The International Committee of the Red Cross and Health

The ICRC Medical Division, established in November 1977, works for the war wounded, for prisoners, for the civilian population and for the war disabled. Its essential purpose is to keep the victims alive, alleviate their suffering and prevent their sicknesses or wounds from ruining the rest of their lives.

In his summary of ICRC activities during his term of office, (1976-1987) President Alexandre Hay said last May, "The medical sector, completely embryonic when I arrived, has developed considerably and has now achieved a highly praiseworthy quality and dimension. The ICRC and the victims of conflicts owe a great deal to the spirit of initiative, devotion and competence of its doctors".

The **Review** *is particularly pleased to publish the following article by Dr. Rémi Russbach, Chief Medical Officer of the ICRC, who traces the evolution of the Medical Division in the past ten years, emphasizing not only the progress achieved in the execution of its programmes but dealing as well with the problems which the ICRC has had to face in this domain.*

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INTRODUCTION

In every period of history, war has decimated populations, not only by the mortal wounds inflicted on soldiers but also through famine and disease, caused by destruction of the material resources indispensable for human survival.

In many situations, state institutions have been able to alleviate the most elementary needs, thus limiting the worst effects of con-

flicts on health. In other cases, such as Solferino, the disproportion between the enormity of the disaster and the deficiency of means to deal with it resulted in a veritable hecatomb.

It was circumstances such as these that prompted Henry Dunant's idea of creating groups of volunteers to reinforce official services overwhelmed by the events. This first spontaneous response, born of intense compassion, was followed by the compelling idea which is the very essence of the Geneva Conventions: that the war wounded and those who care for them must be respected without discrimination by the belligerents.

Ever since the foundation of the Red Cross in 1863, and until wars of liberation, armed conflicts took place between countries whose infrastructures were sufficiently developed to resolve most of the resultant health problems, with the help of volunteers.

Under those circumstances, the need for a country to receive aid in the form of medical teams from other countries did not have the same urgency as it does in many present-day conflicts, in which the lack of a medical infrastructure renders outside help, with material and personnel, indispensable.

Until the 1960s, the ICRC therefore concentrated less on material assistance than on the elaboration and practical implementation of the Geneva Conventions in its efforts to alleviate the suffering of war victims, for the primary concern at that time was to persuade governments to respect the various categories of war victims rather than to meet their material needs.

The situation today is quite different. International humanitarian law has been considerably strengthened and offers adequate protection for war victims. The main problem now lies in ensuring that governments adhere to these principles and duly comply with the Conventions and Additional Protocols. To this effect the ICRC must do all it can to promote knowledge of, and respect for, the principles of IHL.

At the same time, if victims are to be protected, it is necessary to keep them alive and ensure as far as possible the material conditions which make life possible.

Since present-day conflicts take place largely in countries with chronically deficient and vulnerable infrastructures, they often entail human tragedies resulting from the destruction of resources essential to survival. In many conflicts, the living conditions of the civilian population are totally incompatible with health. In any such highly pathogenic environment, there is no escape from disease, suffering and death.

To counter such situations, when disease becomes more lethal than the actual weapons, the ICRC in 1977 decided to set up its Medical Division to be able to protect the victims more fully. The Relief Division was also reinforced, with a strong logistic structure enabling it to supply both relief and the basic facilities needed by the victims.

While much progress has been made by the Medical Division in the past 10 years in tackling the health problems of the victims of armed conflicts, much remains to be done in putting programmes into effect and obtaining access to the victims.

MEDICAL PROGRAMMES

ICRC medical programmes are concerned with four categories of victims:

(*a*) The war wounded;
(*b*) Prisoners;
(*c*) Civilians;
(*d*) The war disabled.

All these programmes are destined first and foremost to keep the victims alive, lessen their suffering and prevent the after-effects of their diseases or injuries from ruining their future lives.

To do so, we have limited means, which must be used to best advantage.

Our work takes place in emergency situations in which the need for medical care always surpasses our possibilities. We are often confronted by the painful need for *triage*, i.e. sorting and making a choice of priorities among those who need care. Our experience has enabled us to define several principles, which may be summed up as follows:

— As far as possible, local personnel and material resources should be used to ensure continuity and avoid excessive dependence on outside help. Co-operation with the National Red Cross or Red Crescent Society, which is natural and customary, is the best way of achieving this objective.

— We must avoid giving special advantages to the victims for whom we are responsible, as compared to the surrounding population, to prevent jealousies and tensions which might give rise to violence.

— We must avoid creating an attitude of dependence in the victims, which might render them incapable of subsequently

assuming their own responsibilities and thus jeopardize their future.

— The frequently chronic character of some conflicts calls for interventions which are on the borderline between emergency aid and development. Care must be taken not to set up development programmes before the necessary conditions of stability, disrupted by the conflict, have been restored.
— During the acute period, plans should already be made to follow up the initial programme, which could be taken over by the government or other organizations as a development project.
— The ICRC should try to harmonize the roles of the various organizations involved, so as to avoid duplication, while retaining under its own responsibility specific tasks which it alone can perform, by virtue of its special role as a neutral and independent institution.

1. Medical care for the wounded

The main problem for war casualties is that they seldom receive adequate first-aid treatment and that their access to a hospital is long-delayed and hazardous. Particularly in guerrilla wars, the nearest treatment centre may be several days away on foot, and the wounded may not be able to get there at all because of the dangers involved. The ICRC is therefore doing all it can to improve the training of both combatants and civilians in first aid and transport of the wounded. At the same time, it is endeavouring to spread knowledge of the fundamental principles of the Red Cross among combatants, teaching them that respect must be shown for the enemy wounded.

The ICRC is often asked to improve the operational capacity of existing surgical centres and may, after evaluation, supply them with surgical and medical material.

In acute crises with which local personnel cannot cope, the ICRC can send in emergency teams to help them.

Sometimes the only way to treat the wounded properly and safely is to set up hospitals for them near the border of the country where the conflict is taking place. About 10,000 war casualties are thus cared for each year, under ICRC auspices, by teams often consisting of volunteers from National Societies.

If local means are insufficient or the assistance of a neutral and independent body is necesarry, the ICRC organizes a system for evacuation and care to meet the needs.

War surgery can be performed with simple material, but it requires a relatively secure location and supplies of water and energy. Good care does, however, require a highly qualified surgical team with special training in war surgery, which presents very different problems from those encountered in peacetime.

For example, it is imperative that wounds caused by high velocity projectiles be treated by special techniques to give the victims the care they need.

The *triage* of the wounded when great numbers of them arrive simultaneously is also a very important and specific problem, for which surgeons must be carefully prepared.

Since few surgeons have polyvalent training and experience in war surgery, which is a very specialized field, the ICRC has to give already highly skilled surgeons additional theoretical training to prepare them for the new problems they will encounter. Instructional material on this subject is regularly kept up to date by the Medical Division and exchanges of information take place constantly with surgeons who have special experience in this field.

Much remains to be done to adapt new techniques to war surgery, while maintaining a simple and realistic approach. The experience of the ICRC in this field should be more widely publicized for the benefit of those who may eventually have to face the problems involved. As early as 1863, Dr. Appia, one of the founders of the ICRC, said, "Whereas the military have to keep quiet about how war is waged, doctors must make sure everyone knows how to treat its effects."

2. Medical care for prisoners

The role of doctors in visits to prison camps and prisons is of great importance, because the greatest concern of prisoners is usually their health.

Everything possible must be done to safeguard the physical and mental integrity of prisoners so that when their detention comes to an end, after-effects of their confinement will not make it impossible for them to return to normal life.

Even if a prisoner is not seriously maltreated or tortured, the prison environment itself is an attack on the body and mind of

prisoners and inevitably leads to more or less serious health problems, depending on the circumstances.

ICRC doctors do not have the power to tackle the cause of such afflictions, except in the rare cases when they can obtain the authorities' consent to repatriations or releases for medical reasons. They can, however, do much to ensure that the conditions of detention are not excessively prejudicial to the health and lives of the prisoners.

The quality and quantity of water and food, the quarters and the conditions of everyday life must be closely examined and the authorties can subsequently be requested to make any necessary improvements.

The quality of medical care provided, and the ready accessibility of this care to the detainees, must also be investigated, followed by appropriate requests to the authorities by the visiting doctors. Interviews without witness with the detainees, which are the cornerstone of all ICRC visits, have more than an informative value, because the human and even therapeutic aspect they give to the visits can enable prisoners to cope more effectively with the abnormal conditions in which they are compelled to live.

When there are allegations of torture or mistreatment, the doctors will look for physical or mental evidence of such abuses and will inform the responsible authorities accordingly. Every possible step will be taken to eliminate violence and prevent further instances of torture.

It is obvious that the medical aspect of the ICRC's work in places of detention is one of the major concerns of the Medical Division, which must pool the information and prepare its doctors and nurses for the delicate task of visiting them.

There, too, to do its job properly and efficiently, the ICRC must meet high standards of professionalism, record all experience gained in the field and pass it on to new staff members.

The complexity of the health problems encountered in the hundreds of places of detention visited by the ICRC—involving surgery, dermatology, epidemiology, infectious diseases, nutrition and psychiatry—calls for highly qualified personnel whom the ICRC must be able to recruit, train and keep.

3. Medical care for displaced persons

It is in its approach to emergency action for displaced persons that the methods of the ICRC have evolved most in recent years.

Curative medicine, for example, consisting of direct treatment, is no longer practised without being accompanied by other measures which are its indispensable complement.

This comprehensive approach to health, which takes into account the causes of disease and integrates the skills of specialists in various fields, is the only way to improve the situation.[1, 2]

When a large group of people are uprooted, forced to flee from their natural and traditional environment to escape the horrors of war, carrying with them only a few personal possessions, the result is often a mass of human beings in an area which lacks the bare essentials for health or even for survival. Typically, water pollution makes the situation even more desperate, producing epidemics of diarrhoea and other infectious diseases.

Malnutrition and the lack of protection against cold and damp reduce resistance to infectious diseases and further aggravate their condition. The first to suffer are those most vulnerable: children old people and pregnant women. Others succumb as the situation continues.

Anxiety, generated by the terror from which they fled and their continuing insecurity, gives rise to psychological disturbances and eventually to many psychosomatic disorders.

If medical consultations are organized in such circumstances, the influx of patients is soon overwhelming and nothing can be done to solve the problem.

Arrangements must simultaneously be made for adequate supplies of water, food and means of protection against the elements. This presents tremendous problems in a conflict situation, in which a relief work is delayed or impeded by any number of political, military and logistic constraints.

Under such precarious conditions, relief work has to be very carefully planned to be of the utmost possible benefit for the victims' health. Priorities have to be decided on the basis of professional evaluations, in order to concentrate assistance efforts on the most vital needs and thus obtain optimum results.

Donors should be informed of the specific needs of the population, to avoid shipments of non-priority supplies which may divert the relief operation from its essential purpose. With this in

[1] Rémi Russbach, "Disaster Co-ordinating Doctor, a multidisciplinary training" — *Newsletter, International Society on Disaster Medicine*, No. 30, August 1986, pp. 1-4.

[2] Pierre Perrin, "*Medical Assistance in an Emergency Situation*", ICRC, 1984.

mind, basic documentation has been widely distributed [3] and general directives have been given in resolutions by recent International Conferences of the Red Cross.[4, 5, 6]

In view of the difficulty of finding medical personnel with all the expertise and know-how required for the complex task of evaluation and co-ordination of emergency medical programmes of this kind, the ICRC, in conjunction with the WHO and the Geneva University's Faculty of Medicine, has organized an annual four-week training course under the name "HELP" (Health Emergency in Large Population). These courses are open to the medical personnel of the ICRC and of other organizations active in assisting displaced populations.

These courses enable experienced doctors and other health personnel to broaden their knowledge in such varied fields as planning, epidemiology, nutrition, sanitation, infectious diseases, emergency, training of local personel, co-ordination of health programmes and the protection of war victims. Fifty persons have already followed this programme, which can train 25 candidates each year.

4. Medical care for the war disabled

When we have had to amputate the leg of a wounded person or have treated the injuries of a paraplegic, we cannot simply walk away and leave the victim to become a burden on his family or community.

We therefore have to think of a lasting solution which will give him a chance to become reintegrated into his social and family environment, in the best possible conditions.

In such cases, contrary to its usual practice, the ICRC has to set up programmes which go beyond its self-imposed emergency criterion, since the situation calls for long-term treatment involving a development project.

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[3] *ICRC Handbook for Donors — Technical guidelines for donation in kind to ICRC relief operations*, ICRC, 1983.

[4] 24th International Conference of the Red Cross, Manila, 1981: *Resolution XXVI* — Role of medical personnel in the preparation and execution of Red Cross emergency medical action.

[5] 25th International Conference of the Red Cross, Geneva, 1986: *Resolution XVIII* — Nutrition and food donation policy in Red Cross and Red Crescent emergency operations.

[6] *Ibid, Resolution XIX* — Medical supplies in Red Cross and Red Crescent emergency operations.

In the past ten years, in co-operation with qualified prosthetic technicians and physiotherapists, the Medical Division has tried to develop the best possible long-term solutions for the rehabilitation of amputees and paraplegics, based on the principles of self-sufficiency and appropriate technology.

In every one of the twelve countries in which the ICRC has developed orthopaedic projects in the form of small workshops, we began by investigating the local resources, in personnel and material, and have worked out technical solutions adapted to local conditions. In this way, we have assured the long-term operation of the project, making it independent of foreign imports and foreign currency.

More than 10,000 amputees have been enabled to walk again and hundreds of paraplegics have been able to go back to their homes.

Many discussions have taken place between the Medical Division and various governments and institutions, aimed at setting up such projects in as many countries as possible.

A Special Fund for the Disabled has been established at the ICRC to finance new projects.[7]

In view of the magnitude of this problem throughout the world, we hope it will be possible to develop many new centres.

CONCLUSIONS

In the past ten years, the ICRC has had to adapt to new types of problems affecting the victims of armed conflicts and substantially develop its operational capacity in terms of medical assistance and relief.

There is every reason to believe that this effort will have to continue, as much remains to be done to meet the victims' basic needs.

To obtain the best results, the professionalism of Red Cross volunteers must be further developed and their training improved, both by the ICRC and by the National Red Cross and Red Crescent Societies.

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[7] 24th International Conference of the Red Cross, Manila, 1981: *Resolution XXVII* — ICRC Special Fund for the Disabled.

The increasingly technical and professional approach, however, must not be achieved at the expense of the spirit of humanity which is at the heart of every Red Cross action.

A permanent dialogue with National Societies taking part in ICRC medical activities is essential to avoid losing sight of the ultimate purpose of all such work and to concentrate all efforts on the single objective of ensuring the survival and relieving the suffering of the victims of war.

The dissemination of training material for volunteers and exchanges of information with all parties interested in the problems of concern to us should also be developed, for it is essential to have mutual understanding and complementarity of action between voluntary agencies working in the same field.

Dr. Rémi Russbach
