

# SIGNALLING AND IDENTIFICATION OF MEDICAL PERSONNEL AND MATERIAL

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At its second session, which it held in Geneva in May 1972, the Conference of Government Experts on the Reaffirmation and Development of International Humanitarian Law Applicable in Armed Conflicts (Commission I) prepared draft articles on medical air transport and an annex relating to their signalling and identification, which were to be embodied in a future legal instrument.<sup>1</sup> The Commission also recommended that a closer study be made of medical transport at sea and on land. If these suggestions were to lead to a draft instrument, it would be imperative to have a general plan which, in the case of signalling, would extend to all medical personnel and material,<sup>2</sup> whether civilian or military.

Moreover, as the solutions put forward for medical air transport have given rise to a number of objections, it seems advisable to survey the whole problem.

## I. Situation in the light of the Geneva Conventions

The Geneva Conventions of 12 August 1949 provide the distinctive emblem of the red cross or its equivalents—the red crescent and the red lion and sun—as a general means of identifying medical personnel and material. In addition, the Second Convention

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<sup>1</sup> *Report on the Work of the Conference, Geneva 1972, Volume I, Report of Commission I, pp. 31-60.*

<sup>2</sup> The term “material” includes medical buildings, installations, transports, equipment and stores.

requires that the exterior surfaces of hospital ships and other medical craft shall be white, and recommends that the Parties to the conflict use "the most modern methods available" to facilitate identification of those maritime medical transports (Article 43).

It also recommended that the Parties to the conflict should provide their medical aircraft "with any other markings or means of identification" (First Convention, Article 36, and Second Convention, Article 39).

Lastly, to facilitate timely identification, the Conventions lay down that the adversaries shall notify one another or even reach agreement. The names and descriptions of hospital ships shall be notified to the Parties to the conflict ten days before those ships are employed (Second Convention, Article 22). The heights, times and routes of medical aircraft may in certain cases be agreed upon (First Convention, Article 36, and Second Convention, Article 39).

The identification of medical personnel and material is thus based on the distinctive emblem, other means being of a purely complementary nature to facilitate identification. Rules on the distinctive emblem are thus necessarily the basis of any signalling and identification system.

The right to protection lies in the nature of persons and things or in the manner in which they are employed. It exists regardless of any distinctive emblem. It is only "the visible sign of the protection accorded to persons or things".<sup>3</sup>

While signalling alone does not afford protection, it is nevertheless essential for effective protection. This virtually constitutive quality of protection has given rise to the term "protective sign", which is often used for the sake of brevity and in contrast to the purely indicative sign. As its name indicates, the latter merely shows the existence of a link with an institution. It cannot establish or illustrate any right to protection. The distinction between the virtually protective sign and the indicative sign is due to the increasingly widespread use of the red cross emblem beyond the compass of those entitled to protection. As regards the signalling of medical personnel and material, the expression "distinctive emblem" is used solely in the meaning of "protective sign".

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<sup>3</sup> Jean S. Pictet, *Commentary on the Geneva Conventions of 12 August 1949*, Geneva 1952-1959, Volume I, p. 324.

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Distinctive emblems may not be displayed without the authorization of the State or of a State authority. Article 39 of the First Convention reads thus: "Under the direction of the competent military authority, the emblem shall be displayed on the flags, armlets and on all equipment employed in the Medical Service". The same provision is embodied in Article 41 of the Second Convention. The Fourth Convention contains a similar provision regarding recognized civilian hospitals (Article 18) and their personnel (Article 20) and medical transports (Articles 21 and 22). In the case of the Fourth Convention, naturally the point at issue is not control by a competent military authority. Hence the general concept "authorized by the State".

The State or, by the delegation of its competency, the military command therefore "controls the emblem"<sup>4</sup> and is free to permit or prohibit the use of the distinctive emblem. It may even prohibit its use entirely without thereby violating the Conventions. In that event, actual protection would obviously be very small.

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As the distinctive emblem must be the visible sign of the right to protection, it must be truly visible in so far as its use is permitted. The Conventions, however, lay down very few precise requirements. In the military medical sphere, "Parties to the conflict shall take the necessary steps, in so far as military considerations permit, to make the distinctive emblem indicating medical units and establishments clearly visible to the enemy land, air or naval forces, in order to obviate the possibility of any hostile action" (First Convention, Article 42). The same system applies to civilian hospitals (Fourth Convention, Article 18) and to hospital ships, on which "a white flag with a red cross shall be flown at the mainmast as high as possible" (Second Convention, Article 43). Medical personnel are merely required to wear an armlet affixed to

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<sup>4</sup> Pictet, *op. cit.*, p. 308.

the left arm (First Convention, Article 40; Second Convention, Article 42, and Fourth Convention, Article 20).<sup>5</sup>

As regards the signalling of medical transports, aircraft "shall bear, clearly marked, the distinctive emblem . . . on their lower, upper and lateral surfaces" (First Convention, Article 36, and Second Convention, Article 39), and naval transports shall have the same treatment as hospital ships (Second Convention, Article 43), while nothing is specified with regard to land transports.

The Conventions make no reference to the colour or luminousness of the emblem, apart from the requirement regarding dark red crosses on hospital ships and other medical craft, and the recommendation relating to measures to render their distinctive emblems "sufficiently apparent by night and in times of reduced visibility" (Second Convention, Article 43).

## II. Present use of the distinctive emblem

In a general way, the authority controlling the emblem widely permits the use of the distinctive emblem by civilian hospitals, but imposes considerable restrictions with regard to the camouflaging of tactical positions and activities, as the presence of more or less considerable medical installations makes it possible to estimate the size and the location of the means of combat. It is general practice that camouflage requirements and military restrictions on the use of the emblem go hand in hand. Near the front they are strict, but they are less severe towards the rear. Thus, minor aid posts and the aid stations near the frontline are marked by small panels visible only at a short distance from the ground, while larger and more numerous signs, visible for flyers and land combatants alike, are used to mark large hospitals in rear areas.

The minimum marking of an aid post in the midst of the battle area, in a cellar or under small cover, should give approaching patrols or assault squads timely notice of the immunity of the place, namely before the attackers enter, open fire with their individual portable arms or throw grenades.

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<sup>5</sup> The First Convention goes so far as to provide for two different armlets, a normal armlet for permanent medical personnel and "a white armlet bearing in its centre the distinctive sign in miniature" for temporary medical personnel (Article 41).

A rear hospital, on the other hand, must be protected not only against light infantry weapons, but against the fire of long-range armament such as used by aviation and artillery.

This practice, which is in keeping with tactical requirements and which might at first sight appear to be discriminative, generally answers the differing needs of protection. In addition to the staff and a considerable medical infrastructure, the large rear hospitals usually hold a great many patients,<sup>6</sup> while the aid post, organized by small units and serving as a place for collection, pre-medical care and expected evacuation, is often empty.

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The distinctive emblem should therefore be duly distinguishable in adequate time and at suitable distances. To ascertain the practical value of the existing rules on the use of the distinctive emblem, in March 1972 the International Committee of the Red Cross carried out tests in co-operation with the Swiss Army, and the tests were repeated in a demonstration held for the technical experts assembled in Geneva in May 1972 for the Conference of Government Experts. The tests yielded the following results:

An armlet worn on the left arm is visible at a distance of 50 m only if clean and smooth and if the wearer is standing with his left side to the observer.<sup>7</sup> Again, it is not sufficient to place any panel on transports or installations such as buildings or tents. An unduly small distinctive emblem creates dangerous illusions. To be really useful, the emblem should be visible at first glance, as soon as its bearer comes into sight and whatever the distance and the mode of observation.

It is therefore advisable to adapt the emblem to the size of the bearer. A man can have it on his chest and his back or on an outer garment across his body. In the case of a lorry, the emblem should be painted or affixed on the full height of the loading-

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<sup>6</sup> The term "patient" covers the wounded and the sick. It also comprises persons rescued from shipwreck if wounded or sick.

<sup>7</sup> In the circumstances, it is unrealistic to believe there can be a distinction between the usual armlet and the armlet bearing "the distinctive sign in miniature" for temporary medical personnel.

platform tarpaulin, and not only on the cover of the motor. This also applies to medical tents and buildings. Lastly, an attempt should be made to render the emblem visible from any angle. It should therefore be placed on the various surfaces of the persons or things entitled to protection.

The white surface of the distinctive emblem should also show up well against the colour of the wearer's clothing. To this end, and particularly in the case of a small distinctive emblem, it is preferable that the bearer's clothing shall be uniform in colour rather than variegated for camouflage purposes.

Whatever the size of the emblem, the total white and red surfaces should not differ too greatly from one another. An unduly small red cross on an unduly large white ground is, so to speak, "swallowed up" by the white. This is particularly noticeable in the case of helmets and armlets, where the cross is necessarily rather small in relation to the white ground. Still from the standpoint of surface, the red cross is to be preferred to the red crescent, especially when the outline is very thin, as is usually the case. Of the three distinctive emblems, the red lion and sun seems to offer the best balance between red and white.

Ordinary paint is sufficient by day. On the other hand, at dusk or dawn and especially at night, only a reflecting coating is visible at a distance. A fluorescent coating, which is too bright by day, is particularly visible at dusk. At night, the reflectorized coating throws back the light of an ordinary torch at 500 m. The image is visible to the naked eye at more than 200 m.

### **III. Requirements of modern armed conflicts**

The increased motorization and mechanization of the means of combat, and in the first place the advance of aviation, have lent considerable impetus to the range of the weapons, the rapidity with which they can be brought into action, and the speed of their vectors, so that the timely recognition of medical personnel and material carrying the distinctive emblem is becoming increasingly difficult. The recent development of light aviation, which makes it possible to pick up the wounded in the battle area, whether land or sea, and to convey them quickly to places where medical treatment

is given, poses similar problems. The visibility of the distinctive emblem can certainly be improved. Modern chemical research, particularly when geared to the prevention of traffic accidents, should allow a combined reflecting, fluorescent and reflectorized coating in order to ensure sufficient visibility by day, at night and under adverse meteorological conditions.

Yet a material improvement of the distinctive emblem is not enough. The recommendation contained in Article 43 of the Second Convention, relating to medical service at sea, should be developed and generalized, and more modern identification methods should be used on land and in the air alike.

Modern technology offers many possibilities in this respect, e.g. in the fields of telecommunication and of sea and air navigation control and safety. The proper functioning of those means, however, is often linked with normal operation in time of peace, while the signalling and identification of medical transports must be carried out in case of armed conflict, and more particularly in combat areas.

What holds good at normal times does not necessarily hold good in times of armed conflict. It is therefore advisable to consider modern signalling and identification methods, those called "distinctive signals" as opposed to "distinctive emblems", by a pragmatic approach based on tactics of medical transport and treatment and on the data regarding combat zones.

The approach should be broad and should allow of solutions applicable not only on land, which are no doubt the most frequent, but *mutatis mutandis* also at sea and in the air. One need only picture a battle area on the coast or in an archipelago, where there are civilian hospitals and medical personnel and material of the land, sea and air forces. In the case of medical aircraft and their crew, besides the air force they may even belong to the naval air arm or to the army aviation. It is easy to imagine the chaos which would ensue if signalling and identification systems differed too greatly or perhaps even conflicted with one another.

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Medical tactics must be based on a typical and complete sampling of all bodies entitled to use the distinctive emblem and able to care for the patient, from first aid to final treatment.

While the Fourth Convention grants only recognized civilian hospitals the right to the emblem, all military medical services enjoy that right. Of the three armed forces' medical services, only that of the army is complete and comprises all medical activities and operations. The right to the distinctive emblem is granted to:

- (a) treatment places (in a broad sense including the sorting): aid post, aid station, dressing station, field hospital, rear hospital;<sup>8</sup>
- (b) medical transports or vehicles for evacuation;
- (c) medical equipment and medicaments, in actual fact mainly their warehouses, and vehicles attached to treatment places and warehouses;
- (d) medical personnel.

This list is sufficient as regards signalling requirements. A civilian hospital may, according to its size, be equivalent to a field hospital or a rear hospital. At sea, a hospital ship is also covered by the two concepts of field hospital and rear hospital. It is a mobile treatment place rather than a means of transport, unlike the smaller craft used solely for evacuation purposes. What distinguishes the hospital ship from the mobile land hospital, which moves on land or in the air, is the fact that it can work at full capacity even when moving from one place to another. Sick-bays on warships, according to the size of the ship, are equivalent to an aid station or a small hospital. Lastly, in the air, there are only means of transport;<sup>9</sup> the fact that emergency or provisional treatment may at times be given in medical aircraft does not change their character as a means of transport; the same phenomenon exists, naturally on a smaller scale, in the case of land ambulances.

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<sup>8</sup> Another term frequently used for describing a dressing station is "clearing station", and for field hospital "evacuation hospital".

<sup>9</sup> The future air hospital, still in the blueprint stage, would be equivalent to the hospital ship.

As regards the data on the “combat zone”, Commission I adopted several terms used in military terminology.<sup>10</sup> While the fact that they are introduced into an instrument of humanitarian law may be surprising, this has proved necessary in order to delimit in space different legal situations.

First, there is a distinction to be drawn between territories “under the control of friendly forces” (or of the friendly Party) and “territory under the control of enemy forces” (or of the adverse Party). The word “control” must be rid of any legal meaning. The point at issue is not a State’s sovereignty over its territory, but *de facto* domination which, in a situation of armed conflict, may be solely due to military supremacy and which does not take into account borders and limits and the attendant sovereign rights. To show that this system is also applicable at sea, regardless of any legal concepts such as high sea or territorial waters, the word “territory” might well be completed by “waters”, and the term “territory and waters under control . . .” might be used.

Commission I defined battle area as “an area where opposing ground forces are in hostile contact with each other”. This refers to the portion of terrain adjoining enemy positions and where the first elements of infantry and armour are engaged. To include the sea in the definition of battle area, one might say “land or naval forces”. On the enemy side, the battle area is not delimited by a continuous frontline formed by combatants facing one another. Either side has its small positions, strongholds organized for more or less all-round defence, and patrol activity. Moreover, there are often imbricate or confused situations arising from current action or a succession of local attacks or counter-attacks. These latter portions of terrain are regarded as “area where control is not clear”.

The Commission distinguished between two parts of the battle area. In the “forward part” are to be found units in direct contact with the enemy. There is little freedom of movement; the forces are exposed to direct enemy vision and hence to direct firing. In the “rear part” of the battle area are the units belonging to the second echelon and the reserve units of the troops in hostile contact.

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<sup>10</sup> Draft Articles 25 and 26 (*Report*, pp. 46 and 47).

They are less exposed to enemy vision and firing, and there is therefore greater freedom of movement.

The "combat zone" is much more extensive. It comprises the battle area and the sectors of the troops engaged further in the rear.

In the context of the definitions outlined, medical treatment places are generally spaced out thus:

- (a) in the forward part of the battle area, company aid posts where, for want of a doctor, only pre-medical care can be provided;
- (b) in the rear part of the battle area, batallion aid stations and possibly regimental or brigade dressing stations;
- (c) in the rear part of the combat zone, further dressing stations and the division or corps field hospital;
- (d) further in the rear, the rear hospital.

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The State and the military command both organize their medical services primarily for their own needs, and the principle of non-discrimination between friends and enemies is practised only with regard to patients collected. Civilian or military hospitals and any other military medical installations are located according to population or troop density. Their location is known to those who must proceed there. But a medical transport has to collect the wounded, wherever they may be, in order to evacuate them to a treatment place or from an advanced treatment place to one lying further back. By definition, it is mobile and its routes may vary.

Any distinctive signal requires minimum special equipment and constitutes an encumbrance for the bearer. It is of no practical use to the medical personnel. On the other hand, it may be of decisive importance for the protection of the means of transport; among these, military medical vehicles engaged near military objectives are very often exposed. The case of treatment places and medical warehouses lies halfway. From this graduation it emerges that the overall rules should answer transport needs.

Where patients are not numerous because of small-scale or episodic fighting, light aircraft such as the helicopter can often be used. Where there are a great many wounded, as a result of fighting which is still going on, a light aircraft may be inadequate or in fact pangerous for those who are to be transported. While the medical transport is entitled to Convention protection, it cannot by its mere presence stop the fighting. The transport must not, therefore, as far as possible, enter such sectors without any special precautions. Often it is easier for a land vehicle than for aircraft to take such precautions, i.e. to follow detours and use cover. The use of land medical transports, possibly of armoured vehicles, may then be advisable. In case of need, recourse may even be had to non-medical transports. Indeed, it is better for a wounded man to be picked up by a transport that enjoys no Convention protection than slowly to die for want of a medical vehicle. Moreover, war experiences have shown that it is not always the quickest means of transport that arrives first. As a general rule, both at sea and on land, the possibility of a combined operation of different means of evacuation should be considered.

A call for a medical transport made by the combat troops necessarily goes through the normal communication channels. There are two reasons for this. First, the higher tactical echelon is just as interested in news regarding a weakening of its fighting potential, as a result of casualties. Secondly, the higher echelon must co-ordinate and supervise medical and other transports. This principle is particularly important near the front and, as a rule, wherever enemy action is encountered.

Wherever the medical vehicle may be, contact must be quickly established between it and the combat units, whose operations might be hindered by its presence, and with the troops who await its action. To organize that link and also the link with treatment places is a matter for the command; it does not concern the enemy and has nothing whatever to do with medical status. It is quite obvious, however, that a distinctive emblem or signal, to facilitate identification, helps to guard against any possible error on the part of friendly troops.

Very different is the case of a medical transport which comes into contact with enemy forces, as for instance when aircraft fly

over territory under enemy control or, in general, when any medical transport is within the enemy's range. Needless to say, any contact between medical transports and enemy military units cannot depend on command channels, and an international signalling and identification system would be advisable.

#### **IV. Possibilities and limits of distinctive signals**

First, the purely complementary nature of the distinctive signal should be borne in mind. It somehow increases the range of the distinctive emblem by extending the effects beyond the limits of vision, whereby it may come into conflict with camouflage requirements, for example. The use of distinctive signals should therefore also be subject to authorization, so that the authority in control of the emblem is necessarily the authority in control of the signal. In other words, no one can use the distinctive signal for the purpose of protection if not authorized to wear the distinctive emblem.

A distinction may therefore be drawn among the following assumptions:

- (a) the control authority permits the use of the emblem and the use of one or more signals;
- (b) the control authority permits the use of the emblem, perhaps a small one, but forbids the use of any distinctive signal; this often occurs with medical installations near the front and medical transports in the battle area, as those installations and transports, for military reasons, should be detectable only at a short distance;
- (c) the control authority rejects all signalling and refuses to authorize any emblem or signal.

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According to military needs, distinctive signals are unilateral or bilateral.

The unilateral signal is emitted by the object entitled to do so in the hope that it will be seen and respected, but there is no form

of acknowledgement, and still less is there any conversation. The entitled object therefore does not know whether it has been recognized as such, or to what extent it will be respected. As far as it is concerned, it has simply done what was necessary to be identified by those willing to do so. At best, it may possibly note a change in attitude such as the suspension of firing.

On the other hand, the bilateral signal, as its name indicates, presupposes an exchange of messages. These may be reduced to their simplest expression or may, on the contrary, consist in actual conversation. They should give those concerned a feeling of certainty that they have understood one another.

At present there is no lack of distinctive signals. Unilateral signals are luminous or sonic, while bilateral signals allow identification by means of radio communication and detection or by electronic media such as radar, or again by a combination of two different media agreed upon for the purpose. Some systems can already be used as a distinctive signal, while others are still at the experimental stage. Finally, one must be prepared for the development of new methods.<sup>11</sup>

Unilateral signals offer the advantage that they do not require a means for reply which we shall call "respondent".<sup>12</sup> Anyone within range can perceive the signal. Thus it is suitable as a general warning to all combat units and the ideal means of signalling medical transports, particularly in improvised movement in the battle area and, in general, wherever medical transports may suddenly find themselves in the presence or within the range of combat units, friendly or adverse. The unilateral signal is also appropriate for increasing the possibilities of identification of treatment places and medical warehouses.

Bilateral signals can in practice be considered only for medical air and sea transports and for hospital ships. Although a bilateral signal implies dialogue, this is possible only if the object entitled to protection is within easy range of an adequate respondent.

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<sup>11</sup> For medical aircraft, Commission I recommended three signals at present considered valid: a unilateral signal by means of a flashing blue light and, as bilateral signals, radiophonic communication on a special medical frequency and the secondary surveillance radar system (*Report*, Annex II, p. 53).

<sup>12</sup> "Respondent" is used here in a general sense and should not be confused with the radar equipment known as "transponder" on board aircraft or ships.

Yet dialogue alone is not enough; the respondent must be able to transmit information regarding identification to the combat units concerned. Each gunner who might endanger the transport or the hospital ship must be informed to this effect. And this is where a major problem arises in the battle area. No army can equip all its combatants with respondents for bilateral distinctive signals. There will always be a limited number of respondents, mainly in air operation centres and with forward air controllers, in air defence artillery positions or on craft of a certain size. Transmission from the respondent to each gunner can be carried out only through the command channels. Unless there is a telediffusion system, it must therefore go through those channels, which always takes time. Moreover, the message regarding medical transports will hardly be given priority, so that in the event of any congestion in the command net, it will be transmitted only after messages relating to the conduct of hostilities.

Lastly, one must be aware of the prospect of jamming, which, while not necessarily directed at the frequencies assigned to medical communications, may nevertheless cause disturbances. Moreover, any technical system is subject to breakdowns and deterioration caused by war.

The foregoing remarks apply only partially to the bilateral signal produced by a combination of two different media. The respondent to an aircraft's luminous signal, for example, may consist in small flags, pieces of cloth, etc., stretched out on the ground in a certain manner. Anyone can have such materials. All that is needed is to know the agreed code. The problem of timely retransmission to the gunners, on the other hand, still remains to be dealt with.

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Distinctive signals, therefore, enable a medical transport to be identified as such and, in the case of the bilateral signal, to be informed of the identification. Assuming that the transport finds itself in the space swept by trajectories of projectiles owing to fighting which is still going on, or that there is a risk that it may enter it, it should be possible to warn the transport in order that it may take cover. This can be done only by means of bilateral

signals that allow of real dialogue. As we have seen, however, in the midst of a battle the technical shortcomings of the signalling system and tactical priorities may deprive bilateral distinctive signals of any timely effect.

In view of the limits of distinctive signals and the right of the control authority to prohibit their use, protection must be ensured by other means. That is why the Second Convention of 1949, and especially Commission I, recommend that States in general, and the Parties to the conflict in particular, agree on the use of specific methods.<sup>13</sup> In so far as the Parties desire it, and especially when there is no unduly large imbalance between their military potential, the inadequacies mentioned in regard to bilateral signals may be considerably reduced or even entirely avoided, so long as the adverse Party has been previously notified of the movements of medical transports or, better still, they are agreed upon by the Parties concerned.

The use of distinctive signals should therefore be combined with notice of movements or a previous agreement on movements in areas where medical transports would be exposed to the effects of combat. To this end, Commission I provides for a graduation of signalling<sup>14</sup> which, being supplemented for land and maritime needs, might be as follows:

- (a) for the overflight of territories controlled by adverse forces, previous agreement is required;
- (b) for movements in the forward part of the battle area under the control of friendly forces, and in areas where such control is not clear, agreement between the local military authorities is simply recommended; it is nevertheless described as the *sine qua non* of effective protection;
- (c) for movements in the rear part of the battle area, no agreement is required; that freedom of movement holds good *a fortiori* in the case of sectors of the combat zone to the rear of the battle area; it is left to the discretion of the appropriate commander whether he simply gives the adverse Party notice of the flights.

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<sup>13</sup> Draft Article 27 (3) (*Report*, p. 48) and Annex II, Chapter I (*Report*, p. 53).

<sup>14</sup> Draft Articles 25 and 26 (*Report*, pp. 46 and 47).

## V. Conclusion

Signalling and identification means for medical personnel and medical material can and should be improved. Uniform design is necessary for all the medical services, whether civilian or belonging to the land, sea or air forces.

First, the size of the distinctive emblem should be adapted to its bearer and visibility should be increased, especially at night and under adverse weather conditions.

The distinctive signal, which is a complement to the distinctive emblem and, like the emblem, subject to the control authority, may be a very useful adjunct to signalling and identification, and hence an effective safeguard for material and, more particularly, for medical transports.

No distinctive signal, however greatly improved, can remove all the risks incurred by a medical transport. The degree of risk inherent in the different parts of the combat zone and the territory under the control of adverse forces should therefore be borne in mind, and signalling should, *mutatis mutandis*, be combined with the requirement or simple recommendation to conclude an agreement with the adverse Party or to notify that Party of the movement of the medical transport in question.

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