Health protection in armed conflicts

by Dr. Rémi Russbach

1. Introduction

Armed conflicts always have dire effects on the health of the civilian population. Apart from the harm — wounds, burns, asphyxia and radiation — caused directly by weapons of war, the people fall prey to disease because of the disruption of their normal living conditions.

In most cases, it is the latter rather than the former which takes the greatest toll.

Some basic health protection principles are therefore common to all development and disaster situations.

These are to be found first and foremost in the relationship between a group of individuals and the environment in which they are living, as it is this environment that will determine the type of risks and problems the community will have to face.

Hence a knowledge of the area and its inhabitants is essential in determining priority measures to protect the health of the greatest number of people.

This strategy has proved its worth; it goes beyond individual medical care in that its preventive effect affords long-term protection to the community as a whole.

Cleaning up the environment, protecting water sources, controlling disease vectors (insects, rodents, etc.) and developing an agricultural and economic system that gives everyone access to food may be the courses of action that an expert in public health would propose after having studied the health situation of a population at risk.

Although today this community approach is fully appreciated and accepted in most cases, it may be misunderstood by the victims if it is not accompanied by curative activities.

Indeed, the demand for medical care is mainly individual and personal and it has to be explained why the common interest takes precedence.

It may happen that those in charge of dispensing medical aid, with limited resources at their disposal, make poor use of those resources, neglecting the interests of the community in general to concentrate on a few individual cases. This indicates a lack of understanding of the problem and the remedy is improved training of medical aid officials.

In the event of *natural disasters*, the victims are initially going to be subject to physical injury, depending on the nature of the disaster. Floods cause death by drowning, volcanic eruptions result in burns and asphyxia, in earthquakes people are crushed, etc.

However, once this initial phase is over, the people who have to live in the devastated area or are obliged to flee will find themselves in an environment harmful to their health. To protect them, the basic principles outlined above must be taken into consideration and emergency action must be taken.

As is the case for industrial disasters, the time factor and logistics are the main constraints.

Difficulty in gaining access to victims, hostility on the part of the authorities and the politicization of aid, which are the major constraints during conflicts, are not usually serious stumbling-blocks in other situations.

To safeguard the health of the civilian population in an armed conflict, the first step is to identify the main problems and the many constraints that make any kind of assistance difficult in such situations.

2. Effects of war on health and on medical services

When a conflict situation escalates into all-out war, the social and economic balance is suddenly disrupted and priorities and values undergo a fundamental change. Everything is geared towards the war effort; non-participants find themselves without support from the authorities. Those who were already living in precarious circumstances before the events become much more vulnerable and risk losing what they need to remain in relatively good health, or even to survive.

Certain ethnic or political groups become suspect in the eyes of the authorities, which will not only deprive them of the protection to which they are entitled but also consider them as potential enemies. They then risk being persecuted without having any possibility of finding protection elsewhere.

In situations of internal armed conflict, the civilian population is often caught in a trap. Families whose only aspiration is to live a quiet life find themselves forced to abandon their land after having been held to ransom by one party and accused of collaboration by the other. As a result they lose their livelihood and their health suffers accordingly.

The population movements prompted by such a complex and hopeless state of affairs themselves represent a major threat to health, since they are always accompanied by serious damage to the environment in which essentially vulnerable people are living.

When war is raging and health problems directly related to the situation get out of hand, the crisis is compounded by wounds caused by bullets, fragments, mines and all other kinds of deadly devices. The medical services, generally disorganized and partly destroyed, are then overwhelmed by the number of wounded and sick.

For in wartime, when the health services should be able to cope with many more patients, they are often themselves on the point of collapse. When hospitals are damaged or destroyed, fewer beds are available. Power cuts bring hospital services to a halt (lighting, ventilation, lifts, sterilizers, etc.). Water shortages seriously disrupt the medical care system and cause insuperable hygiene problems. Furthermore, there may not be enough medicines and medical equipment to provide the most basic treatment.

In such circumstances even the most highly motivated health workers will be disheartened. A stage is reached where conditions become too dangerous, salaries cease to be paid and work is abandoned.

The breakdown of communications and the hazards of travelling prevent patients from reaching health centres and most of them find themselves without any medical care.

All public health programmes, vaccinations, maternal and child health care and campaigns to control major endemic diseases grind to a halt in the same way as the curative services and this in turn leads to an increase in the incidence of disease.

In extreme cases, chaos reigns when all facilities are destroyed and no single authority is in charge; power is split up between small groups that indulge in plunder and arbitrary violence among themselves and against the people.

3. What must be done to safeguard health

This is the type of situation in which humanitarian organizations are called upon to work and it is easy to imagine how difficult and frustrating their task can be, for the resources available are quite insignificant in comparison with the vast range of health problems to be tackled.

Whatever the resources mobilized, humanitarian organizations and agencies specializing in health matters must realize that they could never do everything that needs to be done because of the insurmountable obstacles in the way of aid activities. Yet they must endeavour to take pragmatic and sympathetic action to help those who are suffering the tragic effects of war.

As a neutral and independent organization, the ICRC has a very special part to play in health protection during armed conflicts. The mandate conferred upon it by the States party to the Geneva Conventions and their Additional Protocols, its right of initiative and its role as a neutral intermediary enable it to approach health problems from many different angles and to go beyond the traditional forms of medical assistance which other organizations are also in a position to provide.

The ICRC may adopt various approaches to safeguard the health of victims of armed conflicts:

- direct medical action;
- material assistance and moral support;
- negotiation.

In practice, medical activities often involve all three elements.

Direct medical action is taken when expatriates have to be brought in, either because there are not enough local staff or because neutral personnel are necessary to gain the confidence of the various parties to the conflict.

These operations are planned on the basis of the most urgent needs observed and various means may be deployed. For example:

— war surgery units;

— dispensary teams;

— teams responsible for nutritional surveys and distributing food aid;

— teams in charge of environmental sanitation or water supply programmes;

— teams in charge of orthopaedic rehabilitation programmes.

In such cases the programmes are set up by expatriate specialists, most of whom are seconded to the ICRC by the National Red Cross and Red Crescent Societies. Locally recruited staff play a considerable part in these activities; indeed, for every expatriate ten people are engaged locally to work in the ICRC's medical projects.

We shall not describe activities of this type in further detail here, as they are dealt with elsewhere in this issue.

Material assistance and moral support have proved their worth and yield spectacular results using a small number of personnel. They involve identifying local resources which might be restored with a minimum of external aid and might improve the health of the population.

Sometimes, by donating vital materials and equipment and providing encouragement, facilities such as hospitals, water-pumping stations or pharmaceutical factories, systems for evacuating the wounded or national public health programmes can be repaired or restored, or at least saved from dereliction.

Here the ICRC acts as a catalyst, by enabling local services to function independently with a modest amount of aid and psychological support which gives new courage to those who had given up hope.

The impact of this kind of work goes far beyond the health sphere. The realization that parts of the infrastructure can be made to work again may lead to other indispensable activities being resumed and constitute the first step towards the country's economic recovery.

Negotiating health protection measures with the authorities is one of the ICRC's more specific tasks, and one which can be of the greatest benefit to the health of vulnerable groups.

ICRC delegates, when conducting negotiations with the authorities about problems concerning prisoners of war, displaced people, or access to conflict zones, raise fundamental issues to which those in power cannot remain indifferent and which, if settled, can have a decisive influence on the destiny of entire populations.

In such discussions, ICRC delegates base their arguments on the Geneva Conventions and their Additional Protocols. The provisions of

these treaties, if respected, afford entirely satisfactory protection for the victims of armed conflicts and especially for their health.[1, 2]

Negotiations of this kind may lead to more effective and lasting measures for protecting community health than direct medical action or material assistance and moral support. Agreements to call a truce, lift a blockade, allow farmers to return to their fields, or guarantee due respect for hospitals and medical personnel can have far-reaching effects at little cost.

In conflict situations ICRC doctors and health personnel are in a unique position. Their professional expertise inspires respect and confidence and they are not involved in the conflict. They constitute an external point of reference which helps those caught up in the hostilities to regain a sense of perspective. This external point of reference, provided by people who have chosen to work in such circumstances, introduces a dimension other than that of force and violence; it generates a collective awareness which in turn can lead to a resurgence of the fundamental, universal humanitarian values that become obscured in the heat of war.

This restoration of humanitarian values can resolve certain situations which are very damaging to health, and give new courage to local health staff demoralized by the events.

Some examples:

- A good illustration of this approach was the action taken by the ICRC to reactivate the hospital in Jaffna, ***Sri Lanka.*** This 1,100-bed hospital could no longer function because it was in a zone battered by the conflict between government troops and Tamil rebel movements.

Since neither patients nor medical personnel could reach the hospital, they had to use a small, private institution which had inadequate facilities to cope with the wounded and sick from the Jaffna region.

By negotiating with the parties concerned, the ICRC succeeded in reaching an agreement whereby free access to the hospital and proper protection were guaranteed for patients and medical staff.

[1] J. J Surbeck and R. Russbach, "Le Droit International Humanitaire et la protection de la santé", *Revue Québecoise de Droit international*, Vol. 2, 1985, pp. 155-193.

[2] A. Baccino-Astrada, *Manual on the rights and duties of medical personnel in armed conflicts*, ICRC-League, Geneva, 1982.

At the outset the mere presence of four ICRC medical delegates and nurses gave new confidence to the hospital staff, who even ferried them from their homes to their place of work in vehicles marked with the red cross emblem. The delegates also protected convoys of medical supplies and medicines sent in by the Ministry of Health in Colombo.

After a few days the hospital began to function normally, thanks to four expatriates. Now, with local resources, it can cope with problems which humanitarian organizations would certainly not have had the means to handle on a long-term basis.

- Another example of what can be achieved by negotiation occurred in Santa Cruz, ***El Salvador.*** An entire region was without safe water because the water supply system had broken down in an area inaccessible to government services.

The ICRC succeeded in gaining assurances that the army would not harass the company repairing the water distribution system. The supply of drinking water was thus restored, with obviously beneficial effects on the health of the region's inhabitants.

- ICRC surgical work in ***Afghanistan*** furnishes yet another example.

For several months, ICRC medical personnel were able to evacuate the wounded from rebel-held territory to capital, Kabul, where they were treated before being taken back across the front line. This was achieved by means of constant negotiations with the various parties involved.

4. Constraints

The numerous constraints inherent in situations of armed conflict make it very difficult to safeguard the health of the population.

Among the most serious is the ***difficulty in gaining access*** to the victims, because it holds up every phase of the operation, from the initial assessment right up to the end result.

What can be done to gain this direct access, without which no effective help is possible? The problem can only be solved by negotiations with the military and political authorities; provided, however, that they realize they are not losing any military or political advantage by giving outside organizations access to the victims.

The ICRC's neutrality and impartiality, if clearly explained to the authorities, will win their trust and make it easier to reach the victims wherever they are.

The persuasiveness of arguments based on the Geneva Conventions and their Additional Protocols varies enormously depending on the position of the people being approached.

It is generally the least privileged section of the population that is the most difficult to reach. In some situations the social system raises serious obstacles; the ICRC cannot gain access to people at the bottom of the social scale without going through those in power who govern — and even exploit — them.

Thus a thorough knowledge of social structures in the area is necessary to have any chance of success in helping the weakest.

External constraints may also seriously hinder efforts to protect health.

For example, an international embargo may hamper the dispatch of certain articles which are essential to health although not classified as medical and pharmaceutical products (e.g., items needed to supply drinking water or energy to medical centres, to transport the wounded and sick, etc.).

Media overreaction to certain situations may also disrupt medical relief work by triggering a disproportionate response on the part of the donors; this too is a kind of constraint that can hamper the smooth running of a programme.

Indeed, the dispatch of excessive amounts of non-essential supplies or large numbers of untrained personnel may stall the entire health protection system, divert efforts from priority activities and generally make the situation worse. Specialists in disaster relief are well aware of this phenomenon, which could be avoided by educating the public and the media to react in a reasonable and controlled manner to emergency situations.

Lack of financial, material and human resources also represents a considerable constraint, especially when armed conflict breaks out in an impoverished area.

5. Conclusions

Health protection during armed conflicts is a priority, because war always leads to a deterioration in living conditions and upsets the social and economic balance. Both these phenomena have grave effects on health: armed conflicts can plunge entire populations into poverty and disease and, for the most vulnerable, death is often inevitable.

If they were respected at all times by belligerents, the Geneva Conventions and their Additional Protocols could go a very long way towards protecting health.

An effort must therefore be made to ensure that existing law is applied more effectively before planning new conventions.

Outside aid must be based on a permanent assessment of needs, and the means deployed must be tailored to the priorities observed in order to make optimum use of the resources available.

Health protection is everyone's responsibility and local communities must play a part, with the support of outside organizations at various levels.

The different courses of action must complement each other. Since external resources in terms of qualified personnel and equipment are limited, efforts should focus on developing the role of "catalyst", which encourages local activities, and of negotiator, which can help victims gain access to vital resources.

In our view, the future of health protection for victims of armed conflict lies in this type of activities.

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Dr. Russbach was appointed Chief Medical Officer of the ICRC and Head of the Medical Division, which he founded, in 1977. In 1986 he set up the training course entitled Health Emergencies in Large Populations (HELP). He has been Vice-President of the International Society for Disaster Medicine (ISDM) since 1987.