



World Health
Organization

A GUIDANCE DOCUMENT FOR MEDICAL TEAMS RESPONDING TO HEALTH EMERGENCIES IN ARMED CONFLICTS AND OTHER INSECURE ENVIRONMENTS



**A GUIDANCE DOCUMENT FOR MEDICAL
TEAMS RESPONDING TO HEALTH
EMERGENCIES IN ARMED CONFLICTS ⁽¹⁾ AND
OTHER INSECURE ENVIRONMENTS²**

¹ This general expression covers confrontations between: two or more states; state and a body other than a state; a state and a dissident faction; two or more organized armed groups within a state (<https://www.icrc.org/en/doc/assets/files/other/opinion-paper-armed-conflict.pdf>)

² Defined as areas/regions with a heightened level of risk to personnel, facilities, patients, and operations from various types of violence.

Contents

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i. Foreword

Conflict and war have a catastrophic effect on the health and well-being of nations and have evolved considerably over recent decades. As a result, a significant rise in humanitarian crises, including urban violence, means more people are affected for longer periods with disruption in the delivery of basic services a dire reality.

Health interventions and innovative approaches in responding to the challenges of humanitarian crises have the potential to save lives and lessen the impact of conflicts on civilians.

Medical teams working in armed conflict and other insecure environments frequently face serious threats to their security and safety. Such challenges need to be overcome in order to access patients, with teams sometimes having to deal with limited acceptance by the communities in which they work and parties to the conflict.

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

This publication, also referred to as the “Red Book”, offers a guidance framework and introduces additional verification requirements for medical teams preparing for or involved in responding to health emergencies in armed conflict and other insecure environments.

Developing this document has been a broad consultative process and I am confident it will support countries and organizations in fulfilling their patient-centred mission to save lives, alleviate suffering and protect vulnerable populations.

I would like to extend my sincere appreciation to medical teams working tirelessly in the field under threats, to the EMT Secretariat for leadership in bringing this guidance to fruition and to all contributors, both those who participated in formal working groups and those who provided input through informal channels.



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iii. Abbreviations

- ATLS** Advanced Trauma Life Support
- CCHN** Centre of Competence on Humanitarian Negotiation
- CBRN** Chemical, Biological, Radiological, Nuclear Threats
- EMT** Emergency Medical Team
- EMTCC** EMT Coordination Cell
- EOC** Emergency Operations Centre
- ERC** Emergency Relief Coordinator
- FMA** Foreign Military Assets
- HEAT** Hostile Environment Awareness Training
- IASC** Inter-Agency Standing Committee
- ICRC** International Committee of the Red Cross
- IDP** Internally displaced people
- IFRC** International Federation of Red Cross and Red Crescent Societies
- IHL** International humanitarian law
- IHRL** International Human Rights Law
- IPV** intimate partner violence
- MHPSS** Mental health and psychosocial support
- MoD** Ministry of Defence
- MSF** Médecins sans Frontières
- NGO** Nongovernmental organization
- OCHA** United Nations Office for the Coordination of Humanitarian Affairs
- PEP** post-exposure prophylaxis
- PPE** personal protective equipment
- PTSD** Post-traumatic stress disorder
- QIPs** Quick Impact Projects

iv. Tables, figures and examples

RC Resident Coordinator		
R&R Rest and Recreation		
SGBV sexual and gender-based violence		
SRSG Special Representative of the Secretary-General		
SSAFE Safe And Secure Approaches In Field Environments Training		
STIs sexually transmitted infections		
TSP Trauma Stabilization Point		
UN United Nations		
UN-CMCoord UN Humanitarian Civil-Military Coordination		
UNHCR United Nations High Commissioner for Refugees		
UNSC UN Security Council		
WASH water, sanitation and hygiene		
WHO World Health Organization		
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v. Structure of the Red Book

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

Table 1. Structure of the Red Book

<p>Introduction</p> <p>What is the Red Book?</p> <p>How to use the Red Book?</p>	<ul style="list-style-type: none"> • What, why, when, who, where, how? • Verification and classification requirements • Medical teams and categories defined • Guiding principles for Blue and Red Books • Limitations • The future of humanitarian assistance
<p>Chapter 1</p> <p>International humanitarian law (IHL) and core humanitarian principles in action</p>	<ul style="list-style-type: none"> • Do No Harm! • IHL and core humanitarian principles defined and practical applications • The realities: consequences and implications • Scenarios • Negotiations • Community engagement
<p>Chapter 2</p> <p>Guidance on safety and security</p> <p>Risk management</p>	<ul style="list-style-type: none"> • Hazard and threat identification • Team mental health and well-being • Medical evacuation • CBRN considerations
<p>Chapter 3</p> <p>Guidance on coordination</p>	<ul style="list-style-type: none"> • Coordination principles and considerations • Types of deploying teams • Types of coordination platforms and modalities: national, United Nations global, United Nations clusters, EMT CC, UN-CMCoord, movement, and other.
<p>Chapter 4</p> <p>Guidance on sexual and gender-based violence (SGBV) and protection</p>	<ul style="list-style-type: none"> • What teams need to know • Components of the medical response • Protection, risk mitigation and advocacy • Self-care • Media approaches
<p>Chapter 5</p> <p>Core technical standards for essential emergency clinical care and rehabilitation</p>	<ul style="list-style-type: none"> • Essential emergency clinical and pre-hospital care (including outbreaks) • Clinical guidance per level of care • Nursing care • Rehabilitation • Mental health and psychosocial support (MHPSS)
<p>Chapter 6</p> <p>Selected topics in operations</p>	<ul style="list-style-type: none"> • Logistics, human resources, finance, administration, planning, hand-overs, records management, and monitoring and evaluation.
<p>Chapter 7, Annexes, references, bibliography and contributors</p>	<ul style="list-style-type: none"> • Readiness for deployment checklist for armed conflict • Summary guide to deployment • GBV essential equipment, medicines, and other supplies for examination • Post-rape physical examination checklist • Challenges and dilemmas • Contributors • Bibliography

vii. Important note on the Blue Book and Red Book

The “Blue Book” [2], initially published as: Classification and Minimum Standards for Foreign Medical Teams (FMT) in Sudden Onset Disasters, has been updated as the main reference document for emergency medical teams (EMT) inclusive of both national and international teams responding to disasters and outbreaks. The Blue Book identifies the guiding principles, core and technical standards to be met by EMTs when responding to sudden onset disasters and/or other emergencies [3]. The current process for classification and validation has identified four principal types of medical teams (Type 1 mobile, Type 1 fixed, Type 2, Type 3), and a number of specialized care teams (see Blue Book). The Red Book introduces additional verification requirements for EMTs preparing for or involved in responding to health emergencies in armed conflict and other insecure environments (see Annex 1). The two texts should be viewed as a continuum, with the baseline requirements of a response captured in the Blue Book and the additional requirements of a response in armed conflict and other insecure environments captured in the Red Book.

Team type refers to the medical capacity, while team category (see section B below) refers to the team affiliation or organization.

EMTs [4] are defined as groups of health professionals, including doctors, nurses, paramedics, support workers, logisticians, who treat patients affected by an emergency or disaster. They come from governments, charities/nongovernmental organizations (NGOs), the military, civil protection, international humanitarian networks, including the International Red Cross and Red Crescent Movement, Médecins sans Frontières (MSF), United Nations contracted teams and the private-for-profit sector. They work according to minimum standards agreed upon by the EMT community and its partners, and deploy fully trained and self-sufficient so as not to burden an already stressed national system.

The guidance provided by the Red Book is intended for medical teams that deploy into armed conflict and other insecure environments, and therefore the technical content is appropriate to both classified EMTs and other medical teams (see team categories Table 4).

viii. How to use the Red Book

The Red Book provides expanded guidance on:

1. IHL and core humanitarian principles in action
2. Safety and security
3. Coordination platforms
4. Sexual and gender-based violence and protection
5. Essential emergency clinical care and rehabilitation
6. Selected topics in operations

The Blue Book and Red Book are complimentary and designed to be used together by EMTs responding to health emergencies in armed conflict and other insecure environments. The classification criteria and processes described in the Blue Book are retained and expanded upon to address the contexts described in the Red Book (see Annex 1). Chapters in both books are not stand-alone and need to be read as interconnected and complementary.

The Red Book is designed to be used in conjunction with the Blue Book, and to provide practical guidance, advice, and recommendations. The actions of teams and leaders must at all times ensure safety and security for Self, Scene, and Survivor (3 S's) [5]. Taking undue risks in war that result in the death or injury of team members will not only deny the wounded and sick the medical care they need but will likely result in the withdrawal of other teams and thereby severely compromise the entire operation. Teams do not work in a vacuum and the actions of one team, both positive and negative, can have repercussions for other teams and/or an entire operation.



A. Why, What, Where, Who, When, and How?

The Red Book extracts from references and summarizes the most relevant sections from existing guidelines, manuals, and recommendations published by medical and humanitarian authorities from around the globe, including the World Health Organization (WHO), other UN agencies/bodies,³ MSF, the International Committee of the Red Cross, NGOs,⁴ other agencies/organizations, and the SPHERE standards. These references, while not exhaustive, will help guide medical teams to make principled, patient-focused humanitarian decisions.

1. Why?

Medical care for people caught up in armed conflict and other insecure environments saves lives and alleviates suffering. It is one of the most immediate and high priority needs of an affected population and is often the first type of response activated and/or requested by authorities and affected communities. Medical teams working in armed conflict and other insecure environments frequently face serious threats to their security and safety, challenges to patient access, and at times limited acceptance by affected communities in which they work and parties to the conflict. Such difficulties are likely to increase (6) and thereby creating a critical need to establish contact and trust with all sides in conflicts and in other insecure environments to ensure operational continuity. This trust can best be achieved when all sides perceive the medical teams to be neutral, impartial, and independent, and specifically not aiding (or being perceived to aid) any one party to achieve a military, political or economic advantage. For medical teams that are deploying increasingly closer to the frontlines, the implications of and consequences for both staff and patients of teams not being fully prepared, and/or not fully comprehending the context in which they work, can be severe. Medical response can easily be hindered or compromised by intentional or unintentional acts and the behaviour and conduct of the teams themselves.

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

³ For example, UNSC Resolution 2286; demanding that all parties to armed conflict fully comply with IHL and protection of medical and humanitarian workers

⁴ Term 'NGO' in this document also includes Civil Society Organizations (CSO), and Private Voluntary Groups (PVO)

2. What?

The document details a principled and evidence-based practical framework to support the safety of medical teams when providing clinical care, and to facilitate their access and acceptance and the protection of patients by respecting core humanitarian principles and ethical conduct within the “humanitarian space”,⁵ while being guided by international humanitarian law (IHL).

The document includes practical guidance on key thematic areas with the view that principled and secure medical care in armed conflict requires a full 360-degree awareness of an entire operation (meaning beyond the perimeter of a field hospital or a medical facility). The Red Book includes questions and checklists to aid teams in being better prepared for and respond to armed conflict, insecurity, and violence.

The patient-centred clinical care Chapters 4 and 5 cover a spectrum of injuries and diseases, including trauma care, non-trauma care, infectious disease management, support for outbreak response, burns management, emergency maternal and paediatric care, rehabilitation and sexual and gender-based violence (SGBV).

3. Where?

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

“In order for IHL treaties to apply to a situation of violence, that situation must constitute an armed conflict. As different sets of rules apply to international and non-international armed conflicts, it is also important to identify the nature of the conflict. The entirety of the four Geneva Conventions, as well as the rules of Additional Protocol apply to international armed conflicts (7), while Article 3 Common to the four Geneva Conventions and Additional Protocol II apply (to state signatories) and non-international armed conflicts” (8). Moreover, customary international humanitarian law contains common rules relevant to access to, and delivery of, medical care which apply in all types of international and non-international armed conflict (9). Under international humanitarian law, impartial humanitarian organizations have a right to offer their services

to conduct humanitarian activities, including engaging with state and non-state parties for the protection of victims of armed conflict. For instance, in the case of non-state actors, the Geneva Call⁶ formal unilateral declarations called Deed of Commitments (10, 11) has been utilized.

The core standards and guidance are global and applicable to EMTs responding to health emergencies occurring in armed conflict and/or other insecure environments. EMTs will always be providing services within a much wider response and chain of management or coordination structure guiding the particular operation and, therefore, must be aware of the broader context and needs. Table 2 (12) can serve as a tool for context analysis, needs assessment, risks, and a range of key themes to be addressed.

Table 2. Adapted from ICRC War Surgery (12): Humanitarian intervention for the wounded and sick

	OPTIMAL	AUSTERE	DIRE
Location	Urban in a developed country	Poor rural area	Developing country major destruction
Duration of trouble	Single, isolated event (e.g. act of terrorism)	Ongoing low-intensity fighting (e.g. guerrilla warfare)	Continuous heavy fighting and/or bombardment
Casualty flow	Small irregular numbers (compared to the population of the city)	Discontinuous/ intermittent flow, including massive influx	Continuous but unpredictable flow, including massive influx
Infrastructure (roads, ambulance service, health facilities)	Intact and functioning	Poor or irregular (e.g. few good roads, limited number of ambulances, etc.)	Severely damaged or dysfunctional (roads damaged, debris in streets, hospitals looted, etc.)
Communications	Good	Poor to moderate irregular	None or poor
Personnel	Adequate (in number and skills)	Variable	Minimum available or complete lack
Materials and supplies	Adequate (in quantity and quality)	Irregular and inadequate	Irregular supply or non-existent
Environment	Good (daytime, good weather)	Harsh	Bleak (night, cold, heat, etc.)
Evacuation	Safe and short	Predictable but long and arduous	Uncertain or unknown

⁵ Humanitarian space denotes the protected physical or symbolic space which humanitarian agencies need to deliver their services in accordance with core humanitarian principles.

⁶ In situations of armed conflict, Geneva Call, as a neutral, impartial and independent international humanitarian organization, endeavours to strengthen the respect of humanitarian norms and principles by armed non-state actors (ANSAs), in order to improve the protection of civilians.

Destination of transfers	Known and available	Known but variable	Unknown or absent
Team security	Security context requires routine risk management measures.	Security context requires adaptation to routine measures and/or additional specific measures.	Context requires substantial changes to the team's security profile and/or alternative methods for delivering the programme.

4. Who?

EMTs and medical teams in general will have different affiliations and are categorized accordingly in the Red Book. These include classified national and international EMT, governmental, nongovernmental organizations (NGOs), civil society groups, UN contracted, private-for-profit, Red Cross/Red Crescent, private voluntary organizations and military teams. While all teams deploying to armed conflict and other insecure environments can make use of this document before, during, and after deployments, not all teams can be deployed under the EMT mechanism supported by WHO. See Table 3 for Blue and Red Book contexts, similarities and differences.

According to the International Committee of the Red Cross (ICRC), the definition of health-care personnel encompasses all those working in the area of health care. This includes those working in: hospitals, clinics, first-aid posts and ambulances; health-care personnel, whether working in medical facilities, in ambulances or as independent practitioners; all persons on the premises of medical facilities, including the wounded and sick and their caregivers; Red Cross and Red Crescent staff involved in the delivery of health care, including volunteers; health-oriented NGOs; military health-care facilities and their personnel (13).

It also encompasses their headquarters and field level personnel: management, medical, administrative, communications, logistics, technical and support teams.

5. When?

The application of guidance before, during and post deployments will best inform the policies, plans and processes required to achieve principled, coordinated, safe, and successful medical missions. The guidance notes, checklists and core standards are intended to be applied across the entire deploying organization, including their strategic and operational management and policy developers, headquarters and field offices, including a team's response and return.

Operational engagement requires coordination through established mechanisms, particularly the UN Health Cluster and International Red Cross and Red Crescent Movement.

6. How

The content is presented as a set of recommendations, guidance notes, technical, and core standards. These have been co-authored by experts from multiple agencies/nations and maintained by a community of practice representing stakeholders from a wide representative cross section, including NGOs, governments, the military, UN agencies, ICRC, MSF, Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO), Office of U.S. Foreign Disaster Assistance (OFDA) and academia.

7. Team classification for armed conflict and other insecure environments

Current processes within the Blue Book for engaging with EMTs involve robust pre-verification, verification and classification components. However, the additional threats faced by medical teams and populations in armed conflicts and other insecure environments require there be further steps in preparedness, as detailed in the Red Book.

The level of effort and processes involved in preparing for, deploying to, and returning from response missions to armed conflicts are complex and demanding, and require a high level of attention to detail, as well as awareness of multiple internal and external factors.

Conflicts and other insecure environments, by definition, are dynamic, unpredictable, complicated and often with many local, regional and international stakeholders and across a range of interests and agendas.

Operating successfully in such contexts requires a deep 360-degree awareness of the nature and dynamics at play. Well-prepared teams will have both a solid foundational training in the evolving nature of conflict and the best methods for coping and delivering safe patient care.

Annex 1 provides a checklist that extends the Blue Book verification and classification requirements. Teams wishing to declare their readiness and capacity to respond to armed conflicts are required to ensure compliance with the set of points listed. The Red Book checklist is not a stand-alone list and builds upon the current verification and classification processes in the Blue Book.

B. WHO role and functions

WHO is a specialized agency of the United Nations headquartered in Geneva, Switzerland and is the directing and coordinating authority on international health. It provides leadership in global environmental health matters; shapes the health research agenda; sets health norms and standards; articulates evidence-based policy options; provides technical support to countries; and monitors and assesses health trends.

WHO works with its 194 Member States across six regions and through more than 150 offices. The principle that all people should enjoy the highest standard of health regardless of race, religion, political belief or economic or social condition, has guided WHO's work for the past 70 years since it was set up as the lead agency for international health within the then new United Nations system.

WHO and its teams have multiple roles in an operational response, including support to ministries of health, coordination, outbreak alerts and response ⁽¹⁴⁾, technical support and advice, provision of supplies, mobilization of providers, health cluster lead (see Chapter 3), and Emergency Medical Teams Coordination Cell (EMTCC) lead. Where there are critical gaps in humanitarian response, it is the responsibility of cluster leads to call on all relevant humanitarian partners to address those needs. If this fails, and depending on the urgency and type of emergency, WHO as the cluster lead for health and "provider of last resort", may need to commit to filling the gap.

In armed conflicts, IHL requires the parties to the conflict to provide medical care for the wounded and sick. If they are unwilling or unable to do, they must ensure safe and secure access to medical assistance by other teams (elaborated upon in Chapter 2).

WHO has an internal Operations Guidance Paper that outlines how and when the organization will engage in the provision of trauma care in armed conflict and specifies the roles and responsibilities of WHO and its supported partners such as governmental, military, nongovernmental organization (NGO), civil society, private-for-profit and UN). The document reminds parties to the conflict of their obligations under IHL and discussions with national authorities, ICRC, MSF, and other humanitarian actors.

WHO's *guidelines for essential trauma care* in conflict situations includes the following.

"WHO will consult with the ICRC, other humanitarian actors and operational partners regarding their capacity and responsibilities."

"If no organization provides the necessary care to the wounded and sick,⁷ and WHO has established that there are clear and unmet needs, WHO is within its mandate to provide relevant services."

"All teams supported by or contracted by WHO must agree to providing services in a principled humanitarian manner, adhere to professional standards and ethical principles, provide quality care services and coordinate with national authorities and coordinating bodies."

Moreover, similar to the Sphere Handbook ⁽¹⁵⁾ Humanitarian Charter and Minimum Standards in Humanitarian Response in approach, the Red Book affirms the following commitment:

"By adhering to the Core Humanitarian Standards and the Minimum Standards of the Blue Book, we commit to making every effort to ensure that people affected by disasters or conflict have access to at least the minimum requirements for life with dignity and security, including adequate water, sanitation, food, nutrition, shelter and health care. To this end, we will continue to advocate that states and other parties meet their moral and legal obligations towards affected populations" ⁽¹⁶⁾.

⁷ Defined as Persons, whether military or civilians, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility. Medical units and personnel.

I. Introduction and guiding principles

Medical teams (regardless of type or category and affiliation) responding to armed conflict and other insecure environments are expected to fulfil a patient-centred ^[17] mission to save lives, alleviate suffering, protect vulnerable populations, and mitigate the impact of war and violence in highly insecure, austere, and resource limited environments, and often spanning a continuum of care.

Therefore, teams require access to the affected population, which in turn requires acceptance by the population themselves and the parties to the conflict. This will be rooted in some level of trust which can also contribute to enhanced team security.

Teams need to exercise special precautions to ensure their actions respect core humanitarian principles, meet core clinical standards of care, and are ethical in their conduct while being guided by IHL. The consequences, positive or negative, can have impacts well beyond the timeframe of their intervention. The perceptions of the civilian population, authorities and armed groups of the conduct of medical teams are of paramount importance. Therefore, all behaviour, conduct, and communications must be carried out in a way that enables humanitarian missions and promotes trust from, and access to, all those in need. Seemingly harmless acts, like taking photos (with telephones, cameras or drones), socializing informally with parties to a conflict, dressing in military style attire, displaying national/religious symbols, expressing opinions on social and regular media, and/or operating in close proximity to armed groups, can all have serious unintended consequences for the team and their patients. In fact, an entire deployment may be compromised and the negative impact and damaged reputations (of people and organizations) can last for years afterwards and affect subsequent delivery of health care.

a. Guiding principles for the Blue and Red Books

The contexts and guiding principles for the Blue and Red Books.

Table 3. Blue and Red Book contexts, similarities and differences

Blue Book	Red Book
<p>All EMT types, including specialized care teams, should comply with these guiding principles that govern the practice of teams and individuals.</p> <p>Teams may support existing health facilities or set up stand-alone facilities.</p>	<p>All EMT types, including specialized care teams, should comply with these guiding principles governing the practice of teams and individuals.</p> <p>Teams may take over existing facilities, set up stand-alone facilities, or embed/co-locate into existing civilian structures. Distance from frontlines will vary.</p> <p>Note: some governmental and military medical teams will not be able to deploy under the EMT mechanism as they will face limitations in applying some principles given the nature of their deployment, such as being embedded within a military operation (see Chapter 1).</p>
<p>Contexts Natural disasters including both slow and sudden onset, disease outbreaks, industrial/technological accidents, refugee and internally displaced people (IDPs) settings, that overwhelm local responders but occur in contexts of a sovereign state without armed conflict or insecurity.</p>	<p>Contexts ^[12] Armed conflicts, whether international or non-international, as well as other protracted emergencies, armed revolts, civil disturbances, and other situations of extreme violence and insecurity. Refugee and IDP settings, natural disasters, and disease outbreaks in contexts above would follow these guiding principles.</p>
<p>1. Quality care: the EMT provides safe, timely, effective, efficient, equitable and people-centred care.</p>	<p>Same principles apply. The specific pathology in armed conflict requires adapted training and treatment protocols with attention to damage control approach.</p>

2. Appropriate response: the EMT offers a “needs driven” response according to the context and type of emergency in the affected nation.

Same principle applies framed in humanity and impartiality.⁸ Teams to focus on priority lifes-aving needs.

Assumes population has access to the medical team, and vice versa. Note: this may not be the case for military and governmental teams, but both can apply the same principle in areas they can safely reach and where they are accepted by the population.

3. Accessible care: the EMT adopts a human-rights based approach to their response and ensures they are accessible to all sections of the population affected by the emergency, particularly the vulnerable and those requiring protection.

A practical humanitarian approach, framed by international humanitarian law (IHL) and core principles is required with a focus on gaining and maintaining access to all in need without discrimination, as well as ensuring acceptance, and security for teams and patients.

4. Ethical care: the EMT undertakes to treat patients in a medically ethical manner at all times.

Same principle applies. War and chaos cannot be excuses to compromise ethics and the medical principle of “Do No Harm” (see section 1.1).

5. Accountable care: the EMT commits to be accountable to the patients and communities they assist, the host government and ministry of health, their own organization and donors.

Accountability to patients is retained, while accountability to the authorities is context specific and needs special consideration. The Principle of Neutrality needs to be maintained. Teams must avoid the perception of being parties to a conflict through non-neutral actions.

Note: military or governmental teams are also bound by their own government’s direction and implications and therefore not all may be considered neutral (see section 1.2.2).

6. Coordinated response: The EMT commits to a coordinated response under the designated national health emergency management authorities Emergency Operations Centre (EOC) or incident management system equivalent, and collaborates with the national health system, their fellow EMTs, and the international humanitarian response community, where relevant.

Commitment to coordination with key stakeholders and providers on all sides of a conflict is retained and required. However, principles of neutrality and independence need to be maintained. Teams are to avoid the perception of being parties to a conflict if associated with a governmental/military/UN coordination platform.

Note: with context specific exceptions for military, governmental, and some UN Peacekeeping or UN contracted teams who would not be designated as humanitarian actors.

b. Categories of medical teams

Table 4. Categories of medical teams

Team category	Blue Book Sudden onset disasters/ emergencies/outbreaks	Red Book Health emergencies in armed conflict and other insecure environments
1. EMT Civilian Classified ⁹ 1.a Civilian NGO national 1.b Civilian NGO international 2. EMT governmental 2.a Ministry of health (Classification not applicable) 2.b International, Classified 3. EMT, private-for-profit Classified	Ministry of health grants access and permits to practice Types 1, 2, or 3 (or specialized) as per EMT Classification Process (cross-referenced to Blue Book). Some teams may be contracted by various UN agencies Classification is not applicable to ministry of health and ministry of defence (MoD) teams operating nationally	Negotiated access and permission via parties to the conflict or authorities. Types 1, 2, or 3 (or specialized) as per EMT Classification process. Additional Classification requirements need to be met. See Annex 1. Classification is not applicable to ministry of health and MoD teams operating nationally.
4. Civilian medical teams National or international	Standards apply Mandates and capacities will vary Ministry of health may not grant access or permits	Standards apply Negotiated access and permission via parties to the conflict or authorities.
5. Red Cross Red Crescent medical teams 6.a Local national society 6.b IFRC (natural disasters) 6.c ICRC (conflict)	Classified via Movement channels and standards by International Federation of Red Cross and Red Crescent Societies (IFRC) (standards aligned with EMT) Local national societies are lead coordinator (supported by IFRC) Additional Movement standards apply	Classified via Movement channels and standards Additional movement standards apply ICRC is the lead coordinator of the Movement’s international response
7. Private-for-profit medical teams	Standards apply Ministry of health may not grant access or permits. Mandates and capacities will vary Some teams may be contracted by various UN agencies.	Standards apply Background agenda of contracting party may be an issue. Some teams may be contracted by various UN agencies.
8. Military medical teams national or international	Bilateral deployments via MoD/ ministry of health Standards apply Mandates and capacities will vary	Bilateral state to state or military to military deployments (not under the EMT mechanism supported by WHO). Additional standards and mandates may apply.

⁸ It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

⁹ Classified Teams is inclusive of teams currently in the mentoring and peer review verification processes.

c. Limitations

Medical missions in situations of armed conflict or other emergencies are extremely context-specific and require constant analysis and adjustment as dictated by the realities on the ground. Therefore, it is not possible to provide one prescriptive way of doing things.

Humanitarian assistance is often undermined by the following.

1. Despite the best of efforts by teams and nations, global trends in the conduct of hostilities, including the disrespect of IHL, may limit the acceptance, access to patients and safety of medical teams.
2. National and international medical teams may not have the freedom or space to provide independent, impartial and neutral assistance. In some cases the work may even be criminalized if defined as support to “extremist” or “radical” groups.
3. Some people, authorities and organizations still express opposition to IHL and core humanitarian principles as an “external” or “foreign” construct.
4. Some state and nonstate actors overtly or covertly can instrumentalize medical missions that are perceived as supporting the achievement of certain military/political/economic objectives.
5. The duty of care¹⁰ required of team members may be difficult to deliver, when engaging with and/or recruiting local personnel. For example, evacuations out of the country, provision of insurance, and/or protection from armed groups or factions.
6. The differing and often contradictory incentives, motivations, and disincentives facing deploying organizations rooted in donor and organizational agendas that may not always promote principled and ethical actions and needs-based prioritization.
7. The wide range of medical teams with broad and differing standards of practice, definitions of quality, resources, mandates and missions.

¹⁰ Duty of care: The legal concept of duty of care presumes that organizations “are responsible for their employees” well-being and must take practical steps to mitigate foreseeable workplace dangers, a responsibility that takes on additional implications when the employees are working overseas.

d. What the Red Book does not do

The Red Book does not replace the critical need for states and nonstate armed groups, friendly nations, and/or the UN to engage in negotiations and seek diplomatic solutions to end/suspend hostilities.

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



II. The future of humanitarian assistance

Given the very dynamic, fragile, and evolving nature of field and global realities, and their impact upon humanitarian operations, it is critical that medical teams regularly scan the environment and anticipate change. Teams need to learn and adapt their plans, policies, systems, personnel profiles, and approaches to remain relevant and fit for purpose. Decisions made today are already shaping the future. Decisions related to recruitment, equipment, technologies, policies, strategic priorities will ripple forward for five to 10 years.

Much has been written about the future of the humanitarian landscape [19-21]. The Red Book, where appropriate, incorporates relevant considerations for medical teams, given the trends in the changing nature of warfare; evolving medical technologies; evolving standards of health-care delivery in conflict, and geopolitical dynamics. Today's global phenomena are manifest in increased fragmentation of the political world order; trade wars; cyber-attacks; politicization of aid; challenges to previously accepted global values/norms; and lack of adherence to long established treaties. To adapt to such complexity and access people in need, medical teams require enhanced vigilance, stronger partnerships, more collaboration and plans rooted in interdependence.

These trends also require teams and organizational leadership to be more agile, flexible, adaptable, and principled to cope with a complex, dynamic and often confusing operational landscape. Importantly, the "soft skills" demonstrated through good communications, negotiating abilities, humility, meaningful community engagement [22] and acceptance are of increasing importance for current and future missions.

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

First, warfare is increasingly asymmetric, and trends include siege tactics, urban warfare [23], proxy wars, a focus on counterterrorism, cyber wars, more advanced weapons (and correspondingly complex injury patterns), autonomous weapons, attacks on medical facilities and personnel, increased likelihood of CBRN attacks, and the use of rape as a tactic of war. The anticipated trend, as historical evidence suggests, is the continued weaponization of many new technologies [24] such as drones, digital technology, communications, lasers, space and artificial intelligence. Importantly, while guidelines and manuals for civil-military coordination to safely and rapidly reach people in need using

notification for deconfliction [25]^{11, 12} protocols continue to evolve and there are no absolute guarantees for safety and security.

Second, the above, combined with rapid urbanization and extreme weather events, continue to produce a rise in disease outbreaks, increased migration/displacement, more complex humanitarian needs, and increased numbers of actors and providers [26].

A third trend is the influence of emerging medical technologies and diagnostics on digital devices, communications technologies, transportation, telemedicine and telehealth, mobile platforms, virtual trainings, use of drones, 3-D printing [27, 28], and miniature rugged, field deployable medical devices. Some of those trends have also come with risks associated with hacking and the compromise of confidentiality and patient data as well as the targeting of health-care providers.

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

National organizations and governments increasingly emphasize the centrality of local authorities and their capacity to lead, and grant or deny access to responders. Much of the international debate and commitments are driven by the need for policies and practices that ensure accountability to affected populations [29], including highly vulnerable subgroups [30].

A recent report stated [31] that given the projected level of increasing humanitarian needs and gaps, "an effective surge capacity is essential. Despite major access restrictions faced by humanitarian actors, one "quick fix" for emergency response capacity would be to ensure a minimum number of

¹¹ Deconfliction (a military term): The exchange of information and planning advisories by humanitarian actors with military actors in order to prevent or resolve conflicts between the two sets objectives, remove obstacles to humanitarian action, and avoid potential hazards for humanitarian personnel. This may include the negotiation of military pauses, temporary cessation of hostilities or ceasefires, notification of locations of medical facilities, or safe corridors for aid delivery.

¹² With the caveat that "deconfliction" as a general solution, comes with certain challenges, including 1) shifting the burden away from parties to armed conflicts to live up to their own obligations towards humanitarians to contribute to "deconfliction"; and 2) creating a false dichotomy between "de-conflicted" and "non-deconflicted" persons or objects, while not just "de-conflicted" persons or objects will be protected under IHL.

capable organizations with the capacity, knowledge, readiness and deployability to provide coverage across all life-saving sectors and deliver reliably in acute crises."

Recent studies and reviews have highlighted the critical need (and provided recommendations) for medical teams to perform better in the application of humanitarian principles, as well as in their quality and effectiveness (32). The report's authors call upon all actors "to examine their actions – the end and the means – so that future humanitarian responses will be principled, effective, and accountable to those who need them the most: the victims of war and forced displacement."

In summary, the anticipated future insecurity and fragility requires medical teams to have the following.

- Organizational policies that are updated frequently and deal with duty of care, risk tolerance, security risk management, recruitment and personnel profiles, communications with the public and authorities, and operational readiness.
- Community engagement at both organizational and individual levels, with a dignified, respectful, humble, and empathetic approach, regardless of a rapidly changing world.
- Policies that more clearly articulate both the duty to care for and protect patients.
- Policies to guide technological advancements and their adoption and adaption (12, 33, 34).
- More concrete and meaningful sector-wide collaborative and coordination approaches at both headquarters and field levels that steer towards increased interdependence, interlinkages, and complementarity with other responders and affected communities.
- Policies and sufficient financial sources that are invested in human resources, the development of operational skills and competencies that will enhance the knowledge and skills of headquarters management, operational team leaders and team members through practical training, and continuous learning, with a more formal association with academic institutions and key regional and global agencies.



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Chapter 1

International humanitarian law (IHL) and core humanitarian principles in action

1 International humanitarian law (IHL) and core humanitarian principles in action

Chapter objectives

1. Medical teams have an increased understanding of the relevance of IHL and core humanitarian principles to facilitate, support and protect medical teams, patients, and operations in armed conflict.
2. Teams gain increased awareness of the consequences and implications linked to non-adherence to core humanitarian principles and non-adherence by parties to armed conflict to IHL, including implications for security and access.
3. Teams have increased capacity for principled action and critical thinking (decisions and conduct) in making medical and operational decisions at both headquarters and field levels that treat all with respect and dignity.
4. Teams are aware of the importance and fundamentals of meaningful and accountable community engagement.
5. Teams and leaders have easy access to the most relevant key references and manuals.

Applied IHL and core humanitarian principles enable access to affected populations and help build relationships, trust and confidence crucial to fulfilling and protecting a medical humanitarian deployment.

The humanitarian imperative to provide assistance is incumbent upon all peoples, cultures, religions and humanity at large. Medical teams provide care worldwide in all situations and contexts. To continue with the medical humanitarian deployment, teams are increasingly required to better prepare, train, communicate, manage ethical dilemmas and make complex decisions that focus on saving lives, all tasks made more difficult by war.

This is not a legal authority chapter or text, but it is important for teams to comprehend the abridged frameworks and guidance presented. The focus is on understanding context, principled decision-making, improved self-awareness, mindfulness of consequences, and a pragmatic (not dogmatic) approach. For a truly thorough and deeper understanding of IHL, readers are advised to review *The Practical Guide to Humanitarian Law, 2013* by Françoise Boucher-Saulnier of MSF [\(35\)](#), ICRC IHL online database [\(36\)](#), and the *Handbook on the Practical Use of International Humanitarian Law* by the Danish Red Cross [\(37\)](#), as well as the ICRC digital App [\(38\)](#).

The medical humanitarian deployment, at its core, remains universal.

“There is considerable merit to the theory that champions the approach that “war is war” regardless of whether an armed conflict is fought in an intrastate, interstate, or transnational context. This is particularly true regarding humanitarian obligations since human suffering is common to all types of conflict [23].”

Table 5 illustrates and compares the scope of applications and boundaries that IHL and medical ethics impose as obligations and best practices on medical teams who care for the wounded and sick [39].

Table 5. IHL, human rights and medical ethics laws and applications

	International humanitarian law (IHL)	International human rights law (IHRL)	Medical ethics
Scope of application	<ul style="list-style-type: none"> - International armed conflict - Non-international armed conflict 	<ul style="list-style-type: none"> - International armed conflict - Non-international armed conflict - Other emergencies - Peacetime 	<ul style="list-style-type: none"> - International armed conflict - Non-international armed conflict - Other insecure environments - Other emergencies - Peacetime
Beneficiaries	<ul style="list-style-type: none"> - Wounded and sick - Medical personnel 	<ul style="list-style-type: none"> - Wounded and sick - Medical personnel 	<ul style="list-style-type: none"> - Wounded and sick - Medical personnel
Bound by the law	<ul style="list-style-type: none"> - States - Armed groups - Individuals¹³ 	<ul style="list-style-type: none"> - States 	<ul style="list-style-type: none"> - Medical personnel

¹³ In certain circumstances, also individual civilians may be directly bound by international humanitarian law. For instance, civilians must respect wounded and sick people (cf. Article 18[2] GCII)

1.1 First, Do No Harm! [40]

Primum non nocere,¹⁴ or “first do no harm”, has been central to the concept of good medical practice since the time of Hippocrates: “I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing.”

Implicit in this commitment is that a good physician, or indeed any health-care worker, will practice only within their field of proven competence, and use the required equipment and supplies to ensure patient safety. A failure by some in the past to recognize the importance of this principle when responding to sudden onset disasters was one of the drivers behind WHO establishing and promoting a set of minimum core standards for [41] EMTs in the Blue Book and its mission to reduce the loss of lives, relieve suffering and minimize long-term disability and impairment in sudden-onset disasters and outbreaks through rapid deployment and coordination of quality-assured EMTs [42]. While the “do no harm” principle underpins the Blue Book and is directed primarily at the patients served, it also applies to the organization’s deploying teams (duty of care see Annex 1).

The risks for medical teams in responding to armed conflict can be very significant and cannot be eliminated, but they can be mitigated by adequate preparation, increased awareness, and training. Teams lacking the necessary preparedness, training, supplies, and/or awareness of context, complexity, and importantly, conflict sensitivity [43]¹⁵ should consider not deploying as they can indeed “do harm” to both the patients they seek to treat and to their own staff, as well as undermine trust in medical care across the entire response area. When a health-care worker is killed or injured, the overall response is likely to cease. Conflict sensitivity merits a deeper understanding of the deployment by teams and leaders. Teams needs to understand the context in which they are operating and the interaction between the intervention and its context, and act upon that understanding, in order to avoid negative impacts and maximize positive impacts of their actions on the conflict [44].

¹⁴ Non-maleficence, another way to state it is that, “given an existing problem, it may be better not to do something, or even to do nothing, than to risk causing more harm than good.” It reminds physicians to consider the possible harm that any intervention might do. It is invoked when debating the use of an intervention that carries an obvious risk of harm but a less certain chance of benefit.

¹⁵ Conflict sensitivity means the ability to: 1. understand the context in which you operate; 2. understand the interaction between your intervention and the context (how the context affects the intervention and how the intervention affects the context); and 3. act upon the understanding of this interaction, in order to avoid negative impacts and maximize positive impacts

Civilians and wounded combatants caught up in conflict have some of the most complex health needs that can be made worse by an inappropriate response. Teams, and especially team leaders, need to pay particular attention and be sensitive to the power dynamics, risk of coercion or intimidation, possible lack of social cohesion, reduced resilience and lack of a safety net that affected populations may be experiencing compared with those in non-conflict settings. In war, more than ever, adherence to the four principles of ethical medical care (respect for autonomy, beneficence, non-maleficence, and justice) ^[45, 46] will ensure that not only teams do no harm, but recognize and respect the rights of the patient to the best treatment possible, thereby doing justice to the most vulnerable in their time of greatest need.

The need for core and technical standards and quality assurance of medical teams equally extends from disasters to conflicts, ^[47] a fact recognized by Henri Dunant, the founder of the Red Cross Movement, when he published *A Memory of Solferino* in 1862 ^[48] in which he spoke of the suffering and neglect of the wounded and the need for local volunteers that were trained and experienced.

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

Recent experiences in frontline trauma care provision and coordination have emphasized both the need for EMTs, but also the complex ethical and legal issues that can arise when they are deployed close to the frontline and/or have access to only one side of the conflict ^[33]. Importantly for medical teams and humanitarian organizations in a conflict zone, is how to maintain the core principles of humanity and impartiality as the over-arching driver of the EMT response, addressing suffering wherever it is found in a non-discriminatory manner, strictly based on needs, with priority only allowed for medically more urgent cases, as required by core humanitarian principles and medical ethics (also found in IHL), and still remain guided by the other humanitarian principles of neutrality and independence in delivering the response. The very concept of humanitarianism itself can be threatened when teams are so close to combatants of a party to the conflict as to be deemed to (or perceived to) be operating as one team and in support of military rather than solely humanitarian objectives (a blurring of the lines) to outside observers. “As

emergencies become bigger and more complex, teams are required to protect and strengthen the humanitarian space” ^[49].

EMTs are to be supported and guided by the IHL and core humanitarian principles as they map their path through this insecure, difficult moral and legal territory. They need to guard against abuses and violations of IHL and the core principles as such an approach will further improve the protected status of the team and through confidential advocacy with parties to the conflict may limit suffering and the impact of war on the population and the wounded and sick.

1.2 IHL and core humanitarian principles

IHL ^[50] is a set of rules with the 1949 Geneva Conventions and its two 1977 additional protocols at its core, with the aim to limit the effects of armed conflict. All states in the world are parties to the Geneva Conventions ^[51], while nonstate parties to armed conflict are bound by IHL, especially by virtue of common Article 3 of the Geneva Conventions, customary IHL, and where applicable, the 1977 Additional Protocol II. In addition, even where states have not become parties to IHL treaties, including the 1977 Additional Protocols, they are also bound by customary IHL. Core humanitarian principles are derived from IHL's recognition of the role of “impartial humanitarian organizations” (common article 3 and article 9/9/9/10 Geneva Conventions) and continue to guide humanitarian action across the globe. Battlefield realities, however, show that signature and ratification do not translate into full compliance during armed conflict, and parties to conflict need to be reminded of their obligations.¹⁶ Attacks on hospitals and medical teams performing their exclusively humanitarian functions are commonly observed and reported, in spite of being prohibited by IHL ^[52].

Regardless of national or organizational affiliations, medical teams should be guided in their mission by the legal frameworks of the Geneva Conventions, and IHL more broadly. ^[53]

¹⁶Typically, by ICRC, UN, other nations, NGOs, media, etc.

The core humanitarian principles (humanity, impartiality, neutrality and independence) [54] are a set of values or morals adopted by the UN and most key humanitarian actors and are part of the EMT guiding principles. Together, they have practical operational relevance for medical teams in complex political and militarized environments. Adherence to humanitarian principles and being guided by IHL is therefore critical in distinguishing humanitarian action from the activities and objectives of political, military and other agencies. Actions by medical teams that blur those lines can be detrimental to the medical mission.

1.2.1 IHL

To emphasize again that IHL, (55-57) also referred to as the “Laws of War” or the “Law of Armed Conflict”, is the law that specifically governs armed conflict. Wars are not without rules and states have agreed, including through international treaties such as the Geneva Conventions, to impose limits on the way in which warfare is conducted. IHL is the set of rules which seek to limit the effects of war for humanitarian reasons, by balancing military necessity with humanitarian imperatives. In this perspective, IHL restricts the means and methods of warfare and sets favourable conditions for impartial humanitarian and medical assistance to all wounded and sick, whether or not they have taken part in the hostilities. It protects persons who are not, or no longer, participating in the hostilities. Medical teams working in this field, need to be aware of these rules which are in place to protect the team, patients, medical facilities and medical transport. In addition to IHL, medical and humanitarian personnel must respect the domestic laws of the country in which they are operating, while mindful of their overriding obligation to medical ethics.

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

- not target people who are no longer engaged in the fighting;
- allow impartial humanitarian assistance to the civilian population and all wounded and sick in general, including those who have taken direct participation in hostilities;
- not target those who are providing medical or humanitarian assistance; and
- ensure that all wounded and sick receive medical care and the civilian population receives humanitarian assistance.

IHL protection of medical personnel, facility or transport is not absolute. Such persons or objects may lose their IHL protection if they give military advantage to a party to the conflict to commit acts that are harmful to the “enemy”. Even then, direct attacks on medical teams and facilities are unlawful unless warning has been given. Any perception created (right or wrong) that medical teams are in reality serving military purposes will result in security risks for them and patients in their care.

For example, teams that permit the medical facility and/or medical transport to be utilized for arms storage and/or armed actor activities or as an armed base, assist in violations of international humanitarian law. These acts “harmful to the enemy” include the use of medical units to shelter able-bodied combatants, store arms or munitions, as a military observation post, or as a shield for military action.

Civilians and those who are no longer able to engage in the fighting, hors de combat, are entitled to receive protection and medical assistance. IHL includes obligations placed on the parties to the conflict. One key obligation is that the parties to the conflict have a primary obligation to provide frontline medical assistance to wounded and sick people who are in their care, and secondly, if there are legitimate reasons that prevent them from so doing, the parties to the conflict must allow others to provide medical assistance. This means that they cannot interrupt, interfere with, or prevent the provision of medical assistance to those who are in need. Thirdly, parties to the conflict must not arbitrarily refuse consent to an offer of humanitarian services from impartial humanitarian organizations, and once consent is given, must allow and facilitate the provision of medical and humanitarian assistance.

These are all crucial elements for medical teams to be aware of and raise these issues with parties to the conflict and remind them of their obligations, including across everyday activities in the field such as crossing checkpoints, and to show respect for IHL [57].

There are some contexts in which parties to the conflict do not have the capacity to provide impartial humanitarian or medical assistance to the affected population, and call for support from external and/or humanitarian agencies, and other providers of medical services to address humanitarian needs. This is legal under IHL. In other circumstances, when parties to the conflict have the capacity, but have chosen not to provide such medical assistance at the frontline in contravention of IHL, humanitarian agencies may be put into the uncomfortable position of deciding

to provide such assistance. They must be careful not to be “instrumentalized” and need to advocate strongly for parties to the conflict to fulfil their obligations.

IHL protects medical personnel engaged in medical duties to ensure that they are able to perform their medical activities without undue interference from parties to the conflict and act with independence and autonomy according to medical ethics. In other words, medical personnel must be free to treat patients based on medical need alone and cannot be compelled or give priority to treat one side or the other. Medical personnel may not breach doctor-patient confidentiality and cannot be sanctioned for having acted in accordance with medical ethics, regardless of the status of the patient.

In situations of international armed conflicts, IHL sets medical confidentiality vis-à-vis the opposing party to the conflict as a specific principle. However, it cannot be an absolute principle, but a principle with exceptions, as there may be necessary exceptions to nondisclosure provided for under domestic law, and especially in case of notification of communicable diseases (where there is an overriding public health interest which would prevail over the individual interest of the patient of nondisclosure). It provides that no person carrying out medical activities can be compelled to give out any information concerning the wounded and sick who are, or have been, under his or her care, as long as the medical person considers that such information might prove harmful to the patients concerned or to their families.¹⁷ In situations of non-international armed conflicts, medical secrecy/confidentiality may not be protected to the same extent as in international conflicts, which can create significant difficulties in the field. Nonetheless, humanitarian law applies also in non-international armed conflicts in that it upholds medical ethics and only laws can limit the principle of medical secrecy. It also affirms that, “subject to national law, no person engaged in medical activities may be penalized in any way for refusing or failing to give information concerning the wounded and sick who are, or who have been, under his care”.

Medical personnel may find themselves entrenched in situations of conflicting dual obligations regarding medical confidentiality and medical ethics. IHL and IHRL¹⁸ set of provisions allow medical personnel to adhere to respecting medical ethics in situations where pure legalistic compliance would be harmful to their patients.

¹⁷ This applies whether the person requesting the information belongs to the adverse party to the conflict or to the medical person’s own party, except in cases foreseen by the person’s domestic laws. However, only one exception is foreseen: regulations concerning the compulsory notification of communicable diseases must be respected.

¹⁸ Under IHRL (International Human Rights Law) the right to health (Art. 12 ICESCR) and/or the right to privacy (Art. 17 ICCPR) would be applicable

1.2.2 Core humanitarian principles

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

These principles of humanity, impartiality, neutrality and independence have been grounded within the humanitarian community as the leading operational principles for any organization responding to emergencies. All medical teams, regardless of their level of independence from governments and public authorities, must provide assistance that is humanitarian and impartial. Military and government medical teams – which apart from their duties to patients have a second loyalty to the interests of the government they serve – are by definition not perceived as neutral and independent. While this is not an issue in situations of natural disasters in stable settings, their engagement in humanitarian responses in armed conflict contexts could undermine the overall perception of principled humanitarian action.

Table 6. Principles in action in medical contexts

Principle	In medical practice
<p>Humanity is a principal driver for those who endeavour to prevent and alleviate suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for all. It promotes mutual understanding, friendship, cooperation and lasting peace among all peoples. Humanitarian assistance is often referred to as assistance which is essential for the survival of the civilian population including food, shelter, water, medical assistance, power/energy and sanitation.</p>	<p>Provide life-saving assistance and do no harm;</p> <p>Focus efforts on reaching people in need as quickly as possible and provide assistance as far as practical;</p> <p>Access is critical;</p> <p>Do not place medical teams or patients at undue risk; and</p> <p>Do not work out of clinical scope and competency.</p>
<p>Impartiality means that the decisions to assist and priority settings are solely driven by need, and do not discriminate based on race, religion, nationality, gender, age, disability, or class. Impartial medical care provides services giving priority to the most urgent cases.</p>	<p>Treat all patients based on their medical need and urgency, without discrimination based on race, religion, nationality, gender, age, disability, or class.</p> <p>A patient is always a patient and must be treated with dignity and humanity in all circumstances.</p> <p>Ensure medical confidentiality and anonymity.</p>

In medical practice

Neutrality means that to continue to enjoy the confidence and trust of all, teams may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature. A medical act is in itself a neutral act.

Confidentially raising awareness on violations of IHL by parties to a conflict is not considered a breach of neutrality. (58)

Impartiality means that the decisions to assist and priority settings are solely driven by need, and do not discriminate based on race, religion, nationality, gender, age, disability, or class. Impartial medical care provides services giving priority to the most urgent cases.

Independence requires teams to maintain their autonomy from governments and public authorities to ensure that they are always capable of acting in accordance with key principles.

In medical practice

Taking sides erodes trust and limits acceptance by the population served and undermines and limits access.

Taking sides will not permit the team to access or communicate with parties to the conflict.

Providing medical care to the sick and wounded of all combatants is a duty under IHL and is not to be considered as harmful or as giving material support to one side or another.

A hospital may lose its protected status under IHL if it is used outside of its medical function to commit acts harmful to either side.

Medical teams must retain control over medical facilities, to the greatest extent feasible, and not allow the use of the facilities for acts harmful to either side, for instance, using facilities as an arms and ammunition depot, military observation posts, shelter for healthy combatants, or for installing firing positions in a facility. This can result in medical facilities or transport losing their protection, with potentially dire humanitarian consequences for patients and medical personnel.

Exceptions for military, governmental, and some UN teams apply when they cannot be or will not be perceived as neutral.

Medical actions need to be delinked from military and governmental agendas (see Chapter 3).
Exceptions for military, governmental, and some UN teams apply when they cannot be or will not be perceived as independent.

Neutrality is a central principle of engagement with parties to conflict that enables access to affected populations and operational agreements on the legal and ethical framework of medical and humanitarian action. Furthermore, neutrality requires avoiding interference from, and manipulation of, assistance by any state or non-state party to a conflict.

Neutrality stems from the concept that humanitarians do not engage in any public discourse around political or highly controversial topics related to a conflict in order to maintain neutrality between parties to the conflict. How can one side trust that the team will treat them with dignity and humanity if the team or organization has publicly spoken out in support of their enemy? How can a party to the conflict trust a medical team if the activities are carried out without independence and/or neutrality and for the sole advantage of the opposing party to the conflict? While certain extreme situations have seen leading organizations resort to public denunciation, the consequences in the form of reactions from those denounced need to be anticipated and plans put in place to address ensuing denial of access, expulsions and attacks. However, denouncing IHL violations and their impact in terms of access to medical care for civilian populations is not a violation of the principle of neutrality

Medical teams must focus on responding to the needs of those who require the most urgent assistance, regardless of the affiliations or sympathies of a population. Medical teams ideally need access all sides (not always possible) and so will be required to navigate the political and controversial aspects of often complex and fragile settings to ensure they are able to reach and provide assistance to those in greatest need. Engaging in a non-neutral manner not only puts the lives of responders at risk, but also the lives of those needing assistance and can prevent future assistance. A team that engages in non-neutral actions, conduct, and/or statements can negatively impact the entire response, and far beyond the team that engaged in non-neutral actions, conduct, and/or statements.

On neutrality

Neutrality and impartiality are often confused and even considered to be the same. The two principles differ in that a neutral person does not make judgments related to the conflict. "Neutrality demands self-control and is a form of discipline we impose upon ourselves, a brake applied to the impulsive urges of our feelings" ^[59]. While neutrality does not impose silence on violations of IHL, teams must realize the possible consequences if they engage in public statements that negate their neutrality (perceived or real, see section on consequences below). Impartiality exclusively refers to behaviour towards beneficiaries, and not parties to the conflict or the underlying motives of a conflict.

On independence

There may be difficulty in reconciling two things which seem to be mutually exclusive: to enjoy the freedom of autonomous action of a nongovernmental entity and to simultaneously seem to submit to the requirements of donors, military discipline or national laws. However, operational autonomy can be negotiated and accepted for medical teams providing an arms-length space without undue influence on medical decisions, allocation of resources and triage. This is critical in countering the possible perception by communities, parties to the conflict and stakeholders that a medical mission is biased and partial.

It is also important to note that accepting the principle of independence is not required for medical personnel to be protected from direct attack. As mentioned above, military and civilian personnel providing medical assistance are protected from attack and must be allowed to operate when exclusively assigned by a competent authority of a party to a conflict to medical purposes, protection visualized in the distinctive emblem (Article 18, GC IV; Art. 12, 18 API; Art. 12 APII). This applies to both foreign nationals as well as nationals. Again, it is of the utmost importance that all medical teams understand that regardless of their independence from government, their provision of assistance must be humanitarian and impartial. This, of course, can be incredibly demanding as the deployment of these teams can be driven by (or perceived to be) political and/or military objectives. Once deployed and operational, these medical teams must provide impartial and neutral humanitarian assistance, as captured in the rules relating to the use of the protective emblems ^[60, 61]. The correct use of the protective emblem is detailed below, and the parties to the conflict are obligated to respect its use. However, many organizations, medical teams and

medical facilities have also experienced direct attacks despite clear neutral and independent policies and conduct and despite using an emblem.

Therefore, military and governmental medical activities should remain impartial and medical teams should be acutely aware of the importance of independence and neutrality for other humanitarian actors. Hence, they are advised to do their utmost to abstain from acts that can impact the perceived neutrality and independence of the entire medical response.

1.2.3 Can the principles be decoupled?

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

Medical teams may take deliberate decisions to make concessions but must be well-aware of the consequences. Poorly considered decisions harm teams, patients, facilities and others. The impact of such harm can have a ripple effect for years and across the globe. The central mission of medical teams is to help those in need, supported by the principle of do no harm and extends into their relationships with populations. Medical ethics ^[62] provide a strong base for impartial and nondiscriminatory care. However, it does not sufficiently address the critical nuances required to access civilian populations in armed conflict nor does it address the practicalities and importance of neutrality and perceived neutrality in such complex contexts.

Therefore, a legitimate decoupling or a compromise would be the result of exceptional circumstances and a specific context, and not a team choice made from its own bias or agenda. There is in fact already an established hierarchy in the principles, with the humanity principle regarded as the earliest principle from which all other principles are derived. The others are subsidiary principles, and the use of the word decoupling is not meant to imply that all the principles are as one and indivisible. Decisions on any compromise must be taken at the highest level of a response, not by the individual medical teams themselves, and after much deliberation regarding short- and longer-term consequences. As discussed earlier, military and governmental teams are not expected to be

independent and neutral organizations but must be sensitive to the fact that many other providers are both. They also must be mindful of actions that might jeopardize the space required to deliver principled humanitarian action.

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

Humanity and impartiality are non-negotiable; neutrality and independence are core to all medical teams (with exceptions for military and some governmental teams).

It is stressed again that neutrality and independence are critical but may not always be applied to military and governmental teams at the organizational level. However, both principles must be applied at field operational levels meaning medical care to an individual is neutral and independent even if the politics of being deployed were not.

Additionally, a principled approach to providing medical care can be threatened when countries criminalize ^[64] assistance to groups or individuals labelled as radicals/terrorists under counterterrorism laws. In a positive move, blocks of nations (EU parliament resolution) ^[65] have begun to advance resolutions to prevent the criminalization of aid. Teams need to be aware of current legislation and laws pertaining to their organization and nationality and source of funding for the operation ^[66,67].¹⁹

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

1.3 Who can use the emblem?

In armed conflict, the distinctive emblems ^[68, 69] are the visible sign of protection conferred by IHL especially upon medical personnel, units and equipment. Persons, objects and facilities displaying such emblems must not be attacked and are to be respected and protected at all times. Many organizations, medical teams, and medical facilities have also experienced direct attacks despite the clear use of protective emblems. This has also been the case despite taking other measures to enable their better identification, such as deconfliction measures. Therefore, medical teams should keep in mind that there are no absolute guarantees or zero risk.

The use of the emblem as a protective sign ^[70] during armed conflict is authorized exclusively for:

- The use of the emblem as a protective sign during armed conflict is authorized exclusively for: Medical units, transport and personnel, as well as religious personnel of the armed forces;
- civilian medical units (including those of the ministry of health), transport, and personnel, as well as civilian religious personnel, that have received special permission by the competent authorities to use the emblem; and
- medical units, transport and personnel that a Red Cross or Red Crescent national society has put at the disposal of the medical services of armed forces.

In armed conflicts, the protective emblem ^[71] must be displayed in red on a white background with no additions. It must be displayed in a large size on protected buildings, such as hospitals, and vehicles so as to be clearly identifiable from afar. Emblems on armbands, vests or bibs for protected personnel must also be clear and stand alone. A deliberate attack on a person, equipment or a building marked with the protective emblem is a war crime under international law.

¹⁹ UNSC resolution 2462, adopted on 28 March 2019, uses decisive and mandatory language in OPs 5 and 6 to request that States comply with IHL when adopting or adapting counter terrorism measures, and pressing language in OP 24 to take into account counter terrorism financing measures' impact on impartial and neutral humanitarian activities. This language means that UN Members States will be obliged to domesticate these OP 5 & 6. UNSC resolution 2482 affirms this pressing language and even broadens its application to refer to 'all measures to counter terrorism' in OP 16.

Examples of protective emblem use on facilities, vehicles and armbands.



© ICRC/Musuabo Kivasuwamwo



The distinctive emblems are also recognized as having a second function under the 1949 Geneva Conventions and their Additional Protocols by serving as a sign of identification of the respective components of the International Red Cross and Red Crescent Movement. The emblem must then be displayed in comparatively smaller size together with the name or initials of the Movement component concerned.

The distinctive emblems are protected by IHL and under the legislation in force in multiple national jurisdictions from all forms of misuse, and thus both in times of armed conflict and in peacetime. Those entitled to display the emblem have a legal obligation to act responsibly and in a manner that does not risk placing the respect and prestige of the emblem and its protective function at risk.

Table 7. Emblems usage: protective and indicative

	Protective use	Indicative use
For what purpose?	Notifying of protection by law	Link to the Red Cross Red Crescent Movement
What features?	Large and visible from afar	Displayed in small dimensions together with the name or initials of the component of the International Red Cross and Red Crescent Movement concerned.
Who can use it?	<p>Persons falling within IHL definitions of medical personnel, units and vehicles:</p> <ul style="list-style-type: none"> - armed forces - authorized* national societies - authorized* NGOs - authorized* hospitals <p>The ICRC and the IFRC without restrictions</p> <p>* subject to the express authorization of the competent government authority (72).</p>	<p>National Red Cross and Red Crescent Societies, the ICRC and the IFRC.</p> <p>NB: In peacetime and as an exceptional measure, by vehicles used as ambulances and first aid stations exclusively assigned for the purpose of giving free treatment to the wounded and sick. Such display must be authorized by the national Red Cross or Red Crescent Society.</p>



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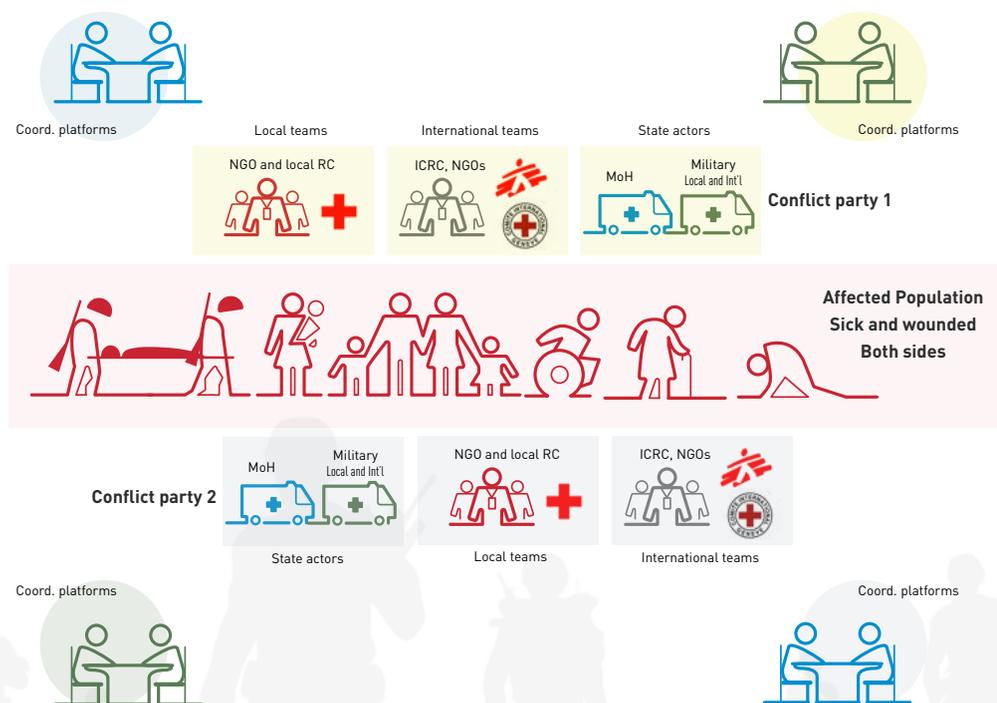
1.4 Scenarios and practice

Applied IHL and core humanitarian principles enable access to affected populations and help build the relationships, trust and confidence crucial to fulfilling a medical mission.

This section presents scenarios and examples to assist in decision-making and the mapping of participants and mandates. It also provides teams and leaders with key questions to support the provision of principled care.

1.4.1 Scenario 1: a generic conflict scenario – mapping actors and populations

Fig. 1. Mapping medical teams in conflict



The stakeholders

Fig. 1 illustrates the range of medical actors, their affiliations and possible implications for acceptance and access. It depicts two parties to the conflict (top and bottom) and shows mobilized medical assistance at state, local and international levels on both sides. The centre shows affected populations from both sides against backgrounds which depict various territories, regions and ethnicities. State actors include the ministry of health and military medical services. Other local actors may include civil societies, NGOs, local Red Cross and Red Crescent national societies which may or may not have a level of independence and autonomy from local authorities. The international medical actors include ICRC, MSF and other NGOs. This may also include for profit and nonprofit private providers and depending on the nature of contracts such providers may be perceived to be linked to state actors or not. Private for profit and nonprofit actors will always be viewed as representing the party funding them, for example, the UN and involved states, and can also apply to local and international NGOs. In peace time, the typical mandate for local Red Cross and Red Crescent is complementary to local authorities in the humanitarian field, which is de facto for many local NGOs which are often funded by governments and implementing national programmes.²⁰

Medical teams responding to treat the wounded and sick in situations of armed conflict have differing organizational affiliations and are therefore categorized as such (see Table 8). All have important roles to play in saving lives and caring for affected populations, however, not all teams have equal access to affected regions and populations. Such access will be shaped by the consent of parties to the conflict, their affiliates, and the population's perception of the team's intent and their safety and protection within or near the facility. This is not simply about ensuring access for all to a facility, but providing similar levels of services to both sides to the greatest extent possible. Although access can also be gained by embedding or co-locating within the operations of an armed actor this may compromise some core principles. However, it is often the only option for military and governmental medical teams as well as some UN operations.

²⁰ UNSC resolution 2462, adopted on 28 March 2019, uses decisive and mandatory language in OPs 5 and 6 to request that States comply with IHL when adopting or adapting counter terrorism measures, and pressing language in OP 24 to take into account counter terrorism financing measures' impact on impartial and neutral humanitarian activities. This language means that UN Members States will be obliged to domesticate these OP 5 & 6. UNSC resolution 2482 affirms this pressing language and even broadens its application to refer to 'all measures to counter terrorism' in OP 16.

The sick and wounded

The civilian population, injured combatants and their comrades will most likely not fully comprehend the plethora of actors, emblems, logos, affiliations and agendas and will observe, view, and judge through the lens of their own values and beliefs, and thus act accordingly when seeking medical care. Those seeking help may use differing terms and labels for teams based on languages spoken, attire, signs used, conduct, rumours and whether they are treated with respect and dignity.

The principled framework

Regardless of a team's affiliation or type of organization, all medical services must be framed in the principles of humanity and impartiality. Moreover, the actions of all are assumed to be framed by IHL.

The United Nations

If the United Nations Security Council (UNSC) has taken a position in a conflict, and the Organization's agencies and peacekeepers are deployed, such teams would be perceived as party to the conflict. If states deploy military medical or civil protection teams to support one side or the other, they become in practice, party to the conflict, intentionally or not. Some states may declare their neutrality and deploy teams to serve wounded and sick on both sides. Fig. 1 also shows WHO, which may be active in coordination in several pillars, deploying EMTs, providing supplies and monitoring mortality and morbidity. The horizontal arrows framing WHO indicate that the perception of an organization's role can be siding with one of the parties to the conflict, again linked to UN's stated position vis-à-vis the conflict. Thus, although a WHO supported team's actions will be framed by humanity and impartiality at the bedside within medical facilities, the organization will be viewed by one of the warring sides through the prism of the UN position with neutrality and independence compromised, and therefore not as a humanitarian actor.

Coordination

The illustration also depicts the varied coordination mechanisms that may exist on both sides including military, civilian, international, UN and within the Red Cross and Red Crescent Movement (see Chapter 3).

What if this was a non-international armed conflict (NIAC) (also referred to as civil war)? Whatever the type of conflict, core principles always apply, and specifically the legal and ethical obligation to provide medical care to those who need it, whatever their status. However, the role of local actors could be complicated by possible pressure from government and military forces to not treat so called rebels or provide care to civilian sympathizers. This would equally apply to medical teams in nongovernment held territories. Again, the medical care given at bedside may remain neutral and impartial, but perceptions by the population will impact acceptance and access.

1.4.2 Scenario 2: in the emergency room (ER)

During a medical deployment into a conflict zone with ethnicity-based tensions, ER staff are presented with victims of a motor vehicle accident. Three are seriously injured multiple trauma cases: an adult male in his mid-twenties, a girl aged about 10 and boy of 16. The children are victims of what appears to have been a reckless driver who lost control and crashed. The driver appears to be from one of the ethnicities fighting each other and the two children from another ethnic background viewed as sympathizing with the opposite warring side. All are in a critical condition, but the team does not have the resources to treat all cases.

As the health-care professional in charge who do you treat first? Why? What principles are involved?

Think of a similar setting to the scenario above, but the ER team is presented with two severely wounded combatants from opposing sides of the conflict. Both are critically injured. The team does not have resources to treat both. The facility is located in territory under the control of a nonstate armed group. The comrades of one of the soldiers are at the gates of the facility.

As the health-care professional in charge who do you treat first? Why? What principles are involved? What is at risk? Please refer to Table 8.

1.4.3 Scenario 3. managing armed intrusion into a medical facility

You are running an ER near the frontline during an upsurge of armed clashes. 20 patients arrive from different sides of the conflict over the course of an hour. Some are accompanied by armed comrades.

Calling the team leader immediately will enable the medical personnel to focus on providing care while they focus on security/negotiation (buy time) as well as ensuring the implementation of pre-agreed protocols to protect patient confidentiality (securing medical files). Other issues for the team to consider and plan for include:

- Security threats from wounded patients brought by fellow fighters still carrying their weapons and who remain in the hospital after they hand over the patient to the medics.
- The dilemma of a demand for preferential treatment for a less critical case.
- Security threat of combatants from one side storming the emergency room and demanding information about patients under your care.

1.4.4 Scenario 4. deployment into internal conflict

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

Your medical team is alerted to a possible deployment into a low-income country in which some districts are experiencing active armed conflict between government and nongovernment forces in urban and non-urban areas. The ongoing fighting has lasted months and precipitated a dire situation with tens of thousands of displaced communities, internally displaced persons (IDPs) and a flood of refugees across the border into a neighbouring country with many more remaining in their respective communities. Much of the

news about hostilities cites ethnic roots to the conflict. Weapons and tactics used have resulted in hundreds of casualties and severe injuries and burns. Infrastructure, homes and road networks have been severely damaged. There have been no reports of chemical or biological agents in use but there are rumours of sexual violence, kidnappings and general criminality.

The scenario can be run as a desktop training exercise for teams and team leaders in which the following questions are posed. Do you deploy? To where? Do you have a choice? What is your mandate? Who provides authorization? Is there consent to access and work on all sides of the armed conflict? Are there other options? If deployed, what is the scope and region(s) for practice? Will that shift? What are the current and anticipated risks? What possible compromises are required and why? What consequences may they bring in both the short and long terms? Who can you consult before, during, and post deployment for support?

The matrix below captures the inherent dilemmas and critical thinking/questioning required prior to and during deployments. It is designed to ensure that teams have increased awareness of and pay close attention to: the context in which they work; the dynamics of war; strategies to protect against unnecessary deployment; potential to harm local efforts; undermining fragile communities; manipulation and perceptions of being party to a conflict; and the protection of teams and patients from suffering and injury.

Table 8. Checklist: IHL and principles in action for national and international teams (red text highlights the key differences between the two columns)

Core principle	National team critical thinking	International team critical thinking
1. Humanity	<ul style="list-style-type: none"> • Is there a humanitarian imperative to act? • Are there other means to assist? • Will many suffer and die if we do not respond? • By acting, are we helping the parties to the conflict to avoid undertaking their obligations to provide medical assistance to persons at the frontline? 	<ul style="list-style-type: none"> • Is there a humanitarian imperative to act? • Are there other means to assist? • Will many suffer and die if we do not respond? • By acting, are we helping the parties to the conflict to avoid undertaking their obligations to provide medical assistance to persons at the frontline?

Core principle	National team critical thinking	International team critical thinking
2. Do No Harm!	<ul style="list-style-type: none"> • Are we ready to offer quality care for this scenario such as suitable personnel, kits, supplies, skill set, organizational capacities, logistics and funds? • Do we have relevant experience and practical IHL training? • What is the nature of medical services now on both sides? • Can we add value to what already exists? • How will the conflict and needs evolve? Injury types? Outbreaks? Mental health? 	<ul style="list-style-type: none"> • Are we ready to offer quality care for this scenario such as suitable personnel, kits, supplies, skill set, organizational capacities, logistics and funds? • Do we have relevant experience and practical IHL training? • What is the nature of medical services now on both sides? • Can we add value to what already exists? • How will the conflict and needs evolve? Injury types? Outbreaks? Mental health?
3. IHL– acceptance	<ul style="list-style-type: none"> • Will affected communities accept treatment from newly deployed teams from other districts? • Will local providers accept teams from other districts operating with them and/or alongside? • Who is collecting and caring for the wounded and sick? Is it with respect and dignity? 	<ul style="list-style-type: none"> • Will affected communities accept treatment from international teams? • Will local providers accept international teams operating with them and/or alongside? • Will local military commanders accept international teams in areas they control? • Who is collecting and caring for the wounded and sick? Is it with respect and dignity?
4. IHL – access	<ul style="list-style-type: none"> • Will the affected communities and military commanders grant the team access to the wounded and sick from both sides without hinderance? • Will the wounded and sick be granted access to the team? By both sides? If not, is influence possible? 	<ul style="list-style-type: none"> • Will the affected communities and military commanders grant the team access to the wounded and sick from both sides without hinderance? • Will the wounded and sick be granted access to the team? By both sides? If not, is influence possible? • Who has authority to grant temporary licence/authority for international medical practitioners?

Core principle	National team critical thinking	International team critical thinking
5. IHL – security	<ul style="list-style-type: none"> • Will it be safe enough to operate the mission for staff and patients? How will it evolve? • What will be the consequences for the patients, team and overall humanitarian response if a team is attacked/harmed? • Will the team be viewed as party to the conflict by virtue of ethnicity? Religion? • Will local staff have safe access? • Is a secure referral mechanism in place or can be set up? • Is there a civil–military coordination mechanism? Other platforms? • Can we evacuate/relocate team and patients if needed? • Do team members understand the importance of their personal behaviour and conduct in relation to security and safety protocols? 	<ul style="list-style-type: none"> • Will it be safe enough to operate the mission for staff and patients? How will it evolve? • What will be the consequences for the patients, team and overall humanitarian response if a team is attacked/harmed? • Will international staff have safe access? • Is a secure referral mechanism in place or can it be set up? • Will the team be viewed as taking sides by virtue of perception of the deploying nation or the team itself? • Is there a clear chain of military command on both sides? • Will the team’s nationality, passports, ethnicity, religion, past social media history and the government’s position influence perception by locals or be seen as party to the conflict? • Is there a civil–military coordination mechanism? Other platforms? • Can we evacuate/relocate the team and patients if needed? • Do team members understand the importance of their personal behaviour and conduct in relation to security and safety protocols?
6. Impartiality	<ul style="list-style-type: none"> • Will we be directed to discriminate and treat one group and not the other? • Will we be forced to make statements and triage preferentially wounded and sick from one side and not the other? • Can we influence decision-makers? • Can we be prosecuted by the authorities and/or stigmatized in local/national media for treating all wounded and sick? • Do we have a strategy to deal with this stigmatization to ensure our access is not impaired? 	<ul style="list-style-type: none"> • Will we be forced to discriminate and treat one group and not the other by virtue of the location of the team or deny access to those in need? • Will we be forced to triage preferentially based on uniform from one side and not the other or perceived sympathies? • Can we influence decision-makers? • Can we be prosecuted upon return for aiding those labelled “radicals/ extremists/terrorists”? • Will we be forced to disclose patient identities or patients for arrest to authorities under domestic laws? How do we protect medical confidentiality of our patients? • How can we be sure our patients have not been triaged along the referral chain according to their political or ethnic identity to ensure care based on needs alone?

Core principle	National team critical thinking	International team critical thinking
7. Neutrality	<ul style="list-style-type: none"> Do we understand the context? Are there international actors present or en route? What is the nature of medical services now on both sides? Will we have access to both/all sides of conflict? What can and cannot be communicated/shared on this conflict and with whom? Will we be perceived as party to the conflict and is this changeable? What can and cannot be communicated/shared on this conflict and with whom? What are the guidelines regarding media and social media? 	<ul style="list-style-type: none"> Do we understand the context? What is the nature of medical services now on both sides? How have others responded? (ICRC, MSF, UN, local NGOs, ministry of health, etc.) Has the UN formally stated its position? Will we have access to both/all sides of conflict? Will we be presented with wounded and sick from one side only? Will they be able to reach us voluntarily? Will my nationality, ethnicity, past social media history, government's position influence the perception by locals as being party to the conflict? Is this changeable? If not? What can and cannot be communicated/shared on this conflict and with whom? What are the guidelines regarding media and social media?
8. Independence	<ul style="list-style-type: none"> Is the team part of governmental, nongovernmental or semi-governmental state structures? Is this alert part of a government or military strategy? Will we be perceived as party to the conflict? Who is funding? Who is staffing? What level of operational autonomy will the team have over medical decisions, deployment location and mobile/outreach if needed? 	<ul style="list-style-type: none"> Who is mobilizing the medical and relief responses? What is the agenda of the donors? Is this alert part of a government or military strategy? Who is funding? Who is staffing? What level of operational autonomy will the team have over medical decisions, deployment location and mobile/outreach if needed?
9. Special Considerations	<ul style="list-style-type: none"> What is the level of sexual and gender-based violence (SGBV)? Implications for team skills and kits? What are the off-limits/taboo topics? Have atrocities been committed or are probable? By whom? Will the team be required to report or provide evidence? 	<ul style="list-style-type: none"> What is the level of SGBV? Implications for team skills and kits? What are the off-limits/taboo topics? Who can they be discussed with? Have atrocities been committed or are probable? By whom? Will the team be required to report or provide evidence?

1.5 Consequences and implications when deviating from principled action

Medical teams must always respect, and be guided by, the four core humanitarian principles. Ensuring that the behaviour and conduct of teams is principled and framed by IHL requires purposeful and thoughtful actions, as well as an awareness of the short- and long-term consequences of such actions. This requires constant monitoring of the evolving context within which teams operate and may also need an advocacy strategy to remind and influence key actors and authorities to ensure that they fulfil their obligations under IHL to provide medical assistance to persons wounded on the battlefield, and not “instrumentalize” humanitarian and nonhumanitarian organizations to provide such care, and thus relieve them of their own obligations. The sources to inform this critical thinking can include conversations with local people, relevant authorities, patients, facilities, print/social media and local staff. Team leaders should never appear to dismiss comments and views, but rather actively listen, observe and reflect. Teams are also not immune to the lasting impact of the actions of others, or their own, from previous deployments (reputations follow teams and persist). Populations and communities do not, or are not, always able to distinguish between the various groups and missions, and often tend to generalize (positively or negatively) from what is heard and observed. In many situations this may require external communications to address rumours and perceptions not reflective of the mission. All external communications need to be tightly managed, well-coordinated and controlled to avoid mixed or confusing messages that may lead to misunderstandings.

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

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

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

The following table, while not exhaustive, aims to guide and support teams in decision-making and planning for a deployment into an armed conflict, and their engagement with various actors. It is critically important to keep in mind that overall awareness of the situation and evolution of conflict are “must do” daily tasks for the team and team leaders.

Maintaining principled humanitarian action in the face of these pressures is essential even if difficult to achieve.

Table 9. Consequences for noncompliance with principles

Requirements for medical teams	Why?	Possible consequences if not practiced
<ul style="list-style-type: none"> Actively engage in the care of, support to, and referral of patients as medically required. 	Humanity and neutrality	<p>Risk categories include loss of protection, security, trust, access, reputation and increased moral distress.</p> <ul style="list-style-type: none"> Risk being subjected to direct or indirect attacks on the facility, team, and/or patients. Risk loss of acceptance by the wounded and sick not seeking services from the team, often preferring to suffer or access other forms of care if available. Risk loss of access via denial of physical entry to areas where the wounded and sick are present including road blocks to facilities or camps, with possible threats and coercion. Risk loss of confidential relationships and influence with key actors that can provide access and/or facilitate various aspects of the mission. Risk heightened levels of moral distress (73) among teams unable to access or care for patients. Risk to reputation, both within the area of operations, and possibly globally as the team may develop a reputation or be perceived as an opportunistic/mercenary type organization. Risk stigmatization and generalizations (realities or perceptions) being applied to most teams throughout the operational space. Risk legal prosecution.
<ul style="list-style-type: none"> Provide medical care and triage that does not favour (or appear to favour) one group, religion, or ethnicity over another. 	Impartiality	
<ul style="list-style-type: none"> Not restrict access to life-saving treatments, devices and pharmaceuticals or prioritize foreign team members.²¹ 	Impartiality	
<ul style="list-style-type: none"> Avoid, where possible, placing facilities in close proximity to or co-locating with the military of one of the warring sides. However, it is not the responsibility of medical teams to never place facilities close to military objectives, which may be unavoidable when situated near a frontline or in an urban setting. 	Neutrality	
<ul style="list-style-type: none"> Avoid utilizing armed escorts and uniformed/armed guards (see OCHA guidelines) (74). 	Neutrality and independence	
<ul style="list-style-type: none"> Avoid expressing opinions and sharing views on those involved in the armed conflict. This can take many forms: in meetings, publications, media interviews, on social media, in conversations with patients/families, with local staff or local authorities. However, this should not prevent public communication to denounce IHL violations of any kind and their impact on the civilian population. 	Neutrality	
<ul style="list-style-type: none"> Avoid expressing sympathy (or being perceived to do so) and solidarity with one side over another via attire/uniform choices, religious symbols, facility logos/emblems, national flags, and/or socializing. 	Neutrality	

²¹ While valid practical and other reasons can justify this action, and such policies often exist due to various organizational duty of care and insurance requirements, it is critical that this is not openly advertised and expressed.

In Summary ^[54]

1. Humanitarian principles must govern the conduct of humanitarian and health-care workers.
2. Humanitarian actors need to engage in dialogue with all parties to a conflict for strictly humanitarian purposes. This can begin with the humanitarian coordinator's office in the affected country and also include ongoing liaison and negotiation with both state, and nonstate, armed groups.
3. Compliance with humanitarian principles affects team credibility and therefore its ability to establish safe access to affected people. However, it is not enough to repeatedly recite humanitarian principles. Rhetoric must be matched by leadership and practical deliverables.
4. There are multiple pressures on humanitarian actors to compromise humanitarian principles, such as providing humanitarian aid as part of efforts to achieve political ends. Humanitarian actors must therefore be prepared for these pressures and have response mechanisms in place to handle them and respond in a principled manner ^[75].
5. Military or governmental teams contributing to EMTs must provide strictly impartial medical care, in keeping with IHL and medical ethics, and must be aware of the impact their actions can have on the perceived neutrality and independence of broader medical operations.
6. Near, or on, the battlefield or frontline medical care is the primary responsibility of parties to the conflict, while civilian and other teams are best suited to provide care along the referral pathway.
7. When many medical teams are making offers to engage in support of a conflict response, preference should be given to those who have an established track record of operational independence that would increase their chance of acceptance by, and access to, the affected population.

1.6 Humanitarian negotiations

A central role for team leaders is to set the tone, attitude and parameters for the medical mission and communicate priorities, risks, plans and dos and don'ts. While not all team members will be negotiating with lead counterparts, many team members will nevertheless engage in various levels of communicating/negotiating with many actors. It is therefore, imperative that everyone has a solid grasp of fundamentals, including engaging with locals of all backgrounds and professions.

The soft skills and competencies required to augment negotiating and communicating are critical for all team members. They include a commitment to caring for people; being self-aware and able to work with others effectively across languages/culture; possessing leadership skills and the ability to follow directives; take initiative; show professionalism and a commitment to ethics; good listening and communication skills; and exceptional cultural sensitivity. It has been said that "Deployment is Diplomacy" ^[76]. Soft skills provide for soft power and influence to achieve mission objectives. While it is challenging to provide a prescriptive or one-size-fits-all approach to the most essential soft skills, experience demonstrates that treating everyone with respect, humility, empathy, patience and sensitivity will enable better outcomes. This does not mean abandoning principles and mission goals, which can be achieved while being firm, focused and persistent.

1.6.1 Humanitarian negotiations

Humanitarian negotiations are defined as:

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

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

A successful outcome from a humanitarian negotiation is linked to the quality of both the personal relationships established between the leadership and members and their counterparts, and the use of the respective networks of influence.

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

The experience of many suggests there are still possibilities and opportunities to reach agreement and find acceptable solutions or compromises, and so possibilities to carry on with the mission exist even in the darkest and most confusing contexts. The MSF experiences and case studies were published [77] and states:

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

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

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

The Geneva-based Centre of Competence on Humanitarian Negotiation (CCHN) [78], launched by five leading humanitarian organizations: the International Committee of the Red Cross (ICRC), the United Nations High Commissioner for

Refugees (UNHCR), the World Food Program (WFP), Médecins sans Frontières (MSF) and the Centre for Humanitarian Dialogue, published a field manual.

In December 2018, the first edition of the CCHN Field Manual on Frontline Humanitarian Negotiation was released and is available for downloading [79]. Drawing on the collective experience and perspective of hundreds of humanitarian practitioners, the field manual offers a set of concrete tools and methods to plan and prepare negotiation processes for the purpose of assisting and protecting populations affected by armed conflicts and other forms of violence.

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

1.6.2 Community engagement

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

Example 1. The importance of community engagement in an outbreak during acute political violence

Post-election violence and criminality that lasted weeks amid a serious cholera epidemic in a major urban centre resulted in a situation in which the fear of the disease within communities saw patients and medical teams attacked, prevented from setting up, and an overall refusal to permit access, meaning no acceptance, no trust, and a high level of insecurity. Certain politicians and other religious leaders condemned those with cholera stating that this was “punishment from God” and that “cholera was the work of the devil”. They would travel in convoys with loudspeakers urging communities to ‘kick out the sick’ and “stop medical teams from treating them”.

Example 2. Community engagement in cholera during high levels of insecurity

As the epidemic peaked with thousands affected, the government sought international assistance (but was unable to force communities to accept the teams). To gain access to one major neighbourhood within the big city and set up a cholera treatment centre (CTC), one international team’s approach was to quickly and actively engage with over 30 community leaders such as political, municipal, religions, schools, women, youth, businesses and the local Red Cross. Through meetings convened in place and times of their choice, the team explained the nature of the illness, the causes, the available treatment, the type of field hospital (CTC) and team that would be set up, the duration, benefits, need/role for the community to be part of the effort to identify sources and spread messages on prevention, seeking their assistance to identify a suitable and acceptable location. The meetings dragged on for more than five days and required extreme patience and a respectful approach. The team shared epidemiological data with the community throughout the process of dialogue which helped highlight the spread of the disease, locations, the important role they need to play, and level of urgency. Violence continued for weeks, curfews were in place with roadblocks and burning tires on many street corners.

Once the violence decreased to an acceptable level most community leaders (not all) gave their approval for the team to set up. There was transparency and agreement as to how to manage such issues as the deceased, waste, condition of the land upon completion of the operation, training for locals and support to prevention efforts.

The CTC started operating after eight days from the team’s arrival into the country; within the first hours, the 80 beds were fully occupied with women, children and men. In the next days, many of the leaders were invited to see how cholera is treated and patients cured. Many seemed pleased and assured.

However, some of the car convoy loudspeakers continued to blare out against cholera. The team decided to invite the politicians leading the negative campaign (through the local church leaders), and they accepted. Similarly, they were shown the facility and patients and local staff (medical and nonmedical) supporting the treatment centre, the training for community members on prevention and hazard identification. The next day, the loudspeakers stopped. The team continued treatment for the next five months, and upon the decision to close down and handover, the politician who lead the negative campaign visited the facility and asked the team to please continue, “If you leave, people will die. Please stay,” he said. He was assured that the situation was under control and the local community and Red Cross could manage from now on.

Attacks on medical facilities and personnel also cause communities, community leaders and local health workers to hesitate in seeking or providing care. Such general insecurity creates challenges, both for populations trying to access health services and for health actors trying to reach populations in need. A road block, checkpoint or blockade can halt all best efforts to offer medical care. At times, medical missions have been attacked (80).

Direct and open engagement with the population, community leaders and local health workers, when providing clinical care will aid in building trust and customizing care to address population specific concerns and morbidities. Community engagement is best conducted by civilian groups and organizations as they well know local communities. However, this is not a substitute for engagement by medical teams themselves and to do so effectively team members require competencies such as interview techniques, working with interpreters, sensitivity to power/gender dynamics and managing ethical dilemmas. Gauging perceptions and determining how to best gain acceptance into a community entails establishing relationships and frequent

communications framed by active listening, soft skills, humility, respect, civility, gender sensitivity, cultural sensitivity, empathy and transparency. A degree of openness, transparency and a predisposition to learn from local health providers, local community wisdom, and a willingness to take criticism, reflect and act, can also aid in building trust, preserving dignity and strengthening acceptance. It is important to note that medical teams with military or government affiliations operating in armed conflict settings need to exercise caution with such engagement, as it will be perceived to be part of security or political agendas.

In a study by the Humanitarian Policy Group ^[81], it appropriately stated that often in crises where there has been a rupture of the existing norms and institutions of governance, NGOs claim authority by appealing to impersonal norms such as freedom, equality, health and security as their international professionals with expert training descend on a local crisis, imposing values and applying standard procedures to their intervention and, in so doing, deny state sovereignty and depersonalize and decontextualize social relationships, reducing social agents to human bodies.

Many humanitarian responders today are quite well-informed on core humanitarian principles and their organizations communications strategies which are shaped by a combination of mission statements, charters, codes of conduct, and/or mandates, and are often briefed on the context of operations. However, in the contexts of war, medical teams are often faced with new challenges, dilemmas, and the need to find a delicate balance: medical teams need to ideally locate services as close as safely possible to a community, however, this may not be possible due to active hostilities and war hazards.

Many organizations are resorting to the use of social media and other digital applications to share vital information and public health messages in hard to reach communities and/or to obtain feedback on needs and services. In this context, “digitally prepared” medical teams can deliver better quality and more accountable services to people affected by crises. This, however, comes with caveats linked to security and data protection that require careful consideration ^[82].

1.7 Guidance notes

Do No Harm!	<ol style="list-style-type: none"> 1. Medical teams and leaders need to frequently analyse and understand the context and nuances within the areas and territories they deploy through a “conflict sensitivity lens” to avoid unintentionally doing harm. 2. Medical teams are required to seriously consider not deploying, and if they do, must closely examine the location of the deployment when minimum conditions of safety, security, impartiality and access to wounded and sick cannot be achieved. 3. Medical teams need to reach patients through principled conduct. Access requires acceptance by communities and stakeholders. Acceptance is rooted in trust which will also provide improved security. 4. Medical teams need to be aware of and provided with pre-deployment practical training (and field training for local staff) in applicable IHL, and the four core humanitarian principles of humanity, impartiality, neutrality and independence. 5. Medical teams require soft skills relevant to the context of planned deployment. <p>Practical IHL training modules can be integrated into existing curricula ^[83] and include local staff and rotating teams.</p>
IHL and core humanitarian principles in action	<ol style="list-style-type: none"> 6. Medical teams are required to guide their response in compliance with IHL and core humanitarian principles through demonstrable actions that ensure they are perceived as neutral and independent and able to understand where deviations, such as military escorts, can and cannot be made, while being fully aware of consequences. 7. Medical teams, if and when possible and safe, need to engage in coordinated contact with all parties to the conflict and treat all wounded and sick without discrimination. 8. The realities, complexities and risks associated with operating as a medical team in armed conflicts require experienced leadership and resilient teams capable of navigating the landscape with a pragmatic and patient focused approach. 9. Team leaders require special training and guidance to navigate the complex and confusing realities of armed conflict. 10. Teams should only consider the use of armed escorts and armed guards as a last resort ^[74] as this can critically impact the perception of their neutrality.
Humanitarian negotiations	<ol style="list-style-type: none"> 11. Teams and leaders require competencies and skills in conflict resolution, consensus building and soft skills applied with humility, respect, patience and cultural/religious sensitivity as critical enablers to achieve objectives.
Community engagement	<ol style="list-style-type: none"> 12. Medical teams need to engage with communities with full transparency and openness framed in active listening, sensitivity to culture, gender, respect and empathy. 13. Digital and social media platforms can be considered (with cautions) in communicating with affected populations and other medical professionals to provide key practical messages and tips on health and hazards.

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Chapter 2

Safety and security Risk management

2 Safety and security Risk management

Chapter objectives

1. Medical teams have a comprehensive security risk management approach in place for operations in conflict settings.
2. Medical teams are able to identify specific security threats associated with armed conflict.
3. Medical teams have considered particular security measures appropriate for providing care in armed conflict (including CBRN).
4. Organizations/agencies adopt minimum requirements for robust preparedness in terms of workforce mental health.
5. Medical teams and their leaders have easy access to the most relevant key references and manuals.
6. Medical teams will be provided with full physical and mental care when adverse events occur.

2.1 Introduction

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

This chapter will further elaborate the proposed means and measures medical teams (regardless of type or affiliation) are required to consider and plan for to protect the medical mission and respond to deliberate and/or indirect attacks. It will present and highlight best practices, safe conduct, and specific dos and don'ts, referencing the selected work of NGOs, ICRC, MSF and WHO. In response to attacks on health workers, many of the key organizations in this field have published guidelines and practical guidance manuals, such as the UN Security Management System *[84]*. Many have launched initiatives to prevent attacks such as the Red Cross Red Crescent Movement's Health Care in Danger *[85]*, Safer Access Framework *[86]*, MSF's Not a Target *[87]*, and WHO's Attacks on Health Care *[80]*.

Organizations deploying medical teams have a legal and moral obligation to strive towards a practical level of judgement and care in safeguarding the safety and well-being of deployed team members, as well as other stakeholders

within the scope of team operations, such as patients and referral cases, their families, local health workers, contractors and counterparts.

The core question at the heart of the EMT's approach: is it worth risking someone's well-being – or even life – to deliver the organization's objectives and safe patient care? Decisions concerning whether to deploy, how to remain in situ and whether to continue with a direct field presence in the face of escalating dangers must be placed within a fully comprehensive and systematic risk management process.

**Armed conflicts might
evolve rapidly and with little or no early warning:
teams need to constantly re-assess and act.**

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

None of these elements – security, access and provision of medical services – is static or stand-alone. This dynamic relationship is illustrated in Fig. 2 where security is an enabler of safer access without which medical programming cannot take place [88].

Fig. 2. Safety and security wheels as enablers of safe access



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

The Blue Book outlines in detail the safety and security risk management considerations for all medical teams, including those operating in conflicts. A comprehensive approach requires action at three levels.

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

Traditionally, aid organizations tend to focus exclusively on the negative impacts of security risks. However, a systematic and comprehensive approach to risk management can have positive impacts as well [89]. Examples of benefits to EMTs in accepting and managing security risks may include:

- reputational enhancement
- stronger relations with and the trust of affected communities
- building an esprit de corps²² among team members
- improved security coordination and response planning
- improved conditions for future access
- improved organizational resilience.
- positive local and international media coverage (especially related to providing care to all in need).

²² French term meaning a feeling of pride, high morale, and mutual loyalty shared by the members of a group.

2.2 Specific security threats

Where health emergencies coexist alongside armed violence, there are usually additional special features to consider that relate to the type of weapons and explosives being used that alter the security environment. With the breakdown of the rule of law that occurs during conflicts, threats from criminality and civil unrest further increase the threat level.²³

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

Table 10. Threat categories (adapted from UN Security Management System)

Armed conflict	Radical violence	Crime	Civil unrest	Hazards
Small arms attack	Improvised explosive device	Kidnapping (economically motivated)	Peaceful protest ²⁴	Road traffic accidents
Aerial assault	Kidnapping (politically or militarily motivated)	Sexual assault or gender-based violence	Violent demonstration	Illness/disease
Landmine strike (anti-personnel)	Assassination	Carjacking	Looting	Natural disasters
Landmine strike (anti-vehicle)	Suicide bomb	Burglary	Patient aggression	Fire in hospital
Unexploded ordnance CBRN(E) attack	CBRN(E) attack	Petty theft		Electrical installation safety

²³ The difference between a Threat and a Risk is that a Threat is a negative event by itself, whereas a Risk is the negative event combined with its probability and its impact.

²⁴ Crowd injuries often occur even when the protest has no aggressive intent. Any build-up of body density can lead to crush injuries, often exacerbated by panic when large numbers of people surge in a certain direction to avoid harm.

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

2.3 Specific security measures

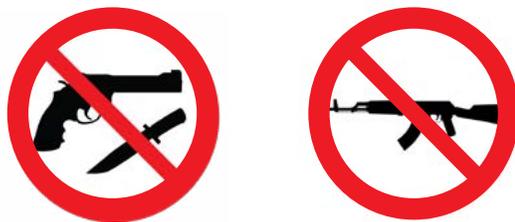
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Following a thorough risk assessment and contextual analysis, in addition to routine measures necessary for any type of deployment, special controls designed to reduce exposure of medical teams to some conflict-based threats might include (but are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

1. Avoiding places and times of day where instances of armed violence are more likely.
2. Negotiating and agreeing safe access protocols with parties to the conflict and arms carriers.
3. Strengthening efforts to demonstrate the medical team's neutral and impartial position, including paying careful attention to attire and use of emblems, measured association with parties to the conflict, personal conduct, restrictions on media and social media statements and treating all with respect.
4. Increased coordination and information sharing on security risks relating to the conflict with other actors behind the scenes.
5. Based on risk assessment, consideration to establishing a hard perimeter around the medical facility or team base.

6. Increasing the stand-off distance separating the perimeter from personnel-heavy areas inside the facility.
7. Enhancing access controls such as vehicle chicane, protective features for unarmed guards.
8. Introducing blast protection infrastructure within fixed facilities such as designation of hardened safe areas, walling off areas containing flammable/combustible including fuel storages and oxygen.
9. Use of blast protective film for windows (type 3M).
10. In case of high risk of abduction/violent intrusion it is imperative to create strong rooms and panic buttons with backup emergency support.
11. Designation of a safe room for staff and patients in the event of shelling or bombing.
12. Using blast protected vehicles for transport of staff and patients.
13. Stockpiling PPE relevant to the armed threat, inclusive of direct and indirect attacks within the team's contingency plans and practical rehearsals, such as medevac, hibernation and relocation/evacuation plans.
14. Incorporating conflict-based threats into the team's critical incident management system, including specific protocols for high risk scenarios such as kidnap or hostage taking.
15. Instituting team protocols for the medical treatment of war wounded, including separate triage areas for different parties and where appropriate protocols for CBRN threats.
16. Establishing a clear "no weapons" policy for the health-care facility and communicating this clearly to both armed visitors and wounded combatants. Safe storage facilities and protocols should be employed for small arms, ammunition and sharp-edged (bladed) weapons – including the use of illustrated examples on facilities and vehicles.

Fig. 3. Examples of "No Weapons" stickers for facilities and vehicles



Context matters, and it is again stressed that no two situations are the same. A nuanced and informed approach is necessary and one which balances acceptance, hardening²⁵ and deterrence measures in degrees proportionate for the risk context and in alignment with the medical team's internal mandate and capabilities. Although an EMT may have a natural leaning towards a soft or hard security profile, those who successfully maintain an operational presence in conflict settings recognize that a mix of methods is needed and are adept at blending the best available tools for each deployment.

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

Moreover, when introducing a new risk reduction measure, the medical team should take care to monitor how this impinges upon the effectiveness of its other measures. Sometimes, a team that makes itself safer in relation to one threat can unwittingly increase its vulnerability to another. Due consideration should be given to ensuring the best possible outcome for local staff, patients and relatives.

Safety and security examples

Example 3. Care within extremist internal conflict

A medical team whose security strategy relies heavily on building trust and an image of positive engagement with local communities surrounding its health facility may undergo reduced exposure to threats of criminal intent or localized crowd violence. However, a team that depends solely on acceptance may also be viewed as a soft target for potential "extremists" attacks, including those of a criminal nature, which can even put communities at increased risk due to association with the medical organization.

²⁵ Hardening measures are intended to make it more difficult for a threat to reach the EMT's critical assets by creating a physical barrier.

Example 4. Care and armed escorts

A medical team in a refugee camp where, for a long period of time, humanitarian road movements were accompanied by police escorts, experienced a reduced vulnerability to carjacking for criminal purposes. However, travel alongside local security forces actually increased the team's chances of encountering improvised explosive devices laid by militants who opposed the host government.

Example 5. Care and transport in situations of criminal violence

A national organization providing first aid and transport to victims of severe violence and criminal activity has had its personnel face threats and harassment in person and over radio communications. The organization continues to navigate a delicate, balanced course to position itself as neutral in the ongoing clashes.

The behaviour of gangs has seen medical personnel taken away from homes and "escorted" to provide care for injured group members. Similarly, ambulances (with and without physicians) are taken over and diverted to areas in which victims of violence are present.

The organization has resorted to using secure digital radio communications to ensure the privacy and confidentiality of ambulance movement and staff locations. After careful consideration and weighing options, the injured were sometimes transported with police escorts.

Despite the hazardous situation, personnel and ambulances have not been attacked. According to the organization, this is thanks to a long process of engaging with all actors, discussing the nature of the medical mission and the respect it deserves, as well as ensuring transparent, neutral and impartial action by the organization.

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

Medical teams should therefore consider the following as preferred alternatives to armed escorts (74):

- maintaining a low-profile approach;
- remote and digital device supported programming options;
- negotiating access;
- raising awareness of IHL among armed groups (see Chapter 1);
- requesting area security, such as clearing and patrolling roads, maintaining a presence in the area but not being visible or accompanying the convoy and providing aerial fly-overs;
- engaging in the Humanitarian Notification System (deconfliction)(90);²⁶ of military and humanitarian activities, to ensure clear separation of actors co-existing in the same space (see section 3.4.10); and
- establishing humanitarian pauses within or corridors through the conflict (although this is not a favoured option).

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

- two or more medical teams (with different affiliations) are co-located or conducting joint operations;
- local health workers are embedded within the medical team's facility, or vice versa;
- a medical team conducts a planned hand-over of its activities to another entity, towards the end of its deployment;
- the security situation deteriorates to a point where a medical team is forced to make a hasty withdrawal, leaving local health workers to continue the service delivery autonomously or with some degree of remote support.

²⁶ Deconfliction (a military term): The exchange of information and planning advisories by humanitarian actors with military actors in order to prevent or resolve conflicts between the two sets objectives, remove obstacles to humanitarian action, and avoid potential hazards for humanitarian personnel. This may include the negotiation of military pauses, temporary cessation of hostilities or ceasefires, notification of locations of medical facilities, or safe corridors for aid delivery.

Teams must remember that, while a security threat may remain the same before and after any point of transference,²⁷ the vulnerabilities of different teams, team members, or health workforces to that threat will often vary. For example, depending on a variety of factors, a clinic staffed by local health workers may be assessed as either more, or less, at risk of violent attack than would the same clinic run by an international medical team.

In each case where a medical team or organization – through choice or necessity – makes decisions such as to exit or relocate that essentially transfers risk to another team that continues to provide services, there is a moral as well as practical imperative to consider arrangements for continuity within the service. Respective vulnerability profiles should be compared, and expertise shared openly, to ensure that a defensible risk treatment plan is maintained as seamlessly as possible within the constraints being imposed.

2.4 Patient safety

The team needs to consider the safety of the wounded and sick to ensure access and protection for patients and families [91].

Table 11. Patient safety considerations

Access, entry, referral and discharge	Consider
<p>A. Prior to admission:</p> <p>Do the wounded and sick have free access to the facility?</p>	<ol style="list-style-type: none"> 1. What are the risks on the roads to the health-care facilities? Checkpoints, hazards, threats, etc. 2. What mitigation actions have been taken? 3. Is transportation to the health-care facility available and safe for patients and families? 4. Are the surroundings of the facility safe for the family to stay at? 5. Does the visitor policy account for the risks?

Access, entry, referral and discharge	Consider
<p>B. Care within the facility</p> <p>Is the facility protected and marked and does its presence have informed consent from parties to the conflict?</p>	<ol style="list-style-type: none"> 6. Is the medical facility recognized as protected, impartial and neutral by all parties to the conflict? What are the measures taken to achieve that? 7. What are the agreements with the military/ law enforcement on the protection of hospitalized combatants? What are the mechanisms to deal with disputes? 8. Are physical protection measures in place for the facility? (fencing, sandbags, hardened walls/rooms, blast doors, window glass shatter protection, etc.) 9. What aspects of care should be carefully transmitted to the patient regarding treatment to avoid misperceptions on lack of ethics or partiality?
<p>C. The referral pathway and discharge</p> <p>Can patients be referred safely to other facilities?</p>	<ol style="list-style-type: none"> 10. Are the medical transports used known to all parties and respected? What actions are needed to ensure this respect? 11. Is the referral path/discharge for the victim safe (roads, transportation modes, referral facility)? Is referral considered also in terms of the victim's safety and security? 12. Is there anything that the health-care team can do to actively reduce risks to the patient and their family around their discharge, such as providing proper documentation on medical care provided?
<p>D. Overall</p>	<ol style="list-style-type: none"> 13. Is an ongoing risk assessment in place to monitor the risks to patients and their caregivers? Does the risk assessment include the autonomous and informed opinion of patients and their caregivers regarding their own risks?

²⁷ Transference risk control strategy occurs when an organization decides to manage/reduce or deflect a risk it encounters to another organization. (It may also occur between network assets or processes, too.) So, instead of trying to handle the risk yourself, you give it to someone else.

2.5 Medical evacuation for team members

It may be necessary to evacuate team members due to injury or illness. If the decision is taken that evacuation from a medical point of view is a necessary measure, EMTs need to act quickly and assess the risk-benefit to the team member and the team. Evacuation protocols need to be well established, clear, and well communicated to the team, with a designated focal point and well-coordinated with external stakeholders as required. See this reference on the transport of critically ill patients as a general guide ⁽⁹²⁾ and on critical air transport ⁽⁹³⁾.

- Generally, overland transport (ambulances and general-purpose vehicles) is the primary means for the evacuation of the injured from emergency zones to the nearest and safest point of medical care.
- Railway, river and marine transport can be considered and may offer certain advantages over road. Usually the final evacuation steps may require a specially equipped civil or military (as a last resort) airplane.
- Teams need to ensure adequate medical documentation accompanies the person(s) evacuated. In cases of infectious diseases, and/or suspected CBRN contamination, special measures must be taken, as well as the (prior) identification of the appropriate referral pathways (considering treatment capacities of the different receiving facilities). This needs to be managed in consultation with and through the designated lead agency and/or authorities, and in compliance with local guidelines and protocols, including those in transit and recipient destinations.
- Importantly, key precautions to ensure safety need to be implemented, including notification/consent of parties to the conflict, agreed emblem use, and coordination with medical providers along the referral pathway.
- Arrangements for medical evacuation contracted to specialized providers need to ensure that the deploying organization has read in detail the so called “fine print” and understood exactly what is covered/included or not and fully understood the capacities and limitations of such agreements.
- If the person to be evacuated has been rendered unable to communicate, a direct contact with family/emergency contacts should be considered, either by the focal point in charge of the evacuation or those in charge of the coordination. Always be mindful of respect for medical confidentiality during the evacuation with non-medical support staff.

2.6 Mental health and psychosocial support (MHPSS) for the team

Responding to the needs of populations affected by armed conflict can be a very rewarding experience, bringing meaning and a sense of belonging to a team. It is also an occupational mental health risk. In addition to physical injuries, working in conflicts poses a risk of stress among workers ⁽⁹⁴⁾.

Emergency responses are highly stressful. Teams are often faced with grave human suffering, overwhelming needs, shortage of supplies, long working hours with not enough rest, harsh physical conditions, suboptimal organization of work and separation from friends and family with often few opportunities to keep in touch. These are just some of the hardships that will have an impact on the responder’s mental health. Some of the additional characteristics of conflicts, that can have a serious impact on the responders include witnessing or experiencing the following.

- Cruelty (including the use of SGBV as a weapon of war).
- Attacks and violations targeting the most vulnerable (children, women, elderly, sick persons).
- Direct threats to health-care personnel, attacks or physical aggression against them or upon the health-care facility.
- Direct threats or violence against the local staff and their relatives (mainly around accusations of “treating the opposing side of the conflict”).
- Armed actors denying care to certain groups and/or hindering their access.

In attempting to care for the wounded and sick in armed conflicts, medical staff (local and international) are likely to experience strong emotions and stress,²⁸ amplified by: the nature of the emergency; rapid intervention; fatigue; their fears; and immersion in violence in all its forms. Conditions are often harrowing with staff witnessing the suffering of victims and daily living in dangerous operational environments. In addition to the danger posed by armed conflict, there may be undisciplined combatants who have no respect for laws or ethics, proliferation of arms in the community and their use in criminal acts, attacks, abductions, outbreaks, and other potential threats ⁽⁹⁵⁾. Stress (when

²⁸ Stress refers to a psychological response, which often includes worry, anxiety, feeling overwhelmed or run-down, or a sense of depression or of not doing well enough. Often these feelings come with somatic complaints such as body pain.”

moderate and manageable) is not necessarily a negative as it can help to keep a person alert, safe and working well in difficult circumstances. However, if this worsens or is prolonged, a person can feel overwhelmed or unable to cope.

To mitigate the adverse effects of the situation on the EMT personnel and prevent long-term consequences for the team members' emotional well-being, all organizations deploying EMTs should develop and implement policies for the following areas ^[94]:

- pre-deployment and post-deployment confidential screening and assessment of the capacities of all staff to respond to anticipated stressors;
- appropriate pre-assignment preparation and training in managing stress;
- regular monitoring of staff response in the field;
- ongoing training and support to help staff deal with their daily stressors;
- specific and culturally appropriate support to staff and teams in the wake of critical or traumatic incidences or unusual/unexpected sources of severe stress;
- practical, emotional and culturally appropriate support for staff at the end of the assignment or contract; and
- ongoing support for staff adversely affected by exposure to stress, trauma or disease during their deployment.

At the individual level, team members need to reflect upon and honestly consider whether they ^[96]:

- Have the patience to work through the inevitably frustrating communication breakdowns that occur during cross-cultural interactions?
- Can be open minded and creative when facing unexpected problems?
- Have constructive and readily available means of coping with stress, anxiety and frustration?
- Are prepared to compromise some of their personal freedom because of security in some areas?

- Have considered how to respond in the presence of extreme suffering and deprivation, part of the day-to-day reality of many of the people in armed conflict zones?
- Have been honest with themselves about their motivation for seeking this type of work and realistic in their expectations of what it will be like?

A simple 10 question stress self-evaluation and checklist called Humanitarian Action and Armed Conflict: Coping with Stress may be considered useful ^[95].

2.6.1 Staff health and well-being

Pre-deployment

Organizations must prepare team members well to cope with the inevitable stress. The following measures should be implemented by emergency managers during the pre-deployment phase and, if applicable, extended to the different stages of the emergency response ^[97].

- Ensure that team members become familiar with the overall emergency response system and the roles and responsibilities of key teams, including their own.
- Establish clear lines of authority and responsibility to minimize stress by eliminating confusion about who reports to whom.
- Provide regular training on stress management techniques.
- Create a facility evacuation plan and practice drills regularly.
- Provide ongoing training to ensure that teams are thoroughly familiar with safety procedures and policies.
- Develop guidelines to help teams prepare for deployment.
- Maintain an updated list of family members' contact information for each team member.

During deployment

Food and water As per guidance in the Blue Book, teams should be self-sufficient in food and have the ability to rapidly produce their own potable water. In the event that teams wish to supplement ration packs with fresh food

and there is sufficient food available to do this without compromising supplies for the local population, teams must ensure that their supply chain comes only from trusted sources and is monitored at all times by a logistics team member.

Rest and Recreation (R&R) It is unlikely that there will be opportunities to offer staff R&R activities off the hospital compound so thought must be given to provision of these activities for the team. The organization may have a broader policy for R&R which covers a number of weeks worked before time off is given but this may not cover how to avoid staff burn-out in a highly charged atmosphere on a day-to-day basis. Staff need the chance to socialize as far away from the work environment as possible even if this distance is not physical. Some of the questions to be considered are: will socializing during time off be “enforced” and if so how; will alcohol be allowed if culturally appropriate; will time away from the compound be allowed if it is safe and under what circumstances will this be allowed? Whatever the policy adopted, it must be clearly explained to staff preferably prior to departure but if not as soon as possible upon arrival.

Valuable information on minimizing stress during and after the crisis can be found in the existing WHO guidance on *Occupational safety and health in public health emergencies: a manual for protecting health workers and responders* [94].

Access to support during mission in case of mental or physical health issues must be guaranteed, either through internal or external health-care providers [95]. Staff must be clearly informed about whom they are to contact and in which situations. Medical evacuation for mental health should be available.

Post deployment

Too often the longer-term welfare of staff post-deployment is given a lower priority than during the imminent pre- and post-deployment phases. The ability and desire of a team member to deploy with the organization on subsequent missions can often be decided by the experience they had on returning home. While this support is primarily for the benefit of the individual staff member, an organization that handles this poorly might find its reputation suffers and its roster numbers decrease. A successful organization will be better served by having rosters which balance experience with the need to renew with novice

team members. This cannot be achieved if the organization is constantly losing its more experienced team members because of a perception that staff were not supported on return from mission.

Ensuring that staff have the time and support they need to fully recover from a physical ailment or mental distress is important. This might include assistance with payment of medical expenses, time off work without a feeling of pressure to return too soon or facilitating supported return to work, or adjustment of working conditions upon return, such as reducing working days or hours if appropriate. The staff perception that an organization is supportive as part of its organizational culture is essential for a returning staff member, (who may or may not then take advantage of the support policies in place) and provides confidence and reassurance. For roster members who do not have permanent contracts with the organization, a robust system of follow up that is easy to access needs to be in place. A transparent system for handling complaints made during any phase of a deployment should be implemented as seen organizationally as an opportunity for learning rather than an annoyance that needs to be dealt with.

Mental health problems arising from a deployment, especially among roster staff, who may have minimal contact with the organization in between deployments, can be hard to identify without organized follow up, and thus support effectively. Symptoms may occur some months after the deployment and may not initially be attributed to the deployment by the individual. Staff members may be reticent to seek or accept help for mental issues for a number of reasons which may be cultural, gender-based or perception-based, to name a few. For staff who are exposed to a potentially traumatic event, measures should be coordinated to ensure that basic psychological first aid is provided immediately (but not psychological debriefing) and staff should be assessed within one to three months of the incident by a mental health professional, to determine whether further follow-up care is required [96].

Lessons²⁹ from the 2013–2016 West Africa Ebola outbreak showed that returning staff were reluctant to contact the programme set up to monitor their mental health and offer support as they felt it might negatively affect their opportunities for further deployments. This must be actively managed by the deploying organization and the issue destigmatized through internal education campaigns and modelling by mid- and high-level management.

²⁹ UK Department for International Development internal lessons review on uptake of post-deployment mental health support assistance for returning staff programme implemented by the South London and Maudsley NHS Foundation Trust.

Campaigns to reduce stigma are important because the public is aware that health-care workers are at higher risk of contracting disease such as Ebola virus disease through occupational exposure, thus health-care workers are often stigmatized and socially isolated. Even families of health-care workers have been known to be stigmatized and socially avoided by friends and acquaintances. As such, comprehensive public education campaigns should address the social stigma and exclusion of health-care workers resulting from the public's potentially excessive fear of contagion or contamination, as well as other commonly-held beliefs. Importantly, campaigns should encourage the public to value the role of the men and women on the frontline fighting the epidemic, so that workers feel proud of what they are doing. Such campaigns can be organized as part of the social mobilization packages in outbreaks.

2.7 Chemical, Biological, Radiological, Nuclear Threats (CBRN)

Whether accidental or deliberate, CBRN³⁰ hazards or attacks are serious and potential threats to medical teams deployed into situations of armed conflict and insecure environments. Therefore, prior to any EMT deployment a needs assessment as well as an analysis of potential CBRN hazards and threats must be undertaken. Such assessments and analyses shall be founded on a risk management methodology and the information and data underpinning the risk assessment must be collected from a range of competent and trusted sources both prior to and during deployment of EMT assets.

Incorporated in the risk profile should be the possibility of a perceived/rumoured release of CBRN hazards which for an EMT can be as challenging as the actual presence of an CBRN agent. The chaos and panic that can follow such a suspicion or rumour can make the triage process extremely challenging as well as potentially draining already limited resources from other priority areas of medical care.

Furthermore, when deployed with a team, CBRN equipment such as personal protective equipment (PPE), detectors, decontamination solutions and specialized drugs are often regulated with export licensing to areas faced with armed conflict.

Such restrictions can affect both the ability to deploy as well as response time and scale of response capacity.

EMTs are not a “stand-alone” operation, but part of a wider response structure, led by a clearly pre-determined leader (national or international). The decision-making process in all its phases – risk assessment, mitigation, preparedness and decision-making during the actual response, must be in close coordination with the lead, who also has the responsibility to ensure a standardized, harmonized and coordinated response across the different EMTs deployed.

If the risk of threats from CBRN is too high, the EMT should not deploy to that specific context/location. EMTs that will be deployed in contexts where limited and manageable risk of CBRN threats exist, must have received specific awareness, safe behaviour and escape training and provided with sufficient escape protective equipment for the EMTs throughout the deployment. A training in pre-hospital decontamination may also be required, and specific protective equipment provided [98]. Furthermore, information management coordination nationally and regionally needs to be in place and identified, to ensure information can be shared in the right way, in the right time and to the right institutions/specific locations, before deployment. In this way, referrals can be done correctly and warning systems properly activated.



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³⁰ CBRN is also known under the abbreviations CBRNE or CBRNe where the letter “E” or “e” designates “explosives” or “energetic” which can be used as a method for rapid dispersal of an CBRN agent in a device. Typically, the term “CBRN” would also include what is covered under CBRNE and CBRNe.

Working assumptions for medical teams working in contexts with CBRN risks.

1. CBRN risks can potentially exist in every widespread violence scenario and a risk assessment prior to deployment establishes the risk in a specific context.
2. CBRN contamination can be caused by:
 - a. toxic industrial material such as chemical, biological or radiological.
 - b. chemical, biological or radiological warfare agents.
3. CBRN contamination can be caused by agents in different forms: solids, vapours and aerosols (mist or droplets).
4. EMTs are not to operate in an area that is contaminated and/or under contamination. Should a situation arise in which a medical team is in a contaminated area, the expected course of action is to shut down and lock down, protect the staff and patients, shelter in place, initiate emergency decontamination and evacuate when safely possible.
5. EMTs outside of the contaminated area should expect to receive contaminated patients (planned or unplanned), brought in by a wide variety of means, thus creating a real risk of cross-contamination of the facility and personnel. EMTs must have a rehearsed plan of action for such circumstances ⁽⁹⁸⁾ and as stated earlier must have undergone training in preclinical decontamination and have deployed the necessary equipment.
6. Detection of possible chemical contamination will be based on signs and symptoms of the victims, without waiting for technical confirmation from technical detectors. An identification of contaminated cases shall activate compulsory decontamination. Any treatment rendered should take place after decontamination done with PPE. In case treatment was done without PPE the EMT team member is considered exposed and shall undergo decontamination and medical check-up.
7. Treatment of patients with suspected chemical intoxication will be based on their signs and symptoms (toxidrome)³¹ as this is a time-dependent pathology. Treatment should not be delayed waiting for laboratory results (laboratories that require specific equipment and technical expertise of the technicians, capacity that normally does not exist within or near the EMT operation), nor for the results and analysis of the technical detectors readings.
8. Detection of radioactive particles on patients can be achieved with the use of appropriate detectors used by trained personnel. When a patient suffers from a life-threatening injury, and the possible presence of radioactive contamination is suspected, treatment of the life-threatening condition comes first (see below).
9. Presence of a biological contaminant can be confirmed only by appropriate laboratories and competent public health authorities. Until such declarations are made, the personnel in the EMT will use PPE, according to WHO guidelines ⁽⁹⁹⁻¹⁰¹⁾.

For international response teams, it is also important to note that the ICRC states, “Mounting an effective international humanitarian response to a chemical, biological, radiological or nuclear (CBRN) event, especially if the response is undertaken on an ad-hoc basis, would be extremely difficult and would pose many risks to the responders”. ⁽¹⁰²⁾

All EMTs deployed to a widespread insecure environment with a CBRN threat established should be capable of or have the following.

1. Conducting a risk assessment, specifically addressing the CBRN threats. This capacity includes access to remote expert advice.
2. All personnel (international and local staff) trained in CBRN awareness, procedures and relevant escape PPE.
3. Identifying the in-country EMT coordination mechanism, contact with the coordination mechanism and coordinate the EMT CBRN contingency plan (as other security plans), coordinate with the EMT coordination on real time, during a suspected incident.
4. Collaborating with the local coordination mechanisms to ensure the distribution of real-time information on the possible use of CBRN agents, threats or rumours on the possible use to key actors.
5. Providing appropriate PPE for all the personnel expected to treat (infectious disease, other contamination, etc.) and decontaminate patients (not all EMT personnel are expected to participate ⁽¹⁰³⁾ in these activities). The equipment should include as a minimum, but adapted to the risk assessment a face mask fitted to the user including eye-glasses if those are used (or a solution such as powered air purifying respirator that ensures the seal without fit testing and allows for the use of glasses) with appropriate chemical canisters, protective garments, gloves (including inner cotton gloves), boots or shoe coveralls – all meeting an internationally recognized chemical protection standard, for example, the National Institute for Occupational Safety and Health (NIOSH) and the National Fire Protection Association (NFPA).
6. Ensured that all personnel expected to wear PPE have been medically checked and cleared for its use (also considering the climate where the PPE is to be used) and trained in donning and removal.

³¹ A toxidrome is a characteristic pattern of signs/symptoms that a patient may present with when exposed to a toxin with specific effects.

7. A contingency plan for the eventuality that the EMT facility falls within a contaminated area should include the following.
 - a. Decision-making processes, in coordination with the national EMT coordination lead.
 - b. Notification (internal and external).
 - c. Shut down of the facility.
 - d. Evacuation: everyone shall be evacuated and temporary shelter-in-place areas can be set up to facilitate a safe evacuation procedure.
 - e. Emergency decontamination for personnel/patients within the EMT facility.
 - f. Emergency treatment for victims within the EMT facility.
8. A contingency plan for patients arriving who are suspected as contaminated with an agent. This plan should include as a minimum:
 - a. Designated area for triage of patients, outside of the EMT premises, including the traffic and crowd control needed considering the fear associated with an incident.
 - b. Established a simple triage algorithm.
 - c. Personnel equipped and trained in the use of PPE who can conduct triage and emergency rapid decontamination, with the appropriate physical infrastructure and processes in place.
 - d. Established emergency rapid decontamination capacity for the walking wounded and none-ambulant patients. The emergency decontamination procedure can be based on wet or dry decontamination.
 - e. Established treatment algorithm for the contaminates deemed possible in the risk assessment.
 - f. Established and clear referral path for patients, those contaminated that have not been admitted and treated by the EMT, and those treated and admitted by the EMT (including appropriate patient documentation).
 - g. Establishing procedures to deal and protect decontaminated patients.
 - h. Established a procedure to deal with patients declared "Dead on Arrival" who were not decontaminated.
 - i. Established procedure for proper decontamination of the facility and safe disposal of contaminated equipment and supplies. These procedures should include the decontamination of vehicles who transferred patients and designated areas outside the EMT used to triage and treat patients.
9. A clear procedure for the resumption of "normal" operations following the treatment of contaminated patients.

10. A supply chain for the replenishment of the equipment and supplies used.
11. Ensuring appropriate hand-over to other rotations and knowledge sharing with other EMT's deployed.
12. A risk assessment for the implications of running a disease outbreak EMT in an insecure environment.
13. A clear mental health and psychosocial support plan for staff, staff relatives, patients and their caregivers, considering the specific impact of a CBRN incident, and associated fear (104, 105).

EMT specialist teams may opt to be recognized as a CBRN EMT

Some governments, authorities and/or military forces may designate specialized CBRN response teams and mandate them to deploy. Such teams are composed of specialized experts with extensive investment, preparations, and training and equipment (106).

2.8 Guidance notes

1. Medical teams need to ensure safety for self, site, and survivors (3 S's).
2. Medical teams deployed into armed conflict are required to have safety and security risk management plans that are context and area specific with training provided before and during deployment to all staff, local staff and rotating teams.
3. Medical teams have a clear responsibility expressed in a policy on duty of care for their teams and legal obligations to ensure team safety and well-being, including mental health, medical evacuation plans and informed consent.
4. Special considerations are required for CBRN hazards and threats, including specific protocols, specialized kits, training and plans, depending on findings of risk assessments.

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Chapter 3

Coordination platforms and modalities

3 Coordination platforms and modalities

Chapter objectives

1. Teams and leaders have increased understanding as to the importance of platforms for and modalities of coordination in armed conflict and insecure environments.
2. Teams better grasp their own roles and responsibilities to help engage and contribute to coordination platforms.
3. Team leadership can put into practice functional liaison with other providers, military actors, UN Peacekeepers, and/or key stakeholders present.
4. Teams have increased familiarity and understanding of existing coordination guidelines and manuals.
5. Teams and leaders have easy access to the most relevant key references and manuals.

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

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

As stated in Chapter 2 on IHL and core principles within armed conflict:

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

In conflict, it is particularly important to maintain close coordination between all medical actors to ensure alignment of interventions and clarity of collective voice, while ensuring that such associations and coordination platforms are not perceived as working with or for one side or another. If such perceptions are detected, measures need to be taken by medical teams to rectify to maintain a principled approach as seen through the lens of parties to the conflict and affected people. This requires constant monitoring and dialogue with key stakeholders.

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

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

3.1 Objectives of humanitarian coordination in conflict settings

There are clear motives to coordinate with others in any humanitarian deployment to ensure the most effective action, efficient use of resources/capacities, the avoidance of gaps, duplication and waste of efforts and inappropriate interventions. It is important to restate that the parties to the conflict in affected areas have the primary responsibility to provide humanitarian assistance. When the state or nonstate actors are not willing or not able to provide humanitarian assistance, humanitarian organizations may assist.

Coordination is of even more paramount importance for medical teams operating in conflict where coordination carries an additional weight and a specific purpose.

3.1.1 Robust principled framework for action

Coordination during deployment into a conflict should guide collective engagement and support principled action. Adherence to humanitarian principles is a key responsibility of individual groups/organizations. Coordination facilitates discussion and collective examination and interpretation of highly complex issues. This brings a greater weight of understanding and analysis, and crucially ensures a degree of alignment.

3.1.2 Collective impartiality and neutrality

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

The collective nature of coordination bodies prevents an undermining of individual positions and interventions. However, this may come with some cost. Coordination needs to be entered into fully and interventions must be considered carefully through the prism of their impact on the impartiality and neutrality of the humanitarian response as a whole, and not just for an individual actor. As stressed earlier in Chapter 2, medical teams need to remember that the actions of one, and how they are perceived, will affect all medical teams.

3.1.3 Impartial access and care

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

The arguments of individual agencies acting alone stand slimmer chances of success in dealing with parties to a conflict than do collective positions backed

by humanitarian principles. This is especially true when parties to a conflict view assistance provided to certain communities as a hostile act and part of the war effort.

3.1.4 Collective security

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

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

Such unity of action in support of principled access is crucial to maintaining humanitarian interventions in highly insecure areas. It is important to note that security coordination can also take place “behind the scenes” and does not necessarily need to compromise a medical team’s independence.

3.1.5 Protection

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

Coordination mechanisms can support the humanitarian imperative that is crucial to the protection of the most vulnerable by providing an important platform and framework for clarifying and highlighting protection priorities, identifying both the invisible and highly exposed population groups and adding collective weight and voice.

3.1.6 Advocacy

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

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

3.2 Pre-deployment considerations

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

It is critically important that medical teams coordinate with each other and identify which coordination mechanisms are essential for them to engage with and how best they should engage once deployed. EMTs should also consider:

- Which coordination mechanism best enables us to access affected populations in a principled manner and throughout the deployment timeframe?
- Does engagement with a given coordination mechanism involve any compromise to humanitarian principles (which ones?) or allow others to perceive us to be biased and/or an unprincipled actor potentially for the entire deployment timeframe?

3.3 Types of coordination mechanisms

Many factors are at play in determining which (and where) coordination platforms are activated. Regardless, medical teams are required to scan the operational horizon and engage in a principled manner as articulated above. Some coordination platforms can exist in state/national capitals, in the field of operations, in neighbouring nations and/or across the globe. They will serve to address a range of issues and functions across funding, strategic directions, alignment of positions and operational considerations. Medical team engagement in coordination needs to prioritize population needs, access, quality medical care, safety, security and protection. Teams may also witness tensions and disagreements between various mechanisms. The focus needs to be kept on the principled humanitarian mission, quality patient care, and safe access to the wounded and sick. It is important to stress that affected populations and some parties to the conflict at field levels may not fully understand the various categories of teams and affiliations as they seek medical care.

3.3.1 Host governments

Local authorities have a primary mandate to respond to the affected population. They will typically stand some type of formal or informal coordination mechanism. Medical team engagement with the host government is essential, as stated in Chapter 2, and needs to be managed in a principled manner, paying close attention to perceptions by affected communities and parties to the conflict.

Implementing agencies need to be aware that all conflicts differ contextually and this extends to the attitude of host governments towards incoming international actors. It is almost inevitable that the national host government will be an actor or party to the conflict and will therefore have an established point of view, political and military positions and established vested interests.

The above factors need to be understood and kept in mind while also remembering that the host government remains the duty bearer, responsible for meeting the basic needs of its citizens. However, host governments may be either unable or unwilling to provide access to specific categories of affected people within its borders. Local or international principled humanitarian assistance may be the solution to bridge the gap.

3.3.2 Host ministry of health

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

3.3.3 National disaster agency/national humanitarian coordination

As in any humanitarian emergency the national disaster agency (if existing) will very likely be a leading actor as part of the national government coordination of agencies. Medical teams will be expected to coordinate or at least to make themselves known to such an agency directly or via their deploying agencies or mechanisms. Again, teams need to be sensitive to the appearance of being directed or manipulated in this context.

3.3.4 Military to military coordination

Military to military coordination mechanisms will also be established. Military EMTs should properly coordinate through both a Civ-Mil and Mil-Mil coordination platform as outlined in the *Guidelines on the Use of Military and Civil Defence Assets (MCDA) to Support UN Humanitarian Activities in Complex Emergencies* (107). Military medical teams need to be sensitive to appearing to be directed or manipulated in contexts of armed conflict and mindful of the impact their actions might have on medical humanitarian actors operating on the ground or elsewhere in the humanitarian environment.

3.3.5 Nonstate armed groups

“Nonstate actors” is a phrase used to describe a range of individuals, groups, and agencies. Nonstate actors and their armed groups can take many forms [108]. It is a feature of modern conflicts to see a proliferation of nonstate actors controlling territory and therefore access to populations. Great care needs to be taken to undertake and maintain a sound context analysis for medical teams to engage safely, gain/maintain access, avoid manipulation, diffuse tensions, be aware of risk of criminalization, take mitigation actions and retain a principled approach.

3.3.6 UN at the global level

The Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator (USG/ERC) is responsible for the oversight of all emergencies requiring UN humanitarian assistance and also acts as the central focal point for governmental, intergovernmental and nongovernmental relief activities (with some exceptions for the Red Cross and Red Crescent Movement, further explained in section 3.3.11). The ERC also leads the Inter-Agency Standing Committee (IASC), an interagency forum for coordination, policy development and decision-making involving key UN and non-UN humanitarian partners. The ERC chairs the IASC. Most humanitarian coordination tools and many humanitarian guidelines are developed at the global level through the IASC.

3.3.7 UN at national levels

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

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

- Strategic level: HCT, led by the HC
- Operational level: Inter-Cluster Coordination Group
- Technical level: Sectors/Clusters

In the humanitarian coordination architecture, ICRC has an official observer status (see section 3.3.11) and MSF also usually engages as an observer.

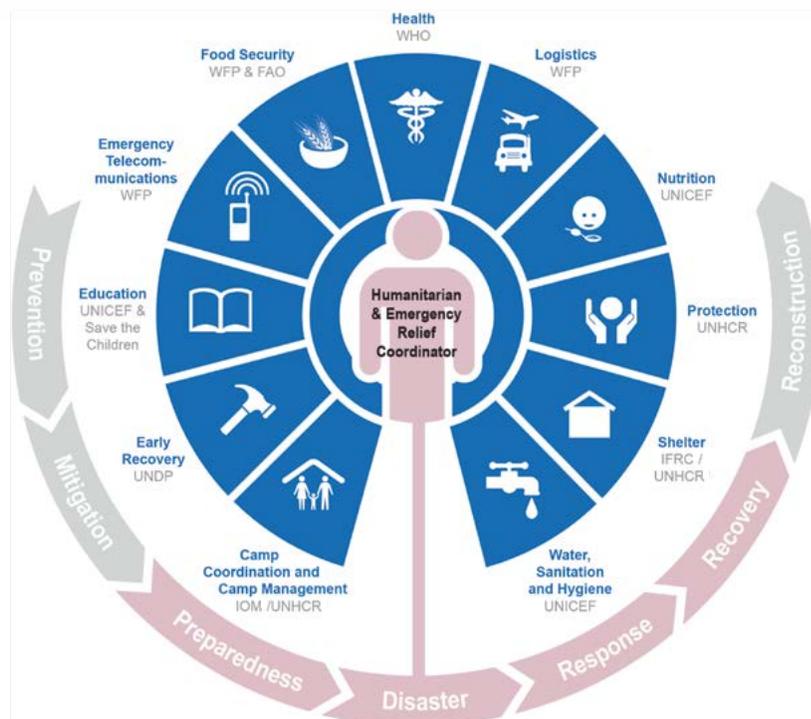
If a UN mission is deployed to a country, the highest representative of the UN is the Special Representative of the Secretary-General (SRSG). The Resident Coordinator (RC) in that case is often the Deputy Special Representative of the Secretary-General (DSRSG). Apart from being the DSRSG and RC, the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

3.3.8 UN cluster system

The cluster system aims to strengthen humanitarian assistance in emergencies by clarifying the division of labour among aid organizations, preventing gaps and ensuring a coherent approach.

Clusters may be formally activated when existing coordination mechanisms are overwhelmed or constrained in their ability to respond to identified needs in line with humanitarian principles. Clusters support the delivery of humanitarian assistance by coordinating, implementing and monitoring projects, and conducting joint needs assessments and gap analyses in the field. They also inform strategic decision-making of the HC/HCT, through sectoral planning and strategy development. There are 11 global clusters (see diagram Fig. 5) comprised of groups of humanitarian organizations, both UN and non-UN, in each of the main sectors of humanitarian action, such as water, health and logistics. They are designated by the Inter-Agency Standing Committee (IASC) and have clear responsibilities for coordination. Up to 11 thematic clusters may be set up in response to emergencies. Each has a designated UN lead agency (WHO for health). It is important to note that the cluster system is designed to support national authorities, including those in nongovernment controlled areas, to implement an effective response. In context of armed conflict, especially civil wars/rebellion, the cluster focus may target a limited population group or geographical region.

Fig. 4. UN thematic coordination clusters and lead organizations



The Health Cluster Guide suggests how the health cluster lead agency, cluster coordinator and partners can work together during a humanitarian crisis to achieve the aims of reducing avoidable mortality, morbidity and disability, and restoring the delivery of and equitable access to preventive and curative health care as quickly as possible. It highlights key principles of humanitarian health action and how coordination and joint efforts among health sector actors working in partnership can increase the effectiveness and efficiency of health interventions. It draws on Inter-Agency Standing Committee (IASC) and other documents (109) but also includes lessons from field experience.

The Health Cluster Guide can be downloaded from the Global Health Cluster website and provides detailed practical guidance to teams (110). Importantly, the Global Health Cluster has published a position paper on *Civil-Military Coordination During Humanitarian Health Action* (18). The paper provides a risk assessment matrix linked to military involvement in humanitarian action. The matrix is organized based on two assumptions:

- (1) as a general rule, direct health assistance shall be carried out only by civilian humanitarian health agencies; and
- (2) the more military actors are entrenched in the conflict dynamics, the more the two worlds – military and humanitarian – should be kept separate to safeguard the actual and perceived impartiality of humanitarian actions.

3.3.9 EMT Coordination Cell (EMTCC)

While EMT coordination normally sits with the government led Health EOC of an affected country in non-conflict (Blue Book) contexts, in cases of active conflict, EMT coordination will often be through a clinical case management or trauma working group acting under the Health Cluster or another independent coordination platform, such as the On-Site Operations Coordination Centre (OSOCC). An online platform may be activated through Virtual OSOCC (111) which can provide useful information and assist with deployment decisions. Not all platforms will automatically be present and therefore teams are required to scan the operational space and determine the best course of action.

The [Blue Book](#) coordination approach for EMTs is as follows.

EMT coordination should occur within existing emergency response frameworks and if possible be led by the clinical care or emergency response sections of the ministry of health, within the health operations pillar of the Emergency Operations Centre (EOC). This serves as the central coordinating point for obtaining and analysing key event related information such as health infrastructure damage and impact on pre-existing services to inform strategic and operational decisions. This EMT function may require WHO experts to support incoming EMTs, United Nations Disaster Assessment and Coordination (UNDAC) team members or direct bilateral expert deployments from neighbouring countries. Some international agencies and international NGOs may deploy EMTs and other health and thematic expertise in the area of water, sanitation and hygiene

(WASH), shelter or sexual and gender-based violence (SGBV). It is critical that the various coordination platforms communicate closely and coordinate internally. EMT Coordination is a specialized field and requires training, ideally through the WHO Emergency Medical Team Coordination Cell (EMTCC) course. If a national focal point is not available, then a ministry of health emergency officer should be designated EMT coordinator but strongly supported by an EMT expert coordinator from WHO or through the channels above.

3.3.10 UN Humanitarian Civil-Military Coordination (UN-CMCoord)

Humanitarian civil-military coordination is one of United Nations Office for the Coordination of Humanitarian Affairs (OCHA) core functions.³² UN-CMCoord facilitates a coherent and consistent humanitarian approach to interaction with military and other armed actors, enhancing understanding and respect for humanitarian action. OCHA is the custodian of UN-CMCoord guidelines and related documents.

The scope and character of interaction between humanitarian actors and military and other armed actors is always context-dependent. In natural, technological or environmental disasters, humanitarian's use of military assets and their coordination with the military focuses on improving the effectiveness and efficiency of combined efforts. In an insecure environment, such as an armed conflict, coexistence often best describes the relationship between humanitarian and military actors. Coordination focuses on minimizing competition and inconsistencies and ensuring a distinction between humanitarian and military objectives and strategies. It thus ensures humanitarian action is viewed as neutral, impartial and independent. The *UN-CMCoord Field Handbook [112]* provides extensive guidance on this topic.

A key principle of the UN-Civil Military Coordination guidelines is the principle of last resort. In disasters in peacetime, Foreign Military Assets (MCDA or FMA³³) should be utilized where there is no comparable civilian alternative in terms of

time and/or capability, to meet a critical humanitarian need. In insecure complex environments, the concept is even more important: military assets, which include EMTs, should be used only if they are the last resort to respond to a critical life-threatening situation. However, EMTs and other logistical support from a foreign military could strengthen military medical responses of the affected state through state-state arrangements in an effort to reduce spillover effects onto civilian health infrastructure. As a matter of principle, FMA of belligerent forces of units actively engaged in combat shall not be used to support humanitarian activities. Decision-makers must weigh the risk to relief workers and their ability access populations, to operate effectively and in the future, against the immediacy of the needs of the affected population and need for the use of FMA.

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

Although not explicitly provided for in the UN Charter, peacekeeping is one of today's main tools used by the UN Security Council to maintain international peace and security.³⁴ Traditionally, UN peacekeeping operations were established in support of a political process, such as the implementation of a ceasefire or peace agreement. Over the past decades, the range of tasks has expanded significantly due to the changing nature of conflict. Some UN Security Council resolutions establish very robust mandates that have the UN become party to a conflict and taking sides. It is important to remember that peacekeeping missions have political and military objectives. Humanitarian actors must keep a visible independence from political and military structures to preserve humanitarian space.

³² OCHA's Civil-Military Coordination Section (CMCS) is the designated focal point in the UN system for humanitarian civil-military coordination, supporting relevant field and headquarter level activities and operations.

³³ The term Military and Civil Defence Assets or "MCDA" is used in the global UN-CMCoord Guidelines. Today, the term "Foreign Military Assets" (FMA) is more commonly used. MCDA and FMA are defined as foreign military personnel and organizations; goods and services provided by military actors (including, but not limited to, logistics, transportation, security, medical assistance, engineering, communications, supplies and equipment); as well as funding, commercial contracting, material, and technical support provided by military actors.

³⁴ The legal basis is established in Chapters VI, VII and VIII of the UN Charter. Chapter VI deals with the "Pacific Settlement of Disputes". Chapter VII contains provisions related to "Action with Respect to the Peace, Breaches of the Peace and Acts of Aggression". Chapter VIII of the Charter provides for the involvement of regional arrangements and agencies in the maintenance of international peace and security.

The CMCoord role is essential in engaging with the peacekeeping mission to promote humanitarian objectives and operational requirements. Context-specific guidance has been developed in a number of countries with peacekeeping operations, and may be signed by the RC/HC, the SRSG and the Force Commander [113]. They may include provisions regarding casualty and medical evacuations for humanitarian purposes involving non-UN personnel, which are coordinated by humanitarian actors without peacekeeping mission involvement. Only in certain circumstances where the humanitarian community cannot support due to mandate or resources, OCHA can request, as a last resort, mission assistance [114]. Context-specific guidance with peacekeeping missions also entails provisions around the Quick Impact Projects (QIPs).³⁵ Activities may encompass “humanitarian-type” activities, including direct medical assistance, but should not be confused with actual humanitarian action undertaken by humanitarian actors in accordance with humanitarian principles.³⁶ Quick Impact Projects (QIPs) must be coordinated with the humanitarian community. Peacekeeping mission QIPs that relate to development and humanitarian assistance cannot be carried out without the consent of the HC [112].

Humanitarian Notification System³⁷ or deconfliction³⁸ [75], [25] mechanisms may be activated. Teams need to ensure being connected to an established Humanitarian Notification System which is complementary to other UN-CMCoord functions, such as establishing, facilitating and maintaining dialogue between humanitarian actors and the military. Information sharing with parties to the conflict is not new. The establishment of formal, systematized and structured notification systems is the result of increased aerial operations led by coalition or state with limited or no troops on the ground.

³⁵ Small-scale, low-cost projects that are planned and implemented within a short timeframe by military actors. QIPs are mainly implemented through local actors including local authorities, nongovernmental and grassroots organizations. As such, the implementation of QIPs help build the community's management capacities while broadening a mission's outreach at the local level.

³⁶ See also Reference 129 In the first instance, humanitarian work should be performed by humanitarian organizations. Insofar as military organizations have a role to play in supporting humanitarian work, it should be primarily focused on helping to create a safe and secure environment to enable humanitarian action and the protection of civilians. Specifically, UNMISS should avoid engaging in direct relief assistance efforts designed to win “hearts and minds”. Further, when asked by civilian populations about humanitarian issues, UNMISS should direct such enquiries to OCHA or the most relevant aid agency present. If there is an extraordinary need to engage in relief activities, this is to be done with prior consultation with OCHA. When UNMISS is requested by humanitarian actors to support activities (e.g. transportation of goods or provision of armed escort, road repair, establishment of communication networks, etc.) such requests will follow agreed procedures as outlined under the point ‘use of UNMISS assets and UNMISS armed escorts/ military protection’.

³⁷ To avoid confusion and blurring of lines, humanitarian actors are encouraged to use a more neutral term such as “humanitarian notification system” and not deconfliction.

³⁸ Deconfliction (a military term): The exchange of information and planning advisories by humanitarian actors with military actors in order to prevent or resolve conflicts between the two sets objectives, remove obstacles to humanitarian action, and avoid potential hazards for humanitarian personnel. This may include the negotiation of military pauses, temporary cessation of hostilities or ceasefires, notification of locations of medical facilities, or safe corridors for aid delivery.

Notification³⁷ mechanisms may be activated. As stressed earlier however, deconfliction must also be viewed with the caveat that, as a general solution, it comes with certain challenges, including:

1. Shifting the burden away from parties to armed conflicts to live up to their own obligations towards humanitarians to contribute to “deconfliction”.
2. Creating a false dichotomy between “deconflicted” and “nondeconflicted” persons or objects, while not just “deconflicted” persons or objects will be protected under IHL.

There is a common misperception that including civilian objects in a humanitarian notification mechanism guarantees or enhances their protection. Under IHL, a civilian object may become a military objective if, by its use, it makes an effective contribution to military action and its partial or total destruction, capture or neutralization, in the circumstances ruling at the time, offers a definite military advantage. Moreover, IHL tolerates a certain level of incidental harm to civilian objects under the rule of proportionality. It is therefore important to note that including a civilian object as part of a notification mechanism does not render it immune from harm or grant it any enhanced protection under IHL.

Important IASC guidelines [113]:

1. Guidelines On The Use of Military and Civil Defence Assets To Support United Nations Humanitarian Activities in Complex Emergencies (MCDA Guidelines, 2003, rev. 2006). Teams better grasp their own roles and responsibilities to help engage and contribute to coordination platforms.³⁹
2. Civil-Military Relationship in Complex Emergencies (IASC Reference Paper, 2004)
3. IASC Non-Binding Guidelines on the Use of Armed Escorts for Humanitarian Convoys (AE Guidelines, 2013)

³⁹ Important provisions include: Humanitarian access to vulnerable populations: civil-military coordination must facilitate, secure and sustain humanitarian access; Perception of humanitarian action: the delivery of humanitarian assistance to all populations in need must come without political or military conditions; Civilian-military distinction in humanitarian action: distinction must be maintained between combatants and non-combatants; Operational independence of humanitarian action: humanitarian actors must retain the lead role in undertaking and directing humanitarian activities; Security of humanitarian personnel: military-based security as last resort.

3.3.11 ICRC and the International Red Cross Red Crescent Movement (the Movement)

The Movement comprises three main components (114): the International Committee of the Red Cross (ICRC); the International Federation of Red Cross and Red Crescent Societies (IFRC); and at country level National Red Cross and Red Crescent Societies (National Societies). Each component has distinct roles and expertise, but all operate according to the same fundamental principles (115). Each component also has its own medical teams, which are certified and coordinated by existing Movement mechanisms and not under/by the EMT mechanism. Movement medical teams, however, will coordinate with EMTs to avoid duplication and gaps and maximize humanitarian impact.

The IFRC coordinates medical teams deploying internationally from Red Cross and Red Crescent National Societies (via Movement existing mechanisms) to situations of natural disaster and other emergencies where the Blue Book applies, whereas in the context of armed conflict, the ICRC is the lead of the Movement's international response and overall coordinator.⁴⁰ The ICRC will typically embed such medical teams within its own operations and will coordinate their deployments with the national society in the affected country(s)⁴¹ using its internal deployment mechanism, the ICRC's Rapid Deployment Mechanism, meaning "conflict equivalent" of the IFRC's Emergency Response Framework, noted below.

The ICRC has a special mandate under IHL that gives the organization an international legal status, distinct from that of NGOs and akin to that of international intergovernmental organizations such as the UN. Through status agreements with governments, ICRC is granted certain legal protections. For example, immunity from certain legal processes and the protection of its premises, documents and data from being accessed for the purposes of criminal prosecution.

Owing to this special mandate, the ICRC has a particular relationship with the UN coordination system, where it is recognized as an observer without being a full member. In sum, the ICRC coordinates with UN-led coordination

mechanisms but is not coordinated by them. In the field and institutionally, the ICRC seeks regular contact with UN and other organizations with a view to improving the overall humanitarian response.

Beyond its special mandate under IHL, the rationale for the ICRC's niche is rooted in its expertise and operational experience in conflict and in its approach to security management, which is in turn based on acceptance through dialogue with parties to a conflict, so the ICRC is perceived by all sides to be neutral, independent and impartial. In this way, the ICRC endeavours to be a benchmark for relevant, timely, and effective humanitarian action in conflict according to humanitarian principles.

Red Cross and Red Crescent National Societies teams deploying across borders are required to abide by rules and regulations of the Movement, which include the fundamental principles and rules of the International Red Cross and Red Crescent Movement, as well as a large body of policies that regulate how they coordinate and cooperate among themselves and with other actors. They are mandated to coordinate with the Red Cross or Red Crescent National Society in the affected country(s). In armed conflict, national society medical teams (surge capacities) are deployed and managed directly by the ICRC under its Rapid Deployment Mechanism. In natural disasters and outbreaks, national society medical teams and emergency response units are deployed under the IFRC Emergency Response Framework. National society personnel can also be deployed as part of their national EMTs.

As for local national societies, they are most often the first responders and will engage with the many responders, actors and affected communities. Their staff and volunteers are often on the frontlines, embedded within communities and coordinate with many stakeholders, in accordance with the Movement's rules and principles. They are often tasked to support affected communities and their activities do usually include, but are not limited to, providing first aid.

These specificities explain why deployment of Red Cross and Red Crescent medical teams are subject to specific Movement rules and must be coordinated by the ICRC in armed conflict and the IFRC in disaster and outbreaks (the two organizations coordinate among themselves in mixed crises, combining both conflict and disaster/outbreaks), rather than by EMT/UN-led mechanisms.

⁴⁰ Emergency Response Units (ERUs) will deploy under ICRC in armed conflict, and under IFRC in natural disasters

⁴¹ This role of the ICRC is recognized in the article 5.4.b of the Statutes of the Movement, which states that "in situations foreseen in paragraph 2 d) [in international or other armed conflicts and internal strife] and requiring coordinated assistance from National Societies of other countries, the International Committee, in cooperation with the National Society of the country or countries concerned, shall coordinate such assistance in accordance with agreements concluded with the Federation."

3.4 Implications for categories of deploying teams

Medical teams will have a range of affiliations, nationalities, capacities and deploying organizations. Regardless, it is critical to coordinate and be aware of overall existing capacities/resources, skills, facility locations, plans, referral arrangements, and disease/injury types and caseloads. This type of critical information can only be gathered if teams report on a regular basis and engage with the coordination platform(s). As described in the Chapter 1, not all teams can be independent and or be perceived as neutral, however, all national and international teams have important roles to fulfil, and spaces to perform their respective roles. This is particularly the case for some military and governmental teams. For a thorough commentary on definitions of impartial organizations and actors, refer to IHL database [116].

Table 12. Categories of deploying teams and special considerations

Team category	Blue Book: Natural disasters/ emergencies/outbreak – humanity and impartiality apply to all	Red Book Health emergencies in armed conflict and insecure environments – IHL, humanity and impartiality apply to all
1. EMT Civilian – classified ⁴² 1.a Civilian NGO, national 1.b Civilian NGO, international	<ul style="list-style-type: none"> Standards apply Ministry of health coordinates response operation (supported by WHO) Some teams may be contracted by various UN agencies 	<ul style="list-style-type: none"> Standards apply WHO coordinated deployments If UNSC has taken a side, WHO role will be affected. If local NGO: neutrality and independence may be an issue.
2. EMT, governmental 2.a Ministry of health (classification not applicable) 2.b International, classified	<ul style="list-style-type: none"> Standards apply Ministry of health coordinates response operation (supported by WHO) Classification is not applicable to ministry of health teams operating nationally 	<ul style="list-style-type: none"> Select standards apply Neutrality and independence may be an issue Classification is not applicable to ministry of health teams operating nationally.

3. EMT, governmental	<ul style="list-style-type: none"> Standards apply Coordinated via contracting organization 	<ul style="list-style-type: none"> Neutrality and independence may be an issue
4. EMT, military 4.a National (classification not applicable) 4.b International, classified	<ul style="list-style-type: none"> Standards apply Bilateral deployments MoD/ministry of health coordinates response operation (supported by WHO) Classification is not applicable to MoD teams operating nationally 	<ul style="list-style-type: none"> Bilateral deployments Neutrality and independence may be an issue Classification is not applicable to MoD teams operating nationally
5. Civilian medical teams national or international	<ul style="list-style-type: none"> Standards apply Ministry of health may not grant access or permits 	<ul style="list-style-type: none"> Select standards apply Neutrality and independence may be an issue
6. Red Cross Red Crescent medical teams 6.a Local national society 6.b IFRC (natural disasters) 6.c ICRC (conflict and internal strife)	<ul style="list-style-type: none"> Classified via Movement channels and standards by IFRC (standards aligned with EMT) Local national societies are lead coordinator (supported by IFRC) Additional Movement standards apply [116] 	<ul style="list-style-type: none"> Classified via Movement channels and standards by ICRC The ICRC is lead coordinator of the Movement's international response Additional Movement standards apply – the risk posed by the role of the local national societies as auxiliary to local authorities is balanced by its obligation to abide by the principle of independence.
7. Private-for-Profit medical teams	<ul style="list-style-type: none"> Standards apply Ministry of health may not grant access or permits Some teams may be contracted by various UN agencies 	<ul style="list-style-type: none"> Standards apply Contracting party agenda may be an issue Neutrality and independence may be an issue
8. Military medical teams national or international	<ul style="list-style-type: none"> Bilateral deployments Standards apply 	<ul style="list-style-type: none"> Bilateral deployments Neutrality and independence may be an issue Additional standards apply

⁴²Classified Teams is inclusive of teams currently in the mentoring and peer review verification processes.

3.4.1 National and international military EMTs

National military EMTs

In many states, national military or civil defence units are part of or even leading national responses to disasters and crises on their territory. Affected states have the responsibility to use whatever means at their disposal to respond to the needs of their citizens. Their militaries may be the most appropriately equipped and best positioned to respond. The foreign military assets (FMA)^{xLIII} or military and civil defence assets (MCDA) (107) guidelines and the principle of last resort are not intended to apply in the case of national militaries and/or civil defence units responding to a disaster or crisis within its own territory. Affected states may, nonetheless, find some of the principles and concepts provided in these guidelines useful in managing the use of those assets.

Bilateral military medical deployment

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

International military medical teams

International military medical teams often do provide much-needed medical services in conflict situations. However, while they may de facto use the Red Book as guidance, they cannot be deployed under the mechanism supported by WHO. This is because international military EMTs will not be perceived as independent and neutral (or even impartial) by some of the recipient populations and the parties to the conflict. This may impact the perception, neutrality and impartiality of the wider humanitarian response as populations (and parties to the conflict) may not make distinctions between various teams and should not be expected to fully comprehend who's who given the many, emblems, logos, (see emblem use section 1.3) and affiliations that are often on display. This, in turn, may impact staff security and the effectiveness of other EMTs in terms of their ability to safely access populations in need without armed escorts. To avoid confusion, military EMTs may want to consider the method and location of their deployment and therefore how they should best coordinate.

While priority should be given to the use of civilian assets (MCDA guidelines and see UN-CMCoord section), military EMTs may be mandated by their governments, as per obligations under IHL, to provide medical care for the wounded and sick (including frontline care). Internationally deployed military teams which are to be considered as Military and Civil Defence Assets (MCDA) may face access and acceptance challenges/difficulties when deploying into conflict settings. Affected states may, nonetheless, find some of the principles and concepts provided in these MCDA guidelines useful in managing the use of those assets.

Military teams should ideally ask themselves the following questions prior to deployment.

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

⁴³ Today, the term "Foreign Military Assets" (FMA) is more commonly used. MCDA and FMA are defined as foreign military personnel and organizations; goods and services provided by military actors (including, but not limited to, logistics, transportation, security, medical assistance, engineering, communications, supplies and equipment); as well as funding, commercial contracting, material, and technical support provided by military actors.

3.4.2 Government/ministry of health EMTs

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

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

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

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

3.4.3 Local NGOs/local actors

Local NGO medical teams are ideally suited for rapid surge, access to a population in need, providing advice to international groups and possibly full acceptance by the population. However, in an internal conflict, trust and acceptance may be eroded when an NGO team is viewed as partial, not neutral, or not independent of parties to the conflict. Similar damage to reputation occurs when the local NGO/actor has a history/reputation of being viewed

as allied with the government or other parties. As outlined in Chapter 2, these challenges need to be addressed upfront and appropriate decisions made to ensure safe access and acceptance by communities and authorities. Coordination is still required within platform(s) that operate. The NGO/actor may opt to self-impose limits on locations it can access safely.

3.4.4 Private contractors

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

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

3.4.5 International NGO (INGO) medical teams

International NGO EMTs should already be aware of coordination methodology and be fully prepared to operate under humanitarian principles. Many such organizations have operated within numerous conflict areas and are highly experienced. For those that have yet to operate within a conflict, a period of engagement with peer international NGOs will prove informative and help to establish relationships. Extensive experience in response to natural disasters and domestic emergencies cannot be assumed to impart transferable skills. This is insufficient preparation for conflict response.

3.4.6 Red Cross Red Crescent teams

Owing to the specificities of the International Red Cross and Red Crescent Movement, as explained in section 3.3.11, deployment of Red Cross and Red Crescent medical teams are subject to specific Movement rules and must be coordinated with the ICRC in armed conflict and the IFRC in disaster and outbreaks (the two organizations coordinate among themselves in mixed crises combining both conflict and disaster/outbreaks).

3.5 Guidance notes

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

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Chapter 4

Sexual and gender-based violence and protection



4 Sexual and gender-based violence (SGBV) and protection

Chapter objectives

1. Highlight the importance and specific roles of medical teams to manage SGBV.
2. Outline specific measures required for prevention, protection and care, including national and organizational legal obligations related to preventing, reporting and responding to SGBV.
3. Provide concrete examples including advocacy measures on SGBV.
4. Teams integrate a capacity-strengthening approach as a pillar of support.
5. Teams and leaders have easy access to the most relevant key references and manuals.

SGBV⁴⁴ is a widespread public health problem and human rights violation that is grounded in gender inequality and that disproportionately affects women and girls. However, it also includes violence against men and boys, and individuals from sexual and gender minorities (SGM) (118). Conflict and complex humanitarian emergencies are likely to increase the risks of sexual violence and intimate partner violence (IPV) due to breakdown of family and social structures, increased militarization, impunity of perpetrators, displacement, lack of community and state protections, scarcity of resources, changing cultural and gender norms, disruption of services and weakened infrastructure. Sexual violence is recognized as a tactic of war (119).

During conflicts, there are often ongoing threats to the physical safety and security of SGBV survivors due to restrictions on movement, presence of armed actors and threats of retaliation by perpetrators. As such, medical teams need to provide accessible, safe, competent and confidential health services for gender-based violence survivors as part of the emergency response to address physical, reproductive and mental health needs. Medical teams should be ready to treat and/or appropriately and urgently refer women with an unintended pregnancy and complications of pregnancy, sexually transmitted infections (STIs) including HIV, pelvic pain, urinary tract infections, fistulae and chronic conditions. Medical teams should also respond to the mental health condition of SGBV survivors, including acute stress reactions, post-traumatic stress disorder (PTSD), depression, anxiety, sleep disturbances, self-harm and suicidal behaviour.

⁴⁴ SGBV is "an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private." Women and girls are disproportionately affected by SGBV due to the systemic inequality between males and females globally. However, the term SGBV may also be used to describe gendered violence against men and boys, and individuals from sexual and gender minority groups.

Confidential documentation is vital to the safety of patients who have experienced or are experiencing violence and medical teams must follow strict privacy, confidentiality and safety principles (120).⁴⁵ These are critical to protect the patient from further harm, including stigma, discrimination or retaliation by the perpetrator.

4.1 What medical teams need to know before providing services

In setting up a service for survivors of SGBV and developing a treatment protocol, the following questions and issues need to be addressed, and standard procedures developed for implementation within the local context. Treatment options, such as provision of emergency contraception or safe abortion, post-exposure prophylaxis, legal obligations and requirements (for example, for documentation) will be determined by national laws and policies, where they exist. In the absence of national policies or protocols, medical teams should refer to WHO guidelines and treatment recommendations (121, 122, 123).

It is not the role of medical teams to address, confront, and/or change societal norms and practices, but rather confidentially advocate and persuade local leaders and influencers.

4.1.1 Relevant laws and policies

- What forms of sexual violence and intimate partner/domestic violence are considered crimes under the applicable law?
- Are same-sex relationships criminalized?
- What are the national laws, and community practices, relevant to the management of the possible consequences of rape such as emergency contraception, abortion, testing and prevention of HIV infection?
- What are the legal requirements for health-care providers when reporting cases of sexual violence or partner violence to authorities?

- Does the law have requirements for who may provide clinical care to survivors? For example, if the person wishes to report SGBV officially to the authorities, the country's laws may require that a certified, accredited or licenced medical doctor provide the care and complete the official documentation.
- What are the legal requirements with regard to forensic evidence? Who may collect it? Are laboratories for testing forensic evidence available and accessible?⁴⁶
- What are the existing or emerging legal services and routes made available to survivors for assistance?

4.1.2 Available resources and medical services

- Do national or subnational protocols for managing the care for survivors of sexual violence already exist?
- Is there a national STI treatment protocol, a post-exposure prophylaxis (PEP) protocol and/or a vaccination schedule?
 - Which vaccines are available?
 - Is emergency contraception available?
 - Is comprehensive abortion care available, and for which indications?
- What mental health and psychosocial support services are available?
- What social or community support structures are available?
- What possibilities are there for referral to:
 - a secondary health-care facility;
 - a specialized service provider; and
 - another deployed medical team that can provide the necessary care, for example, gynaecology/obstetrics, counselling, surgery, paediatrics, SGBV specialized service?
- What facilities exist for testing for STIs, including HIV?
- Is there equipment for documenting, collecting and storing forensic evidence? What laboratory facilities are available for forensic testing such as DNA analysis and acid phosphatase? (see annex 7.3)

⁴⁵ In conflict contexts, the ability to collect and process forensic evidence is often extremely limited. The primary purpose of an examination is to determine the required medical care.

⁴⁶ In conflict contexts, the ability to collect and process forensic evidence is often extremely limited. The primary purpose of an examination is to determine the required medical care.

4.1.3 Staff training

- Ensure that medical team members and local health providers such as doctors, medical assistants, nurses and midwives are trained to provide appropriate care, including first-line support (LIVES) and referral when and where feasible and that they have the necessary medicines and medical supplies [124].
- Female (and male if requested) health-care providers should be trained as a priority, but a lack of trained female health workers should not prevent the health service from providing care for survivors. If a male health-care provider conducts the examination, a female chaperone must be present.
- All other health-care facility staff, such as cleaners and administrators, should also receive awareness training, including on how to respect confidentiality and communicate with survivors compassionately and without discrimination.

4.1.4 Coordination with other service providers

- Referrals, with the patient's consent, are essential for meeting the full range of survivor needs and ensuring that the medical team's health providers are not overwhelmed when presented with a SGBV case. This is particularly true in conflicts where medical team members' time is constrained, and survivor safety and psychosocial needs are more complex.
- Ensure ability to refer survivors to other services relevant to their needs and with their consent. This includes mental health and psychosocial support, safety/security and legal services/justice services, and potentially economic support.
- A referral focal point within the team to ensure safe and appropriate outcome of referral is essential.
- Develop or obtain a copy of a referral directory detailing the clear focal points and contacts for each service provider, their locations and procedures for making a referral and sharing information. This process should also identify referral options that address the specific needs of men, children and other survivors, such as people with disabilities, sexual and gender minorities.
- In humanitarian settings, there may be a SGBV subcluster/working group (see Chapter 3 on coordination platforms and modalities) or other relevant coordinating body that has an active referral pathway that team members can be part of and consult.

4.2 The components of a medical response to SGBV

Medical teams and local health-care providers may be the first and sometimes only point of contact for SGBV survivors. During conflict, a minimum package of health services [123]⁴⁷ for SGBV should be provided at all levels: emergency mobile teams; primary health clinics; secondary and referral hospitals, and the package should be integrated into existing health services.⁴⁸ Patients/survivors presenting with life-threatening or severe conditions should be referred immediately (after urgent medical care is provided) to specialist facilities for more complex care and/or surgery. If referral occurs, follow-up of outcomes in terms of the clinical status, as well as safety and protection, should be ensured.

Health facilities and field hospitals should be equipped with the appropriate infrastructure, equipment and commodities to provide quality SGBV care. These will include private spaces for consultation (this is critical for safety and comfort), protocols for provision of health care to survivors, essential medicines and supplies and confidential mechanisms for documentation and referrals [121]. Identify a named focal point within the medical team such as a doctor, nurse or midwife, ideally female (or male if requested by patient), who is trained to provide clinical care to SGBV survivors⁴⁹ and who will ensure informed consent to treatment from the survivor.

4.2.1 Survivor-centred care and first-line support

When addressing the health needs of survivors of sexual violence and IPV, medical teams need to deliver care in a confidential, nonjudgmental and nondiscriminatory manner that respects the survivor's decision-making role and considers the patient/survivor's sex, age and their specific needs, regardless of the medical team's own beliefs or organizational values. Medical

⁴⁷ Essential drugs and supplies for managing the consequences of sexual violence are available through the Inter-Agency Reproductive Health Kit 3 (IARH Kit 3, <https://www.unfpa.org/resources/emergency-reproductive-health-kits>) and the Interagency Emergency Health Kit (IEHK) 2017 additional module for PEP; <https://www.who.int/emergencies/kits/iehk/en/>

⁴⁸ Many women suffering health consequences of violence, particularly intimate partner/domestic violence, are first seen in primary health care services. They are seen particularly in departments or services that serve women and children (for example, antenatal or postnatal care, family planning or HIV clinics), although they may not disclose their experience of violence. Emergency departments are also frequent entry points, particularly for women with injuries and for survivors of sexual assault.

⁴⁹ Female health care providers should be trained as a priority, but a lack of trained female health workers should not prevent the health service from providing care for survivors; if a male health care provider conducts the examination, a female chaperone should be present. Male survivors should also be offered a choice of a male or female provider. It should be noted, however, that male survivors often also prefer to see a female provider.

teams must address immediate and ongoing emotional/psychological health needs, physical health needs and safety needs. First-line support is an essential part of the care provided and involves responding to a person who discloses violence in a way that is supportive, helps to meet their needs and prioritizes their continued safety without intruding on privacy [122].⁵⁰

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

- **Listening** to the survivor closely, with empathy, and without judging. Do not pressure them to tell their story or judge what they have done or how they are feeling.
- **Inquiring** about needs and concerns. Assess and respond to the survivor's various needs and concerns – emotional, physical, social and practical. Ask open ended questions such as, "Could you tell me more about that?"
- **Validating**. Show the survivor that you understand and believe them. Assure them that they are not to blame. Tell them that it is not their fault and that they are not to blame for the violence they experienced.
- **Enhancing safety**. Ensure the medical team understands existing protection referral pathways. Discuss a plan to protect the survivor from further harm if violence occurs again.
- **Support** them by helping them access information, services and social support. Ask if they have a trusted person they can talk with for support. You should also see if they need other services by asking, "What would help most if we could do it right away?"

4.2.2 Clinical management of rape

Rape survivors require urgent medical care that should begin with first-line support and be accompanied by the following steps after obtaining informed consent for the history, physical examination and for obtaining forensic evidence, if applicable [191].⁵¹

⁵⁰ The steps in providing first-line support are to Listen to her; Inquire about her needs and concerns; Validate her feelings and experiences; Enhance safety concerns and Support her by helping her connecting to information, further services and social support.

⁵¹ Informed consent is required for examination, treatment and for the release of information to third parties, such as the police and the courts, as relevant.

- ✓ **Taking the patient's history.** This has four parts: (a) general medical information including current or past health problems, allergies, medications the survivor is taking; (b) talking about the rape incident(s) and politely asking the survivor to briefly describe events, explaining that she/he does not have to tell you anything that she/he does not want to; (c) gynaecological (anal/rectal history as applicable); and (d) assessment of mental state. It is important to limit questions to what is required.
- ✓ **Perform physical and genito-anal examinations.** Examinations are carried out to determine what medical care is needed. Women or men who do not consent to a physical examination, or who are not able to complete the examination, must still be offered treatment based on a thorough history.⁵² For a full physical examination, please see the post-rape physical examination checklist in Annex 4. Survivors may be very sensitive to being examined or touched, particularly for the genito-anal examination, so proceed slowly, explaining every step and securing permission each time before continuing.
- ✓ **Treatment** This will depend on how soon after the incident the survivor presents.

Table 13. SGBV treatment guidelines

	Treatment	Timeline and specifics
Priority within 72 hours	Treatment of physical injuries	Immediately refer the survivor to emergency care for life-threatening conditions. Clean and treat less severe injuries on-site.
	Post-exposure prophylaxis (PEP) for HIV infection	Provide PEP as soon as possible and within 72 hours of possible exposure. Provide the full 28-day course at first visit as survivors may not be able to return. If after 72 hours, provide the range of other essential interventions and referrals for HIV testing and treatment.
	Emergency contraception	Provide emergency contraception as soon as possible and for up to 120 hours (five days). Levonorgestrel-only regimens work better and cause less nausea and vomiting than combined regimens. Provide 1.5 mg levonorgestrel in a single dose. Any woman can take emergency contraception pills. There is no need to screen for health conditions or test for pregnancy.

⁵² While the health care provider may document the examination and care they provide, it is NOT their job to determine whether a rape has occurred. Rape is a legal definition and it is not necessary to make this determination in order to provide appropriate care.

	Treatment	Timeline and specifics
Priority within 72 hours	Presumptive STIs	As soon as possible, provide presumptive treatment for gonorrhoea, syphilis and chlamydial infection. Give the shortest course available according to the local or national protocol. If survivor presents after a few weeks, treat according to syndromic model or laboratory testing.
	Tetanus prophylaxis	Provide according to risk and pre-exposure vaccination status.
	Hepatitis B prophylaxis	Vaccinate according to protocol, unless already vaccinated.
	Management of unintended/unwanted pregnancy	Provide counselling and discuss options with the survivor. Offer safe abortion, where legal, or refer to other support services, such as adoption, if available.

- ✓ **Follow-up visits.** During conflict, follow-up may not be feasible and therefore providers should aim to provide essential information and care during the first visit. Ask the survivor if they have a trusted friend or family member who can provide support following the initial visit. Keep in mind that family members may not be supportive and may be the perpetrators of violence, and therefore it is important to let the survivor determine who to involve in her care. Set up a 2-week follow-up appointment to continue first line support and assess emotional state, check that any treatment given was taken for the full course, test for pregnancy and evaluate for STIs and treat as appropriate.
- ✓ **Mental health and psychosocial support.** Medical care for survivors of rape and IPV includes assessing for psychological and emotional problems, and providing basic psychological and other support and, if necessary, referring the survivor to other service providers to address common mental disorders, substance abuse, risk-taking behaviour and other mental health or social problems (126).⁵³
- ✓ **Referrals for specialist care and/or mental health.** According to your referral pathway, ensure the survivor has access to safety, protection and psychosocial services. Life-threatening injuries or those necessitating surgical intervention should be referred to a specialist facility.

4.2.3 Special considerations when dealing with intimate partner violence (IPV)

Women (and sexual and gender minorities) (99) who have experienced IPV (also referred to as domestic violence) may have physical injuries or other health conditions that require medical treatment. Often, they will not disclose the violence due to shame, fear of being judged by their community, or fear of their partner. Regardless of disclosure, it is important to address the survivor's health needs while asking about violence and providing first-line support.

4.2.4 Special considerations for children

For children, attention to the best interests of child should be the primary consideration. To do so, the safety, privacy and confidentiality of the survivor are critical.

Medical teams need to be trained in providing sensitive care to children who may have been abused, and be able to adapt procedures for obtaining informed consent; preparing the child for the physical examination; and conducting the examination and providing treatment according to age, sex and stage of development (121, 127). Medical teams should be aware of the international standards on children's rights to protection, privacy, participation and health, as well as how these standards are translated into national law and applied within the local context (127).

4.2.5 Self-care for medical teams dealing with SGBV

Working with survivors of SGBV can be deeply rewarding, particularly when one sees a positive impact from the assistance provided (see also Chapter 2 section 2.6.1, and the [Blue Book](#)). At the same time, SGBV cases can be difficult, demanding and emotionally exhausting. Seeing survivors in distress and hearing disturbing details of traumatic events can be upsetting and can sometimes bring up memories of personal experiences of violence. If the emotional demands of this work are not addressed, medical teams are at risk of developing stress-related conditions such as burnout, compassion fatigue, or vicarious trauma. These risks can also be compounded if a medical team is

⁵³ Trauma-related symptoms may not occur, or may disappear over time. However, persistent problems with mood, thoughts or behaviour and an inability to function in daily life, can be indicative of more severe mental health problems.

implementing a policy that potentially conflicts with or widens the interpretation of the domestic laws related to SGBV which may be perceived as inadequate and unjust. Medical teams should be aware of these risks and establish standard and routine mechanisms for supporting staff well-being and safety (128).

- Being aware of workload and ensuring that sufficient time is given to handling complex cases, such as SGBV.
- Providing supervision to medical team members working directly with survivors to ensure they have the support and information needed to handle these cases.
- Implementing a differentiated risk model, particularly between national and international staff, in determining which team member will be the treating health-care worker.
- Sharing information about stress reduction exercises such as slow breathing, grounding, or progressive muscle relaxation (team members need to find the technique that works best for the survivor).
- Ensuring medical teams have time for relaxing activities and are able to engage in physical activity and maintain a regular sleep schedule.

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

4.3 Protection, risk mitigation and advocacy

4.3.1 Security risks to SGBV survivors

There are often on-going and life-threatening risks to the safety of survivors from the perpetrator, the survivor's family, community or armed actors. During conflicts and in other insecure environments, protection, legal and security services may be limited and family and community support reduced. Health staff need to help the survivor assess any immediate risk of violence, identify and take steps to make them safe and access support. Key questions to ask include:

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

If the survivor is not safe to go home, or if they are struggling to carry out day-to-day activities, explore referral pathways to find them a focal point (local) within a protection or psychosocial service who can help.

4.3.2 Risk mitigation and SGBV

Health-care staff have a responsibility to guarantee the privacy and confidentiality of the individual they are treating (99). During conflict, health-care staff must take extra measures to avoid any harm to patients/survivors. Privacy, confidentiality and safety are key principles (120) that should inform the development of health information and surveillance systems for documenting reports of violence and for programme monitoring. A privacy and confidentiality policy (120) should be established at the start of an intervention and data security procedures must be put in place throughout to avoid putting survivors and potentially health-care providers at risk if confidentiality is breached.

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

Guidelines for ensuring the confidentiality, safety and privacy of the survivor *[121]*.

- ✓ Always obtain the survivor's informed consent before sharing any information about them. If mandatory reporting is applicable, ensure the survivor is aware of the limits of confidentiality so that they can choose what to disclose.
- ✓ Decide who will be responsible for collecting and recording information.
- ✓ Determine where and how information will be collected, recorded and stored.
- ✓ Maintain the confidentiality of health records by using anonymizing coding systems and by keeping paper-based records in a safe and secure location, such as a locked filing cabinet or as electronic files password-protected.
- ✓ In situations deemed too risky or insecure for paper files, consent can be obtained verbally, and examination and treatment still provided. If referral information cannot be written, if possible, offer someone trusted to accompany the survivors to the desired destination and service.
- ✓ Where survivors or legal custodians are given their medical records (treatment and care) to take home, information about their experience of violence should not be included.

4.3.3 Advocacy

Medical teams may have opportunities for advocacy and access to decision-makers such as local leaders, government officials and military leaders who can be used to strengthen responses to SGBV. Many teams have reported successful advocacy interventions when senior military commanders and governmental leaders have been alerted to SGBV.

Examples of advocacy could include:

- Highlighting the needs within the health sector to ensure that quality services are available to SGBV survivors.

- Speaking with community members, local leaders and NGOs working in the geographic and subject areas to determine if action can be taken to promote a more protective environment for women, children, sexual and gender minorities, or other vulnerable groups and to support survivors returning to their communities.
- Speaking with government officials to raise awareness of SGBV and build political will to strengthen the response.

Medical teams can convey key messages that present SGBV as a preventable, serious problem that affects survivors' health, well-being, and societal ethics, using both global data and information gathered from their own service delivery, ensuring no individual survivor information is ever disclosed. Medical team leads should consider when and if advocacy may be needed, carefully weighing the risks of speaking out on SGBV. Survivor and medical team safety are paramount and should always be at the centre of any advocacy decisions.

4.4 Media and SGBV

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

- ✓ All media requests should be coordinated and authorized by medical team leads or the designated lead agency. Medical team members should never accept requests from the media, without prior authorization from their lead. Media and advocacy strategies are the role of the team lead, not individual members.
- ✓ Ensure that fully informed consent is obtained from survivors for any media story about their experience. It is important that survivors understand the full implications of their involvement in a media story.
- ✓ Ensure that details, such as names, photographs or other identifying information about survivors, family members or even those providing assistance are not used, unless informed consent is given. Make sure that survivors are not pressured and understand fully the potential risks.

- ✓ If you are considering contributing information and analysis on SGBV to the media, carefully consider the risks and benefits. Advocacy on SGBV is important and media engagement can be a key way to raise awareness that such violence is occurring. However, it can also compromise perceived neutrality and independence and jeopardize security. It can put services and service providers at risk, particularly if it becomes known that your facility or team is treating survivors of SGBV and therefore might have information about alleged perpetrators. Spotlight on the provision of SGBV services can also make those services less accessible where stigma due to victim-blaming attitudes prevails. Weigh carefully the risks that this will bring to your services and if you decide to proceed, plan for any potential security issues that could arise such as demands for information and files, closure of services.

4.5 Legal and security frameworks

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

Because of the increased focus on ending impunity for conflict-related sexual violence in particular, medical teams should be aware of their role in the collection of forensic or medico-legal evidence, even if forensic evidence cannot be collected providers have a responsibility to ensure proper documentation of SGBV cases. This includes thorough and complete documentation of the survivor's [129] account, any injuries, findings on physical examination and collection of blood and DNA evidence.

Only medico-legal evidence that can be collected, stored, analysed and used should be gathered, and only if a survivor wishes it to be collected and has given their fully informed consent. Ideally, the forensic medical examination should be done at the same time as the provision of medical care. Health workers must be specifically trained and have supervised experience to conduct forensic medical examinations. Even when forensic evidence collection is not

feasible, medical teams should ensure the exam findings and treatment are well-documented. The examination documentation itself can be useful if a survivor decides to pursue a legal case.

In cases of rape, medical care of a survivor includes preparing a medical certificate [129], which is a legal requirement in most countries. The medical team member who examines the survivor must make sure a certificate is completed. The medical certificate is a confidential medical document that the health-care provider must hand over to the survivor, while keeping a copy on file. The medical certificate constitutes an element of proof and is often the only material evidence available, apart from the survivor's own story. The medical certificate should be available for free and survivors should never be charged for it.

4.5.1 Tips for SGBV documentation

Medical teams may have opportunities for advocacy and access to decision-makers such as local leaders, government officials and military leaders who can be used to strengthen responses to SGBV. Many teams have reported successful advocacy interventions when senior military commanders and governmental leaders have been alerted to SGBV.

- ✓ Record the interview and your examination findings in a clear, complete, objective and nonjudgmental way.
- ✓ It is not the responsibility of medical teams and local health providers to determine whether or not a woman has been raped. Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.
- ✓ Completely assess and document the physical and emotional state of the survivor.
- ✓ Document all injuries clearly and systematically, using standard terminology and describing the characteristics of the wounds. Record your findings on pictograms. Health workers who have not been trained in injury interpretation should limit their role to describing injuries in as much detail as possible, without speculating about the cause, as this can have profound consequences for the survivor and accused attacker.

- ✓ Record precisely, in the survivor's own words, important statements made, such as reports of threats made by the assailant. Do not be afraid to include the name of the assailant, but use qualifying statements, such as "patient states" or "patient reports".
- ✓ Avoid the use of the term "alleged", as it can be interpreted as meaning that the survivor exaggerated or lied.
- ✓ Make note of any sample collected as evidence.

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

4.6 Guidance notes

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

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Chapter 5

Essential emergency clinical care and rehabilitation

5 Essential emergency clinical care and rehabilitation

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

Chapter objectives

1. Provide insights into how the clinical caseload and presentations vary between responses to emergencies and outbreaks in non-conflict and armed conflict areas.
2. Medical teams acquire knowledge of how conflict and other insecure environments impact health service provision and access by patients.
3. Medical teams adapt their care, team composition and equipment to acute presentations of trauma, noncommunicable diseases (NCDs) and communicable diseases, as well as maternal and child health conditions.
4. Ensure awareness of the medical skills and protocols needed to manage acute and complex injuries, outbreaks, CBRN threats, burns, and mass casualty incidents (MCI).

5.1 Introduction and setting

This chapter outlines best available practices in clinical care for civilian health problems that medical teams will encounter in armed conflicts and other insecure environments. It gives guidance notes for clinical care provision that follows a principled humanitarian approach and focuses on the civilian population. It has a patient-centred perspective and includes medical and nursing care as well as physical rehabilitation guidance across community, pre-hospital, hospital, referral and rehabilitation. It is not a stand-alone chapter, but serves as a compliment to the clinical chapter in the “Blue Book” and adds specific considerations required for the delivery of clinical care in armed conflicts and insecure environments.

Armed conflicts and other insecure environments create special health-care needs that require additional services and expanded skill sets of responders over and above those required in disasters and outbreaks in non-conflict settings. Key differences between the two contexts regarding clinical care needs, presentations and operational aspects are highlighted in Table 14 below.

Table 14. Key clinical service needs differences in Blue and Red Book contexts

		Blue Book	Red Book
General context		Relatively stable and disaster impact has already occurred. Potentially damaged health infrastructure.	Unstable, moving frontlines, cyclical violence and mass casualty incidents (MCIs), access limitations, health system degradation and health facilities may be damaged.
Clinical care needs	NCDs	Significant and varies depending on context, conditions may be worsened due to the disaster.	Same as Blue Book but context dependent with some patients without NCD care for years or with continuum of care disrupted.
	Communicable diseases	Significant and acute if lack of WASH and poor living conditions.	Significant and chronic due to long-term degradation of WASH and poor living conditions and collapsed public health programmes of preventive routine vaccinations.
	Injuries	Mainly closed fractures, affecting mainly limbs, crush injuries and often infected wounds.	Mainly open contaminated fractures; often severe penetrating complex polytrauma affecting mainly limbs caused by bullets, fragments and blast. Wounds prone to infection, as in a disaster. Severe truncal injury if transport time short (otherwise proves fatal).
	Maternal and reproductive health	Continuous and depend on birth rate.	Continuous and depend on birth rate and to what extent context affects programme.
	Child health	Paediatric population may be large in low income settings. Displacement and susceptibility to communicable disease possible.	Children may be preferentially at risk of wounding (exposure to improvised explosive devices (IEDs), large organs with susceptibility to blast injury). Population displacement and lack of vaccination increases risks for this vulnerable group.

Clinical care needs			
	CBRN	Not likely, except in industrial accidents from disaster.	Potential need especially if combined with MCI.
Outbreaks	Occasionally	May be common and need special consideration.	
Presentation pattern	Timing	Medical teams arrive hours to days post disaster and will treat "old" injuries and manage acute presentations of other conditions.	Medical teams will be in a setting of ongoing violence and recurrent presentations of fresh injuries and acute presentations of other conditions. Access may be a critical issue in stopping people from arriving early.
	Severity	Mainly old injury cases, and issues of lack of access to chronic medications.	Will depend on distance from frontline, the closer the proximity the more severe will be the injuries seen requiring advanced management.
	Mass casualty incident (MCI)	Occasionally	Common, primarily penetrating and blast injury or burns related, but may also include CBRN.
Operational issues	Rehabilitation	Difficult follow up, often overwhelming demands in short time frame. Must be considered early.	Difficult follow up, insecurity, movement restrictions, potential long-term burden of rehabilitation needs and complex cases.
	Referral chain	Infrastructure destruction and lack of transport may limit referral. Referral facility may not be available.	Insecurity, lack of transport, capacity and movement restrictions, ongoing challenges as frontlines shift or move away from health facilities. Referral facility may not be available.
	Patient records	Follow Blue Book standards.	Potential security issue for patient. Patient transfer of data only with permission, and stored securely. Bring records with you if evacuated. Only report anonymized compiled data.
	Surveillance	Report outbreaks and data to contribute to overall public health response. Complete patient documentation.	Report outbreaks and data in a de-identified way. Clear patient documentation (wound pattern) is important to examine conduct of hostilities afterwards.
	Infrastructure	Tented facilities can be adequate.	A more firm, protective structure required.

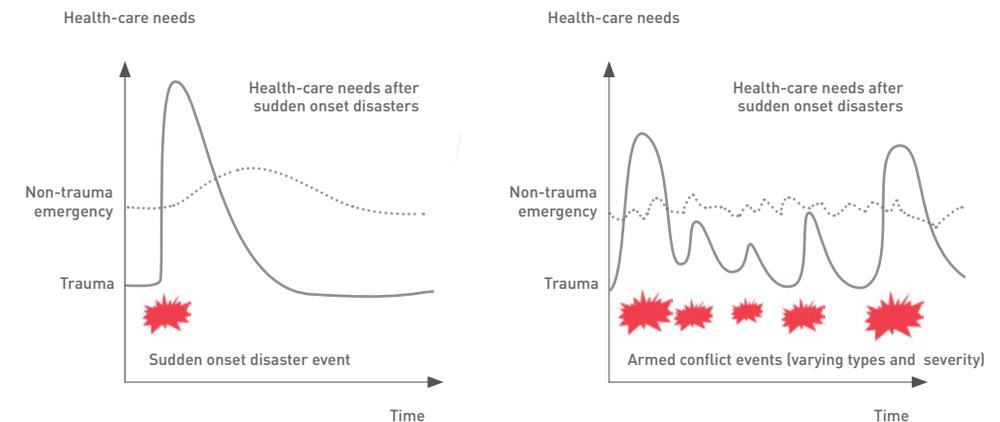
5.2 Type of health-care needs medical teams should be able to manage

In addition to conflict-related injuries, patients will also present with conditions that were already prevalent in the area. These will vary depending on the socioeconomic status of the affected area. For example, the disease burden in middle income countries is dominated more by NCDs compared to low income countries. However, the social disruption caused by conflicts may cause a re-emergence of communicable diseases.

The duration and intensity of the crisis will influence its impact upon the health system and disruption of routine public health services, such as vaccination and preventive programmes, as well as water and sanitation, shelter and access to food, causing health problems that were not an issue prior to the conflict. Of particular relevance to clinical care in armed conflict and other insecure environments are impaired access to patients by teams or services for patients due to insecurity, closure and targeting of health facilities, as well as fear among national and international health staff that deters them from turning up to work. It is essential for any medical team before deployment to critically assess health-care needs by analysing the context of the conflict and its development, and direct and indirect health effects. The analysis will also include the conflict period, demographics, death and birth rates, vaccination coverage, malnutrition level, burden of disease, and existing health system capacity and coverage. The results prepare and guide the deployment design, operational strategy, set up, staff qualification and equipment. For better clinical outcomes, such as reduced mortality and morbidity, planned follow-up and rehabilitation, deployment time for EMTs in the Red Book context is considerably longer compared to [Blue Book](#) contexts and should be for at least three months and preferably longer.

Given the high degree of unpredictability in armed conflict, Types 1, 2 or 3 medical teams should be able to manage both event-related injuries and provide general urgent care for the civilian population, including acute presentations of maternal and child health conditions, communicable diseases and NCDs. Experience demonstrates that teams will not be able to control the types of patients presenting. For example, patients with acute asthma and women in labour will also show up at the facility and require urgent care.

Fig. 5. Health-care needs differences Blue and Red Book context (von Schreeb 2019)



The pattern of presentations to health facilities will vary depending upon the transport time of patients. For trauma and other emergency conditions, transfer time is critical, and will not only depend on the distance from the conflict but also on the availability of transport, the security situation, number of checkpoints and road conditions. The numbers of injured presenting at any one time in armed conflicts will be sporadic, coming in waves, and dependent on the conflict intensity which in turn can change access to the facility and provoke population movement. During response to recent conflicts, such as in Iraq, trauma care was provided in much closer proximity to the frontline and by a wider range of providers than in previous conflicts, yet transportation times remained long [33]. Some data suggest that placing facilities closer to the conflict led to patients with more severe injury surviving to reach a clinical care facility. This included patients with acute, complex, penetrating polytrauma, and multiple injuries sustained from ordnance, bullets and blasts [130]. The complex referral pathway system that was set up, involving more shared levels of care between more providers, has been praised, but its cost/benefit and set up requires further critical evaluation.

Recent conflicts have presented new and different challenges to an effective trauma response and call for the updating of old paradigms, including the

type and level of trauma services to be provided and the systems for referrals. The recent experience of civilians providing advanced trauma care in a conflict marks a new era that has seen new providers and strategies contribute towards more lives being saved (33). A main challenge for civilian EMTs providing trauma care within an active conflict zone is security of the staff, patients and the facility. To date there is limited information on increased security risks for EMTs working in such contexts and how to ensure sufficient protection.

Team preparedness in triage and mass casualty management (MCI), and previous deployment training exercises are essential for MCI. Adding to the complexity, in armed conflicts it is possible for patients with CBRN exposure to present as part of an MCI and a significant number of contaminated patients may arrive, simultaneously overwhelming the medical teams and exposing them to the risks of contamination. There are several triage systems that can be used for CBRN casualties. With no one standardized system globally, it is important to deploy a triage and decontamination system which is easy to follow and appropriate for available medical resources, casualty numbers and severity of injuries. Hospitals should have pre-established protocols regarding decontamination, patient treatment and dedicated equipment.

MCI preparedness plans for the sudden influx of significant number of patients must be in place and include practiced trauma triage protocols with dedicated roles and responsibilities for all staff. Triage protocols for identification and initial sorting must also be available to the staff for CBRN events, as well as protective gear and antidotes. Space and equipment for safe decontamination outside the facility should be readily available, for example, consider such issues as the appropriate removal of clothing and water supply.

Outbreaks in armed conflict and other insecure environments pose significant and complex challenges. Recent examples of high consequence pathogen outbreaks in Central Africa and very high case numbers of cholera and diarrheal disease during active armed conflicts in the Middle East, have severely impaired the ability of local health authorities and international organizations to mount a “normal” clinical and public health approach to the response. Outbreak response requires a multi-pillar response, with equal weighting given to public health measures of surveillance, active case finding and safe and dignified burials. Public health messaging and community engagement, along with the more clinically focused laboratory services, supports the treatment and isolation of patients, infection prevention and control in health facilities,

continuity of access to health services, such as safe births, NCDs and other communicable disease care not related to the specific outbreak. Traditional use of IHL to support dealing with care of the injured among civilians by parties to the conflict is well covered elsewhere in the book, but the specific role of parties to the conflict responding to an outbreak requires special attention. While many read into the wording of IHL that “providing care” to the civilian population should also include response to outbreaks, this does not seem to be the interpretation of military forces in the examples above. Intra-state violence, which involves the governmental forces against non-state actors, and the additional complexity of UN peacekeeper direct action, make other UN agency actions more complex, especially when completely aligned with the government side.

Effective clinical and public health outbreak response, more than any other form of health intervention, requires an approach that ensures communities perceive it as both neutral and impartial, or they may disregard or oppose it. Trauma care such as surgery, wound management and airway control procedures, and operative or invasive reproductive services in an area affected by an outbreak are particularly high risk for personnel (as seen in 2019 Ebola outbreak with intrauterine deaths and septic complications requiring surgical procedures in Ebola patients). Furthermore, the chaotic first moments of an MCI during conflict exposes staff to a heightened risk of exposure to bodily fluids or medical sharps. New advances in PPE, immunization of health-care workers against pathogens such as Ebola, and improved designs of operating theatres for use during the Ebola response, have helped mitigate these risks to some degree but not removed them.

5.3 Special operational issues

An insecure and dynamic environment impacts upon all aspects of clinical care including, but not limited to, care site set up, referral pathways, medical supplies and critical medications and surgical case planning and its implementation. For example, in a high-threat environment, health facilities may need to be moved closer to, or further away from, the conflict areas thus requiring a balance between patient needs against responder safety. Continuity of care must be maintained and standards of care not lowered along the referral chain.

As a guiding principle, the level of care provided during transport must aim to be at least equal to that at the point of referral and must prepare the patient for admission to the receiving service. If this is not possible due to limitations in medical transport capacities such as staff skill, equipment, drugs, then the referring team should avoid initiating a level of care that cannot be maintained during referral. Preparation for and surveillance of communicable diseases and outbreaks, such as epidemic diarrheal diseases, highly contagious diseases, including viral haemorrhagic fever, and influenza, is essential.

A critical issue is maintenance and storage of patient record files that in a conflict can constitute a potential threat to patient security. As per the [Blue Book](#), patients require a copy of their medical record, or in cases of complex care at least a discharge summary. Other hospital identification, such as wrist bands, should generally be removed prior to discharge in case these pose a risk to the patient if later recognized by armed groups. Patient records in armed conflicts are a potential source of information for one or other party to the conflict. Medical teams should ensure that identifiable data are always kept confidential and never shared with any side, without the clear consent of the patient and after very careful consideration of the implications for patients, who may later suffer reprisals (direct and indirect). This is a clear difference between the Red and the [Blue Book](#). If patients agree to be transferred to another facility, their medical record and notes must accompany them. Any digital records, daily surveillance reports, and Minimum Data Set (MDS) ^[131] reporting must all be anonymized. Hard drives and passwords for secure computers should be carefully managed and contingencies for urgent evacuation by a medical team should also include plans for securing the safety and integrity of patient records and data.

5.4 Clinical guidance per level of care

The successful management of patients with acute, severe conditions requires an interlinking chain of levels of care and each is equally important. This means ensuring an understanding of what health services and referral pathways are available in the area where the team has set up. Every facility should understand the capacity and capability of the facilities from where they receive and to where they refer their patients. As described in the [Blue Book](#), the first response in an armed conflict is often carried out by untrained bystanders,

family members, survivors, first aid trained rescue staff and occasionally pre-hospital ambulance staff. The different types of EMT (Type 1 mobile and fixed, Type 2 and 3) and specialized care teams all have a place in armed conflict, though not all patients will necessarily be seen in each level. The section below describes adaptations to the normal typology of medical teams required for deployment into armed conflict. All team members should understand the principles of IHL, and ensure medical ethics are understood, respected and followed. All EMT staff must be qualified in their specialty of practice, have a current licence to practice in the country where they are registered (or their national equivalent) and have authority to practice in the affected country.

The design, staffing, equipment and focus of medical teams deployed to armed conflict and other insecure environments may vary, depending on the context and transportation time of casualties. Nevertheless, there are core functions required of teams wherever they are sited which follow the standards defined in the [Blue book](#). A Type 1 outpatient medical facility will include the management of emergency presentations of NCDs and communicable diseases, injuries and maternal health conditions, including normal delivery.

5.4.1 Community first responders

As indicated above, most of the injured will first be treated, and potentially saved, by bystanders such as neighbours and family members. The injured may be dragged out of direct danger and provided with basic care before being transported to a medical facility. The 1-2-3 of safety: 1 Self, 2 Scene, 3 Survivor ^[5] should guide first responders and essential first aid guidelines for bystanders made available ^[132] (see Table 14).

Transportation from the site of injury to clinical care will vary and be shaped by the type of conflict, the level of insecurity and distances to be travelled. Depending on the context, there may be ambulances and trained pre-hospital care providers/paramedics who, without unnecessarily delaying transport, can apply external compression to stop haemorrhage, protect the airway and if needed rapidly apply basic fracture immobilization ^[133].

5.4.2 Pre-hospital outpatient care, (Type 1)

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

5.4.2.1 Type 1 Mobile Teams

Mobile teams may add value in contexts covered by both the Blue and Red Books, though their overall impact on addressing health needs remains largely undocumented. The strategy of sporadic and irregular visits by mobile teams in underserved areas may be effective, but coverage remains limited, especially for responding to acute emergencies (obstetric emergencies and other acute presentations) given the short time such services are available in one location. Efforts should be focused more on providing a regular service that is well accepted by the local community. Mobile clinics should be seen as a strategy of last resort for reaching populations cut off from health services (134).

In recent conflicts we have seen an increasing use of mobile teams from a range of backgrounds. It is important that a degree of coordination be established and maintained through the relevant medical coordination system(s) to ensure equity across communities, with no communities missed or underserved, and easy to reach communities not over-served by multiple and potentially contradictory medical visits.

5.4.2.2 Type 1 Fixed Teams

Although fixed, these clinics still need a degree of mobility in case of evacuation due to security threats or population movement. They may be established at IDP and refugee camps, or close to populations directly affected by conflict. A Type 1 fixed may have to focus on trauma management and include the functions of a trauma stabilization point (TSP), although true stabilization will only be achieved with definitive surgery. The TSP when deployed in conflict has provided far-forward, emergency resuscitation and stabilization in the form of airway, haemorrhage and fracture control. It also has an important triage role, identifying minor injuries and rapidly transferring the more serious injuries to

a higher level of care. To maximize benefit, it should be accessible within 10 minutes from the time of injury. Surgery is not performed at this site (133). TSP services must be adapted to the context in which they work, including transport time to the next level of care and medical facilities available during transport, but should include the following interventions.

Table 15. Initial resuscitation for trauma patients arriving at a TSP

Airway	Basic airway management. Advanced airway management can be considered, up to and including intubation according to agreed protocols and only if the intubated patient can be transferred safely and the receiving facility has the capacity for continued mechanical ventilation.
Breathing	Supplemental oxygen and if needed chest decompression, chest seals and pleural drains.
Circulation	Haemorrhage control via pressure dressings and if needed, careful use of tourniquets and/or placement of pelvic binder or femoral splinting. Resuscitation including administration of intravenous and intraosseous line placement, limited crystalloid infusion according to agreed protocols and adapted to length of referral time and when indicated Tranexamic Acid (TXA).
Disability	Recognition and protection to prevent further damage and referral of spinal cord injuries and other neurological emergencies, including eye injuries.
Exposure	Prevent hypothermia. Rapid secondary survey. See CBRN section for details on management of potential exposure.

TSPs MUST also be prepared to receive acute non-trauma emergencies, as they are often close to an extremely vulnerable population with multiple unmet medical needs (see Table 17).

The transfer time to the definitive care facility and the level and range of services available there will influence treatment strategy in the TSP.

Survival from severe haemorrhage is most likely when transfer to hospital is rapid, without pre-hospital delay, and the receiving facility has the appropriate skills and capacity. [\(See safety and security chapter\).](#)

Table 16. First Responder Guidance (5)

Self	Without PPE and correct training, you are in danger of becoming another casualty and worsening the situation. The injury or death of a medical team member brings the possibility of being forced to end the entire mission. Put your own safety and that of your team above everything else. Ask yourself, are you trained to work in this forward position with this level of risk?
Scene	Is the scene safe? Are there secondary devices and IEDs waiting? Are there active shooters, snipers or residual CBRN contaminants? Is there structural instability of the buildings? Contrary to the natural instinct of many responders, as long as there are ongoing threats, it remains a security situation rather than a medical situation.
Survivors	Now patients and survivors can be brought to safety and treatment instigated. Can you encourage the victims to evacuate to you rather than you entering the scene? First stand at a safe distance and call survivors out and to safety. If they obey commands it tells you they are still perfusing their brain and able to mobilize, this is a vital first observation contributing to triage. Those who remain lying down may be dead or badly injured. If safe to do so render initial first aid and bring them to a casualty clearing point or EMT 1.

5.4.2.3 Clinical considerations in pre-hospital

Trauma care

Ensure the teams apply a triage system (such as the Interagency Integrated Triage Tool, jointly developed by WHO/ICRC/MSF) and have practiced it, to sort and prioritize the injured. Assessment and stabilization should follow the ABCDE principles (134) and include acute haemorrhage control (pressure bandage or tourniquets if necessary), basic airway management (such as nasopharyngeal tube), applying the recovery position, intravenous infusion (limited to crystalloids and as part of an agreed protocol) as well as prevention of hypothermia (135). If an advanced life-saving procedure has been carried out, the patient must be accompanied during transfer by medical staff sufficiently trained in maintaining the intervention. Advanced initial trauma care, including endotracheal intubation and chest tube insertion, may be considered to temporarily stabilize critically injured patients prior to their transfer to a higher level of care (Types 2 or 3). However, to avoid a misuse of limited resources, such interventions must only be commenced when it is known that there are

sufficient human and technical resources to both safely transfer the patient to an appropriate facility, and that the facility is one that can safely receive them and continue the level of care established. Avoid futile interventions and ensure access to appropriate end-of-life or palliative care.

ABCDE or c-ABCDE? (12)

In statistical terms, severe peripheral haemorrhage is the main lethal yet salvageable injury in a context of armed conflict. Various studies show that far more soldiers die from catastrophic peripheral haemorrhage than from airway obstruction or respiratory inadequacy. Thus, the “c” which stands for catastrophic bleeding, may be put first, simply because it is more common.

Once catastrophic external haemorrhage, which is quite obvious (as are the great majority of cases), has been excluded the first-aider should resort immediately to the standard routine of ABCDE.

For penetrating injuries and blast injuries, rapid transportation to hospital will determine chances of survival. How far resuscitation is pursued will be based on the level of services available at the onward referral unit and the transfer time. Further adaptation will be required in an MCI. Care must be exercised when attempting to resuscitate severely injured patients with no likelihood of survival, including those with complex brain injuries, to avoid a futile waste of precious resources. Remember that those with internal haemorrhage are only effectively stabilized by surgery at hospitals. Do not delay transport to hospital with unnecessary interventions and too-long a quest for stabilization. Tourniquets may be applied to control external haemorrhage, but caution is required when there is a long referral pathway. It is painful to apply and if applied for too long will cause ischemic damage that itself may lead to amputation. If applied, the time of when the tourniquet must be removed (within two hours) (136) must be noted on the device and there should always be an accompanying person capable of managing its removal should unavoidable delays be encountered.

Uncomplicated superficial injuries without sign of penetration can be managed in pre-hospital medical facilities. Ensure that established protocols for this level of care are followed, including wound assessment and management, anti-tetanus immunoglobulins/vaccine, pain control, follow up and rehabilitation (12, 137). Additional considerations for trauma care are highlighted in Box 1 for Q/A.

Burns may require special consideration. They may present individually or as part of an MCI. Initial care for burns in the pre-hospital (rescue) phase is focused on basic stabilization of the burned patient. New guidance on burns MCI has emphasized the value of pain relief, covering burns pre-hospital and “No fluid” administration pre-hospital, while care at a Type 1 mobile or fixed should be equally essential and basic [138]. Pre-hospital estimation of the depth and surface area of burns is very difficult and often incorrect and may either under or overestimate the extent/severity by 10–20%. Nevertheless, burns with an estimated surface area of 5% or more should be referred to a Type 2 facility for debridement, fluid therapy and further care. Overestimation also occurs when assessing very severely burned individuals and therefore decisions about survivability and/or palliative care should not be done in the pre-hospital setting, but only after review by those with specialist burns experience and a definitive estimation of the total burns surface area (TBSA). Burn specific instructions for EMT management have been developed [139].

Outbreak

Any EMT should have the capacity to identify diseases with outbreak and epidemic potential and have protocols in place to manage infectious patients, including separate waiting areas, temporary isolation facilities, PPE, infection control measures, transfer capability to appropriate care centres and background surveillance and reporting in place. Type 1 mobile and fixed teams are expected to provide basic care to patients with a communicable disease and act as a cholera treatment unit, for example, or an oral rehydration point in an outbreak.

Mass casualty incidents (MCI)

It is essential to have a well-rehearsed triage system in place. There are several types and teams should choose one and ensure that it is well known to all team members and has been well tested in team exercises.

CBRN care

Safety and security aspects of CBRN, including decontamination, are dealt with elsewhere in this document (chapter 2.7). After decontamination, Type 1 should have personnel able to recognize the clinical symptoms of poisoning and provide basic supportive care. Where a known antidote is available such as atropine this should be given and patients transferred quickly to higher levels of care. Treatment should occur only after decontamination has been completed and if decontamination is not possible, then the safety of the EMT personnel comes first. Information on the management of chemical and radiation risks are available at [WHO Managing environmental health risks in emergencies](#)

while care protocols for those exposed to chemical weapons are available in the WHO publication “[Initial clinical management of patients exposed to chemical weapons: interim guidance document](#)” [140].

5.4.3 Referral

Type 1 are the first link in the trauma care chain of survival and must ensure that a robust patient evacuation system is in place as the poor-quality referral of patients will impact badly upon their chances of survival. Ambulance transport is often not available, as in armed conflict, roads have often been shelled or bombed, fuel is scarce and ambulance vehicles themselves are unavailable. Transport by air may be the only feasible option, but this is not always available, and takes time to organize. It is essential that appropriately trained staff accompany the injured patient in their transfer to definitive care. As in non-conflict settings, the clinical team sending the patient remains responsible for the patient until they arrive at the next level of care. Accordingly, the capacity and capability within the evacuation process will shape the clinical interventions in the pre-hospital setting. Only patients requiring a higher level of care should be transferred to the definitive facility. Referrals between Type 1 and 2 may be improved by having specific coordination teams and a “hot line” to call. In conflicts, referrals may take hours, even when distances are short. This is especially relevant when tourniquets have been applied and therefore will at some point need to be temporarily loosened. Similar considerations are required in the use of advanced airway techniques. Endotracheal intubation of critically injured patients should only be done if transportation time is sufficiently short to allow for safe continued manual ventilation during transportation [91].

5.4.4 Hospital – EMT-2 and 3

The main role of the first hospital in the trauma referral chain (Type 2) and the referral hospital (Type 3) is to manage patients with burns, penetrating, complex and multiple-trauma, provide definitive general surgical care, and treat and stabilize medical emergencies. The difference between Types 2 and 3 is the greater bed capacity of a Type 3 and the presence of an intensive care unit (see [Blue Book](#)). In an armed conflict it is likely that the Type 2 will be closer to the frontline and receive complicated fresh injuries that once surgically

controlled may be referred to a Type 3. It may also be that a Type 2 needs to refer onwards due to a lack of beds or threats to its security. Such referrals can be to local hospitals further away from the frontline. Comprehensive contingency plans need to be established early. Experience from recent conflicts shows that frontline Type 2 at times did always have the space and/or the capacity to provide definitive surgical care. Post-operative patients were rapidly referred putting significant pressure on transportation services and the receiving hospitals that sometimes received immediately postoperative patients without prior notice.

The need for surgery is usually the reason patients are referred to a higher level of care facility. This is not exclusively surgery for acute injuries, but also to meet the general emergency surgical needs of any community, including obstetric emergencies, the “acute abdomen”, and non-conflict-related trauma. Elective surgery does not come within the remit of the emergency EMT facility. Care must be taken to avoid introducing treatments that are beyond the existing health system’s capability. Specialized care teams may provide specific surgical reconstruction and will need to be deployed over a significant period of time, considering the complexity of this surgery and the extended rehabilitation required. Teams must possess the capability to manage the complications and postsurgical care of patients that they treat. Importantly, Type 2 and 3 must work in support of and linked with the pre-hospital and rehabilitation services to ensure a continuity of care. There are significant ethical and cultural considerations to be taken into account before commencing advanced treatments of severely injured patients. Besides obtaining consent and giving culturally appropriate information to the patient, clinically futile interventions should be avoided. Care, including rehabilitation, will in the longer term, be shaped by the resources available in the place to where the patient is ultimately referred. Nevertheless, despite these constraints, teams must strive to provide the highest quality of care that they can. The technical standards and capacities for Type 2/3 are defined in the [Blue Book](#).

5.4.4.1 Clinical considerations – hospital

Any hospital (Type 2 and 3) must always have medical, nursing and physical rehabilitation services and corresponding protocols in place to manage acute presentation of NCDs, communicable diseases and obstetric emergencies. Staff must be trained in basic psychosocial support which includes Psycho-

logical First Aid (PFA) skills and other interventions. A more comprehensive description of the standards to be met when providing such care is available in the [Blue Book](#). In Table 1 some of the main operational concerns relevant to the contexts addressed by the Red Book are highlighted.

Trauma care

Clinical care in conflicts will focus on the management of injuries from bullets, blasts and fragments. Teams should have a basic understanding of ballistics and the type and complexity of organ injury that can be caused by firearms and explosives and clinical experience of their management. The basic principles of the treatment of these injuries have been outlined in ICRC and partner manuals [12, 137]. Damage control trauma resuscitation has successfully improved the survival of critically injured patients. It builds on a systematic approach and includes aggressive mechanical haemorrhage control, limited crystalloid resuscitation, early balanced blood product administration, hypothermia prevention, use of haemostatic adjuncts such as tranexamic acid, and early progression to damage control surgery [141].

Uncontrolled haemorrhage is the leading cause of preventable death in trauma. However, timely access to blood products and blood transfusion is a major logistical, administrative and clinical challenge in conflicts. Availability of blood is a limiting factor that may be difficult to address. When the regular supply of blood for transfusion is unavailable, a “walking blood bank” based on volunteer donations must be instituted, or autotransfusion, for example, in cases of massive haemothorax [142].

This document does not provide technical details of clinical management. However, it should be noted that any EMT deploying to an armed conflict must have surgeons and anaesthesiologists well acquainted with damage control principles and concepts [143]. These concepts include (1) abbreviated surgical procedures limited to haemorrhage and contamination control; (2) correction of physiological derangements; and (3) definitive surgical procedures.

There are established clinical standards for the management of penetrating injuries in resource poor conflict zones, including wound care, limb, orthoplastics and the essential management of neurological and spinal injuries [144, 137].

Fractures

Fractures are common, often open and associated with other injuries. They will be a dominant condition for Type 2 or 3 and will require significant resources, including specialized trauma orthoplastic skills as well as active and early rehabilitation. Essential management will include surgical debridement, adequate stabilization with plaster, traction or external fixation, but never internal fixation as initial treatment. More detailed descriptions of fracture management can be found here [\(137\)](#).

Burns

Burns may place significant demands on health services in armed conflicts, as burn care is resource-intensive (see WHO Specialist Cell Burn care). Depending on the severity of their burn, patients might normally be referred to a specialized unit where care is based on best practice protocols. In conflicts, such units are almost never available and Type 2 and 3 will be required to manage these injuries. It is expected that all Type 2 and 3 will be required to have the capability to initially manage burned patients, including MCIs involving burns. This will include secondary triage, stabilization and resuscitation, wound scrubbing, laminar excision and application of dressings. Tertiary triage and definitive percentage burn estimation facilitates the appropriate distribution of patients to specialist burns facilities. Burns up to 20% body surface area and patients requiring palliation due to unsurvivable burns injury will be managed in Type 2 and 3 [\(145\)](#). Detailed descriptions on how to manage a significant number of burns in the EMT setting has been addressed by the WHO EMT technical working group on burns [\(146\)](#).

Chemical, biological, radiological, and nuclear (CBRN)

CBRN care at Type 2 and 3 facilities depends on full decontamination of patients prior to admission into the facility. Escalating supportive care measures should be available at Type 2 and on to Type 3 facilities depending on severity of symptoms, up to and including ICU if the agent's effects are considered reversible and danger to staff is not present. Treatment protocols are available at [WHO Managing environmental health risks in emergencies](#) [\(147\)](#) while care protocols for those exposed to chemical weapons are available in the WHO publication ["Initial clinical management of patients exposed to chemical weapons: interim guidance document"](#) [\(140\)](#).

Outbreaks

As in the [Blue Book](#), all Type 2 and 3 facilities need to be able to triage and recognize highly infectious patient presentations, such as TB, diphtheria and cholera, separate triage areas and wards that can manage communicable disease presentations, along with appropriate PPE for staff. Referral of patients to appropriate specialist facilities may or may not be possible depending on context. Specific outbreak treatment centres such as Ebola or cholera treatment centres are termed specialist teams for outbreak and have the same standards as [Blue Book](#) contexts but with additional requirements for community engagement, as per earlier in this chapter.

MCI

Any medical facility providing care in conflicts and other insecure environments must have defined and exercised their plans for MCI events. Unlike sudden onset natural disasters, in conflict zones MCIs are more frequent, generate more high acuity patients, and are by nature sporadic and recurring. At Type 2 and 3 levels, teams must be prepared to manage patient surge from point of entry into the facility, through damage control surgery, into postsurgical care and evacuation. Type 1 and 2 should work in coordination with other advanced resources such as local hospitals to develop mutual aid plans and strategies for the rapid evacuation of patients.

5.4.5 Specialized care teams

Deployment of specialized care teams to armed conflict and other insecure environments should follow a specific request and address specified needs. They should be prepared for a prolonged deployment. Specialized care cells that are particularly relevant to conflict include orthoplastic and maxillofacial surgery, maternal and child health, rehabilitation, burns management and outbreak care teams. Such teams should be well-prepared and already WHO verified prior to deployment. They are unlikely to be a stand-alone facility but set up in combination with and as an addition to an Type 2 or 3, embedded into a local hospital. Outbreak treatment centres such as Ebola or cholera may deploy to support existing facilities but can be self-contained if fully supported. More information about specialized care teams is available in the [Blue Book](#).

Table 17. Clinical consideration and answers

Question/statements	Answer
Should blood transfusion be available in the pre-hospital setting?	Blood transfusions save lives. However, blood transfusion for bleeding patients in the pre-hospital setting is complex and risky. If it is available and can be given safely and without delay of rapid transfer to higher care, it may be considered following careful planning. However, rapid haemorrhage control and fast evacuation will remain most important.
What about pre-hospital tranexamic acid?	Current research indicates that for a bleeding patient early tranexamic acid provision saves lives. However, timing is critical and extra doses may be needed. Tranexamic acid protocols must be agreed upon and accepted throughout the referral system before being provided.
Should emergency thoracotomies be done?	Due to poor long-term prognosis and high risks, resuscitation of pulseless patients and emergency resuscitative thoracotomy should not be performed unless ICU care is available (Type 3).
Can thoracic drains be inserted in a pre-hospital setting?	Invasive procedures such as thoracic drains carry risks and should only be considered if directly life-saving (tension pneumothorax). If so, they should be done without any delay and this should be done at Type 1 fixed/TSP rather than outside a facility.
Our team is a trauma stabilization point and only provides trauma care.	Any medical team deployed to conflict areas must be able to manage all acute medical conditions in addition to trauma.
We are paramedics that deploy without medical doctors.	All medical teams must have a medical doctor responsible for the care provided, and care should only be provided based on a licence to practice. Paramedics are a diverse group of professionals that in some countries have limited training and no licence to practice.
What about use of internal fixation?	Not performed as it carries significant risks in a field setting including high energy transfer, extensive soft tissue injury, contamination and non-sterility. For management of complex and open fractures. ⁽¹³⁷⁾

5.5 Nursing care

Nursing care is an integral part of clinical care and all teams require a sufficient number of nurses with the relevant competencies and skills. The nursing role in EMTs deployed into conflicts and other insecure environments will include a broader range of skills and competencies than encountered in many high-income health-care systems. A nursing team in an EMT may also include a range of nationalities alongside local nurses who, trained under a different system, may have a different nursing education curriculum. Nursing procedures and scope of practice in some countries are not part of their duties, as in others. Therefore, it is recommended to list the clinical procedures that nurses will perform after having received specific training and ensure these are within the normal scope of practice of the deployed nurse. It is important to include senior nurses in EMT management and to have nursing focused meetings as well as interdisciplinary clinical meetings throughout the mission.

Written protocols are essential to support nursing care decisions and the continuity of care across staff rotation between international nurses and doctors as well as the systematic application of evidence-based clinical and nursing care.

5.6 Rehabilitation

Rehabilitation is recognized as an integral part of the emergency response by the WHO and its partners ⁽¹⁴⁸⁾. It is similarly an essential component of clinical care in armed conflict and complex emergencies and essential to mitigating the considerable legacy of disability that follows a surge in traumatic injuries and exacerbation of chronic medical conditions ^(149, 150, 151) with devastating consequences for individuals, families and communities are a result of insufficient access to rehabilitation ^(33, 145).

EMTs providing rehabilitation in conflicts face a broad range of conditions, including physical as well as mental health-related, limited national rehabilitation capacity, damaged infrastructure, a reduced workforce, disrupted services, compromised procurement and coordination pathways. They may be located within an EMT facility Type 1 to 3 or as part of an EMT specialist care team embedded into a host facility. Due to the differing mechanisms of injury sustained in conflict, adaptation of surgical and rehabilitation practice and protocols may be required. Depending on access to orthoplastic surgical

limb reconstruction, rehabilitation staff will have a range of tasks, including interventions to maintain tissue quality and promote mobility while awaiting definitive surgery as well as mobilization and breathing exercises, for example, after laparotomy or thoracotomy. Amputations themselves produce disability, especially in low and middle income countries (LMIC). Limb salvage must always be considered first, and rehabilitation advice sought before surgery to ensure optimal results and rehabilitation. Standards for rehabilitation have been established and should be followed (148). However, in the local health-care system the importance of perioperative physiotherapy may not be recognized.

EMTs working in contexts affected by armed conflict need to identify referral pathways and/or local providers who can complete the rehabilitation of patients after the EMT deployment has finished.

5.7 Mental health and psychosocial support (MHPSS)

International guidelines (152) recommend services at a number of levels, from basic services to clinical care, and indicate that mental health-care needs to be made available immediately for specific, urgent mental health problems as part of the overall health response (153).

- Almost all people affected by emergencies will experience psychological distress, which for most people will improve over time.
- Among people who have experienced war or other conflict in the previous 10 years, one in 11 (9%) will have a moderate to severe mental disorder.
- One person in five (22%) living in an area affected by conflict is estimated to have depression, anxiety, PTSD, bipolar disorder or schizophrenia.
- Depression tends to be more common among women than men.
- Depression and anxiety become more common as people get older.
- People with severe mental disorders are especially vulnerable during emergencies and need access to mental health care and other basic needs.

Teams should anticipate (153) encountering a range of social problems and mental health conditions in any large emergency.

Mental health problems:

- pre-existing mental disorders such as depression, schizophrenia or harmful use of alcohol;
- emergency-induced: grief, acute stress reactions, harmful use of alcohol and drugs, depression and anxiety, including PTSD; and
- humanitarian response-induced: anxiety due to a lack of information about food distribution or about how to obtain basic services.

Social problems:

- pre-existing: poverty and discrimination of marginalized groups;
- emergency-induced: family separation, lack of safety, loss of livelihoods, disrupted social networks, and low trust and resources; and
- humanitarian response-induced: overcrowding, lack of privacy and undermining of community or traditional support.

5.7.1 Prevalence

Most people affected by emergencies will experience distress, including feelings of anxiety and sadness, hopelessness, difficulty sleeping, fatigue, irritability or anger and/or aches and pains.

This is normal and will, for most people, improve over time. However, the burden of mental health conditions among conflict-affected populations is extremely high. A WHO review of 129 studies in 39 countries showed that among those who have experienced war or conflict in the previous ten years, one in five (22%) will have depression, anxiety, PTSD, bipolar disorder or schizophrenia.

According to the WHO review, the estimated prevalence of mental disorders among conflict-affected populations at any specific point in time (point prevalence) is 13% for mild forms of depression, anxiety, and PTSD, and 4% for moderate forms of these disorders. The estimated point prevalence for severe disorders, such as schizophrenia, bipolar disorder, severe depression, severe anxiety and severe PTSD, is 5%. It is estimated that one in 11 people (9%) living in a setting that has been exposed to conflict in the previous 10 years will have a moderate or severe mental disorder.

In conflict-affected settings, depression and anxiety increase with age. Depression is more commonly diagnosed in women than in men.

People with severe mental disorders can be especially vulnerable during and after emergencies and need access to basic services and clinical care. A review of the health information system published in 2014 from 90 refugee camps across 15 low- and middle-income countries found that 41% of health care visits for mental, neurological and substance use disorders were for epilepsy/seizures, 23% for psychotic disorders and 13% for moderate and severe forms of depression, anxiety or post-traumatic stress disorder. (PTSD)

EMT team members are generally not specialized practitioners in mental health. However, they are expected to have a minimum set of skills to manage mental health conditions frequently encountered in situations of armed conflict and other insecure environments and should be skilled in the following.

Basic psychosocial support skills, such as psychological first aid, offers first-line emotional and practical support to people experiencing acute distress due to a recent event and should be made available by field workers, including health staff, teachers or trained volunteers [73, 95].

Basic clinical mental health care covering priority conditions, such as depression, psychotic disorders, epilepsy, alcohol and substance abuse, self-harm and suicide should be provided at every health-care facility by trained and supervised general health staff [153].

Protection and promotion of the rights of people with severe mental health conditions and psychosocial or intellectual disabilities are required. For EMTs this might include discussing with authorities how to strengthen visiting, monitoring and support of people at psychiatric facilities and residential homes.

Links and referral mechanisms need to be established between mental health specialists, general health-care providers, community-based support and other services, including schools, social services and emergency relief services such as those providing food, water and housing/shelter. This requires engagement with country-level mental health and psychosocial support (MHPSS) actors in different clusters and in country level MHPSS technical working groups (TWG) to coordinate and identify existing services and resources. A list of all active MHPSS TWG is available and continuously updated at the global IASC MHPSS Reference Group mhpss.refgroup@gmail.com.

Finally, WHO-endorsed interagency mental health and psychosocial support guidelines [96] provides a framework for an effective response to emergencies and recommend services at a number of levels, from basic services to clinical care. It is important to note that clinical care for mental health should be provided by or under the supervision of mental health specialists, such as psychiatric nurses, psychologists or psychiatrists.

Public health emergencies such as COVID-19 and Ebola virus disease have mental health and psychosocial consequences and specific resources are available to address mental health needs of a population affected by a public health emergency [154,155].

If EMTs have the capacity, they could provide psychological interventions [156] for people impaired by prolonged distress. However, these should be offered by specialists or by trained and supervised community workers in the health and social sector.

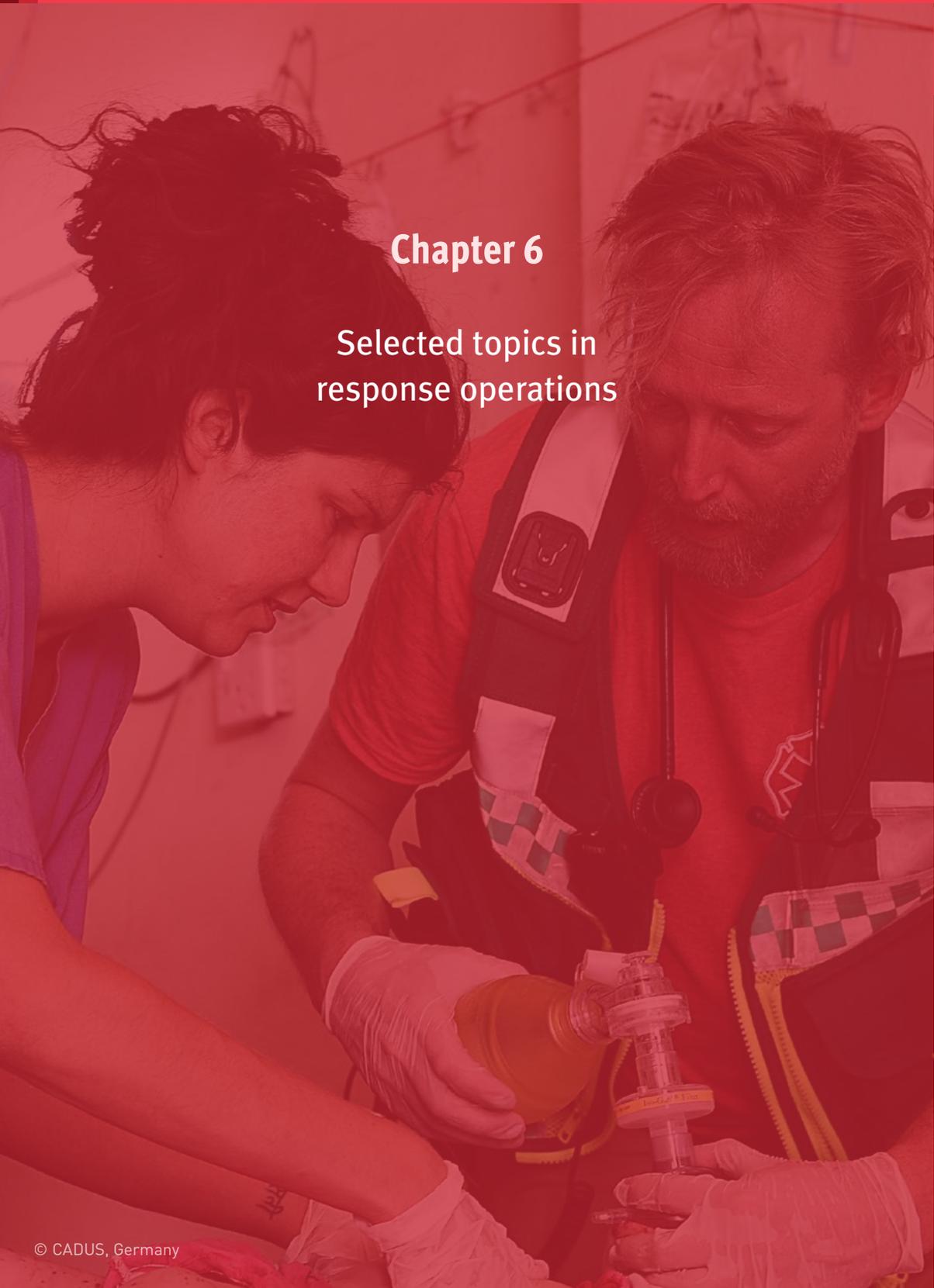
5.8 Guidance notes

Get to know the context before deployment	1. Medical teams and leaders must critically analyse and understand the context including burden of disease, trauma and what type of other conditions to manage, as well as IHL.
The team	2. Ensure a multidisciplinary team is adapted to the burden of disease expected and has respect for all disciplines, including medical, surgical and nursing, as well as rehabilitation services.
Trauma care	3. Follow existing ABCD principles and adapt to available resources. 4. Provide services that are adapted to what level of care is available further down the trauma referral chain. 5. Early rehabilitation is essential on all levels. 6. Ensure triage system and MCI plan is in place that is well exercised. 7. Security in place for the staff including protective gear.

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Chapter 6

Selected topics in response operations

6 Selected topics in response operations

Chapter objectives

1. Teams understand the preparedness and deployment requirements for organizational resource and customized systems/processes for logistics, human resources, finance, administration, planning, handovers, records management, and monitoring and evaluation.
2. Teams can integrate capacity-strengthening as a pillar of support.
3. Teams and leaders have easy access to the most relevant key references and manuals.

The ultimate success or failure of an operational platform for delivering medical services in a highly insecure environment is as conditional on pre-deployment preparation as it is on having systems flexible enough to rapidly adapt to changing circumstances during deployment.

This chapter outlines best practices for the preparation, deployment and post-deployment phases of an operational platform to and from armed conflict. It is not a stand-alone chapter but draws on guidance from the [Blue Book](#) as well as preceding chapters to ensure that medical teams have considered key aspects and are fit for purpose. Table 18 contrasts the key similarities and differences between Blue and Red Book scenarios.

Table 18. Blue and Red Book considerations during operations

	Blue Book	Red Book
General context	Relatively stable and disaster impact has already occurred. Operating environment is mostly safe with manageable elements of insecurity.	Unstable, moving frontlines, cyclical violence and access limitations. Operating environment is highly insecure and possibly hostile.
Administration and organizational management	EMTs will maintain administrative and finance systems that allows them to rapidly and safely deploy teams and maintain headquarters office support from their home base throughout missions.	Largely applicable to Red Book context but consider appropriate and adequate insurance. Operational cash management and safe cash transfer mechanisms.

	Blue Book	Red Book
Human resources	EMTs have a system in place to ensure staff are readily deployable and are recruited, screened and have access to preventative measures to decrease risk of ill health on deployment and have arrangements in place for care of team members during deployment and for their repatriation and after care, if required. It also must ensure its policies regarding human resources management promote protection of the vulnerable through adequate police checks and other measures.	Applicable to Red Book context but consider any implications of the nationalities and ethnicities of the team, regardless of official passport or ID. Abilities for the management and team to recognize and cope with extreme stress (see Chapter 2). Duration of deployments depending on the hardship anticipated. Regular monitoring of conditions and hazards.
Training of teams	EMTs will ensure they have a training and learning programme in place, either by directly training staff themselves or combining this with outsourcing to training providers and recognizing prior learning. EMTs must also have a system to provide mentoring to those identified as future leaders of the team or sections of the response in their roles of escalating complexity and seniority (as validated by the EMT verification process).	Practical team leader and member training related to the five preceding chapters: <ol style="list-style-type: none"> 1. IHL and core humanitarian principles; 2. Safety and security Risk management including self-care; 3. Coordination; 4. SGBV and protection; 5. Clinical care for war wounded; 6. Hostile Environmental Awareness Training (HEAT) or Safe and Secure Approaches in Field Environments (SSAFE) training; 7. Physical and mental resilience training.
Professional conduct	EMTs should have in place systems to ensure all staff are licenced for the practice they will undertake while deployed and to have an ability to process complaints, investigate and correct the outcomes of such complaints and medical indemnity insurance for all clinical staff.	Applicable to Red Book contexts

Field management and operations	EMTs must be able to manage their day-to-day operations while deployed including managing their own safety and security, critical incident management and liaison with relevant local authorities and the media.	Applicable to Red Book and must be enhanced. Hazards and dangers associated with direct or indirect attack, looting, and CBRN must be considered and plans made accordingly (see Chapter 2). Crisis management plans must be updated and followed for each context.
Records and reporting	EMTs will keep confidential patient records of interventions, clinical monitoring and possible complications of care received, with a copy available to the patient, as well as to report regularly and prior to departure, to the relevant local health authorities using national reporting forms, or if not available, the agreed EMT MDS. Teams undertake not to conduct research without appropriate consent of the patient and of national authorities.	Research caveat from Blue Book applicable. Maintaining the confidentiality of health records by using anonymizing coding systems and by keeping paper-based and electronic files in a safe and secure location, such as a locked filing cabinet. Patient consent forms and subsequent use of data for analytical purposes is a challenge. Restrictive use of clinical data might apply. Consent from patients prior to life-saving procedure can be difficult to secure when patients present in extremis from penetrating wounds and without relatives. Adherence to humanitarian principles is essential.

6.1 Pre-deployment

6.1.1 Training

There are several training courses and modules which team members must complete prior to deployment.

Technical training – although it is assumed that teams have recruited medical staff for conflict deployments against a profile which includes the necessary technical skills, additional training on the types of injuries they can expect to encounter must also be offered (see Chapter 5). Examples of relevant training courses are: Definitive Surgical Trauma Skills (DSTS); Advanced Trauma Life Support (ATLS) and battlefield ATLS; Hostile Environment Surgical Training (HEST); Surgical Training for Austere Environment (STAE); Definitive Anaesthetic Trauma Care (DATC) European Trauma Course (ETC); and ICRC War Surgery Seminar.

Hazardous environment training – it is essential that all deployable staff have successfully completed and regularly updated hazardous environment training. While this is primarily for the safety and security of deployed staff, it is also likely to be a precondition of an insurance provider. Examples of this type of course are Hostile Environment Awareness Training (HEAT) or Safe and Secure Approaches in Field Environments (SSAFE) (157). There are many providers of such courses but teams should consider asking providers to compile a bespoke course as many of the “off the shelf” products include large components of trauma first aid which may not be relevant for medics.

Stress management training – teams must consider the mental health of their staff when working in fragile or openly hostile environments. Chapter 2 provides guidance on mental health and psychosocial support (MHPSS) which teams should follow. While the prevention of mental health problems at work encompasses multiple facets of action at management and organizational levels, there is also the possibility to prepare individual staff in building their personal coping strategies or through supporting peers or staff they supervise. The WHO *Doing What Matters in Times of Stress* is a self-directed guide for users to learn strategies to manage stress (158). The IASC *Basic Psychosocial Skills: A Guide for COVID-19 Responders* provides a practical guide for responders to not only learn how to support the public in distress through the techniques learned, but also the peers and staff they supervise (95).

Physical resilience is also important, and teams should seek to enhance the physical resilience of members wherever possible. Teams might consider specialist training in, for example, climate-controlled environments designed to build capacity to work for prolonged periods under temperature stress in PPE (see Chapter 2) not usually required for deployments to natural disasters. Mobile teams in particular should consider the physical suitability of team members, especially if they intend to deploy any significant distance on foot in difficult terrain. While this sort of deployment should only ever be to areas that have been cleared as safe for deployment, team members must be capable of arriving at their destination in a fit state to carry out their duties.

6.1.2 Staff readiness

Pre-departure screening – although teams are likely to have a regular annual or biennial medical assessment for rostered staff, it is recommended that organizations also implement a pre-departure physical and mental health screening. This can be carried out at a rendezvous point or at the airport of departure and will ensure that an individual staff member is as physically and mentally fit as they were at their last scheduled medical check.

Vaccinations and prophylaxis – as per guidance in the [Blue Book](#), all staff members should have the full range of vaccinations to allow them to deploy to most countries in the world. Any prophylaxis required for a particular deployment should also be provided. For the latter, it is often cheaper to provide this at the rendezvous point or airport of departure rather than provide staff with a standing dosage which often expires in the interim between deployments.

Insurance – there are a number of insurance policies which must be in place prior to deployment to protect both staff and the organization. For staff these should include the following at a minimum.

- Health – check that this is valid in fragile and conflict-affected countries.
- Travel – including medevac but check that this covers fragile and conflict affected countries.
- Medical indemnity (purely economic loss)
- Medical malpractice (negligence that causes injury)

- “War zone” – this is particularly important if the area a team is deploying to is contra-indicated by the travel advice of the relevant authorities in the deploying country. Many firms provide this type of insurance but it is likely that teams will require customized coverage policies which involve payment of a standard cover premium which is then updated and an additional premium paid for a specific deployment.

For organizations it may be possible to find worldwide all risk insurance to cover the infrastructure in transit. It is necessary however to check which countries are covered and have fragile and conflict-affected countries added if not included. This will, of course, require an extra premium so a bespoke product which is activated for a specific country only when required is advised.

6.1.3 Operating expenses

Regardless of how self-sufficient the team is, there will still be unavoidable daily operating expenses which might include fuel, raw water delivery or payment of local staff. Teams will need a policy to balance the need for these expenses with the risk to staff of carrying cash or the risk that the hospital compound (health facility or living quarters) is known as a place that holds large amounts of cash. Administrators must be aware of the currency amount, types and denominations required for hospital operational costs on a daily, weekly and monthly basis, which is not simply daily expenses multiplied by seven or 30, and plan accordingly.

Risk mitigation strategies might include: incoming staff bringing smaller amounts of currency when staff rotate regularly; use of prepaid debit cards if the local infrastructure allows; and use of a local money transfer system network. Money transfer strategies must be flexible enough to be modified on the advice of the deployed team so it will be necessary to involve headquarters finance teams to ensure that their systems are capable of such flexibility and risks.

6.1.4 Locally hired staff

In those instances where it is necessary to hire local staff, it is important that deploying teams and headquarters human resources staff agree on how this will take place. How will the staff be contracted? What are the contractual and

legal obligations as per local labour laws? How will they be paid? What security checks will be carried out prior to employment? How will the organization’s codes of conduct be adequately communicated to incoming local staff? Types of on-the-job training required? Will serious breaches of these codes which result in dismissal also be reported to local authorities? Is the team aware of national employment laws in the affected country and how this might impact on the organization’s employment policies? Will the organization accept staff “recommended” for employment by local authorities or militias? What is the duty of care extended to local hires? What will be the level of access to confidential patient data, that is mechanism and/or place of injury?

Having clear organizational-level policies expressed in writing on official letterhead is useful for deploying teams to use as an “opt-out clause” when under pressure to hire staff they deem to be unsuitable.

6.1.5 Exit planning

It is important that organizations have considered exit strategies as far ahead as possible before deployment. Knowing this will allow teams communicate clearly with local authorities, the local population and their own staff about the length of the mission, what its focus is and what red lines exist. The team’s senior management and senior staff at headquarters should be clear on how long is the intended stay; what may replace the team when it departs, which will necessarily be updated when work starts and a better picture gained of what is occurring on the ground; under what conditions is the team prepared to extend the mission; what circumstances will cause the team to shorten the mission; and how and which parts of the exit plan will be communicated to relevant stakeholders.

6.2 Deployment

6.2.1 Patient records, continuity of care and monitoring of aggregated data

In practice, health data (159)⁵⁴ and patient data are considered to be sensitive personal data (160). Two main scenarios are to be considered when processing this type of personal data.

When used to ensure continuity of care – for instance in the context of patient referrals or the handover of facilities – the [Blue Book](#) states that thorough medical records of the treatment provided are required by the organization, the patient, and the local medical authorities. In highly insecure and conflict-affected environments, whether the local medical authorities have access to medical records must be carefully considered. There are a number of requirements (82) to be fulfilled when processing patient data. Below is a non-exhaustive list of requirements which also aim to strengthen confidentiality and to prevent harm that could be caused to the individual(s) concerned in case of misuse, such as retaliation and stigmatization, if information is disclosed on a possible rape or gender-based violence.

- Medical data should be kept separate from other types of personal data.
- Technical and organizational safeguards should be set in place. For instance, personal data contained in the patient record as well as the record itself should be pseudonymized⁵⁵ as a security measure. A numbering system, for example, might be used with the organization retaining the key to identifying patients from the number given. In addition, patient records should only be accessed by authorized humanitarian health-care providers. Whichever system is adopted, records should be kept in secure locations and plans made on how they will be handled in the event of an emergency evacuation.

- Medical data should be kept separate from other types of personal data.
- Patient records should only be transferred to trusted health-care providers for the purpose of providing humanitarian health-care and to ensure continuity of care. Can the team ensure that records handed over will not be misused to target patients and staff? If the answer to this question is no, then it may be necessary to refrain from transferring records.

Data can also be used to monitor, map or identify regional or global health emergencies, for instance, to identify and track pandemics. In such cases, the data used should be anonymized⁵⁶, for example, aggregated data, to the extent relevant and possible, so that it can no longer be regarded as personal data. This means in practice that no personal data is included in the data set used for monitoring and that the patients, as well as other individuals concerned, cannot be re-identified.⁵⁷ For instance, "... it is important to ensure that the data sets do not divulge the actual location of small, at risk groups, for example, by mapping data such as country of origin, religion or specific vulnerabilities to the geographical coordinates of persons of concern".

6.2.2 Implementing exit and handover strategies

However well planned the exit and/or handover strategy is, it will often need to change once the team is deployed and has a more detailed picture of context and needs. It is easy to overlook discussions about how and when the team will leave when daily operations are so time consuming, but it is important that sufficient time be spent updating the exit strategy. Pressure to stay or to leave may come from many directions, such as the host nation, other external actors and the organization's headquarters, therefore team leaders must have clear and concise arguments for why their recommended course of action is best, noting that such decisions are with the leadership of the response operation typically at headquarters levels.

⁵⁴ Health Data means data related to the physical or mental condition of an individual that reveal information about the state of his or her health. Personal Data relating to health includes in particular: 'data pertaining to the physical or mental condition of a Data Subject; 'information about registration for health services; 'a number or symbol assigned to an individual to uniquely identify the individual for health purposes; 'information derived from testing or examining a body part or bodily substance, including Genetic Data and biological samples; 'any information on a disease, disability, mental health or psychosocial disorder, disease risk, medical history or clinical treatment, or information on the physiological or biomedical state of the Data Subject; 'any information on a traumatic experience that had an adverse effect on the Data Subject's mental health or led to psychosocial disorders.

⁵⁵ Ibid., p. 24: "'Pseudonymization', as distinct from Anonymization, means the Processing of Personal Data in such a manner that the Personal Data can no longer be attributed to a specific Data Subject without the use of additional information, provided that such additional information is kept separately and is subject to technical and organizational measures to ensure that the Personal Data are not attributed to an identified or identifiable natural person. This may involve replacing the anagraphic data in a data set with a number. Sharing registration/identification numbers instead of names is good practice, but does not amount to Anonymization."

⁵⁶ Ibid.: "The term 'Anonymization' encompasses techniques that can be used to convert Personal Data into anonymized data. When anonymizing data, it is essential to ensure that data sets containing Personal Data are fully and irreversibly anonymized. Anonymization processes are challenging where large data sets containing a wide range of Personal Data are concerned and may pose a greater risk of re-identification."

⁵⁷ "The term 're-identification' describes the process of turning allegedly anonymized data back into Personal Data through the use of data matching or similar techniques. If the risk of re-identification is deemed to be reasonably likely, the information should be considered to be Personal Data and subject to all the principles and guidance set out in this Handbook. It can be very difficult to assess the risk of re-identification with absolute certainty."

6.3 Post deployment

6.3.1 Deployment legacy

There may be requests for the team to leave some or all of the infrastructure to a local stakeholder. This needs to be carefully considered and several questions need to be asked.

- Is the team able to leave a small team of trainers to ensure that the local stakeholder is able to operate the equipment and function properly within the infrastructure? If so, how long can this team realistically stay once the main team has departed?
- Are there logos and signage on equipment, tents, kits that must be removed prior to handover?
- Does the receiving stakeholder have the necessary funding to operate the equipment or is funding from the organization required? If the latter, how long can this funding be provided?
- How stable is the country and how sure can the organization be that any equipment left in country will not be used for purposes contrary to principled delivery of health care? This is particularly important in terms of organizational reputation, especially if facilities left behind continue to be perceived as belonging to the deploying organization.
- Supporting local medical community-based actions to continue principled and quality care efforts is important. Teams need to factor such approaches into plans and ensure some level of continuity.

6.3.2 Lessons and learning

With the notable exceptions of organizations such as MSF and ICRC, the deployment of EMTs to armed conflicts may be, for many, a new experience. This makes a robust lesson-learning procedure through all phases of the deployment extremely important. Regardless of how well-planned the first deployment is, the lessons that can and should be learned and implemented will be the most important factor for the success of the second deployment. This is true not only for a specific team or rotation, but for all teams. Lessons should be compiled in a format that is accessible to all wherever possible while ensuring this does not adversely affect the organization.

6.4 Guidance notes

1. When using and extending the **Blue Book's** minimum standards, organizations and medical teams need to ensure a range of customized policy and operational requirements are met (and resources allocated) before, during and post deployments in logistics, human resources, team well-being, finance, administration, planning, handovers, records management, and monitoring and evaluation.
2. Teams must ensure capacity and systems for the confidential management of patient information to protect and do no harm.
3. Medical teams and leaders require specialized trainings and expanded kits to adequately prepare for armed conflict response.

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7 Annexes, references and bibliography

Annexes

Annex 1. Readiness checklist for armed conflict and other insecure environments

This chapter builds on and extends the Blue Book classification checklist.

EMT checklist for deployment into armed conflict

Important note

1. This is not a stand-alone check list, as it builds on the Blue Book verification checklist.
2. Reference to trainings below do not necessarily mean separate courses, but rather modules to be embedded within existing training, online e-learning, and/or specialized courses. This is determined by the background and skill/knowledge baseline of the target audience.

Category	Check	X ✓
1. Duty of care	For the organization	
	1. Adopted specific policies for the legal aspect of duty of care including safety, protection, health measures and related insurance policies.	1
	2. Informed consent forms for staff deploying to armed conflict and other insecure environments are in place with full transparency and clear accountability frameworks.	2
	3. Headquarters team care, support policies and measures are in place before, during and after deployment.	3
	4. Team leaders and team member rosters have training for armed conflict contexts including select topics from chapters of the Red Book.	4
	5. Team leaders and members have training on self-care and stress management.	5
	6. Stated policy on prevention of sexual exploitation and abuse, including confidential reporting.	6
	7. Stated policy on reporting of breaches of conduct and abuse in the field.	7
	8. Profile for leaders and members written and communicated.	8
	9. If needed, arrangements with peer groups that have experience in conflict are in place and documented before and during deployments.	9
	10. A code of conduct is in place, understood, signed and adhered to by team members.	10
	11. Team evacuation protocols and plans are drafted and communicated (then customized for each deployment).	11
12. Protocols for family/significant other protocols are in place in case of harm, death, kidnap, disappearance, loss of communications and other severe circumstances.	12	

2.

Category	Check	X ✓
	13. Post-deployment medical and relevant psychosocial support are in place.	13
	14. Written policy as to duty of care towards local staff including protection, pay, insurance and training.	14
	In the field, for the medical team	
	15. Team leaders and members apply the duty of care principles during operations – applicable field checklists are part of the training and the kit.	15
IHL and Core Humanitarian Principles	For the organization	16
	16. Stated policy on compliance with IHL.	17
	17. Stated policy on compliance Core Humanitarian Principles (humanity, impartiality, neutrality, independence).	18
	18. Team leaders and members have received practical IHL training.	19
	19. Team branding: logos, attire, protective emblems for facility, personnel, vehicles are pre-agreed and printed with clear instructions to team leaders and team on proper use.	20
	20. Communications protocols (internal and external) are stated and agreed upon (including traditional and social media).	21
	21. Team leaders and members have training on community engagement techniques and approaches.	22
	22. Team leaders have training in humanitarian negotiations.	23
	In the field, for the medical team	24
	23. Team leaders and members commit to compliance with IHL and core humanitarian principles, including a mechanism to deal with breaches.	24
24. Team leaders to act as guardians, implementers, and influencers related to policies and approaches in this list, including a mechanism to deal with breaches.		
Safety, security and team well-being	For the organization	25
	25. Specifically written SOPs and protocols for safety and risk management in the field including critical incident management (CIM).	26
	26. Team leaders and members have received armed conflict and other insecure environments focused safety and security risk management training.	27
	27. Specific written policies on team and facility use of emblems and logos (context specific).	28
	28. Measures and supplies are in place for protection of the facility including fencing, hardening, fire extinguishers, sand bags, lighting and communications equipment.	29
	29. Signage – “no weapons” for facility and vehicles.	30
	30. Written policy on use of armed escorts and armed guards as option of last resort. (does not apply for military or civil defence teams).	31
	31. Medical evacuation protocols are in place and team understands how to activate (including headquarters staff).	

3.

4.

5.

Category	Check	X ✓
Safety, security and team well-being	32. MHPSS – specialized personnel screening and briefings for conflict response and training on coping.	32
	33. CBRN – context analysis plans, specialized training and specialized kits.	33
	In the field, for the medical team	
	34. Teams have a designated security focal point with special training and skills to liaison with armed actors.	34
	35. Formal commitments (including local staff) to adhere to security protocols where breaches will result in termination of field assignment and disciplinary action.	35
	36. CBRN precautions – plans for continuous monitoring, briefings and on-site drill/review for use of PPE, implement agreed plans (including managing rumours).	36
	37. MHPSS – monitoring of team coping and stress levels including in-field support as needed.	37
Coordination	For the organization	
	38. Team leaders and team members have received specific training on the importance and methods of coordination in armed conflict and other insecure environments.	38
	In the field, for the medical team	
	39. Mechanism to follow up and ensure contributions to coordination platforms, representation, and compliance when indicated, including precautions to avoid perceptions of bias and/or being party to the conflict.	39
SGBV and protection	For the organization	40
	40. Stated and communicated policy on management of SGBV in the field.	41
	41. Team leaders and members have received training to care for SGBV survivors including special considerations for children.	42
	42. SGBV and post-rape medical kit and supplies deployed to the field.	43
	43. Confidential documentation policy and field arrangements including informed consent forms.	44
	44. Team leaders and members have training on confidential advocacy and protection including how to manage media.	
	In the field, for the medical team	45
	45. Ensure team and local staff compliance with SGBV management with sensitivity to confidentiality, protection and local laws.	

6.

Category	Check	X ✓
Essential emergency clinical care	For the organization	
	46. The organization has specific modules appropriate for care of war-wounded and for general medical presentations expected for their deployment type.	46
	47. Medical team members have experience and credentials in their specialist area and have training and ideally experience in conflict injuries (when deploying as a TSP, Type 2 or Type 3, or specialist team for war wounded care).	47
	48. Teams have arrangements in place for consultation with other specialists such as tele-consultations in dealing with complex cases, especially those potentially requiring reconstruction and prolonged rehabilitation.	48
	49. Teams need to have the required staff and equipment/consumables to support patient rehabilitation not just their acute care.	49
	In the field, for the medical team	
	50. Teams and staff continue to act within their competency limits and refer patients as necessary and practicable. Teams should continue to advocate for patients and their right to care at escalating levels of complexity such as tertiary referral if required, no matter their background or side of the conflict.	50
	51. Despite the conflict setting, teams continue to respect and support national health services and staff, if possible, helping train local staff to replace international staff functions and to continue to use local protocols and standards far as possible and appropriate for patient safety and continuity of care.	51
	52. Teams respect the wishes of patients who chose to remain rather than accept referral due to fear or threat. Special efforts and novel clinical solutions may need to be found using virtual support from other teams in country or outside, protecting patient confidentiality throughout.	52

7.

Operations	For the organization	
	53. Capacity to analyse and assess context of deployment, own readiness and fitness for task, risk preparedness, legal implications, funding and resources.	53
	54. Kits and supplies for self-sufficiency up to determined duration of response.	54
	55. Kits and supplies for self-sufficiency up to determined duration of response.	55
	56. Special patient documentation kits with confidentiality and anonymity.	56
	57. Team composition plans account for gender/cultural sensitivity.	57
	58. Policy on team rotations (written and communicated).	58
	59. Check readiness on: power, lighting, water, sanitation, shelter, waste, IT, kitchen, laundry, climate control, cold chain and sterilization, including physical protection measures that may be needed in the field.	59
	60. Policy and logistics for resupply.	60
	61. Dead body management training and specialized kits.	61

8.

Category	Check	X ✓
Operations	In the field, for the medical team	
	62. Detailed knowledge with the relevant modules, kits and supplies.	62
	63. Attitude and capacity for field conduct and behaviour to treat all locals with dignity, respect, civility and empathy.	63
	64. Ability to manage conflict and ethical dilemmas within the team, and with other teams.	64
	65. Training of members in technical, safety/security and resilience courses/modules relevant to the assigned roles and context.	65
Other considerations	For the Organization	
	66. Clear policy and guidance as to media (local and international) communications content, focal points, and issues management, including all forms social media.	66
	In the field, for the medical team	
67. Clear field policy and guidance as to media (local and international) communications content, focal points in the team, communications with headquarters, coordination with other teams and issues management, including all forms social media.	67	

Annex 2. Summary guide to deployment and operations ⁽¹⁶¹⁾

For organizational and field team leaders to consider.

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

Annex 3. SGBV essential equipment, medicines and other supplies for examination

Medical teams will also need to ensure that they have all core requirements for examination and treatment of victims/survivors of sexual violence: male, female, both adult and children. Below is a checklist of these essential items (those with an asterisk are minimum requirements).

Checklist of requirements for providing quality clinical care for survivors of rape and intimate partner violence (IPV)	
1. Protocol	Available?
Written medical protocol in the language of the provider*	
2. Personnel (pay attention to gender)	Available?
Trained (local) health-care professionals (where possible, it is ideal to have an on-call system 24 hours a day, 7 days a week)*	
A female health-care provider who speaks the same language as the survivor is optimal. If this is not possible, a companion of choice or another female health/social worker should be in the room during the examination* (male survivors may prefer male professionals).	
3. Furniture/setting	Available?
A clean, quiet, child-friendly, accessible consultation room, with access to a toilet or latrine, and with a door, curtain or screen for visual privacy.*	
An examination table*	
Light, preferably fixed (a torch may be threatening for children)*	
A magnifying glass (or colposcope)	
Access to an autoclave to sterilize equipment*	
Access to laboratory facilities/microscope and a trained technician	
Weighing scales and a height chart for children	
4. Supplies	Available?
Speculums* (only adult sizes)	
Tape measure or ruler for measuring the size of bruises, lacerations, etc.*	
Syringes/needles* (butterfly type for children) and tubes for collecting blood	

Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)*	
Resuscitation equipment*	
Sterile medical instruments (kit) for repair of tears, and suture material.*	
Tongue depressor (for inspection of oral frenulum and injury)	
Cover (gown, cloth, sheet) to cover the survivor during the examination*	
Spare items of clothing to replace those that are torn or taken for evidence.	
Sanitary supplies (disposable or cloth pads)*	
Pregnancy tests	
Pregnancy calculator disk to determine the age of a pregnancy.	
Additional supplies that may be needed for forensic evidence collection/documentation	
Comb for collecting foreign matter in pubic hair	
Cotton-tipped swabs/applicators/gauze compresses for collecting samples	
Glass slides for preparing wet and/or dry mounts (for sperm)	
Laboratory containers for transporting swabs	
Paper sheet for collecting debris as the survivor undresses	
Paper bags for collection of evidence	
Paper tape for sealing and labelling containers/bags	
5. Drugs (with age-appropriate dosages)	Available?
For treatment of STIs as per country protocol*	
For post-exposure prophylaxis of HIV transmission (PEP)*	
Emergency contraceptive (EC) pills* and/or copper-bearing intrauterine device (IUD)	
Tetanus toxoid, tetanus immunoglobulin*	
Hepatitis B vaccine*	
Pain relief* (e.g. paracetamol)	
Anxiolytic (e.g. diazepam)	
Sedative for children (e.g. diazepam)	

Local anaesthetic for use when suturing*	
Antibiotics for wound care*	
6. Administrative supplies	Available?
Medical consultation form including chart with pictograms*	
Medical certificate/medico-legal forms	
Referral directory	
Job aids in the language of the provider (e.g. care/treatment algorithm, referral flow chart).	
Consent forms*	
Information pamphlets for post-rape care (for the survivor)*	
Safe and locked filing space to keep records confidential, or password-protected computer for electronic files.*	

Annex 4. Post-rape physical examination checklist

Look at all the following	Look for and record
Physical examination checklist	
<ul style="list-style-type: none"> • General appearance • Hands and wrists, forearms, inner surfaces of upper arms, armpits • Face, including inside of mouth • Ears, including inside and behind ears • Head • Neck • Chest, including breasts • Abdomen • Buttocks, thighs (including inner thighs), legs, feet 	<ul style="list-style-type: none"> • Active bleeding or fresh wounds • Bruising • Redness or swelling • Cuts or abrasions • Evidence that hair has been recently pulled out, and evidence of recent loss of teeth • Injuries such as bite marks, or stabbing or and gunshot wounds • Evidence of internal, traumatic injuries to the abdomen • Ruptured ear drum
Genito-anal examination checklist	
<ul style="list-style-type: none"> • Genitals (external) • Genitals (internal examination, using a speculum) • Anal region (external) 	<ul style="list-style-type: none"> • Active bleeding or fresh wounds • Bruising • Redness or swelling • Cuts or abrasions • Foreign body presence

Annex 5. Concepts of challenges and dilemmas

See CCHN <https://www.icrc.org/en/publication/nh-cchn-negotiator-handbook>

Concepts of challenges and dilemmas

The capacity to perform medical humanitarian action in a safe and secure manner requires some degree of negotiation whether with high authorities or family members or even one's self, which is often not straightforward.

Proper categorization of events may be helpful in navigating the tensions that may come up in humanitarian negotiations, the distinction between challenges and dilemmas has been used to assist medical humanitarian actors move from possible paralysis to action, as each somehow implies a different reaction and response.

Challenges have been defined as the specific obstacles or barriers that constrain the overall process and are managed by directly or indirectly addressing that inhibiting factor. It calls for mitigation strategies.

Dilemmas on the other hand poses a choice, which sometimes can seem to be an impossible one to make. At the heart, it is an issue of norms vs pragmatism. Addressing it requires one to make a conscious choice, which may often demand making a compromise.

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Chapter

The Sphere Handbook, 2018; <https://www.spherestandards.org/handbook-2018/>

(see mental health section in health chapter: e.g. coordinate, assess, mental health in general health care, PFA, community engagement, psychological interventions, harm reduction, institutions support)

The Interagency Emergency Health Kit 2017; <https://www.who.int/medicines/publications/emergencyhealthkit2017/en/>

WHO Mental Health in emergencies; <https://www.who.int/en/news-room/fact-sheets/detail/mental-health-in-emergencies>

WHO Ensuring a coordinated and effective mental health response in emergencies; https://www.who.int/mental_health/emergencies/en/

6. Classification and Minimum Standards for Emergency Medical Teams (add hyperlink to Blue Book <https://extranet.who.int/emt/guidelines-and-publications>)





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