medical mission so long as they are needed for the wounded, sick and shipwrecked on board.

3. The protection provided in paragraph 1 shall cease only under the conditions set out in Articles 34 and 35 of the Second Convention. A clear refusal to obey a command given in accordance with paragraph 2 shall be an act harmful to the enemy under Article 34 of the Second Convention.

4. A Party to the conflict may notify any adverse Party as far in advance of sailing as possible of the name, description, expected time of sailing, course and estimated speed of the medical ship or craft, particularly in the case of ships of over 2,000 gross tons, and may provide any other information which would facilitate identification and recognition. The adverse Party shall acknowledge receipt of such information.

5. The provisions of Article 37 of the Second Convention shall apply to medical and religious personnel in such ships and craft.

6. The provisions of the Second Convention shall apply to the wounded, sick and shipwrecked belonging to the categories referred to in Article 13 of the Second Convention and in Article 44 of this Protocol who may be on board such medical ships and craft. Wounded, sick and shipwrecked civilians who do not belong to

any or the categories mentioned in Article 13 of the Second Convention shall not be subject, at sea, either to surrender to any Party which is not their own, or to removal from such ships or craft; if they find themselves in the power of a Party to the conflict other than their own, they shall be covered by the Fourth Convention and by this Protocol.

Art 24. Protection of medical Aircraft

Medical aircraft shall be respected and protected, subject to the provisions of this Part.

Art 25. Medical aircraft in areas not controlled by an adverse Party

In and over land areas physically controlled by friendly forces, or in and over sea areas not physically controlled by an adverse Party, the respect and protection of medical aircraft of a Party to the conflict is not dependent on any agreement with an adverse Party. For greater safety, however, a Party to the conflict operating its medical aircraft in these areas may notify the adverse Party, as provided in Article 29, in particular when such aircraft are making flights bringing them within range of surface-to-air weapons systems of the adverse Party.

Art 26. Medical aircraft in contact or similar zones

1. In and over those parts of the contact zone which are physically controlled by friendly forces and in and over those areas the physical control of which is not clearly established, protection for medical aircraft can be fully effective only by prior agreement between the competent military authorities of the Parties to the conflict, as provided for in Article 29. Although, in the absence of such an agreement, medical aircraft operate at their own risk, they shall nevertheless be respected after they have been recognized as such.

2. "Contact zone" means any area on land where the forward elements of opposing forces are in contact with each other, especially where they are exposed to direct fire from the ground.

Art 27. Medical aircraft in areas controlled by an adverse Party

1. The medical aircraft of a Party to the conflict shall continue to be protected while flying over land or sea areas physically controlled by an adverse Party, provided that prior agreement to such flights has been obtained from the competent authority of that adverse Party.

2. A medical aircraft which flies over an area physically controlled by an adverse Party without, or in deviation from the terms of, an agreement provided for in paragraph 1, either through navigational error or because of an emergency affecting the safety of the flight, shall make every effort to identify itself and to inform the adverse Party of the circumstances. As soon as such medical aircraft has been recognized by the adverse Party, that Party shall make all reasonable efforts to give the order to land or to alight on water, referred to in Article 30, paragraph 1, or to take other measures to safeguard its own interests, and, in either case, to allow the aircraft time for compliance, before resorting to an attack against the aircraft.

Art 28. Restrictions on operations of medical aircraft

1. The Parties to the conflict are prohibited from using their medical aircraft to attempt to acquire any military advantage over an adverse Party. The presence of medical aircraft shall not be used in an attempt to render military objectives immune from attack.

2. Medical aircraft shall not be used to collect or transmit intelligence data and shall not carry any equipment intended for such purposes. They are prohibited from carrying any persons or cargo not included within the definition in Article 8 (f). The carrying on board of the personal effects of the occupants or of equipment intended solely to facilitate navigation, communication or identification shall not be considered as prohibited,

3. Medical aircraft shall not carry any armament except small arms and ammunition taken from the wounded, sick and shipwrecked on board and not yet handed to the proper service, and such light individual weapons as may be necessary to enable the medical personnel on board to defend themselves and the wounded, sick and shipwrecked in their charge.

4. While carrying out the flights referred to in Articles 26 and 27, medical aircraft shall not, except by prior agreement with the adverse Party, be used to search for the wounded, sick and shipwrecked.

Art 29. Notifications and agreements concerning medical aircraft

1. Notifications under Article 25, or requests for prior agreement under Articles 26, 27, 28, paragraph 4, or 31 shall state the proposed number of medical aircraft, their flight plans and means of identification, and shall be understood to mean that every flight will be carried out in compliance with Article 28.

2. A Party which receives a notification given under Article 25 shall at once acknowledge receipt of such notification. 3. A Party which receives a request for prior agreement under Articles 25, 27, 28, paragraph 4, or 31 shall, as rapidly as possible, notify the requesting Party:
(a) that the request is agreed to;
(b) that the request is denied; or
(c) of reasonable alternative proposals to the request. It may also propose prohibition or restriction of other flights in the area during the time involved. If the Party which submitted the request accepts the alternative proposals, it shall notify the other Party of such acceptance.

4. The Parties shall take the necessary measures to ensure that notifications and agreements can be made rapidly.

5. The Parties shall also take the necessary measures to disseminate rapidly the substance of any such notifications and agreements to the military units concerned and shall instruct those units regarding the means of identification that will be used by the medical aircraft in question.

Art 30. Landing and inspection of medical aircraft

1. Medical aircraft flying over areas which are physically controlled by an adverse Party, or over areas the physical control of which is not clearly established, may be ordered to land or to alight on water, as appropriate, to permit inspection in accordance with the following paragraphs. Medical aircraft shall obey any such order.

2. If such an aircraft lands or alights on water, whether ordered to do so or for other reasons, it may be subjected to inspection solely to determine the matters referred to in paragraphs 3 and 4. Any such inspection shall be commenced without delay and shall be conducted expeditiously. The inspecting Party shall not require the wounded and sick to be removed from the aircraft unless their removal is essential for the inspection. That Party shall in any event ensure that the condition of the wounded and sick is not adversely affected by the inspection or by the removal.

3. If the inspection discloses that the aircraft:
(a) is a medical aircraft within the meaning of Article 8, sub-paragraph j),
(b) is not in violation of the conditions prescribed in Article 28, and
(c) has not flown without or in breach of a prior agreement where such agreement is required,

the aircraft and those of its occupants who belong to the adverse Party or to a neutral or other State not a Party to the conflict shall be authorized to continue the flight without delay.

4. If the inspection discloses that the aircraft:
(a) is not a medical aircraft within the meaning of Article 8, sub-paragraph j),
(b) is in violation or the conditions prescribed in Article 28, or
(c) has flown without or in breach of a prior agreement where such agreement is required,

the aircraft may be seized. Its occupants shall be treated in conformity with the relevant provisions of the Conventions and of this Protocol. Any aircraft seized which had been assigned as a permanent medical aircraft may be used thereafter only as a medical aircraft.

Art 31. Neutral or other States not Parties to the conflict

1. Except by prior agreement, medical aircraft shall not fly over or land in the territory of a neutral or other State not a Party to the conflict. However, with such an agreement, they shall be respected throughout their flight and also for the duration of any calls in the territory. Nevertheless they shall obey any summons to land or to alight on water, as appropriate.

2. Should a medical aircraft, in the absence of an agreement or in deviation from the terms of an agreement, fly over the territory of a neutral or other State not a Party to the conflict, either through navigational error or because of an emergency affecting the safety of the flight, it shall make every effort to give notice of the flight and to identify itself. As soon as such medical aircraft is recognized, that State shall make all reasonable efforts to give the order to land or to alight on water referred to in Article 30, paragraph 1, or to take other measures to safeguard its own interests, and, in either case, to allow the aircraft time for compliance, before resorting to an attack against the aircraft.

3. If a medical aircraft, either by agreement or in the circumstances mentioned in paragraph 2, lands or alights on water in the territory of a neutral or other State not Party to the conflict, whether ordered to do so or for other reasons, the aircraft shall be subject to inspection for the purposes of determining whether it is in fact a medical aircraft. The inspection shall be commenced without delay and shall be conducted expeditiously. The inspecting Party shall not require the wounded and sick of the Party operating the aircraft to be removed from it unless their removal is essential for the inspection. The inspecting Party shall in any event ensure that the condition of the wounded and sick is not adversely affected by the inspection or the removal. If the inspection discloses that the aircraft is in fact a medical aircraft, the aircraft with its occupants, other than those who must be detained in accordance with the rules of international law applicable in armed conflict, shall be allowed to resume its flight, and reasonable facilities shall be given for the continuation of the flight. If the inspection discloses that the aircraft is not a medical aircraft, it shall be seized and the occupants treated in accordance with paragraph 4.

4. The wounded, sick and shipwrecked disembarked, otherwise than temporarily, from a medical aircraft with the consent of the local authorities in the territory of a neutral or other State not a Party to the conflict shall, unless agreed otherwise between that State and the Parties to the conflict, be detained by that State where so required by the rules of international law applicable in armed conflict, in such a manner that they cannot again take part in the hostilities. The cost of hospital treatment and internment shall be borne by the State to which those persons belong.

5. Neutral or other States not Parties to the conflict shall apply any conditions and restrictions on the passage of medical aircraft over, or on the landing of medical aircraft in, their territory equally to all Parties to the conflict.

Appendix 5 The articles of data analysis in chronological order

Year and author of publication	Title	Type of data	Publisher	Findings
2006. Weissman, F.	Darfur: Humanitarian aid held hostage	Article [online], originally published on Le Monde.	Médecins San Frontières. International medical humanitarian organisation. http://www.msf.org/msf/about-msf/about-msf_home.cfm	Increased insecurity, also in areas under government control Suspension of operations due to security concerns Direct targeting International military and aid organisations possess a threat to government Negotiations are challenging since neutrality of organisations is compromised due to international politics
2009. Stoddard, A., Harmer, A. & DiDomenico, V.	Providing aid in insecure environments: 2009 Update.	Briefing paper/ research	Humanitarian Policy Group (HPG) / Overseas Development Institute (ODI). HPG is a team of international researchers and professionals working on humanitarian issues. ODI is a UK based registered charity focusing on international development and humanitarian issues. http://www.odi.org.uk/about	Attacks have increased, especially in most violent areas High rates for international staff, but also increasingly for national Attacks politically motivated

				Security threats, acceptance, dilemma of remote management, and relying on natives might not be enough Relying on humanitarian principles is debatable Lack of systematic documentation of injuries and violation, especially considering natives
2010. Merlin	A grave new world	Campaign paper	Merlin: Registered UK based International Health Charity. http://www.merlin.org.uk/about-us	Attacks have increased Humanitarians as easy targets Economic gains from attacks Blurred vision of what is humanitarian aid Lack of security for native workers, remote management issues Insecurity causes restrictions

2010. Rubestein, L.S. & Bitte, M.D.	Responsibility for protection of medical workers and facilities in armed conflicts	Research article	Health Policy. Journal of health issues and systems. Editor-in-Chief: Professor Reinhard Busse.	Attacks to health care have become part of modern warfare Lack of respect to medical ethics Attacks are increasing leading to lack of staff, departures, and compromising access to health care Compared to other war crimes, attacks on health care institution receives less attention Lack of evidence-based and systematic data Importance of International Humanitarian Law, already existing guidelines needing to be strongly applied Attacks with political, military, and economic gains International political pressure, need for strategies for protection and accountability

2011. Egeland, J., Harmer, A. & Stoddard, A.	To Stay and deliver: Good practice for humanitarians in complex security environments	Independent study	Office for the Coordination of Humanitarian Affairs (OCHA). Part of United Nations Secretariat for humanitarian issues. http://www.unocha.org/about-us/who-we-are	Armed escorts compromise humanitarian principles and action Governments affection on aid delivery: ban of access, undermined negotiations Criminal groups attacking humanitarians for ransom, power, political advantage, and economical gains Attacks have become more complex involving several parties e.g. international security Problem with natives: less security training
2011. ICRC	Health Care in Danger: Making the case	Brochure	The International Committee of Red Cross. International humanitarian organisation. http://www.icrc.org/eng/who-we-are/index.jsp	Highly increased attacks Active fighting brings access issues, displacement, and disruption of health care Hospitals do not necessarily remain neutral: launched attacks, political propaganda

				High criminality Natives bear the most of violation
2011. ICRC	International Humanitarian Law and the challenges of contemporary armed conflicts. 31st International Conference of the Red Cross and Red Crescent	Report	The International Committee of Red Cross. International humanitarian organisation. http://www.icrc.org/eng/who-we-are/index.jsp	Attacks have increased Health care part of warfare Insecurity causes lack of access Deprivation of care Conflicts are longer with economic and political motives Government, military, and bandits have influence on the delivery of humanitarian aid
2011. MSF	Activity Report 2011	Report	Médecins San Frontières. International medical humanitarian organisation. http://www.msf.org/msf/about-msf/about-msf_home.cfm	MSF had to suspend activities due to demands of authorities Blurring vision of humanitarian aid Negative influence of international politics, military, and international community to humanitarian aid Problems with negotiations and fulfilling humanitarian

				mission Need for humanitarian space
2011. MSF	Health services paralyzed: Bahrain's military crackdown on Patients.	Briefing paper	Médecins San Frontières. International medical humanitarian organisation. http://www.msf.org/msf/about-msf/about-msf_home.cfm	Hospitals have become places to be feared Problems with authorities Politicised health care: Hospitals part of warfare, political propaganda Compromised neutrality
2011. Stoddard, A., Harmer, A. & Haver, K.	Aid worker security report 2011. Spotlight on security for national aid workers: Issues and perspectives	Report	Humanitarian Outcomes. Team of specialist providing research and policy advice for humanitarian aid organisations and donor governments. http://www.humanitarianoutcomes.org/index.php	Attacks increased since 2008, political motives Problems come when associated with Western politics and military Natives bear most of the violation: remote management issues and lack of security training
2012. MSF	Syria: Safety of wounded and medical workers must be prioritized	Press release	Médecins San Frontières. International medical humanitarian organisation. http://www.msf.org/msf/about-msf/about-msf_home.cfm	Health care targeted and threatened Deprivation of care, lack of access Need for respect towards medical community

				Compromised neutrality of health care Problems with government
2012. Serle, J. & Fleck, F.	Keeping health workers and facilities safe in war	Article	The Bulletin. A public health journal of World Health Organisation (WHO).	Adherence to humanitarian principles might be difficult "Knock on effect" of increased violation towards health care workers Hospitals part of warfare Increased attacks Negotiation issues with all parties of conflict International Humanitarian Law needs to be applied