
Non-State Armed Groups, Health and Healthcare

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Background

In 2005 all WHO member states made a commitment to achieve universal health coverage. This commitment was a collective expression of the belief that all people should have access to the health services they need without risk of financial ruin or impoverishment, and that working towards universal health coverage is a powerful mechanism for achieving and promoting human development. In a similar vein, recommendations in the report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda include developing a ‘... *new partnership [that] should be based on a common understanding of our shared humanity, based on mutual respect and mutual benefit. It should be centred around people, including those affected by poverty and exclusion ...*’¹

Those affected by conflict, particularly non-international armed conflicts, deserve the same access as others to universal health coverage and a share in the post-2015 development agenda. Yet in conflict-affected areas, particularly where territories are contested or controlled by non-state armed groups (NSAGs), access is usually reduced and there is an increase in violence against health systems (patients, health personnel and health facilities). In these areas, healthcare is available to a greater or lesser extent from a variety of agencies and organizations, including NSAGs. As part of a wider project examining the relationship between health and conflict, a two-day roundtable was held in Geneva to address how NSAGs contribute to the provision of healthcare during conflict, to examine the barriers to their providing health services and to consider how such barriers might be eliminated or mitigated.

This is a summary of the key points made at the roundtable, which brought together current and previous members of NSAGs and selected representatives of international organizations, non-governmental organizations (NGOs) and academia. It is emphasized that this document is a summary of what was said at the meeting, with additional explanatory comment when thought necessary, and is not a representation of the views or position of the authors or any single contributor. The meeting was held under the Chatham House Rule,^a but a breakdown of attendees by category is shown on p. 14 of this summary. The purpose of the meeting was to identify the contribution that is, or could be, made by NSAGs, operating in situations of armed conflict, in safeguarding access to healthcare to their wounded and sick fighters and to the civilian population; what barriers there are to NSAGs working to improve access to healthcare; and how such barriers can be overcome.

The roundtable was preceded by presentations and analysis of two papers on the issue that were subsequently published. One was written by Chatham House² as part of the CAERUS Project,^b a European Union-funded initiative to develop policy options for post-conflict stability, while the other is a publication issued by the International Committee of the Red Cross (ICRC) as part of the Health Care in Danger (HCiD) Project.^c The ICRC publication presents operational practices and relevant international humanitarian law (IHL) concerning armed groups in relation to safeguarding the provision of healthcare during armed conflict. A summary of the background papers can be found in Annex A of this summary.

^a When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.

^b The CAERUS project involves an international consortium exploring the transition from conflict to recovery and development, seeking to identify those policies that maximize the likelihood of a successful transition. More information can be found at: <http://caerus-info.eu/>.

^c The International Committee of the Red Cross (ICRC) began the Health Care in Danger (HCiD) project in 2011 under the auspices of the Red Cross and Red Crescent Movement. In this framework, the ICRC has consulted a wide range of individuals and organizations keen to develop practical recommendations aimed at improving the effective and impartial delivery of healthcare during armed conflict or other emergencies. The report, *Safeguarding the provision of Health Care: Operational practices and relevant International Humanitarian Law concerning armed groups*, can be found at <https://www.icrc.org/eng/resources/documents/publication/p4243.htm>. More information on the HCiD project can be found at: <https://www.icrc.org/eng/what-we-do/safeguarding-health-care/index.jsp>.

The meeting was divided into three sessions. The first two were intended to be factual, drawing on the participants' experiences of how NSAGs were involved in healthcare and the barriers to NSAG healthcare provision. The report on these sessions is a compilation of the contributions by the various participants. The third session addressed how barriers to NSAG-provided healthcare could be mitigated, and an attempt has been made to order the various contributions thematically. The meeting addressed healthcare provided by NSAGs for themselves, and – when this was the case – for the civilian population, although speakers did not always make this clear distinction.

Not all armed groups play the role of healthcare provider, or are willing to play such a role. However, the intention of the conversations was to take stock of some armed groups' practice as healthcare providers and to identify obstacles and solutions. Many practices and examples shared refer to armed groups that are no longer active and/or had or have political motivations.

Experiences in the field

NSAGs take many different forms, and they vary in the contexts within which they work and in their relationships with governments and external backers

The variety of NSAGs and the services they offer is often overlooked. NSAGs are generally perceived as being only a problem for health (e.g. disrespecting IHL, attacking health posts, or endangering health workers). This characterization may apply in many cases, but it overshadows the fact that several NSAGs play constructive roles in health – for example, providing services in remote areas and to groups of civilians not covered by the state. The provision of healthcare has also been shown sometimes to act over time as a moderating influence on combatants, whereby NSAG members adopt some of the professional ethic of the healthcare professions (such as respect for injured persons).

Health service provision in conflict situations is complex and provided by many actors.

The bigger picture of health service provision in conflict situations should be considered, and efforts should be made to better understand how the various pieces fit together. There are often multiple healthcare providers in conflict: the state, NSAGs, external aid organizations and external development partners. With all these different groups, there is a need to understand how NSAGs fit, or could fit, into the broader scheme of health services provided for populations. For example, in the 1980s the Tigrayan People's Liberation Front trained more than 20,000 health personnel, including 12,000 village and sub-village health community assistants and traditional birth attendants, all of whom worked direct with the community and not as fighters. Another example is Polisario after the end of Spanish occupation. It set out a main objective to provide free healthcare for every Sahrawi, which involved building from a weak health infrastructure to an infrastructure with laboratories and pharmacies for drugs and vaccinations.

In conflict settings, there is a major fragmentation of actors and the services provided.

The space for negotiating and providing services to populations where NSAGs operate is much more complex and fragmented today than it was in the 1970s and 1980s. Then, for example, conflicts in Angola, Kenya and Ethiopia were characterized by having only a small number of NSAGs. Today in Libya, for example, there are more than 300 militias, while in Afghanistan it is alleged that there may be hundreds

of non-state armed actors operating across the provinces.^d For many of these armed groups, gaining territory is often much easier and a higher priority than is managing public services.

In addition to providing healthcare services or systems in areas or populations that they control, NSAGs often have affiliated organizations that work with international organizations and international NGOs

These affiliated organizations are sometimes humanitarian wings set up by NSAGs, including healthcare organizations that have been established covertly by armed groups or that are openly linked to them. They frequently partner with international organizations. For example, many mine action organizations set up by, or linked to, armed groups work with, and are trained by, some international agencies. It may be easier for donors to work with the affiliated organizations than with the armed groups themselves. It is important to acknowledge that such organizations have sometimes been established by the armed groups, or at least most are authorized in some way by them. These affiliations could provide an opportunity for the international community to work more closely with, and influence, NSAGs.

Sometimes NSAG-provided healthcare is used as a device to reward supporters or punish others

While there is evidence that some NSAGs provide healthcare impartially and have even incorporated this principle into their codes of conduct, this is not always the case. Some armed groups will destroy healthcare provided by their opponents (which applies to both the state and NSAGs) or to populations that they consider supportive of the opposite side.

In times of conflict, warring parties, including armed groups, may provide uneven distribution of aid, rewarding those in the community who have provided, or whose relatives have provided, support. An important consideration should be how to ensure the impartial delivery of aid that covers a range of health issues.

Barriers to NSAG-provided healthcare: military

NSAGs are frequently in conflict with a state that directly targets their ability to provide healthcare

Unsurprisingly, the state acts as a major barrier because it frequently aims to cut off the capacities that allow NSAGs to function. To note, states have a legitimate right to do so in order to maintain or to re-establish law and order in the state's territory, or to defend the national unity and territorial integrity of the state. This will often affect the provision of healthcare. Some participants in the roundtable expressed the view that in some conflicts, that the state (in contravention of IHL) directly targets health structures in order to undermine and weaken an NSAG or to undermine its credibility where that group is providing healthcare to civilians. Thus, the NSAG's own wounded, and sometimes civilians as well, must be

^d For example, the UN Assistance Mission in Afghanistan (UNAMA) uses a broad working definition of NSAGs that estimates there were 1,800 such groups in Afghanistan in 2009, although other, narrower definitions would result in a smaller number. For more information, see the Disbandment of Illegal Armed Groups (DIAG) website (<http://www.diag.gov.af/diagproject>). DIAG defines an illegal armed group 'as a group of five or more armed individuals forming an association outside of the lawful state security organs, drawing its cohesion from (a) loyalty to the commander, (b) receipt of material benefits, (c) impunity enjoyed by members, (d) shared ethnic or social background'. For more information on the definition of NSAGs, see Krause K and Milliken J. Introduction: The Challenge of Non-State Armed Groups. *Contemporary Security Policy*. 2009; 30 (2): 202-20.

constantly moved around to avoid attack or capture, and additional resources are needed to construct underground health facilities, for example.

The illegal nature of armed groups under domestic law makes it extremely difficult for them – or for any civilian populations for whom they are assuming responsibility – to gain access to medical supplies and treatment

According to IHL, the wounded and sick, be they civilians or members of armed groups, have the right to be treated. If healthcare is not available in areas where they find themselves, they may have to cross borders. Although states may take specific security measures in respect of some wounded and sick persons, the need for medical treatment must prevail over these security considerations. None the less, some participants in the roundtable raised the issue of borders guarded by state militaries that block the movement of the wounded and sick members of NSAGs, or even civilians suspected to be affiliated to NSAGs, hampering their access to medical treatment.

In this regard, each party to the conflict bears the primary obligation to meet the needs of the population under its control. Moreover, impartial humanitarian organizations have the right to offer their services in order to carry out humanitarian activities, in particular when the needs of the population affected by an armed conflict are not fulfilled. Once impartial humanitarian relief schemes have been agreed to as required by IHL, the parties to the armed conflict must allow and facilitate the rapid and unimpeded passage of the relief schemes, subject to their right of control. They must also ensure the freedom of movement of authorized humanitarian relief personnel essential to the exercise of their functions, and only in cases of imperative necessity may their movements be temporarily restricted.

However, participants shared examples of cases where the passage of medical equipment and supplies was denied. Besides the obvious negative direct impact on patients, it was pointed out that such practices might push NSAGs to find novel and tortuous routes to obtain supplies, including ones that breach IHL (e.g. looting state-run medical facilities not under their control). The challenges facing NSAGs in obtaining medical supplies limit the supplies that NSAGs are able to obtain and add delays to the use of such supplies.

Barriers to NSAG-provided healthcare: legislation and perception

International counterterrorism legislation limits the ability of humanitarian aid to reach populations living in territories under NSAGs, designating them as being under terrorist control

Counterterrorism measures, such as standards and rules for funding set by states and/or the UN and other international organizations, often prevent donors from affiliating with, funding or providing support to any NSAG-provided health activities. In other cases, some roundtable participants considered that legislation had reduced the ‘risk appetite’ of many faith-based humanitarian organizations to engage with certain armed groups. This is particularly acute in organizations that perceive their reputation to be highly vulnerable, most notably faith-based Islamic NGOs.

A report published by the Norwegian Refugee Council and UN Office for the Coordination of Humanitarian Affairs (OCHA) in 2013³ showed that counterterrorism legislation is directly affecting humanitarian action by restricting funding, stalling project implementation and fostering a climate of self-censorship by aid workers. The report provides two pertinent illustrations, from Somalia and the occupied Palestinian territory (oPt). Between 2008 and 2010, following the United States’ decision to list

al-Shabaab as a terrorist group in 2008, there was an 88 per cent decrease in earmarked aid to Somalia; in the oPt, beneficiaries can be excluded from humanitarian aid, especially in Gaza and areas under Hamas control. (Hamas is listed as a terrorist organization and subject to sanctions by a number of states that are also significant humanitarian donors, among them Australia, Canada, the EU, Japan and the United States). In some cases, the risk of criminal prosecution and reputational damage can lead to overcompliance with counterterrorism legislation. Problematically, the NGO community did not react and challenge such legislation, an example being the US Patriot Act, drafted following the 9/11 (11 September 2001) attacks on the United States.

National legislation makes it difficult for international organizations and actors to offer support to NSAGs providing healthcare, and also affects the care for NSAG fighters and supporters

In many armed conflicts the state will not acknowledge a conflict with an NSAG; instead, the state will characterize this as an issue of domestic law enforcement, which effectively criminalizes the NSAG. Even when conflict with an NSAG is acknowledged, the latter usually remains criminalized.^e

The implications of this are seen in practice when the state's laws are applied to hospitals and/or healthcare professionals who are sometimes required to pass individual patient information to the authorities for specific conditions (e.g. gunshot wounds) and in a particular manner that will enable identification of NSAG fighters, and in some cases supporters. This clearly deters many NSAG members from going to state hospitals or indeed any medical facility under the control of the state in order to receive care. In some cases, information requirements can even run counter to medical ethics (e.g. when they serve no health-related purpose).

The labels applied to NSAGs (whether or not deserved) also act as a barrier to healthcare provision in territories controlled by NSAGs

Many NSAGs are labelled by media and government as terrorists or destroyers of state services. Although many NSAGs are responsible for destructive behaviour, a number of NSAGs provide services that benefit civil populations. The widespread negative portrayal by the media and states makes it exceedingly difficult for donors to contribute to their programmes, including those designed to improve the quality of health services. Stable funding is necessary to implement health programmes, but many armed groups (including affiliated organizations) are unable to gain financial support for healthcare programmes from major international donors – even where the intent is to provide care to civilians – because of the pervasive negative perception of NSAGs.

NGOs have to think carefully about their reputation and image when providing assistance to a particular group in conflict, because such decisions can affect an NGO's ability both to fund itself and to collaborate with external partners. Recently, this has made it difficult for some faith-based organizations to provide aid unless the services and funding provided are very clearly community-based.

Health is often low on the political agenda in post-conflict settings, especially as the course of the post-conflict peace process is predominantly political in nature.

Post-conflict processes that ensure the integration into public health services of NSAG members with valuable health-related skills are frequently lacking. However, an example was given where NSAG health

^e See article 3 (2) common to the Geneva Convention: “the application of the preceding provisions shall not affect the legal status of the Parties.”

personnel were incorporated into the post-conflict health system in Angola; this serves to demonstrate that it is possible to overcome the political barriers to integrating health concerns and personnel into the peace process in post-conflict settings.

Barriers to NSAG-provided healthcare: economic and health resources

The lack of trained healthcare workers is a significant barrier to NSAG-provided healthcare, especially in countries with few registered doctors

The quality of health services provided by NSAGs, or available from other providers in areas controlled by NSAGs, is generally much lower than state and international standards. High-quality services are hard to guarantee for the long term, especially in volatile areas where the sustainability of integrating military health personnel in development (using UNDP, WHO or other organizations) is still to be addressed. ‘Brain drain’ – the outward migration of highly trained and intelligent people from a particular country – is another issue in conflict areas, as doctors and other healthcare workers often try to leave and rarely wish to return. Many medical doctors and other health personnel are also leaving conflict-affected countries because they are being targeted. In the Central African Republic, for example, there are now fewer than 200 national-registered doctors, very few of whom are specialists.

Although medical referrals of patients from the community to specialist levels of care are crucial in the provision of healthcare, it is extremely challenging for NSAGs to refer patients – particularly if they are denounced by a community where specialist care is available. For example, an NSAG member in the southern Sudanese province of South Kordofan would be subject to many difficulties, such as the risk of being arrested, if referred to a cardiac hospital in Khartoum or even in neighbouring South Sudan.

The lack of access to specialist services also has a knock-on effect on healthcare provided by NSAGs at the local level – whether to the civilian community or their own fighters – as the inability to interact with specialists hinders the development of quality medical services that go beyond basic health services at the community level.

There is a need to put greater emphasis on the importance of preventive measures and means of sustaining them after the conflict

Paying attention to preventive health measures – such as education and counselling, or community planning and coordination – is a cost-effective way to identify and address potential health problems before they develop or worsen. They are often a low priority on the health agenda, but are critically important for averting future health crises and can be particularly effective. One example was given in which an NSAG eventually came to recognize the value of prevention for the civilian community in the territory that it controlled.

There may be a disproportionate focus on communicable diseases and on health issues associated with military forces, with insufficient attention given to the major challenges of chronic diseases and women’s health

A good example is the crisis in Syria, where there are numerous chronic diseases and mental health issues that have been left unaddressed. The focus on communicable diseases raises the question of whether NSAGs are providing some types of health services but not others.

Medical equipment and medicines are also lacking, or can't be delivered, in many areas where NSAGs operate

For example, backpack health workers in Myanmar and the various health clinics in Karen (Kayin) state are forced to operate with very minimal funds and resources. Lack of infrastructure in NSAG-controlled areas often means that health workers must physically carry the sick or wounded from place to place. Equipment is very under-resourced and underprovided in such areas, and obtaining it requires cumbersome travel to other districts or countries.

There is reluctance on the part of many in the international community to engage with on-the-ground providers of healthcare and to map what is needed, where it is needed, and how to get it provided for. Strengthening data collection, statistics and mapping will be essential to supporting these healthcare providers in the future. NSAGs can act, and in fact arguably should act, as a collector of important data, but some NSAGs reported that in spite of wishing to do so they encountered numerous obstacles (including internal organizational ones) and considered that more thought was required as to how to better collect and process relevant data.

Barriers to NSAG-provided healthcare: religion, culture and education

Religion and culture can also serve as barriers to providing healthcare, for example in the case of funeral and burial practices

There are different circumstances in which religion and culture may have an impact on the provision of healthcare. For instance, some international organizations have found it increasingly difficult to place international personnel to support health structures in Islamic communities. It was claimed, for example, that one organization came under pressure to staff regional offices with local people with religious affiliations similar to those in the community, rather than with workers coming from Western traditions. Religion could also be a barrier to women and children receiving certain healthcare services – such as abortion or emergency contraception – in Islamic areas, or where some funders, influenced by Christian doctrine, require assurances (which are more difficult to give or to audit in NSAG-controlled areas) that their funding will not be used for abortion and contraception. Similar or analogous issues are reported in areas where local beliefs are antagonistic to Western-style medicine or practices, such as the cultural beliefs that surround funerals in Ebola-affected states.

Lack of knowledge and understanding of IHL can affect and impede the impartial delivery of healthcare

Knowledge and understanding of IHL plays a major part in ensuring compliance with IHL in armed conflict situations, which should reduce illegal interference with healthcare provision – regardless of who provides it. This is a subject promoted, among many others, by the HClD project of the Red Cross and Red Crescent Movement, which aims to improve the efficiency and delivery of effective and impartial healthcare in armed conflict or other emergencies.

Towards removing the barriers: military and political barriers

When discussing removing barriers, military and political barriers were combined because solutions for each were frequently interlinked.

Ways to integrate actors working to provide healthcare should be explored

There are several benefits to integrating local actors working to provide healthcare impartially: minimizing the ‘brain drain’ of healthcare workers; moving healthcare out of the domain of conflict in the long term; and reducing NSAG health workers’ association with military objectives and delivery, and instead realigning it with civilian delivery and more traditional healthcare norms. This could have a moderating impact on abuses of IHL. In the Zapatista movement in Mexico, for example, civilian healthcare was originally part of the programme of Zapatista military healthcare provision. Despite the political conflict, the Zapatistas maintained civilian healthcare provision, and over time they made strong efforts to tie healthcare provision into local forms of civilian government.

Establishing who in the health field will provide leadership over this area is important

There is a pressing need to establish a leader in this area that can help coordinate all health actors in non-international armed conflict (where territory is controlled by NSAGs) and resources throughout the duration of a conflict and afterwards. Although there are many functions that are best fulfilled by other actors, and a range of institutions can play a part in the context of UN interventions, the WHO plays, or should play, a particularly important role because it is the only health agency that is present before, during and after conflict. Leadership – whether from the WHO or another organization – is essential because there is a growing and widely recognized need to bring together health and health-related organizations to coordinate resources and influence health personnel and units to behave in compliance with international law.

It is important to look at non-state and state actors to avoid parallel services where possible, and to consider whether external actors can reinforce systems and facilitate convergence rather than build new ones

The international community should avoid creating unnecessary parallel structures, which can end up causing more harm than good because they replace or compete with the local capacities that exist. Furthermore, international organizations should think about how they can support the local development plan and the surrounding communities to reinforce systems that are already there. In the case of state or non-state armed groups, the international community should think about supporting and rebuilding schools and health centres rather than setting up parallel and duplicate services.

Consideration should be given to intervening through communities

The importance of community engagement has been a lesson learned from the Ebola outbreak, as organizations such as the WHO have recognized how valuable communities are in implementing health programmes and conveying messages that promote healthy behaviour. There should be a stronger focus on working with communities to see how local demands can affect NSAGs’ investment in increasing access to health services or improving their quality. It requires a lot of work to build the capacity of members of communities to ensure that they understand their human right to have access to health services and good health outcomes, and to enable them eventually to conduct the negotiations with the NSAGs themselves. It was said at the meeting that this process has taken place and is ongoing in Afghanistan in Taliban areas. Organizations such as the WHO sometimes ask communities to consider interceding with an NSAG in order to get the latter to feel responsible for what is delivered into the community over which the group has a certain control.

Creative ways should be found to overcome the barriers created by counterterrorism legislation

This is an important area for research that has attracted quite a bit of attention within the humanitarian community over the past five years or so, as agencies have taken a more pragmatic stance. Because of the impact of counterterrorism legislation on humanitarian programmes, health-concerned actors should collaborate and try to play a role in influencing counterterrorism legislation. It may be necessary to recommend amending current counterterrorism legislation and exclude humanitarian relief from its scope, even in ISIS-controlled areas, for example. This may be difficult or impossible to achieve, but there need to be ways to deliver healthcare and other humanitarian assistance to populations living in areas controlled by NSAGs. Influential voices must also be added to this debate, especially from the health sector.

It is important to think about building in sustainability and development from the beginning of the intervention

The objectives for health actors are very different during a conflict from those after it. During conflict, providing access to services is often the paramount goal of health actors. Post-conflict, the focus shifts towards building capacity and seizing the opportunities created (for example, taking advantage of the international actors present and resources available). When entering the post-conflict phase, there is a need to address the long-term functioning of services. Many services normally provided by local authorities can be provided by NSAGs, but the provision of healthcare – involving medical doctors, training, supply chains, vaccinations, laboratories and a functioning blood bank – is much more challenging.

Healthcare needs should be built into peace processes to enable health to play a central role in post-conflict development, and not a secondary role to political processes

Typically, health provision has been seen as a technical issue, an area to be dealt with after the peace process had ended. However, it is increasingly important to place healthcare needs on the table during ceasefire discussions.

The integration of UNITA health personnel in Angola provides a robust example of how health workers can be assimilated into a national health system post-conflict. UNITA and the Angolan government ministries, for example, raised healthcare needs during the peace negotiations, thereby spurring the reintegration process. After the conflict ended, the UN Department of Humanitarian Affairs (now OCHA), other international organizations and local governments helped to promote dialogue between the health professionals of the UNITA and existing national health systems, which led to the adoption of a set of national guidelines and protocols on priority health issues. As a result of these processes, about 1,500 demobilized UNITA military health personnel were functionally incorporated into the national health system.

The case of Angola helps show that it is critical to involve NSAG actors themselves at the table and not just civil society groups and international organizations. The participation of NSAGs in wide multi-stakeholder negotiations about reintegration is vital to the success of the reintegration process. The healthcare community must also learn to understand the mediation–peace–disarmament, demobilization and reintegration (DDR) process better, as it has been highlighted that there has not been much debate as to how this can be used to improve the leadership of post-conflict health systems.

Despite the value of integration of health in peace processes, it is nevertheless important that health is not reduced to an instrument used for political ends in the negotiations. In the case of Karen state, for example, it was alleged that an unintended consequence of the ceasefire was the strengthening of Myanmar state healthcare structures and the withering of those of the local ethnic groups, as a result of the redirection of financial resources. The danger of emphasizing healthcare in the wrong way is that it may create the conditions for renewed political competition, which intensifies the conflict drivers and makes further conflict more likely.

Nevertheless, integration of health workers into the peace process makes it more likely that what was agreed in the peace process will be followed up, and also that healthcare services can be built into longer-term development practices. This will also help gain support from donors who are interested in long-term sustainability of the funds they provide.

Towards removing the barriers: economic and health resources

Cross-border support, medical resources, training and an international community engaged on all sides of a conflict are needed to ensure better all-around outcomes

There should be a focus on investing in people, be they backpack health workers in Myanmar or providers of health education in other conflict-affected areas. There have been some successful cases where special agreements have been reached or space has been arranged for humanitarian services, such as polio vaccination campaigns in Afghanistan, Angola and the Democratic Republic of the Congo.⁴ Note should be taken of the lessons learned and the experiences that have made this coordinated delivery possible, as well as of the agreements that have been reached between the different parties to the conflict. However, readiness to seek innovative solutions through task shifting and the use of mobile platforms for delivery is also important when fixed structures are not possible.

Health systems strengthening can have major benefits, including the civilianization^f of military health workers, the creation of task shifting, and the building of the foundation for a basic package of health services among NSAGs. Training for the delivery of health services is of paramount importance. Supporting training programmes will facilitate the reintegration of health resources and personnel post-conflict and help the building of effective health systems. Additionally, more needs to be invested in supporting the continuation of medical education systems during conflict so that the country continues to produce health professionals.

The delivery of quality health services requires a coordinated approach, based on improved data systems and existing tools such as technical standards

Better data systems are needed to help with identifying needs and pinpointing where resources could help delivery. Data systems that work across NSAG territories are of critical importance – for example, those that allow for prompt identification of, and response to, infectious disease outbreaks. The initial data received by the WHO about the first cases of polio in Syria came from medical institutions that were working in the opposition-controlled area and participating in an early-warning system that was put in place and supported by a medical group also working there.

^f To civilianize means to ‘make (something) non-military in character or function.’ Source: Civilianize. [Online] Oxford Dictionaries. Oxford: Oxford University Press; 2015. Available from: <http://www.oxforddictionaries.com/definition/english/civilianize> [Accessed 16 September 2015].

Whatever solutions are prescribed, they need to be contextualized to adjust for the local dynamics. It is important to work with local actors – rather than just with international institutions – towards building the capacity of local health sector human resources and systems. Health information systems should not only follow international standards for delivery, but also should assess the needs and epidemiological profile of the specific country and populations involved.

Towards removing the barriers: perception

A nuanced understanding of NSAGs needs to be developed, and the misperception corrected that all NSAG actions are destructive

It needs to be acknowledged that NSAGs vary in their form and in their actions. Many NSAGs are involved in destructive activity, but there are many that can play a constructive role, and some that may be categorized as having both destructive and constructive impacts, as evidenced in the literature and in fieldwork with NSAG actors. It is essential to develop a holistic understanding of NSAGs and to use the findings to challenge the model that has been dominant in the international community's agenda – which has limited NSAGs' ability to provide healthcare services.

Fundamentally, some of the assumptions underlying the way in which these issues are currently approached need to be challenged. While states are the legitimate authority on health issues, NSAGs that control territory or populations may be able to articulate the requirement for the provision of services to populations. It is important to have a more comprehensive discussion of how the needs of a population affected by conflict are represented and recognized, particularly if articulated by NSAGs, while recognizing that much of the formal international architecture – including the UN system – finds it very difficult to see beyond the dominant and familiar member-state-based paradigm. Given the complexities, the UN may be best suited to lead on certain areas of the global response to conflicts, while other organizations may be better suited to lead in other areas.

Towards removing the barriers: religion, culture and education

The importance of religious law in many societies needs to be acknowledged, and the common ground between traditional or religious law and international law emphasized

Islamic rules of war share many commonalities with IHL, and emphasizing common rules – such as do not attack the wounded or sick – is important. The international community should emphasize the mutual responsibilities required by these health rules in conflict by, for example, underscoring that opponents should assist the wounded and sick regardless of their affiliation. There should be a focus on creating trust between the parties, and on highlighting what they can gain from respecting adversaries' development of healthcare capacity.

It is essential to educate the international community and NSAGs about the impartiality of healthcare

Acceptance of IHL, and in particular recognizing that healthcare should be impartial while also recognizing that it does not have to be provided by neutral actors, will benefit the populations affected by conflict. This requires understanding of IHL, which in turn requires education. The current Red Cross and Red Crescent Movement HCiD project seeks to raise awareness among all stakeholders in the provision of healthcare about their legal responsibilities and the practical ways to comply. Parties to a conflict may

consider it entirely reasonable to use healthcare as a military or political instrument, and efforts are therefore required to ensure that they comply with their legal obligations to provide impartial healthcare and not to obstruct others from providing it.

Note on attendees

The breakdown of the background of those attending the roundtable (some are counted in two categories) was:

Academics: 5

Consultants: 3

Members of/associated with/work or worked with NSAGs: 7

Members of international organizations: 4

Members of NGOs: 5

Members of non-health policy units: 3

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The views expressed in this document reflect comments made by participants during the roundtable, and nothing written should be interpreted as reflecting the views of Chatham House, the ICRC, Geneva Call or any other participant. Responsibility for this summary lies entirely with Chatham House.

Annex A – Discussion of background papers

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The interpretations of the two works referred to in this summary do not necessarily represent the views of the works' authors.

The roundtable drew on two documents: one a report (subsequently published in June 2015) by the ICRC, *Safeguarding the Provision of Health Care -- Operational Practices and Relevant International Humanitarian Law Concerning Non-State Armed Groups*, arising out of its Health Care in Danger (HCiD) project; and one by Chatham House, a literature review of health and healthcare by non-state armed groups, as part of its CAERUS Project.

The following points are drawn from the documents. (They are not intended as a summary of the works, and have been edited to make them relevant to the roundtable and to facilitate debate.)

The two documents address NSAG involvement in healthcare services from different perspectives. The ICRC report is derived from interactions with NSAGs themselves, motivated by a desire to improve healthcare by enhancing coherence with various principles of humanitarianism and compliance with legal instruments, and to develop practical measures. In contrast, the Chatham House paper, derived solely from published literature, seeks to understand the extent of NSAG engagement in health and healthcare provision, and to identify explanatory factors that underpin this engagement. There is synergy between the two works: the premise of the Chatham House paper is that by understanding the factors that have led to constructive and appropriate healthcare provision by NSAGs, it may be possible to support or enhance that care and to incentivize other armed groups to start providing health services. The ICRC report focuses on respecting, protecting and facilitating access to and provision of healthcare in non-international armed conflicts by taking measures that are compliant with or go beyond IHL. The thrust of both papers is that it is possible to provide healthcare during non-international armed conflict.

The ICRC report highlights the documentation between January 2012 and December 2014 of 2,140 incidents of violence against healthcare workers (perpetrated by a combination of state forces, criminal gangs, family members and NSAGs), affecting at least 3,958 persons in a selected number of countries affected by non-international armed conflict. The ICRC analysis indicates that 26 per cent of such incidents are attributable to NSAGs. In addition to the immediate impact of such incidents, the ICRC report makes the point that all acts of violence against healthcare workers have a wider knock-on effect by contributing to reducing access to healthcare for whole populations. This is significant and yet is all too often overlooked as a humanitarian issue.

As a consequence, the ICRC over the last two years has consulted members of more than 30 NSAGs that are (or have been) involved in non-international armed conflicts around the world. The armed groups that have been willing to participate in this endeavour are very diverse, yet issues they have described regarding the safe delivery of healthcare have often been similar in nature. The openness, constructive spirit and commitment of those involved in the consultation process allowed for a deeper understanding of certain issues related to violence against healthcare workers and resources and of identifying practical measures to remedy them.

These measures are presented in the ICRC, report and revolve around 10 key principles:

1. Ensuring healthcare personnel are allowed access to the civilian population
2. Respecting and ensuring the safety of healthcare personnel
3. Understanding and respecting principles of healthcare ethics
4. Respecting healthcare facilities and ensuring access to medical supplies
5. Mapping healthcare facilities
6. Taking precautions when planning and conducting military operations
7. Respecting wounded adversaries
8. Collecting and caring for the wounded
9. Ensuring safe and speedy passage of medical transports at checkpoints
10. Respecting the protective emblems

The ICRC report recognizes that the contexts in which NSAGs operate are very varied, and that both intrinsic and extrinsic factors influence an armed group's behaviour around the provision of healthcare. The intrinsic factors include an NSAG's organizational capacity, its degree of command and control, its operational policies, and the extent to which it controls territory. The extrinsic factors include the nature (quality, quantity, extent) of the existing health services, the nature of the environment and the behaviour of opponents towards the NSAG.

The report outlines the legal obligations that bind NSAGs, and the views of NSAGs on their adherence and commitment to these legal principles, as well as suggestions as to how the intent of NSAGs to adhere to the legal principles could be improved in practice. The suggestions include attention to formal doctrine, training, disciplinary policy, standard operating procedures, debriefing after operations and public declarations. The report also makes practical recommendations on how medical personnel may be respected, and on how the care of the sick and injured may be facilitated and supported. This includes making arrangements and linkages with healthcare personnel over access, treatment and training; resourcing their own NSAG healthcare personnel; ensuring that NSAG members know (and respect) the location of healthcare facilities (including medical vehicles and supplies); and ensuring that they know, respect and do not misuse the protective emblems.

The Chatham House study seeks to provide a better understanding of NSAGs' involvement in healthcare through an analysis of academic and grey literature. It highlights the fact that many academic papers portray NSAGs in a negative light, assuming that they act out of motives such as greed; while the reality suggests this is overly simplistic, with many examples of NSAGs being the sole providers of healthcare, of NSAGs cooperating with state-provided healthcare or through various co-opted NGOs, and of NSAGs taking over and operating (or sanctioning the operation of) state-funded healthcare facilities. The paper describes various forms of NSAG provision of (or obstruction of) healthcare; attempts to understand the motivation of NSAGs; and explores their interaction with state health services. It identifies a significant number of gaps in the literature – for example, concerning the range of incentives and obstacles facing NSAGs in choosing to deliver public services, and the ways in which this shapes the actual patterns of health delivery.

Like the ICRC report, the Chatham House work identifies the many different contexts within which NSAGs operate. It seeks to identify the range of variables that explain the various models adopted by the NSAGs. These include (and the paper gives examples of): the nature and ferocity of the armed struggle; the politics (the balance between efforts to attract support, cement loyalty and deny provision to outgroups); organizational development; the sustainability and sophistication of the NSAG; the degree to

which the NSAG is socially and culturally embedded in co-ethnic or confessional groups; sources of funding (whether external or reliant on locally available resources, such as through rents); governance structures; and expectations by the population of what should be provided. An additional key factor appears to be the commitment to aspirations for territorial and population control and the relative degree of control shared between the state and the NSAG.

Unsurprisingly, these diverse factors result in a wide variation in the nature of the 'health system' (that is, the overall structure and functioning of the individual components). At one extreme, NSAGs provide only emergency care. At the other, they provide sophisticated preventive and curative services, including secondary care. There are also models in which the state and the NSAG appear to cooperate in or 'co-own' healthcare.

While many NSAGs have been instrumental in closing down humanitarian space, the literature review finds that several (including both politically and criminally motivated groups) have also played prominent roles in opening it up, and that some armed groups do both simultaneously and as a matter of routine. The work points to some behaviour that, while rational, is arguably inappropriate but could be rectified. Thus, in some situations where resource limitations force service providers to prioritize assistance to particular armed groups, NSAGs can distribute benefits unevenly – for instance not denying care to non-supporters but rather providing additional care to reward existing followers and to attract new support. Providing additional resources to such groups may, with appropriate safeguards, enhance access and simultaneously reduce the use of healthcare as a strategic instrument. Similarly, the paper points to the need to study further the benefits to both the state and to NSAGs of cooperating or co-owning healthcare, and the potential for this to incentivize other NSAGs to adopt a similar model.



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¹ A New Global Partnership: Eradicate Poverty and Transform Economics Through Sustainable Development. [Online] New York: United Nations; 2015. Available from: <http://www.post2015hlp.org/wp-content/uploads/2013/05/UN-Report.pdf> [Accessed 25 June 2015].

² Gordon S, Cooper-Knock S, Lillywhite L. *Dynamics of provision of health services by non-state armed groups – an analysis of the literature*. [Online] CAERUS – Evidence-Based Policy for Post-Crisis Stability, EC Project Number 607960; 2015. Available from: <http://www.caerus-info.eu/Portals/10/Docs/Deliverables/CAERUS-D2.2-Dynamics%20of%20provision%20of%20health%20services%20by%20non-state%20armed%20actors-250315.pdf> [Accessed 21 May 2015].

³ Mackintosh K, Duplat P. *Study of the Impact of Donor Counter-Terrorism Measures on Principled Humanitarian Action*. [Online] UN Office for the Coordination of Humanitarian Affairs, Norwegian Refugee Council; 2013. Available from: https://docs.unocha.org/sites/dms/Documents/CT_Study_Full_Report.pdf [Accessed 27 May 2015].

⁴ World Health Organization. Health as a Bridge for Peace – Humanitarian Cease-Fires Project (HCFP). [Online] 2015. Available from: http://www.who.int/hac/techguidance/hbp/cease_fires/en/ [Accessed 27 May 2015].