The Red Book

A Guidance Document for Medical Teams Preparing for, & Responding to Armed Conflict & Complex Emergencies

A humanitarian Imperative to Act &
Do No Harm

Draft 0
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i. Special Notes on The Blue Book & Red Book

Please Note that the consultations with key stakeholders continue

- The Blue book\(^1\) (currently being updated) initially published under the name: ‘Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters’, in currently being updated as the main reference document for “Emergency Medical Teams” inclusive of national and international teams in situations of disasters and outbreak response. The Blue Book extends/builds upon the 2003 [WHO-PAHO Guidelines for the Use of Foreign Field Hospitals]\(^2\)

- The Red Book (builds upon, links to, and extends the Blue Book) The project started Nov 1 2018, and is planned for one year (see timeline illustration below). It is to be co-created and co-authored by a community of practice as a consensus document addressing key challenges facing medical response to armed conflict and complex emergencies scenarios.

- Both Blue and Red Books have an associated digital Tool Kit that elaborate in detail the “how?’ to reach requirements, supplies, and resources for the various standards and recommendations.

[Insert note 1 - The difference between Blue and Red Books including anticipated context(s) and related nuances, who may decide, applicability of each, and relevant links, and outline the associated Tool Kits].

[insert note 2 – How will the Red Book be rolled out & used in the future? Trainings, HQ and Field guidance, Reference, etc.]

\(^1\) [https://www.who.int/hac/global_health_cluster/fmt_guidelines_september2013.pdf?ua=1](https://www.who.int/hac/global_health_cluster/fmt_guidelines_september2013.pdf?ua=1)

Red Book Roadmap: EMTs in Armed Conflict and Complex Emergencies

**Phase 1: Oct ’18 – Jan ’19**
- Info gathering and Analysis
- Consultations
- Literature search & review
- Coordination and links w/ Blue Book
- Set up a small reference group?

**Phase 2: Feb – May ’19**
- Development of draft Red Book
- Ongoing consultations
- Convene small reference group?

**Phase 3: Jun – Aug**
- Distribute First Draft
- Review Process
- Second round of consultations

**Phase 4: Sep - Oct**
- Revision
- Finalization
- Dissemination
- Plan to monitor application and use

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WHO EMT RED BOOK PoA

Ver 1.0
1 Introduction, Concept & Approach

The Red Book is a guidance document aiming to support and protect the mission and work of Medical Teams (national and international) providing care in armed conflict and complex emergencies. The support is framed in a robust respect to core humanitarian principles, and International Humanitarian Law (IHL), ethical conduct with the view that such a framework provides for a safer (for both providers and patients) and more accessible ‘humanitarian space’ to fulfill the central mandate to: save lives and alleviate suffering; as well as improved quality of patient care.

The Red Book is a practical guidance document for the principled preparedness, engagement, activation, deployment, coordination, protection, and monitoring of medical teams in armed conflict and complex emergencies.

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3 And not a ‘guideline’ or ‘policy’ or ‘normative document’
4 ‘Medical’ in the context of the Red Book implies all health and related support activities along the entire continuum of care. The phrases ‘Medical Teams’ and ‘Medical Providers’ are used as equivalent synonyms
5 Refers to both acute and protracted armed conflicts. International humanitarian law distinguishes two types of armed conflicts, namely: international armed conflicts, opposing two or more States, and non-international armed conflicts, between governmental forces and non-governmental armed groups, or between such groups only. IHL treaty law also establishes a distinction between non-international armed conflicts in the meaning of common Article 3 of the Geneva Conventions of 1949 and non-international armed conflicts falling within the definition provided in Art. 1 of Additional Protocol II. 
https://www.icrc.org/eng/resources/documents/article/other/armed-conflict-article-170308.htm
6 Complex emergencies are situations of disrupted livelihoods and threats to life produced by warfare, civil disturbance and large-scale movements of people, in which any emergency response has to be conducted in a difficult political and security environment. Complex emergencies combine internal conflict with large-scale displacements of people, mass famine or food shortage, and fragile or failing economic, political, and social institutions. Often, complex emergencies are also exacerbated by natural disasters. (WHO, 2002). For the purposes of The Red Book, disease outbreaks in acute and protracted conflicts, and crises settings are applicable.
7 International humanitarian law (IHL) is the law that regulates the conduct of war (jus in bello). It is that branch of international law which seeks to limit the effects of armed conflict by protecting persons who are not participating in hostilities, and by restricting and regulating the means and methods of warfare available to combatants.
8 Humanitarian space denotes the protected physical or symbolic space which humanitarian agencies need to deliver their services according to the principles they uphold.
Through practical examples [including contexts from various regions] and key references, the document will also highlight best practices, minimum standards, professionalism requirements, evidence base, links to associated tool kits, and team preparedness requirements to ensure quality patient care and safer, more secure operations. The quality of care will include a focus on a wide spectrum of injuries and diseases including trauma care, non-trauma care, infectious disease management, support to outbreak response, burns management, emergency maternal and pediatric care, mental health, and gender-based violence.

The Red Book does not replace the critical need for States and Armed Groups to engage negotiations and seek diplomatic solutions. It also does not replace the need for important Humanitarian Diplomacy and advocacy to remind, achieve diplomatic solutions, promote agreements, seek cease fires, and holding warring parties accountable to their responsibilities under the Geneva Conventions and additional protocols.

*The Red Book proposes a complementary and parallel track to diplomacy and advocacy underpinned by the humanitarian imperative to act, and not delay!*

It proposes a complementary and parallel track underpinned by the humanitarian imperative to act, and not delay! And it cannot fully address the many inherent dilemmas medical teams continue to face in an increasingly complex and highly politicized world. Moreover, the Red Book aims to bridge, and cross-reference key relevant existing Guidelines and recommendations published by many, including WHO, other UN agencies, MSF, ICRC, and other agencies/organizations.

*The Red Book is written with the future Humanitarian Landscape in mind and offers medical teams technical and operational guidance on how to prepare for and better respond to armed conflict and complex humanitarian emergencies*

It is composed with the projected future of the humanitarian landscape in mind. The document will, where appropriate, incorporate relevant considerations for medical teams given the need for increasing interdependence and cooperation amongst providers (continuum of care, humanitarian-development-security nexus, civilian-military coordination), asymmetrical warfare, more advanced weapons (and injury types), autonomous weapons, likelihood of CBRNE attacks, rapid urbanization, deconfliction, politicization of aid, rise in disease outbreaks, increased fragmentation of political world order, erosion of accepted global values/norms and lack of adherence to long established treaties, increased migration/displacement, insecure humanitarian space, increased numbers of actors and providers,

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9 For example UNSC Resolution 2286; demanding that all parties to armed conflict fully comply with IHL and protection of medial and humanitarian workers https://www.un.org/press/en/2016/sc12347.doc.htm

10 Deconfliction: The exchange of information and planning advisories by humanitarian actors with military actors in order to prevent or resolve conflicts between the two sets objectives, remove obstacles to humanitarian action, and avoid potential hazards for humanitarian personnel. This may include the negotiation of military pauses, temporary cessation of hostilities or ceasefires, or safe corridors for aid delivery. [Stay and Deliver](https://www.unocha.org/sites/unocha/files/Stay_and_Deliver.pdf) [https://www.humanitarianresponse.info/en/operations/stima/document/turkeysyria-humanitarian-deconfliction-mechanism-humanitarian](https://www.humanitarianresponse.info/en/operations/stima/document/turkeysyria-humanitarian-deconfliction-mechanism-humanitarian)
influence of communication and medical technologies, and the centrality of local actors and the special needs affected populations and highly vulnerable sub-groups.

Given the projected level of increasing humanitarian needs and gaps, some have called for a future system with “An effective surge capacity is essential. Despite major access restrictions faced by humanitarian actors, one ‘quick fix’ for emergency response capacity would be to ensure a minimum number of capable organisations with the capacity, knowledge, readiness and deployability to provide coverage across all lifesaving sectors and deliver reliably in acute crises.”11 Partnerships and interdependence amongst teams are key features increasingly required to deliver medical assistance in

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complex and risky environments. Recent studies and reviews have highlighted the critical need for medical teams to perform better on both the level of the application of humanitarian principles, as well as quality and effectiveness. The report authors call upon all actors “to examine their actions – the end and the means – so that future humanitarian responses will be principled, effective, and accountable to those who need them the most: the victims of war and forced displacement.”

The Geneva Conventions clearly state that it is the responsibility and obligation of the warring parties (and their affiliates) to provide medical care to affected civilians, wounded combatants, and prisoners of war (PoWs); and in the case of both international or non-international armed conflicts, “each Party to the conflict shall be bound to apply, as a minimum, provisions to

**COMMON ARTICLE 3 - GENEVA CONVENTIONS**

https://ihl-databases.icrc.org/ihl/WebART/375-590006

“In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions:

1. Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed ‘hors de combat’ by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.

To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

(a) violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;

(b) taking of hostages;

(c) outrages upon personal dignity, in particular humiliating and degrading treatment;

(d) the passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court, affording all the judicial guarantees which are recognized as indispensable by civilized peoples.

2. The wounded and sick shall be collected and cared for. An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict. The Parties to the conflict should further endeavour to bring into force, by means of special agreements, all or part of the other provisions of the present Convention. The application of the preceding provisions shall not affect the legal status of the Parties to the conflict.

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12 Johns Hopkins Mosul Trauma Case Study, Spiegel et al, Feb 2018

13 The Geneva Conventions and their Additional Protocols are international treaties that contain the most important rules limiting the barbarity of war. They protect people who do not take part in the fighting (civilians, medics, aid workers) and those who can no longer fight (wounded, sick and shipwrecked troops, prisoners of war)

14 Customary Humanitarian Law: Rule 139. Each party to the conflict must respect and ensure respect for international humanitarian law by its armed forces and other persons or groups acting in fact on its instructions, or under its direction or control. https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_cha_chapter40_rule139

15 Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Geneva, 12 August 1949 and Common Article 3, as well as articles 12 and 15 - “Persons taking no active part in the
collect and care for the sick and wounded. Some contexts in which the warring parties may not be willing and/or able to provide essential life saving medical assistance to the affected population, have called for the support of external and/or humanitarian agencies, and other providers of medical services to fill the gap. Regardless of the organizational affiliations, the supporting response medical teams need to be guided to conduct operations framed by a set of agreed upon core principles, ethical conduct, adhere to minimum standards, and be patient focused. To not do so, risks the medical teams’ mission, safety of patients, safety of medical facilities and transport, as well as compromise of the medical mission’s intent/purpose as perceived by the civilian population and the parties to the conflict. Moreover, access to the affected population will likely be limited as the people may or may not seek care from teams they view as partial and/or biased or not.

To save lives and intervene in a timely manner, medical teams may increasingly be required to operate in proximity to active hostilities. Such deployments demand a high level of attention to risk management and engagement with stakeholders from all sides. Otherwise, medical teams risk appearing biased and to providing a military/political advantage to one side of a conflict. Therefore,

The Red Book is a practical guidance document for the principled preparedness, engagement, activation, deployment, coordination, protection, and monitoring of medical teams in armed conflict and complex emergencies.

A principled medical response is comprised of both operational and clinical interventions that are guided by and adhere to the core humanitarian principles of Humanity, Impartiality, Neutrality, and Independence. Operational considerations include appropriate leadership, logistical capacities, agility of teams, and understating of complexity and coordination requirements. Depending on the affiliation of the medical team (military, quasi-governmental, civil protection, NGO, or certain local providers) the principle of ‘independence’ (from public authorities or government) merits some exemptions and cannot be applicable to all. Moreover, as an MSF report states as pertains to local actors: “In terms of applying the principles, national and local actors may find several of the principles particularly challenging. As part of their defining characteristics, they are part of the society in which they work and live. Religious, ethnic and political affiliations, as well as economic privilege and power relations, all play a key role in the interaction between local actors and their domestic contexts.” Therefore, the MSF report continues: “Some compromises in the application of and adherence to the principles framework may be required but not all compromises are equally acceptable”. The document will also explore the consequences and implications when principles are not applied and IHL is not respected.

In the concrete realities of responding to war wounded and needs of civilians caught in armed conflict, the principles here are presented not as moral abstraction, but rather as rules, “based upon judgement

hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria. To this end the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:”

https://ihl-databases.icrc.org/ihl/7c4d08d9b287a42141256739003e636b/fe20c3d903ce27e3c125641e004a92f3


MSF, The Challenges of Localized Humanitarian Aid in Armed Conflict, 2016
and experience, which is adopted by a community to guide its conduct”\textsuperscript{18}. Medical teams that deviate by choice or unawareness can do harm to themselves, their patients, facilities, and other teams. The central mission of medical teams is framed by the Hippocratic Oath\textsuperscript{19} and the “do no harm” principle. Medical ethics\textsuperscript{20} provides a strong base for impartial and non-discriminatory care; however, it does not sufficiently address the critical nuances required to access civilian populations in armed conflict settings, nor does it address the practical and importance of neutrality in such contexts. Neutrality is a central principle that enables safe access affected populations, and engagement with parties to conflict. Neutrality and impartiality are often confused to be the same. While both demand a level of self reserve, the two principles differ in that a neutral person does not make judgments. “Neutrality demands self control and is a form of discipline we impose upon ourselves, a brake applied to the impulsive urges of our feelings”\textsuperscript{21}.

Applied Core Humanitarian Principles enable access to affected populations and help build relationships, trust and confidence crucial to fulfilling a medical mission

IHL and Medical ethics intersect in situations of armed conflict and can be mutually re-enforcing. IHL provides for a broader understanding of the ‘humanitarian space’ in that it is focused on mitigation of the suffering and impact of war on civilians’ lives and livelihoods; aims to limit and regulate methods and means of warfare; and is people focused and principled.

1.1 Scope, Limitations & Gaps
The Red Book is not intended to be a normative or policy document. It is a consensus guidance (not guideline!) for a select community of practice.

It is non-binding; however, it does assume voluntary uptake/acceptance by a diverse community of practice and is a consensus document. The scope of the work may include subject matters that are deemed beyond the control of medical teams and leaders [examples: peace talks, cease fires, means and methods for conduct of hostilities, control over patient selection and flow into facilities, etc...list...], but in which medical teams can influence events to save and protect patients.

It will provide recommendations for member states as to how to work in coordination with medical teams from an IHL perspective, focus on quality patient care and protection angles. As well as recommendations for non-state actors and other key stakeholders.

The assumptions can be challenged/undermined by the following:

\textsuperscript{18} Jean Pictet, Commentary on the Fundamental Principles, 1979
\textsuperscript{19} The Hippocratic Oath and the Ethics of Medicine, Steven H. Miles. Oxford University Press, 2004
\textsuperscript{20} “Ethical principles of health care do not change in times of armed conflict and other emergencies and are the same as the ethical principles of health care in times of peace.”
\textsuperscript{21} Jean Pictet, Commentary on the Fundamental Principles, 1979
1. Global trends in the conduct of hostilities including the increase in proxy wars disrespect of IHL may limit the acceptance and uptake for this guidance document.

2. National medical teams may not have the freedom or space to provide impartial and neutral assistance, in some cases the work may even by criminalized.

3. Given current global security paradigms, International Medical teams may risk prosecution at home if impartial conduct in the field is perceived to aid radical groups.

4. Challenges to core humanitarian principles as a Western/Colonial construct, coupled with alternative narratives that do not fault the instrumentalization of a (patriotic) medical mission in support of the achievement of military/political/political objectives.

5. Multiplicity and wide diversity of medical providers with broad and differing standards, definitions of quality, resources, mandates and missions.

6. Accountability frameworks go beyond the mandate of this work. Incentives and disincentives to promote principled conduct and behaviours require broader global governmental and multilateral agreements/treaties and norms.

7. Grey zones and inherent ethical and moral dilemmas in providing care in hostile and highly politicized and sensationalized conflicts.

1.2 Problem Statements & Focus

To ensure a practical and concrete approach, the document will focus on addressing the following gaps:

1. **Awareness:** Current level of awareness as to IHL applications/practices in armed conflict and complex emergencies is insufficient to guarantee a principled medical response, safe and secure operations, appropriate civilian-military coordination, and monitoring.
   
   [Some teams are simply not aware as to how IHL applies to response, others are aware, but lack know-how/resources to operationalize/contextualize, and a third group are aware, but do not accept the principles.]

2. **Compliance:** Current compliance with IHL needs better mechanisms, monitoring, and accountability frameworks.
   
   [Some teams do not have the freedom or choice to comply (risk prosecution!), others do, but do not see added value or incentives/disincentives to comply, and a third deliberately do not wish to comply]

3. **Suitability and Fit:** Current EMT classification, verification, and minimum standards need to be adapted to better fit contexts of armed conflict and complex emergencies including minimum technical standards, preparedness, and associated tool kits. This would necessarily include mechanisms to select (and therefore options to de-select) most appropriate teams for a particular context on a case-by-case basis. The criteria will also need to adapt/accommodate local and national team contexts who are the true first responders and require special recognition and support.
   
   [Some teams do not recognize the key differences in care provision within a context/environment of armed conflict versus natural disasters (beyond the obvious types of]
injuries), others do, but lack resources to prepare and conduct operations differently, and a third group may approach this with amateurism and are ill prepared.]

2 Medical Team Roles & Services in Armed Conflict & Complex Emergencies

Objectives:
1. Teams understand the operating environment/context of armed conflict and complex emergencies, as well as their respective role(s) and that of other key national and international actors
2. Teams increase awareness as to own personal and organizational fit (suitability) or non-suitability to provide medical care to various contexts

Key Reference Documents and existing Policy Frameworks:
[To be added here]

This chapter will include the following sections:

2.1 Context
• Explain the operational environment and context of:
  o 1. Insecurity, lack of access, shortages in supplies, minimal human resources, limited infra-structure, multiple providers (and only the very few in some scenarios), the possible chaos,
  o 2. from a health perspective: the types and nature of disease and injuries in armed conflict and complex emergencies, and not limited to war wounds & PoWs, but including the general medical/surgical needs of a population requiring maternal, pediatric, communicable disease, NCD, SGBV, chronic illness, mental health, and fear.

2.2 Expectations
• Explain the key expectations as related to quality patient care, professional conduct, self reliance, support services, liaison with others & continuum of care (from community based, primary care, transport, hospitals, physio/rehab, home care) and protection.
• List the main known groups of actors in medical services provision including local government, civil protection agencies, militaries, UN peace keepers, WHO, selected UN agencies, domestic and international NGOs, faith-based organizations, Red Cross Red Crescents, International bodies, professional associations and academic institutions, and private enterprise.
• Why do labels and brands matter? Perceptions matter! Trust, confidence, access, track records,
• Present the unique roles for each of the above groups and articulate possible niche/speciality areas, unique aspects of the mandates
2.3 International Agencies’ Roles

- Present the role of WHO as cluster lead, EMTs coordinator, normative body, and explain “provider of last resort”, and reference WHO Trauma Care Policy.

- Role of UN and relevant Policy: “The policy sets out measures that all United Nations entities must take in order to ensure that any support that they may provide to non-United Nations [security] forces is consistent with the purposes and principles as set out in the Charter of the United Nations and with its responsibility to respect, promote and encourage respect for international humanitarian, human rights and refugee law.”

- Reference UNSC Resolutions when relevant. Example UNSC 2286.

2.4 National Agencies’ and Local Providers Roles

- Elaborate the difference and challenges posed by complex contexts of internationalized and Non-Internationalized armed conflicts.
- Include a special section on the role of local providers in terms of having rapid access, deep knowledge of context/culture, special access to communities, and challenges (resources, affected, neutrality, etc).

2.5 The ICRC

- Present the role of ICRC and explain the special status vis-à-vis Geneva Conventions. The ICRC enjoys a status equivalent to that of an international organization and has international legal personality in carrying out its work. Also address role of oversight for medical care for POWs, detainees.
- Elaborate the medical team response capacities of key Red Cross Red Crescent Societies within a framework led by ICRC.

2.6 MSF

- MSF states: “We provide medical assistance to people affected by conflict, epidemics, disasters, or exclusion from healthcare. Our teams are made up of tens of thousands of health professionals, logistic and administrative staff - most of them hired locally. Our actions are guided by medical ethics and the principles of impartiality, independence and neutrality.”
- Present the unique role of MSF including the outbreak response leadership, knowledge, and expertise.
- Elaborate the ‘bear witness’ concept.

2.7 Key Medical Actors and Providers

2.8 Lexicon

- Propose a lexicon for the above.

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22 WHA Resolution 6520, WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies, 2012.

23 Page 1

24 https://www.msf.org/
2.9 Interdependence and Suitability
- This chapter may also begin to elaborate that given the varied and special roles and mandates for the various groups, the fit/suitability of various teams into differing contexts will depend on many criteria including experience, languages, known history, social media profile, public persona, nationalities, perceived political/military affiliations, perceived agenda, deployment durations, ability to build/strengthen local capacities, etc.

3 International Humanitarian Law (IHL) & Applied Humanitarian Principles

Objectives – *(Note that this is a key chapter to the Red Book Project)*
1. Teams will have better understanding of the critical role the application of IHL and core humanitarian principles have on medical care providers and their patients in armed conflict and complex emergencies
2. Teams will have a better understanding of the consequences and implications on non-adherence to IHL and implications on security and access
3. Teams will be able apply critical thinking (decisions & conduct) rooted in IHL in making medical and operational decisions at both HQ and Field levels

Key Reference Documents and existing Policy Frameworks:
[To be added here]

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How can medical teams provide services with 360-degree awareness of the entire operation (not simply within the perimeter of a field hospital) in a principled and ethical manner?

3.1 First, Do No Harm!
- Elaborate the roots and implications of ‘Do No Harm’ in both medicine and humanitarian/aid operations, and from a “conflict sensitivity” perspective25. This would entail critical thinking, reflective measures, and understanding of multi-dimensions of any context (politics, economics, social, environmental, etc)
- Provide examples

3.2 IHL in Practice

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25 Reychler, L. (2006). Humanitarian aid for sustainable peace building. In P. Gibbons & B. Piquard (Eds.), Working in conflict – Working on conflict: Humanitarian dilemmas and challenges (pp. 135-154). Bilbao: University of Deusto. - Conflict sensitivity means the ability to: 1. understand the context in which you operate; 2. understand the interaction between your intervention and the context (how the context affects the intervention and how the intervention affects the context); and 3. act upon the understanding of this interaction, in order to avoid negative impacts and maximise positive impacts (Resource pack)
• Revisit the central question of the chapter (with detailed answers/examples): How do medical providers conduct themselves and their entire operation (not simply within the perimeter of a field hospital) in a principled and ethical manner? What dilemmas will be encountered, anticipated, and offer approaches to handle.
• Explain the relevant IHL chapters from a practical viewpoint (with a target audience of medical providers and leadership) – Common article 3, articles 12,15
• Provide examples to highlight good practices and better illustrate the guiding principles.

3.3 Principles in Practice

• Provide operational examples for each of the four core principles (humanity, impartiality, neutrality, independence) to demonstrate field applications
• Explain consequences of non-compliance on team & patient safety, security, access, trust, confidence, etc.
• Share best practices and a list of suggested/recommended Do’s and Don’ts

Insert text boxes with examples for each principle.

3.4 Organizational & Individual Responsibilities

Articulate the expected level of awareness (relevant policies), professional conduct, and code of conduct as relates to IHL in the field and at HQ levels ranging from providing quality impartial patient triage and care, to media/social media statements/policies, to behaviors and actions towards the local communities/staff, authorities, warring factions, other providers, UN agencies, etc

3.5 Humanitarian Diplomacy & Negotiations

Define humanitarian diplomacy and importance of negotiating access to affected communities
Objectives of HD, Who is in charge, if any? Different levels of diplomacy.

4 Preparing & Deploying: Processes & Mechanisms
Objectives:
1. Teams understand the preparedness requirements for organizational systems, processes, communications, confidentiality, team profiles, trainings, kits, resources, and self-reliance
2. Teams understand the selection and decision-making processes for team Activation and Deployment

Key Reference Documents and existing Policy Frameworks:
[To be added here]

Current processes within the Blue Book of engaging with EMTs for the Blue book involves robust pre-verification, verification and classification components.

However, Red Book contexts [to be defined] will require additional preparedness steps. The level of effort and processes involved in preparing for, deploying to, and returning from missions are complex, demanding and require a high level of attention to detail, as well as both awareness of multiple internal and external parameters. Conflicts and complex emergencies, by definition, are dynamic, unpredictable, complicated, often with many local, regional and international stakeholders with varying interests and agendas.

Operating successfully in such contexts requires a deep understanding (and 360 degree awareness) of the nature and dynamics at play. Well prepared teams need both solid foundational trainings into the evolving nature of conflict and best methods for coping and delivering.

This chapter will build upon the Blue Book: Classification and Minimum Standards of Emergency Medical Teams (EMTs), and provides additional standards and criteria that teams wishing to declare capacity for deployment into armed conflict and complex emergencies need to consider.

4.1 Classification Enhanced

This section will highlight the additional key data points utilized in the classification/verification processes required for respond to armed conflict and complex emergencies. The current Blue Book classification of three types of units may be augmented with further [simple] sub-classification to capture the need for lighter, more mobile, and increased proximity to affected populations, PoWs (restate ICRC role), and war wounded.

Areas to be included, IHL team profiles/selection, expanded clinical care for war wounded, trainings, kits, media/social media/communications policies, logistics, protection, security training and management, protection measures & policies, critical incident management, insurances, management, community engagement policies, and other factors.
4.2 Activation & Deployment

This section will illustrate the process to activate and deploy teams including the necessary documentation and commitments and responsibilities for parties concerned (legal, financial, effort, support, logistics, communications, contacts, emergency procedures, etc).

This section will also build upon and extract the lessons learned from The Mosul deployments to provide a more generic model to illustrate different types of potential field set-ups. The illustration below does not sufficiently capture the local response. Future model(s) will need to account for the central role local providers play pre, during, and post emergencies and crises.

![Figure 1: Mosul, Iraq - The following displays the escalating request for trauma care providers;](image)

4.3 Who Decides?

Although not yet fully discussed, articulated or decided upon, the decisions as to who deploys, to be made by whom? With what criteria? Etc. will be elaborated including contexts that may be considered ‘grey zone’. In certain situations, no one may decide, or there may be multiple authorities with contradictory positions/decisions, and obscure groups may emerge!

The activation and deployment process often involve multiple teams with varying and complementary capacities. Close collaboration with National teams and between International teams in the field is critical. (see chapter xx). Deployment decisions will need to factor complementary capacities, geographic placements, and contexts on a case-by-case basis. And may exclude certain teams/nationalities as the context dictates.
5 Minimum Standards for Medical & Support Teams

Objectives:

1. Teams understand the standards of care and support services requirements, prepare for, and have ability (not just intention) to implement in the field as per declared capacities
2. Team leadership and management understand the complexity, critical thinking/analysis, and operational demands associated with deployments
3. Teams understand and comply with reporting and the special/confidential information management requirements

Key Reference Documents and existing Policy Frameworks:
Blue Book, Tool Kits, etc.
[To be added here]

This chapter will partially highlight and re-state selected sections/minimum standards from the Blue Book, and with Special section and considerations for National teams. This will include Dead Body Management and needs for documentation/identification/evidence collection if/when required.

This would also cover more robust requirements for self-sufficiency, QA, reporting, referral pathways, burns, care, leadership agility, etc

5.1 Logistics
5.2 Clinical
5.3 Leadership & Management
5.4 Information Management, Monitoring & Reporting
6 Security & Risk Management

Objectives:
1. Teams fully comprehend the risks, mitigation measures, security planning, and special preparations/trainings associated with providing care in armed conflict and complex emergencies (including in proximity to the frontlines)
2. Organizations/Agencies understand the minimum requirements for robust preparedness at HQ level of insurance, legal, health/mental fitness, communications, and critical incident management.

Key Reference Documents and existing Policy Frameworks:
[To be added here]

The chapter (another key one for the Red Book) will further elaborate the means and measures medical teams are required to undertake to protect the medical mission. It will present and highlight best practices, safe conduct, and specific Do’s and Don’ts referencing the work of ICRC, MSF, WHO on the topic. (reference and extracts to published works from ICRC’s “Health Care in Danger”, MSF’s “Not a Target”, and WHO’s “Attacks on Health Care initiative”)

This chapter will also include systems and procedures required by organizations at HQ levels including proper training, duty of care, critical incident protocols, and medivac arrangements.

A section on coping mechanism and managing stress in the field.

A section on the safety and protection of patients and vulnerable groups (women, children, orphans, disabled, elderly, minorities)
7 Special Requirements & Considerations

Objectives:
1. Teams, including specialized units, understand and can put apply/practice special protocols and measures required for the themes articulated below.

Key Reference Documents and existing Policy Frameworks:
[To be added here]

The is chapter will provide practical guidance for selected special topics that merit specific attention.

7.1 Engagement with Communities

An Introduction to centrality and importance of community engagement, as well as proven approaches and techniques. This will include working with local/national staff. It will also discuss the digital sphere and social media to highlight critical areas and measures that can be taken for mass communications on disease prevention, health promotion, promotion of positive coping behaviors. (and when not to utilize social media!)

7.2 Access to, & Protection of Vulnerable Groups

Define the various types of highly vulnerable groups expected to be encountered, including PoWs. Evidence base as to special medical and protection needs. Elaborate duty of care beyond the clinical components.

7.3 Outbreaks

- Explain role of Global Outbreak Alert and Response Network GOARN in surveillance and reporting [conversation with GOARN pending]. GOARN website: During outbreaks, the Global Outbreak Alert and Response Network ensures that the right technical expertise and are skills are on the ground where and when they are needed most.

GOARN is a collaboration of existing institutions and networks, constantly alert and ready to respond. The network pools human and technical resources for rapid identification, confirmation and response to outbreaks of international importance.

WHO coordinates international outbreak response using resources from GOARN.
- SOPs and Protocols for the set up and safe practice in outbreak response including coordination with key stakeholders dealing with prevention, community engagement/education, contact tracing, safe and dignified burials, Psycho-social support, and vaccination where applicable.

7.4 Chemical, Biological, Radiological, Nuclear, & Explosive (CBRNE) Considerations

Special clinical, operational, safety considerations for teams, patients, kits, and communicatees to address the unique aspects posed by various types of deliberate and non-deliberate attacks.
7.5 Technologies & The Digital World

This section will highlight the evolution of medical technologies (tele-health, tele-consultations, tele-radiology, etc) and implications for team compositions/profiles, infra-structure, and quality of patient care, communications.

Also address use of drones for medical and non-medical objectives, and implications for teams.

The digital identity of individuals and communities in the humanitarian sphere has been a topic of exploration and much writing/debate. Patients/communities share and communicate via social media and other forms of rapid communications that transcend borders and contents. Implications are to be presented and explored as to how to promote health, prevent disease and communicate en-mass to affected communities.
8 Prevention & Response to Sexual Based Violence & Exploitation

Objectives
1. Highlight the importance and role medical providers can play as to this very often taboo subject matter
2. Outline specific measures required for prevention, protection, and care, including legal duties on SGBV.
3. Provide concrete examples including advocacy measures

Key Reference Documents and existing Policy Frameworks:
[To be added here]

9 Coordination

Objectives:
1. Team leadership has clarity as to coordination mechanisms in place and their role/responsibility to contribute/inform/adhere to.
2. Team leadership understand the critical role various levels of coordination play for quality patient care including referral chains, continuity of care, sharing of resources, and standardized data.
3. Team leadership can put into practice functional liaison with military and UN peace keepers when present

Key Reference Documents and existing Policy Frameworks:
Health Cluster, EOC, etc.
[To be added here]

9.1 Coordination Mechanisms

e.g. Activated Cluster, EMT coordination cell, clinical care pillar within government-lead EOC, interface with humanitarian architecture, ad hoc? And how do all of the above relate to one another.
Define role and importance for each, explain roles of national actors.
Also elaborate IASC coordination mechanism and role of OCHA.

9.2 Civil-Military Coordination

Teams will require a solid understanding as the importance and mechanisms in place to liaise with both military medical providers and operational commanders. Civil-Military coordination (CIMIC) has evolved over the years and clear coordination platforms may be in place to engage with. This involves both focus on patient care and protection, alleviation of suffering, access to communities & vulnerable groups

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26 [https://www.who.int/hac/network/global_health_cluster/chapter1.pdf](https://www.who.int/hac/network/global_health_cluster/chapter1.pdf)
as well as safety and security for the medical mission. This will include coordination and liaison with UN peace keepers if present.\textsuperscript{28}

Deconfliction efforts are required, where deconfliction is defined as the exchange of information and planning advisories by humanitarian actors with military actors in order to prevent or resolve conflicts between the two sets of objectives, remove obstacles to humanitarian action, and avoid potential hazards for humanitarian personnel. This may include the negotiation of military pauses, temporary cessation of hostilities or ceasefires, or safe corridors for aid delivery. \url{https://www.irinnews.org/analysis/2018/11/13/what-humanitarian-deconfliction-syria-yemen}

Chapter will elaborate the types of relations that can manifest with military actors and providers, use of military assets and emblem use, operating with proximity to military operations\textsuperscript{29}, etc. (see figure below).

\textsuperscript{28} \textbf{Recommended Practices for Effective Humanitarian Civil-Military Coordination of Foreign Military Assets (FMA) in Natural and Man-Made Disasters}

\textsuperscript{29} Civil-military coordination\textsuperscript{1} during humanitarian health action Provisional version – February 2011 \url{https://www.who.int/hac/global_health_cluster/about/policy_strategy/ghc_position_paper_civil_military_coord_2_feb2011.pdf}
10 Quality Improvement

Objectives:

1. Teams include real-time data gathering, monitoring, and reporting systems with a set of internationally accepted quality indicators addressing patient outcomes, process efficiencies/effectiveness, and safety incidents.
2. Teams understand the centrality of patients in the continuum of care and are able to implement measures to limited siloed and/or risky interventions.
3. Teams understand the importance of evaluations and further studies beyond the deployment phase and can provide data/input into future research/publications including engagement with Academia.

Key Reference Documents and existing Policy Frameworks:
[To be added here]

Through a quality improvement lens, this critical chapter will introduce the expected levels of accountability against the agreed upon minimum standards (indicators) to ensure that teams can monitor, self report, course current in real-time, evaluate, and co-publish
11 Training & Human Resources

Objectives:
1. Organizations/agencies comprehend the minimum pre-deployment skill/competency requirements for team members and profiles
2. Organizations/agencies’ human resources and training units/departments gain an understanding for personnel training and briefing requirements pre, during, and post missions.
3. Provide a list of key recognized existing trainings (online and practical) that can benefit various groups and individuals

Key Reference Documents and existing Policy Frameworks:

The success of operations hinges on the ability of the team to function in harmony, provide quality care, and be safe/secure. Different team member profiles (beyond standard accredited certifications they present) may require special induction, refresher, orientation, practical trainings/updates just-in-time or on an annual or semi-regular basis. This includes management, medical practitioners, support teams and technicians, security personnel, etc. This also includes cultural sensitivity and exposure to the nature and complexity of the humanitarian/aid landscape.
12 Annexes

12.1 Standards of Care
Section that augments, expands or re-states what is in the Blue Book

12.2 Media & Communications

12.3 The Tool Kit
A specific section in being planned to elaborate and detail tool kit recommendations as to the various above requirements and minimum standards

12.4 Accountability
With a focus accountability to affected populations
https://interagencystandingcommittee.org/system/files/iasc_aap_psea_2_pager_for_hc.pdf


12.5 Reporting & Minimum Data Sets

12.6 References
13 Peer Reference Group Terms of Reference

The Red Book Reference Group is a peer review advisory team of experts that is envisioned to support, steer, co-author, and review the drafting of the Red Book. Working with the consultant on a needs basis, members of the group contribute draft and/or review relevant chapters/sections as per agreed upon subject matters. Members may also be required to disseminate and share the work on the Red Book with relevant stakeholders.

The Strategic Advisory Group (SAG) will have final say and sign off on the document.

Membership
By invitation, as per the focus areas of the Red Book. Some members will be required for the entire period of Jan to Nov 2019, others for defined durations associated with specific outputs agreed upon. The Red Book consultant will act as convener and chair of the Reference Group. The WHO EMT Secretariat will provide admin support as needed.

Engagement
The members of the group will be engaged based on a number of criteria including subject matter expertise, organizational affiliation/representation, relevant academic/operational background, and regional representation.

Examples of engagement include suggesting relevant references and guidelines, additional groups/individuals to consult with, flag pitfalls, draft select sections, co-author select sections, review/edit select sections, disseminate the work as needed, peer review, critique, propose solutions, etc.

Meetings/Communications
The group will meet mostly virtually utilizing appropriate communications technologies. An option to hold one face-to-face meeting is being considered during the first half of 2019 and linked with the launch of the first draft (late May or early June 2019).

Duration
Feb-Nov 2019

Level of Effort
The level of commitment, individual or organizational, will vary depending the subject matter focus area and availability of relevant references and materials. However, given the timeline associated with the Red Book project (final product planned for Nov 1 2019), the group will need to prioritize the drafts and reviews as needed.

Remuneration
The Group’s engagement will not be remunerated, but all associated expenses will be covered as per policy.
14 Authors, Contributors, & Reviewers