Policy Document

Healthcare in Conflict Zones policy

Background

The Australian Medical Students' Association (AMSA) is the peak representative body for medical students in Australia. AMSA believes that all individuals should have the right to the best attainable health care, including in conflict zones, which can dramatically affect the availability and quality of care. Accordingly, AMSA advocates on issues that impact health outcomes both domestically and internationally.

Conflict is a seemingly constant presence in the contemporary world. It is often motivated by geo-political, social, economic, environmental, ethnic or religious reasons, all of which can also exacerbate existing conflict [1,2]. A conflict zone is here defined as any area experiencing a period of armed conflict between two or more organised groups, governmental or non-governmental. The geographical designation of a conflict zone depends on areas affected by armed violence. Similarly, the temporal characteristics of conflict zones vary greatly; currently, conflicts that have spanned decades are contrasted by relatively short-term examples. Importantly, conflict zones encompass areas experiencing periods of threatened violence in addition to discrete events of armed violence. Accordingly, the challenges of delivering healthcare in conflict zones can be viewed from two perspectives. Firstly, managing the provision of healthcare services in the immediate response to discrete events of armed violence. Secondly, the challenges associated with the ongoing provision of healthcare services due to compromised social, economic, governmental and infrastructure services. This policy will aim to address this biphasic view of conflict.

Short-term effects of conflict on health care

The acute consequences of war and conflict on health care are extensive. These include direct attacks on health care services as well as secondary effects causing barriers to health care access. Attacks on health care services represent an acute consequence of conflict. They prevent the adequate provision of healthcare to the community and directly threaten the wellbeing of health care personnel. The frequency of such attacks is difficult to document for a range of reasons. However, WHO compiles existing information each quarter to estimate the global incidence of attacks. Between 2014 and 2015 there were an estimated 595 attacks resulting in 959 deaths and 1561 injuries. The vast majority of these attacks targeted health care facilities as well as health care personnel. Both state and non-state actors in regions of conflict and political unrest have been responsible for such attacks [3-5]. A pertinent example is the attack on a

AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Head Office
42 Macquarie Street,
Barton ACT 2600

ABN 67 079 544 513

Email info@amsa.org.au
Web www.amsa.org.au
Twitter @yourAMSA

Medecins Sans Frontieres Hospital in Kunduz, Afghanistan in 2015 perpetrated by the United States Air Force; 42 medical personnel were killed [6]. In addition to direct attacks on healthcare services, there are secondary consequences. It may not be safe for workers to remain in the facility and they may be forced to withdraw; the wounded and sick may be afraid to seek health care for fear of becoming victims of such violence; and equipment and infrastructure, ranging from ambulances to basic utilities such as water and electricity which are required for the facilities to function may be damaged. The delivery of vital preventive health care may also be impacted, which can have future impact on population well-being [7-9]. In addition, violence against and impedance of medical vehicles prevent the sick and wounded from accessing timely medical care. These have a devastating impact: for example, during the protracted conflict in the Democratic Republic of Congo, a denial of medical care is estimated to have resulted in nearly 40,000 easily preventable deaths per month [10].

Long-term effects of conflict on health care

The aftermath of conflict also presents a unique set of health care concerns. The consequential loss of infrastructure places the populations of these post-conflict zones at significant risk [11]. Infant, child and maternal mortality (key indicators of population health) in these zones can remain at wartime levels due to reduced access to power, clean water, sanitation and healthcare infrastructure and workers [12]. Provisional support can be provided by foreign states and aid organisations to support local governments during acute periods of post-conflict recovery. However, in low-income countries, the long-term restoration of infrastructure and replenishment of healthcare personnel is often limited. States with fragile healthcare systems that are unable to meet the basic health care demands of their populations are susceptible to disease outbreak and continued poverty [13]. Guinea, Liberia and Sierra Leone demonstrate the severity of this risk; all suffering from recent civil wars which have had profound impacts on their health system infrastructure [14]. Ebola outbreaks that arose within these countries following conflict in each nation were attributed to a significant extent to weakened healthcare systems [15]. The spread of Ebola consequently presented an international infectious risk, prompting WHO to declare a public health emergency of international concern [16]. In response to conflict, it is essential that external humanitarian programmes function in a collaborative and structured sense in order to provide support to vulnerable populations, and supplement the capacity of local governments.

Syrian War

The Syrian War is illustrative of healthcare systems destroyed and exploited in the crossfires of conflict. In 2016, conflicts in Syria amounted to 69% of attacks on health care globally [29], highlighting the crippling impact state and non-state actors have on healthcare provision. Since the Syrian War first began, political conflict has escalated into a civil war involving a number of stakeholders including the incumbent government, rebel militia, religious groups, and other, external parties [15]. The civilian population has experienced devastating losses;

300,000 people have died and 1.5 million people have been injured, whilst more than 6 million people have been forcibly displaced [16]. Since the war began, there have been armed and chemical attacks on social infrastructure and health care facilities. Much of Syria has developed into a complicated and divided battleground, with certain areas detached from essential services such as clean water, food, education and shelter. The humanitarian response, coordinated by the United Nations Office for Coordination of Humanitarian Affairs (UNOCHA), has predominantly included food aid, medical supplies and vaccinations. The provision of healthcare has been significantly compromised by repeated attacks on health care infrastructure alongside social and economic services, which have prevented the delivery of essential services [17].

Legal issues in conflict

The protection of health care workers, patients and infrastructure in conflict zones is largely governed by International Humanitarian Law (IHL). IHL is a body of law applicable in armed conflict which seeks to protect those who are not or no longer actively participating in hostilities [19]. However, breaches frequently occur. This is often attributed to the lack of a centralized authority of international law enforcement. Treaty law mainly draws from the 1949 Geneva Conventions and their additional protocols of 1977. Under treaty law, protection of health care workers in areas of armed conflict is specifically provided for by the First, Second and Fourth Geneva Conventions. Together, the conventions call for the respect and protection of medical personnel involved in searching for, transporting or treating the wounded and ill whether they are civilians or involved with armed forces [20]. The red cross, red crescent or red crystal emblems are identified as non-participants in conflict and are therefore not to be targeted. The code of medical ethics during times of conflict is no different than during times of peace and medical professionals are to be impartial and discriminate only on the basis of medical need [21-22].

A critical focus of doctors and other health care workers in conflicts is to preserve and save life. Unfortunately, incidental and deliberate attacks on health care professionals, patients and health infrastructure are increasing [25]. Combined with the long-term effects of conflict on the environment, infrastructure and health, both domestically and internationally, a new approach is needed regarding how Australians and health professionals view war, as is increased scrutiny on how IHL is implemented. Health care in conflict zones represents the complex interplay between politics, culture, and medicine. The impact of conflict on health care can broadly be considered in terms of the acute phase and chronic phase. In the acute phase, health care services are directly threatened and the provision of care to affected communities is significantly compromised. In the longer term, the destabilising of government authority, social infrastructure, and the economy due to conflict, collectively undermine health outcomes and healthcare services.

Position Statement

AMSA believes that:

1. Violence against healthcare workers, patients and infrastructure in conflict zones is unacceptable, and constitutes a war crime;
2. Physicians, who act in conflict have an ethical obligation to provide impartial medical care in times of conflict;
3. Medical Students' Associations, either directly or as members of the International Federation of Medical Students' Associations, can support efforts to ensure all people in conflict zones have adequate and safe access to health care through support of, and participation in international community networks;
4. International groups and states must work towards preventing violence against health care and enforcing IHL;
5. The Australian Government should work towards supporting conflict resolution.

Policy

AMSA calls upon:

1. Health care professionals to:
    a. Adhere to international conventions on human rights and international humanitarian law;
    b. Act in areas of conflict in accordance with the International Code of Medical Ethics (WMA). In particular, provide medical attention indiscriminately, regardless of sex, gender, political affiliation, race, nationality, social views, whether civilian or combatant, with distinction made only for medical need;
    c. Preserve patient confidentiality unless a patient poses a significant risk to other individuals;
    d. Ensure to the best of their ability and circumstances, the quality of medicine and other medical materials that they administer;
    e. Lobby governments and authorities to provide infrastructure that is vital to health, including clean water, food and shelter;
    f. Condemn and not facilitate or participate in the practice of torture or any form of cruel, inhumane or degrading treatment;
    g. Ensure that the privileges afforded to medical professionals in times of conflict, such as access to health care facilities and resources, are used solely for healthcare purposes;
2. Providers of medical education and medical students to:
    a. Provide students with opportunities for IHL training;
    b. Provide students with the opportunity to learn about the adverse effects of conflict on provision of healthcare services;

c. Advocate against attacks on health care workers, facilities, and patients in whatever capacity and streams are appropriate;

3. The Australian federal government to:
    a. Adhere to international conventions on human rights and international humanitarian law, in particular, implement UN Security Council Resolution 2286 and all previously adopted Security Council resolutions on protection of civilians in armed conflict;
    b. Discourage misuse and appropriations of the red cross, red crescent or red crystal symbols within Australia and worldwide as per the Geneva Conventions Act;
    c. Take steps to improve international relations and Australia's diplomatic corps to reduce incidents of conflict;
4. Actors (state and non-state) involved in conflict to:
    a. Adhere to international conventions on human rights and international humanitarian law;
    b. Allow consistent and safe entry and delivery of humanitarian aid in areas of conflict;
    c. Identify and protect internationally recognised symbols including the red cross, red crescent or red crystal;
    d. Investigate acts of violence against healthcare and collect data relating to these incidents;
    e. Avoid use of weaponry which does not comply with principles of IHL or comply with agreed and ratified conventions (cluster bomb convention, Ottawa Treaty) with regards to the use of weaponry;
    f. Promote the functions of the International Criminal Court to take and support appropriate action to prosecute individuals for crimes relating to violence against health care.

References

1. Stewart F. Root causes of violent conflict in developing countries. BMJ. 2002;324(7333):342-5.
2. Reynal-Querol M. Ethnicity, Political Systems, and Civil Wars. Journal of Conflict Resolution. 2002;46(1):29-54.
3. International Committee of the Red Cross. Health Care in Danger - violent incidents affecting the delivery of health care. 2014 [cited 2015 May 1]; Available from: https://www.icrc.org/eng/assets/files/publications/icrc-002-4237.pdf.
4. 4.Centre for Research on the Epidemiology of Disasters CRED. People Affected by Conflict - Humanitarian needs in numbers. 2013 [cited 2015 April 20]; Available from: http://www.cred.be/publication/people-affected-conflict-humanitarianneeds-numbers.
5. World Health Organization. WHO condemns rising violence against healthcare workers, patients. 2014 [cited 2015 March 30]; Available from: http://www.who.int/hac/events/HCWviolence/en/.

6. MSF Kunduz Hospital Airstrike
Available from: http://www.msf.org/en/topics/kunduz-hospital-airstrike
7. International Committee of the Red Cross. Humanitarian Law, Human Rights and Refugee Law - Three Pillars. 2005 [cited 2015 April 6]; Available from: https://www.icrc.org/eng/resources/documents/statement/6t7g86.htm.
8. International Committee of the Red Cross. Customary international humanitarian law. 2010 [cited 2015 April 8]; Available from: https://www.icrc.org/eng/warand-law/treaties-customary-law/customary-law/overview-customary-law.htm.
9. International Committee of the Red Cross. Practice Relating to Rule 25. Medical Personnel. 2015 [cited 2015 April 20]; Available from: https://www.icrc.org/customary-ihl/eng/docs/v2_rul_rule25.
10. Webster, P.C., The deadly effects of violence against medical workers in war zones. Cmaj, 2011. 183(13): p. E981-2.
11. Balalian, A.A., Simonyan, H., Hekimian, K. and Crape, B., 2014. Adapting continuing medical education for post-conflict areas: assessment in Nagorno Karabagh-a qualitative study. Human resources for health, 12(1), p.39.
12. Rubenstein, L.S., 2011. Post-conflict health reconstruction: search for a policy. Disasters, 35(4), pp.680-700.
13. Haar, R.J. and Rubenstein, L.S., 2012. Health in fragile and post-conflict states: a review of current understanding and challenges ahead. Medicine, Conflict and Survival, 28(4), pp.289-316
14. Boozary, A.S., Farmer, P.E. and Jha, A.K., 2014. The Ebola outbreak, fragile health systems, and quality as a cure. Jama, 312(18), pp.1859-1860
15. Shoman, H., Karafillakis, E. and Rawaf, S., 2017. The link between the West African Ebola outbreak and health systems in Guinea, Liberia and Sierra Leone: a systematic review. Globalization and Health, 13(1), p.1
16. WHO: Key Events in the WHO response to the Ebola outbreak, January 2015
Available at: http://www.who.int/csr/disease/ebola/one-year-report/who-response/en/
17. Reisch, N., & Kretzmann, S. (2008). A climate of war. The war in Iraq and global warming, Report by Oil Change International.
18. Military Balance 2016. Arundel House, Temple Place, London, UK: Routledge for International Institute for Strategic Studies, 2016. Print. {cited 2016 August 18]
19. Sidel, V. W., & Levy, B. S. (2008). The health impact of war. International journal of injury control and safety promotion, 15(4), 189-195.
20. Library Council of New South Wales. Implementation and enforcement of IHL. 2012 [cited 2015 April 20].

21. World Medical Association. WMA International Code of Medical Ethics. 2006 [cited 2015 March 30]; Available from: http://www.wma.net/en/30publications/10policies/c8/.
22. World Medical Association. WMA Regulations in Times of Armed Conflict and Other Situations of Violence. 2012 [cited 2015 March 30]; Available from: http://www.wma.net/en/30publications/10policies/a20/.
23. 23. 2016 Defence White Paper (PDF). Australia: Commonwealth of Australia. 2016. p. 20. ISBN 978-0-9941680-5-4. http://www.defence.gov.au/whitepaper/Docs/2016-Defence-White-Paper.pdf
24. F, Sam P. "The Opportunity Cost of World Military Spending." SIPRI. N.p., 5 Apr. 16. Web. 18 Aug. 2016.
25. International Committee of the Red Cross. Health Care in Danger Report: The untold suffering. 2015 [cited 2015 March 31]; Available from: https://www.icrc.org/en/document/health-care-danger-what-will-it-take.
26. International Committee of the Red Cross. International criminal justice: The institutions - Factsheet. 2013 [cited 2015 May 2]; Available from: https://www.icrc.org/en/document/international-criminal-justice-institutions.
27. International Criminal Court. About the court. 2015 [cited 2015 April 7]; Available from: http://www.icccpi.int/en_menus/icc/about%20the%20court/Pages/about%20the%20court.as px
28. International Committee of the Red Cross. Domestic Normative Frameworks for the Protection of Health Care. 2015 [cited 2015 April 15]; Available from: https://www.icrc.org/eng/resources/documents/publication/p4215.htm
29. WHO.int. (2016). *Attacks on Health Care Dashboard*. [online] Available at: http://www.who.int/emergencies/attacks-on-health-care/attacks-on-health-care-2016.pdf?ua=1 [Accessed 27 Jun. 2017].

Appendix

Background: Health provision and War laws

Implementation of customary law and treaty law is problematic for several reasons. There is no centralised authority of law enforcement, so there is wide variation in how IHL disputes are settled between involved parties [19]. The primary responsibility for implementing IHL lies on individual states, which are required to investigate and prosecute war crimes committed by their nationals or military or within their territory [20]. Wars are increasingly being fought within, rather than between, countries with clearly defined front lines, making it more difficult for IHL to be enforced. This is exemplified in the case of crimes being committed by a State against its own citizens. Without approval of the United Nations Security Council, other states are unable to directly interfere in such civil conflicts as each nation has its right to sovereignty in the practice of its own laws [19].

The International Criminal Court (ICC) was founded in 1998 as an intergovernmental justice system to that of individual nations in order to address cases where a State is unable or unwilling to prosecute a war crime in its jurisdiction [20, 21]. The ICC can only intervene in States party to the Rome Statute of the ICC. Australia is one of these states. However, the primary responsibility for enforcing IHL still lies on each individual State.
The ICRC has sought to raise awareness as well as provide solid statistical data on these issues through the release of their Health Care in Danger report in 2015, which outlines violence against health care workers and its ramifications in 11 countries [22]. It urges states, armed carriers, the healthcare community and all other relevant parties to implement measures to improve the protection of safe, secure, impartial and efficient health care in armed conflict and other emergencies [22]. Recommendations for States on how to implement such measures are outlined in the ICRC Domestic Normative Frameworks for the Protection of Health Care publication, released in 2015 [23]. There is a particular focus on legal protection for patients and health personnel and facilities as well as medical ethics, and how to effectively enforce IHL.

Policy Details

Name: Healthcare in Conflict Zones policy
Category: G – Global Health policies
History: Adopted, Council 2 2015
Reviewed, Council 2 2017

T. Tan, A. Keen, V. Pillutla, C. Lee, A. Rottler, P. Walker