Workshop

Conflict and the Protection of the Medical Mission:

Improving Knowledge and Protection

10th & 11th December 2014

QUEEN PALACE BABUR GARDEN

KABUL

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The international consultation on conflict and the right to health was convened to provide an opportunity to review the situation of conflict in Afghanistan, share experiences, identify challenges and brainstorm ideas towards improving the enjoyment of the right to health during all stages of conflict.

The two day consultation consisted of multi-health workers panels focused on specific themes: To increase health organizations' awareness of the rights and responsibilities in the provision of healthcare in Afghanistan; To establish opportunities for the use of mechanisms for investigation and accountability; To increase interaction with the United Nations and other agencies which administer mechanisms for the protection of health services; and to discuss joint advocacy strategies to convey the situation of the protection of healthcare services in Afghanistan.

WORKSHOP

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Day 1: Wednesday 10th of December 2014

Venue: Queen Palace Babur Garden

Overview of the situation in Afghanistan from a national standpoint – current trends and issues:

8:30am-9:00 am Registration

9:00am-9:05am Opening Prayers

9:05am– 9:20am ACBAR overview and introduction

9:20am–9:40am Briefing by Medical INGO-This session provides an overview of the problem of attacks on health care globally and in Afghanistan.

9:40am – 10:20 am Health cluster and UNHCR protection of civilians working group: impact of the conflict on healthcare in Afghanistan and updates about the situation

10:20am – 10:50am Coffee break

Scope of protection under the law – International Humanitarian Law (IHL), International Human Rights Law (IHRL) Afghan law and Islamic law:

10:50am-11:50am Human Rights Law & International Humanitarian Law

This session will review how these two sources of law protect healthcare in conflict through addressing direct attacks, threats and conditions of insecurity; imposing obligations on various actors, and providing rights to health providers and health workers.

11:50am–12:20pm Briefing: linking humanitarian and Islamic law

12:20pm—12:30pm Briefing TLO research

12:30pm–1:20pm **Lunch**

Mechanisms for protection and accountability:

1:20pm-1:50pm **Overview of mechanisms for protection and accountability:** This session will provide an overview of available mechanisms for protection and accountability through both UN systems and local mechanisms to protect health service providers.

1:50pm–2:20pm **Children in armed conflict:** This session will address how mechanisms available under UN Security Council resolution 1612 can be used to promote investigations of and accountability for the protection of healthcare in conflict. It will specifically cover new guidance issued by the Special Representative for Conflict in Armed Conflict for investigations of attacks on schools or hospitals.

2:20pm-3 :00pm **UN Human Rights Mechanisms:** This session will address how the Office of the High Commissioner for Human Rights and UNAMA's human rights office investigates attacks on health care and how NGOs can interact with these mechanisms. Additionally, the session will cover how NGOs can participate in UN treaty bodies and other mechanisms regarding the obligations of Afghanistan government to adhere to human rights obligations.

3:00-3:30 **Coffee Break**

3:30pm-4:00pm **Access: –** Security issues and humanitarian access

4:00pm–4:30pm **Role of ICRC**: negotiation with perpetrators and potential perpetrators to secure adherence to obligations to respect and protect health care.

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Day 2:Thursday 11th of December 2014

Venue: Queen Palace Babur Garden

NGO Monitoring and Advocacy for the Protection of Healthcare in Afghanistan:

9:00– 9:30 Role of NGOs in data collection and reporting: Methods of data collection to influence accountability mechanisms and advocacy– The role of ACBAR and other groups

9:30- 10:45 Potential use of Johns Hopkins incident reporting tool– A description of the new tool and a discussion of how it can be used in Afghanistan.

10:45-11:15 **Coffee Break**

11:15- 11:30 Advocacy recommendations for key actors involved in conflict situations

11:30-12:00 Global advocacy through Safeguarding Health in Conflict Coalition.

12:00 – 1:00 **LUNCH**

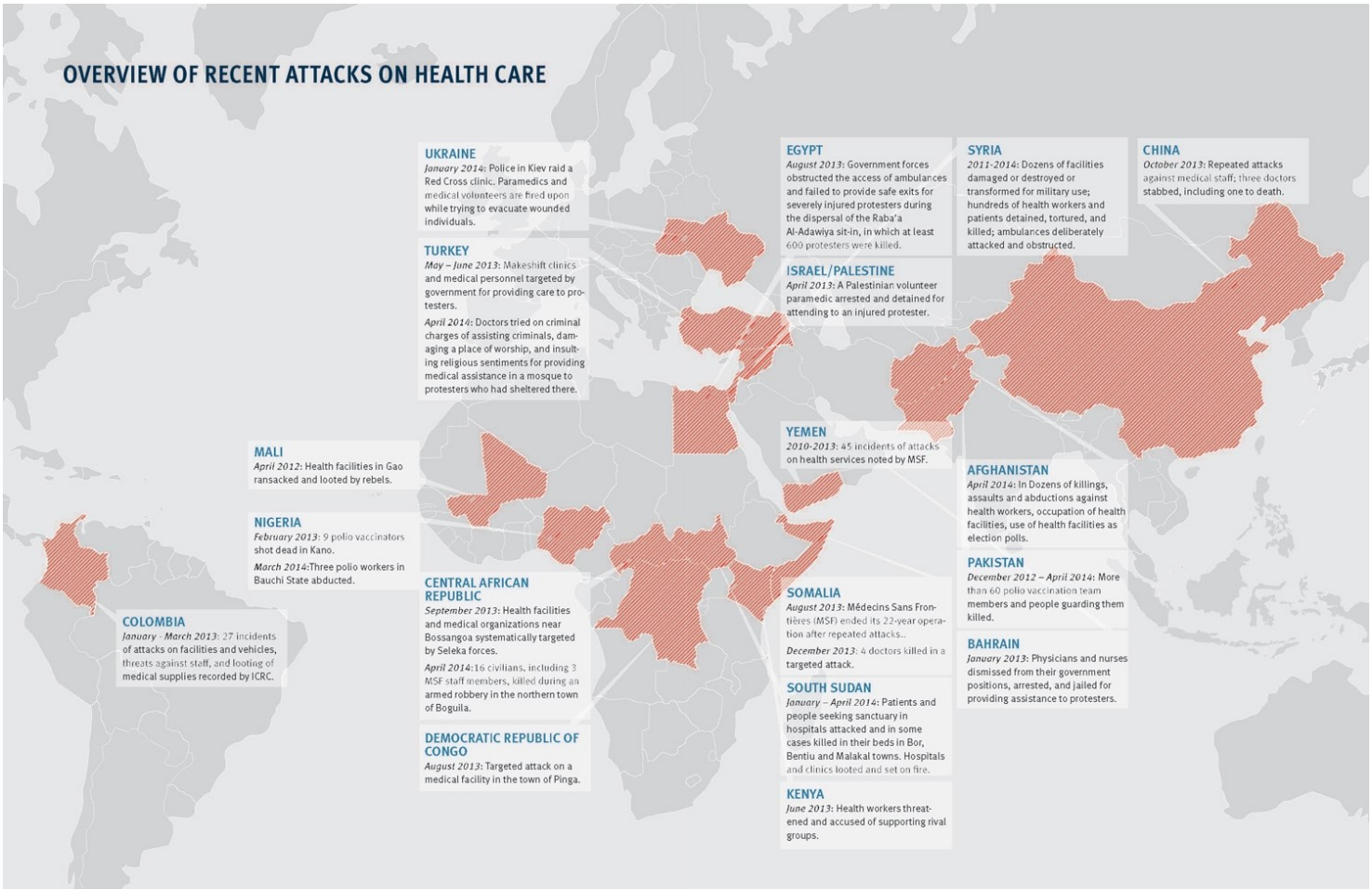
John Hopkins Presentation

The Director Program on Human Rights, Health and Conflict for Center Public Health and Human Rights at Johns Hopkins Bloomberg School of Public Health gave a global overview on health security and conflict.

Through this workshop participants seek the attention of humanitarian actors on focusing onward strategy which might make some progress toward the protection of health services in Afghanistan.

After the battle of Solferino in 1859, Jean-Henri Dunant toured the battle field and was horrified by the sight of the suffering wounded soldiers, he initiated a process that led to the first Geneva Convention and the founding of International Red Cross.

In overview to the recent attacks on healthcare, the Safeguarding Health in Conflict Coalition issued its first global report in May 2014. This report identifies which countries are experiencing high levels of attacks on healthcare services and Afghanistan is included. The report identifies the types of attacks and interferences with healthcare in terms of:



- ✦ Direct attacks or threats on medical facilities;
- ✦ Attacks and threats on ambulances and other medical transport;
- ✦ Attacks, threats and interferences with medical personnel. This includes arrests, harassment for impartial care, detention, torture, killings and disappearances.

The global incidents affecting health care in the last 20 years were, in some cases, systematic attacks. For instance, during 1990 in Kosovo, more than 100 health facilities were destroyed; in the year 2000 during the war in Chechnya, the Russian forces bombed many hospitals; and 2003 saw many kidnappings and murders of health workers and destruction of health facilities as targeted attacks in Iraq.

With regards to the 2011 ICRC study "*Health Care in Danger Study*", ICRC has investigated their programs in 16 countries. During two and half years they found 655 violent attacks by armed groups or government forces and the killings of over 1800 innocent people, including aid workers. This resulted in a global campaign to protect aid workers.

Based on an updated report in 2012, ICRC conducted its program survey in 22 countries and found that over 900 violent incidents had taken place globally. 91% of these attacks concerned local health care providers. Both state security forces and armed non-state actors were responsible for a large proportion of incidents and the two emerging trends in the data are “follow up attacks” on first aiders and disruption of vaccination campaigns through violence (as seen in Pakistan and in Nigeria). In an additional 35 cases, it was insecurity, and not a specific violent, act that had impeded access to health. Therefore the existence of insecurity is very important to be considered as major problem in the protection of health care.

As a global tour: what recently happened in Syria, Gaza, Mali, Bahrain, South Sudan, Turkey, Burma, Nigeria and in Pakistan:

- Syria has suffered over 207 attacks on 166 separate medical facilities. 90% were launched by government forces with 33 instances of systematic usage of barrel bombs on health facilities. Over 500 medical personnel have been killed, all but nine of which was a result of assaults by government forces.
- In 2014, a series of grave attacks on ambulances, killing of paramedics, attacks on hospitals occurred in in Gaza.
- During March 2012, in Mali, patients in local government hospitals were forcibly removed from their beds, while the hospital was looted. Patients in Gao, including elderly patients on oxygen, died after terrified medical staff fled the scene.
- In the Central African Republic executions and heavy fighting was reported around hospitals. This created fear to attend clinics. Hospitals were looted and destruction of medical centers left patients without care. The displacement of entire populations, with unsanitary health conditions and inadequate health care led to many civilian deaths
- During the 2011 ‘Free Bahrain Medics’ protests in Bahrain, security forces entered hospitals where they beat, tortured and interrogated health personnel. 48 health workers were detained. In 2014, there were more reports of torture. Two nurses and one doctor remain imprisoned and those in need of healthcare have been denied hospital treatment.
- More than 60 polio vaccine team members have been killed in Pakistan since December 2012. In Nigeria 9 vaccinators were shot dead in February 2013. Polio remains endemic in Nigeria, Pakistan, and Afghanistan as the community health workers are mostly targeted.
- In 2014**,** MSF aid workers found 14 bodies in Malakal Hospital, Upper Nile State, in South Sudan. Some patients had even been shot dead in their beds. In February 2014, In Bor town, Jonglei State, a woman was found shot dead, along with 10 other decomposing bodies in Bor Hospital and fear of ethnic targeting has led patients in need of specialist care to refuse transfers and flee to regions with almost no health care.
- During the recent protests in Turkey, attacks on medical personnel, beatings and detention of staff occurred, while people were in desperate need of emergency healthcare assistance. In January 2014, Turkey passed a new law that prohibits doctors from providing “unauthorized care”
- Fifty years of conflict has seen Myanmar, in particular, the eastern regions with no access to healthcare. The national army still target healthcare workers in ethnic minority areas. This includes a confiscation of medical supplies, preventing health workers free passage to areas where care is needed and threatening health workers. Moreover, the ongoing pervasive fear and insecurity has impacted on the work of aid workers over decades, including the expulsion of a healthcare office in Rakhine.

“Follow-up attacks” at a global level, including the emerging trend of the same site being targeted repeated times to injure and kill first responders are a big problem. Furthermore, obstruction remains a major problem. In various contexts there are still legitimate concerns over checkpoint stop and searches. Lengthy searching and questioning, mostly intentionally designed to deprive people in need, can cost lives and violate principles of Human Right Law.

Chechnya – at least 24 medical facilities damaged by federal forces; >20 doctors arrested

A brief overview of the protection of healthcare in Afghanistan:

Attacks on health facilities in Afghanistan are increasing. In 2014, 39 health personnel were killed, injured, abducted or intimidated. All but 3 of these attacks have been the responsibility of armed opposition groups *(SRSG 2014 report)*. This includes, attacks on the ICRC in Jalalabad and an ambulance in Laghman. There is also a problem with military forces taking over clinics and demanding priority for healthcare. Furthermore, the placement of IEDs near health facilities creates a major barrier to health access.

Although the Taliban publicly expressed cooperation to support polio vaccinations, in some areas of Afghanistan they still refuse to do so, or areas are still too insecure for health workers to cover targeted groups of children under 5. Insecurity and the abduction of health workers additionally prevent access (MSF report).

Health consequences:

Attacks or interference by both the Afghan Government and armed opposition forces directly affect civilian populations, medical personnel and health facilities, thereby compounding issues concerning access to healthcare, and mortality.

The targeting and destruction of medical infrastructure disproportionally affects the vulnerable, including children, mothers, and the elderly. Moreover, reductions in in capacity to deliver healthcare, due to attacks on medical personnel and the destruction of services, undermines short and long-term goals and is against humanitarian principles.

Such incidents mostly occur due to the following reasons:

- Healthcare services to an enemy or alleged terrorists is considered an act against the State;
- There is a predominance of strategic or tactical military considerations over the respect for health;
- There is a lack of knowledge or interest in the requirements of the Geneva Conventions;
- There is an acceptance of impunity for violations;

Trends involving the taking over of clinics or the demand to be given priority treatment by military personnel may actually result in limited health services for them in the future.

Health response:

To provide a better humanitarian response, humanitarian actors should gather accurate data to inform better protection methods in the field. Protection strategies should include community rootedness, security precautions, negotiation mechanisms and remote management. Onward, qualitative studies towards understanding the contexts, motives, and dynamics should be undertaken (as recommended by MSF). Healthcare service providers should also insist on respect for humanitarian values.

Humanitarian strategies:

To safeguard health in conflict situations, there should be training courses, in addition to continued negotiation with perpetrators. Improvement of military protocols on hospital entry or at checkpoints is very much essential and should be viewed as a matter of urgency. There should also be practical measures to improve the safety of healthcare facilities and health transportation. Furthermore, there is a need for guidance on ethical responsibilities of healthcare providers, in addition to a strengthening of national laws and their enforcement. Expanded partnerships act as the core components for overcoming the problem of violence against healthcare services. ICRC has a platform strategy to address this problem. All humanitarian actors should work collectively to ensure that legal standards are well observed and emplaced.

Human Rights Strategies:

Existing norms and standards regarding data collection, child rights in conflict, monitoring and reporting must be considered in the humanitarian response. This includes:

- Reinforcement and the expansion of norms shared with humanitarian responses
- General Assembly resolutions
- Ongoing monitoring, surveillance and public reporting
- The requirement of WHO reporting attacks on healthcare
- Data collection by States
- The role of NGOs in data collection and reporting
- Accountability through formal mechanisms of the UN
- UN human rights investigation and reporting
- Human rights reporting by States
- Children in Armed Conflict (MRM)
- Public pressure – media, diplomacy

> "*There is a need for political pressure to stop attacks and against impunity. The sense of outrage has been muted. The fact that these attacks have become so widespread must not be tolerated as the new normal*."
>
> Margaret Chan, September 2014.

Response at global level:

- UN Security Council
  - ⇒ 2014—new guidance from Special Representative on Children and Armed Conflicts on investigations of attacks, listing and actions plans
- WHO
  - ⇒ 2012—World Health Assembly mandated WHO to provide global leadership in collection of data on attacks on health care in complex emergencies
- Special Rapporteur on the Right to Health
  - ⇒ 2013—Thematic Report to General Assembly—Right to Health in Conflict
- UN General Assembly
  - ⇒ April 11, 2014 – Relying on IHL and the right to health resolution condemns attacks on healthcare in all circumstances as undermining long-term health and health systems, and calls for preventive measures through legal frameworks, physical protection, training, and data collection.

Photo Credit: Reuters/Hamad I Mohammed

Swedish Committee for Afghanistan (SCA) Presentation

SCA presented their overview of experiences and perspectives regarding healthcare delivery during conflict situations in terms of types of incidents they faced and how they were mitigated.

SCA is an organization which has been active in Afghanistan for the last three decades. During this time, they have established effective development programs which incorporate lessons learnt. SCA have witnessed several security incidents which affected their work. In some cases, they were able to successfully mitigate harm and in other instances, they were unable to do so.

Introduction of SCA health program:

SCA's strategic approach to development rests on three key pillars, namely, service delivery, capacity building and advocacy. These pillars are inter-related and support each other. Following these core components allows for good results within their program.

SCA provides service delivery by implementing the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) in Wardak and Laghman provinces. SCA also implement a number of innovative supplementary interventions funded mainly by SIDA and other donors including, MCH, Community Midwifery and Nursing Education, School Health, Learning for Healthy Life (LHL) and others.

Capacity development is a major part of the program to cover target groups and government partners. SCA works with the vision that one day Afghanistan will lead their own development. For advocacy, SCA works closely with the Afghan Midwifery Association (AMA) and other civil society organizations to promote right based approaches in healthcare.

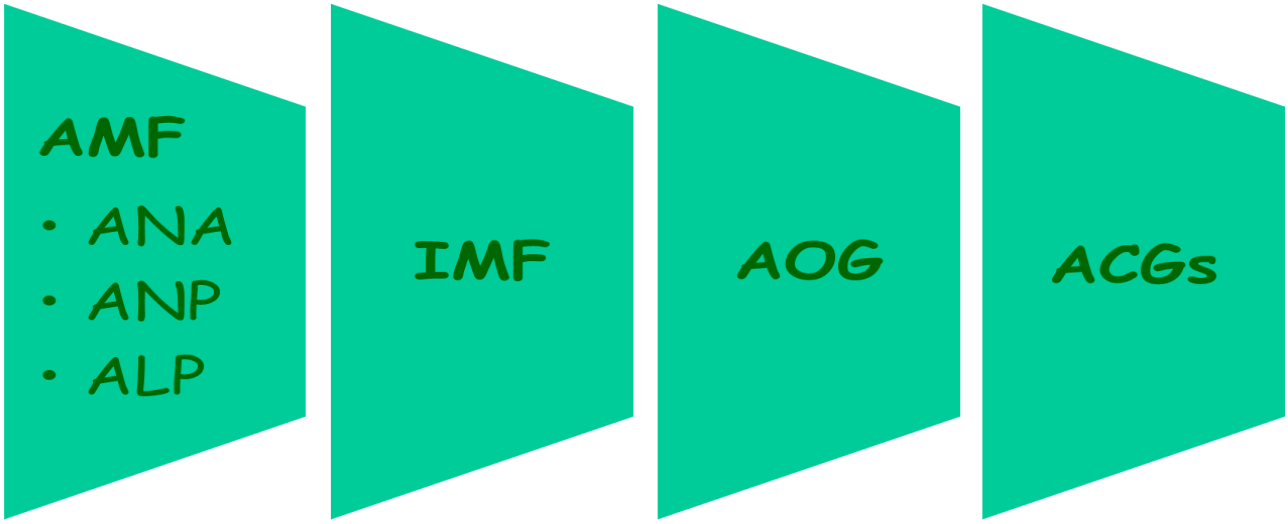
Type of security incidents faced during 2013/14:

Based on SCA security records, SCA have experienced the following types of attacks / incidents by both Afghan Military Forces (AMF) and International Military Forces (IMF).

- The occurrence of collateral damage through clashes between armed groups can affect health facilities and health workers. In 2013, SCA's midwifery education programs were threatened by the risk of being caught in collateral damage.
- The intrusion of health facilities by both national and international military forces. Military forces, for their own purposes will violate rules and regulations pertaining to healthcare rights.
- The frequent searches of health facilities by all parties to the conflict created challenges and obstacles for healthcare providers.
- The use of clinics as a shelter for national security forces to take rest when returning from their operations.
- The abuse of staff members particularly when health workers try to prevent national forces from entering their clinics. In some instances, health care staff members were assaulted.
- The closure of clinics due to conflict or threats to health workers resulted in health care activities being interrupted.
- A direct attack on a healthcare transportation vehicle recently happened in Laghman Province.
- Arrests of healthcare workers are becoming a trend. National security forces arrest staff members and later release them with no reason.
- The ANSF seeking healthcare in public health facilities causes problems.
- Staff abductions, robberies, the occupation of clinics and looting of medical supplies.

The prevention of health projects and banning the movement of motorbikes are also type of incidents SCA faced which impact upon their work.

Who is doing this?



SCA response to incidents:

Depending on the type of incident, SCA are sometimes required to change their response strategy to mitigate risks. This mostly involves and seeking community support.

Recommendations and ways forward:

SCA believes that the following key recommendations and operational precautions will help healthcare workers overcome challenges and lower the risks they face in their lines of duty.

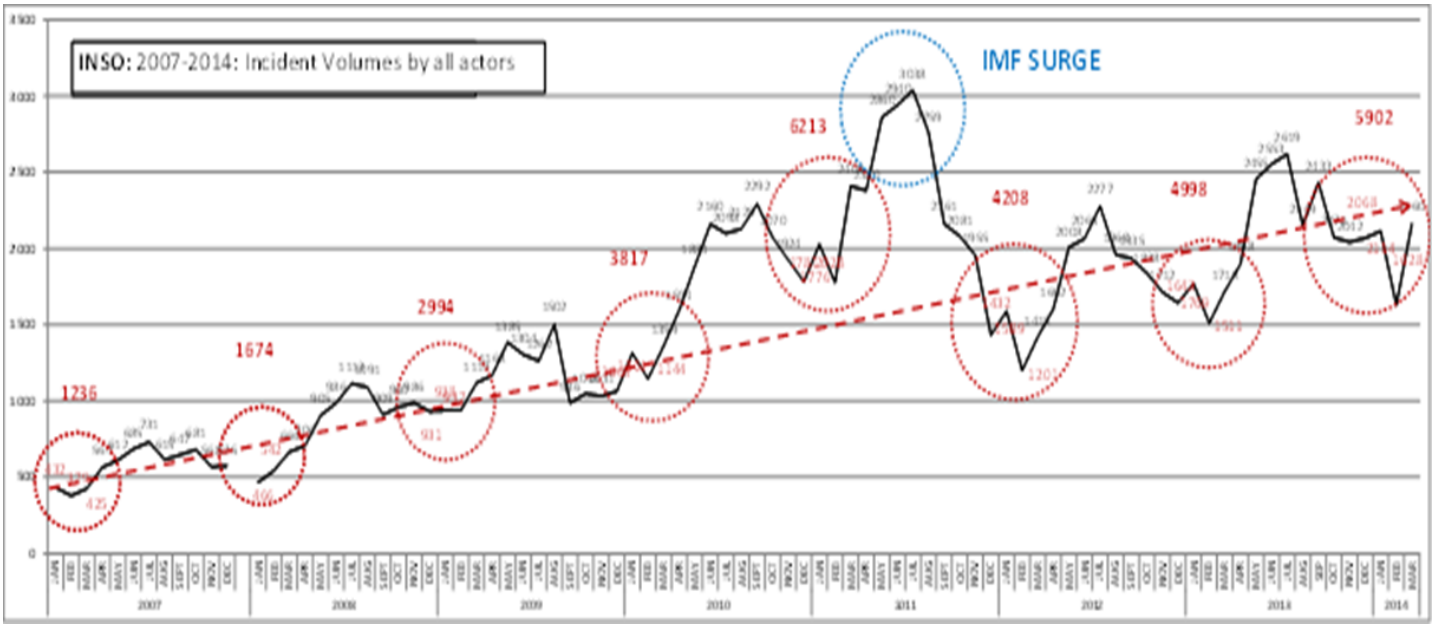
- Health providers should enhance their understanding of the Afghan context in terms what is sensitive, what works and what does not work.
- Health providers must continue to remain neutral and to prove it practically.
- Health providers should strengthen participation and the faith of ownership of local communities (stakeholder consultations and joint monitoring).
- Health providers should raise community awareness on their right to health, particularly through religious leaders.
- An advocacy forum should be established incorporating health protection represented by NGOs, ICRC and the UN. Currently, NGOs are lacking such a forum to advocate for protection. If this forum is created SCA will contributed and share their resources to:
    - Raise awareness on the Geneva Convention, health services neutrality, and health rights
    - Follow up policy "*Security Plan for Health Workers and Health Facilities*" finalization
    - Hold the Government accountable to the Geneva Convention
- Operational precautions: SCA found the following safeguarding provisions to be very successful:
    - Local staff recruitment to utilize local human resources
    - Respect for local customs
    - Keeping a low profile when traveling, for example by using local transport
    - Coordination with the Afghan Government
    - Staff training on personal safety and security
    - Security risk mitigation plans
    - Insecurity measures/ incident reports
    - Family members with female staff at field (Mahram usually goes with female staff)

MRCA presentation

MRCA has been working in Afghanistan for the past 30 years, providing health services in terms of Basic Health Packages (BPHS) and Essential Health Packages (EPHS). The organization has delivered capacity building to medical staff and runs midwifery and nursing school projects. MRCA support some MoPH programs in areas with hospital construction/rehabilitation. In places where healthcare is critical, they also provide equipment and mobile health teams.

The withdrawal of foreign troops and the decrease of military hospitals has resulted in an increase of military wounded patients in public hospitals. Furthermore, there is an increase in the types of security incidents by all armed actors, including AMF, AOGs and criminal groups. INSO figures show a steady increase of security incidents since 2007 with a corresponding steady increase of casualties, whether civilian or military:

- Civilian Casualties based on UNAMA figures from 2012 to 2014:
  - ⇒ 2013 : 2959 killed and 5656 injured, which was a 14% increase from 2012
  - ⇒ 2013: Civilian casualties in cross-fire increased by 43% from 2012
  - ⇒ 2013: Weapon wounded patients: saw an increase of 77% from 2012
- Military Casualties based on ISAF figures from 2012 to 2014:
  - ⇒ Afghan security forces killed in combat increased by 80% between the summer of 2012 and the same period in 2013. Numbers are still increasing in 2014.



Health Facilities capacities:

Health facilities have difficulties to cope with these increases because of the following reasons;

BPHS/EPHS implementers have signed a three year contract with the MoPH. However, as armed conflict increases, the numbers of trauma care patients also go up. Hospitals face an increase workload, with specific types of surgery and treatment needed, but often without the set up or available funding to deal with this.

The number of military hospitals dropped from 800 in 2011 to only 30 in 2014. BPHS and EPHS health facilities have seen major increases of military patients which, again, is challenging due to a lack of funding flexibility.

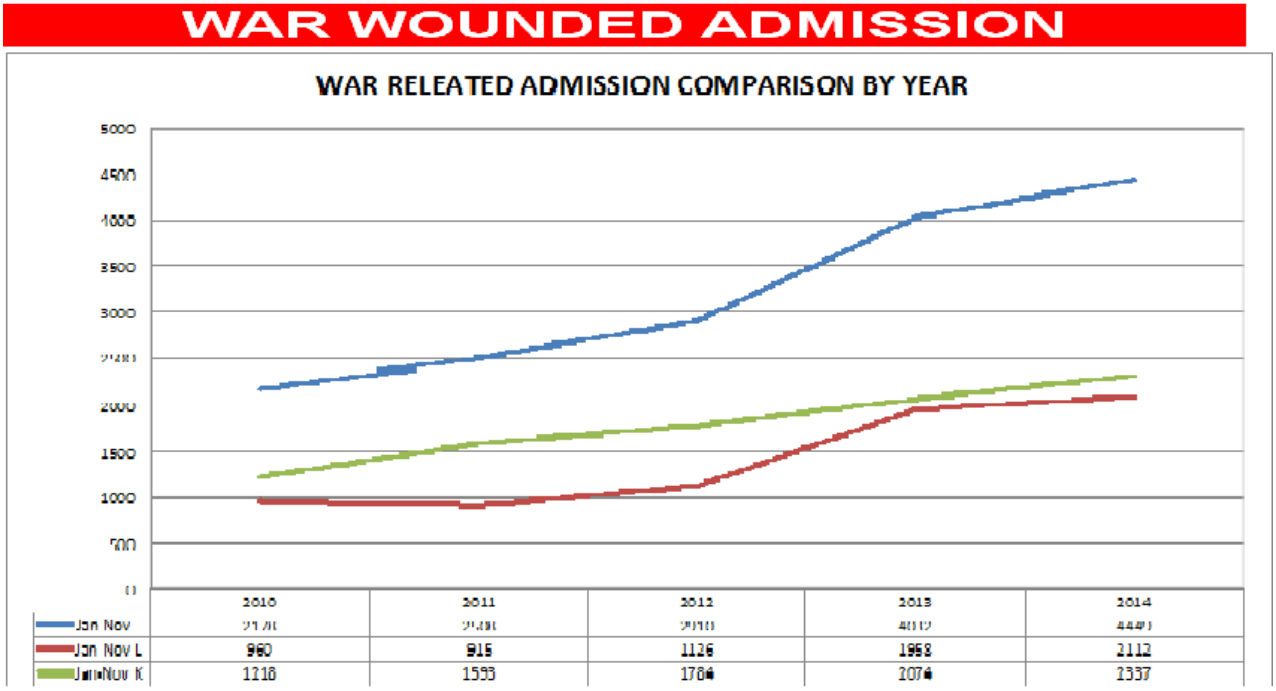
Impact on BPHS / EPHS health centers:

In addition to the increased strain on the public health system, a military presence around health centers where soldiers and armed opposition groups (AOGs) are treated represents a threat to civilian access. Several cases have been observed where police or military personnel demonstrate aggressive behavior when entering health facilities to receive priority treatment. Staff members come under threat and civilians are not willing to bring women to hospitals because of this. UNAMA reported 32 incidents impacting health facilities and its personnel in 2013, compared to 20 in 2012.

Emergency NGO Presentation

Emergency NGO Afghanistan has been working in working in Afghanistan to provide free medical and referral systems. They have 3 main hospitals and 43 clinics in areas of Kabul, Lashkergah and Panjshir Valley.

2014 was the worst year for the growth in war, security incidents and casualties in Afghanistan. From 2014, Emergency NGO covered 37.000 Out-Patients-Department trauma treatments, of that, 1 756 trauma patients were referred in Helmand and 1.330 trauma patients were referred in the central region.



Since 2012, four new First-Aid-Posts have opened in high risk in areas of Urmuz, Helmand, Tagab, Kapisa, Sheikabad, Wardak and Andar district of Ghazni. Emergency NGO has plans to further expand the program to other districts and possibly open 12 new clinics.

Where and how Emergency NGO works

Emergency NGO focuses areas where difficult access and high security risks means that people are marginalized of healthcare. Emergency NGO works closely with communities to ensure good relations and local contacts. During last 15 years, they have built a good reputation and even successfully provided healthcare services to the Mujahedeen or Taliban during the civil in very dangerous situations.

Emergency NGO refresh their potential, maintain their reputation and develop trust in communities by delivering high quality services, staying neutral and not compromising their values. This is especially important when different armed authorities are taking advantage of the Emergency NGO programs.

Emergency NGO involves local communities, Shuras, elders, authorities and opposition groups as part of the program in order to try to aid communication and make all parties responsible for ensuring the protection of health workers.

Monitoring projects:

Communication with local communities, elders and others groups eases project monitoring in areas of high insecurity such as Helmand and Ghazni. To ensure success of projects health workers and other aid actors should keep refreshing their relations, diplomacy and advocacy techniques. At the same time, they should never accept abuse, should be firm on rules and should always choose the right battle.

During last 15 years, Emergency NGO has never been an international target but in 2014 they paid the biggest cost when an ambulance driver was killed during cross-fire on the way from Tagab to Shiekhabad.

Beside this, two other major accidents have happened:

- An ambulance went over a mine
- An ambulance was involved in a cross fire

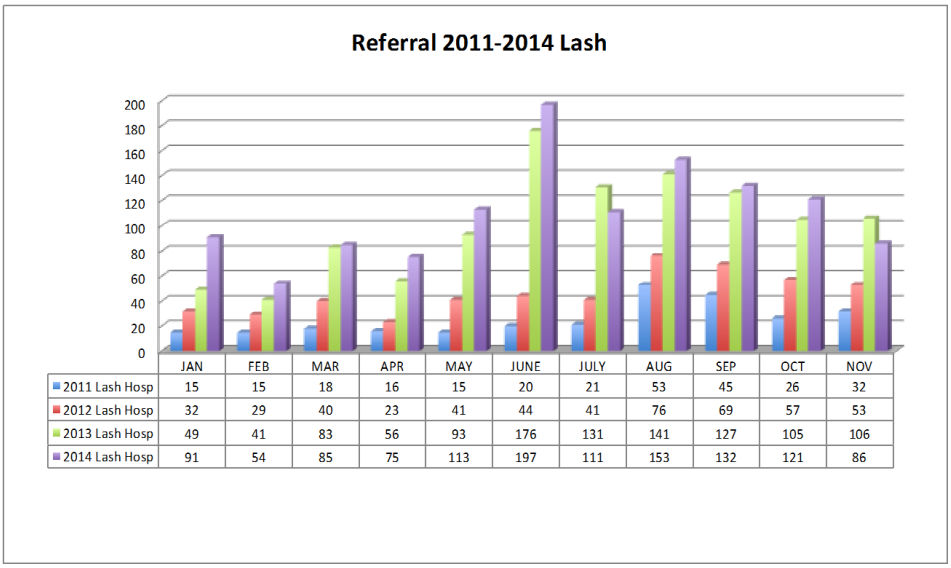
Poor analysis of a situation can result in bad consequences for health workers. For example, in Logar Province, Emergency NGO chose the wrong location for a health facility (Azrà First-Aid-Post) and due to a lack of involvement and monitoring it was forced to shut down. Although this is regrettable, Emergency NGO learned the valuable lesson of being present where really needed.

Lessons learnt:

Through lessons learnt, Emergency NGO have realized the importance of transparency within operations and employing local staff. This is especially important in areas of low education as people there are concerned with what you appear to be doing and not what you are saying.

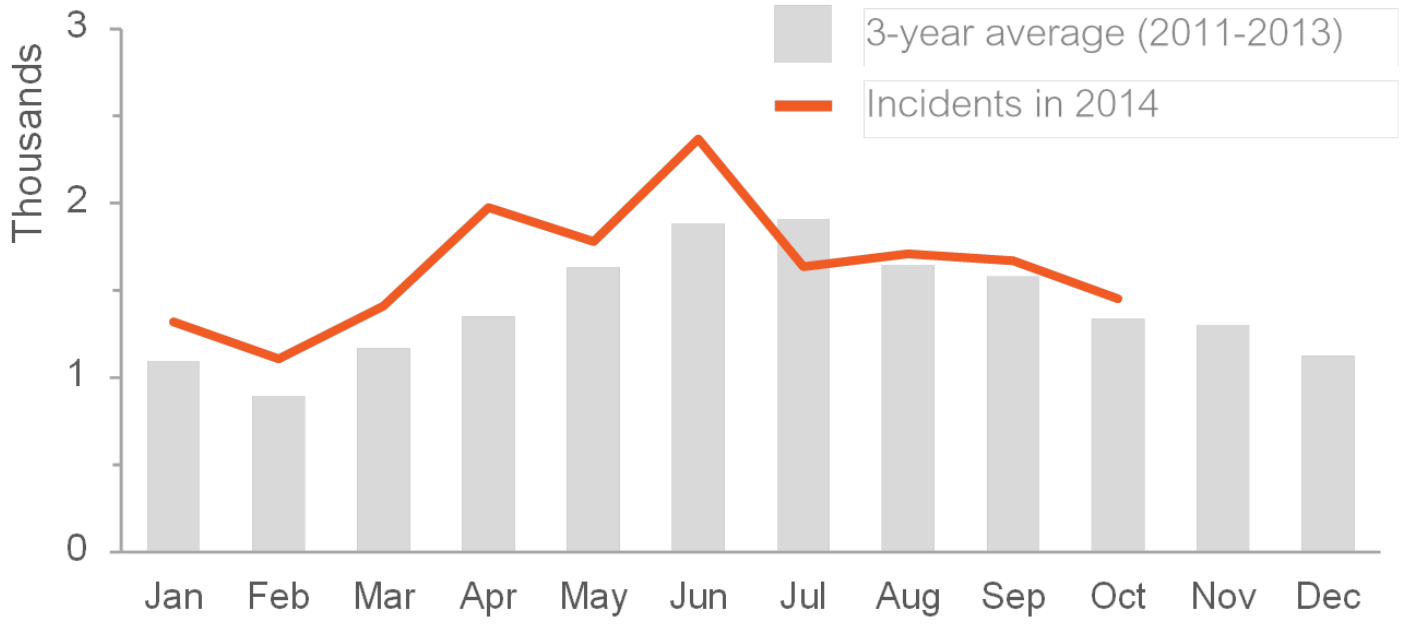
All these casualties require access to health facilities for treatment.

WAR WOUNDED REFER TO LASH

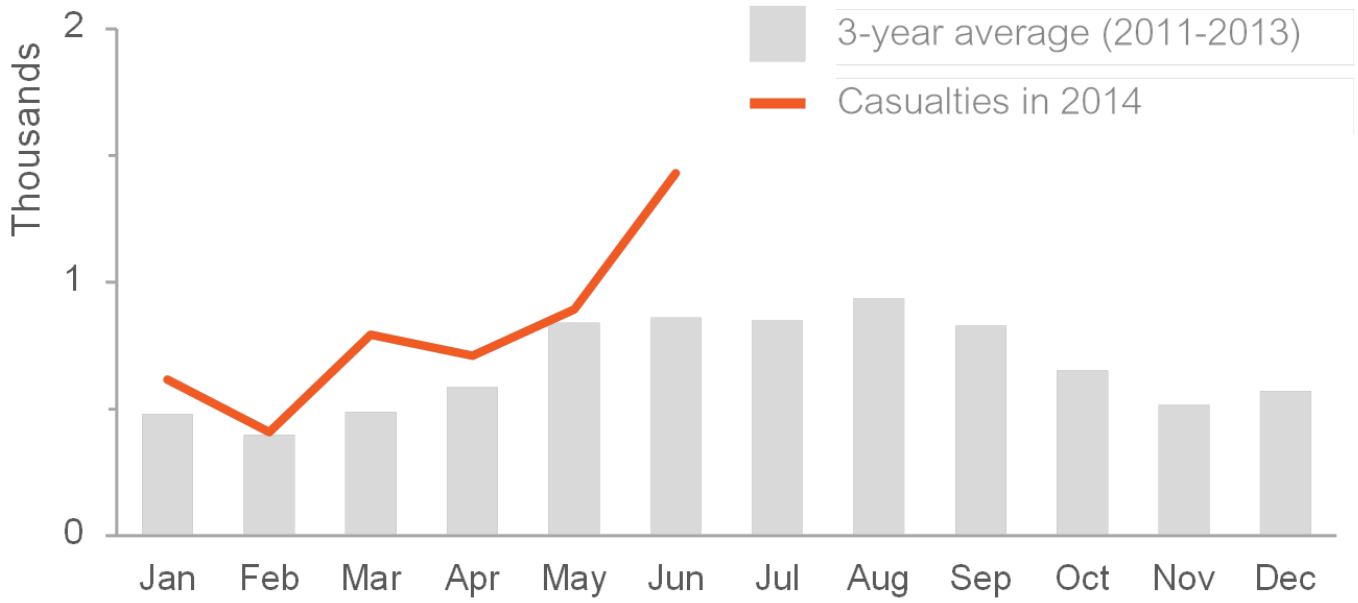


	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT	NOV
2011 Lash Hosp	15	15	18	16	15	20	21	53	45	26	32
2012 Lash Hosp	32	29	40	23	41	44	41	76	69	57	53
2013 Lash Hosp	49	41	83	56	93	176	131	141	127	105	106
2014 Lash Hosp	91	54	85	75	113	197	111	153	132	121	86

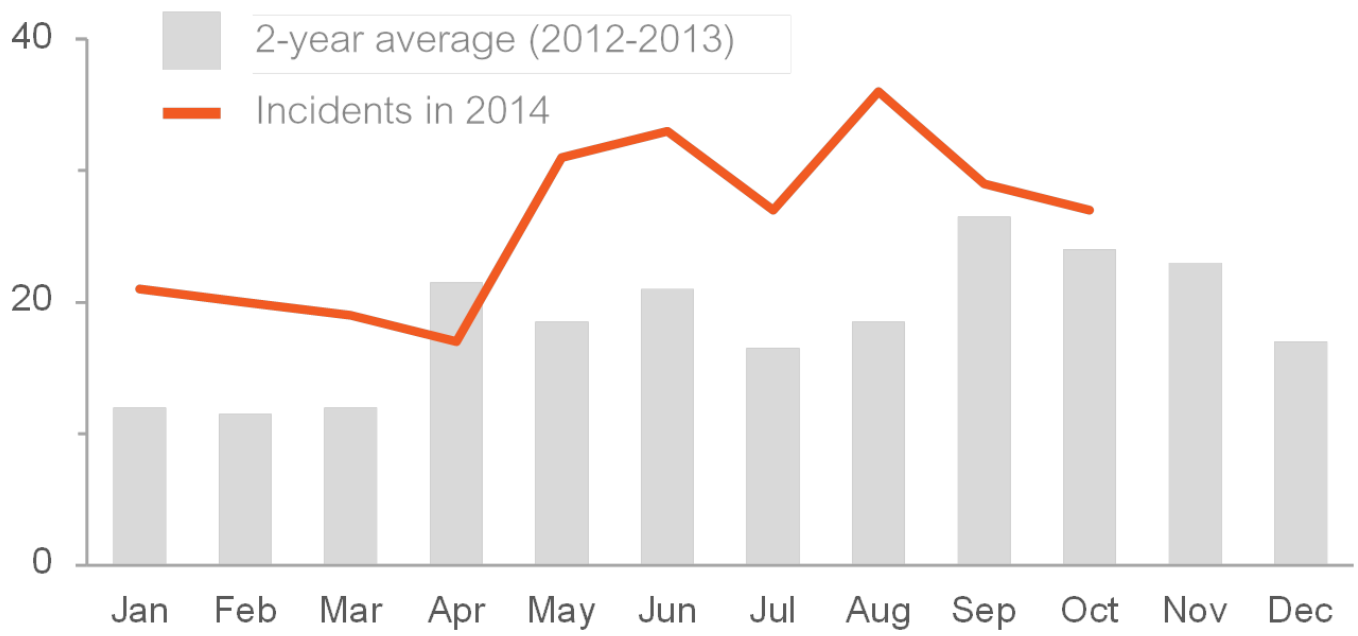
Incident types include: abductions, air strikes, armed clashes, assassinations or attempted assassinations, IED detonated or discovered, mine/UXO incident, stand-off attacks, or suicide attacks



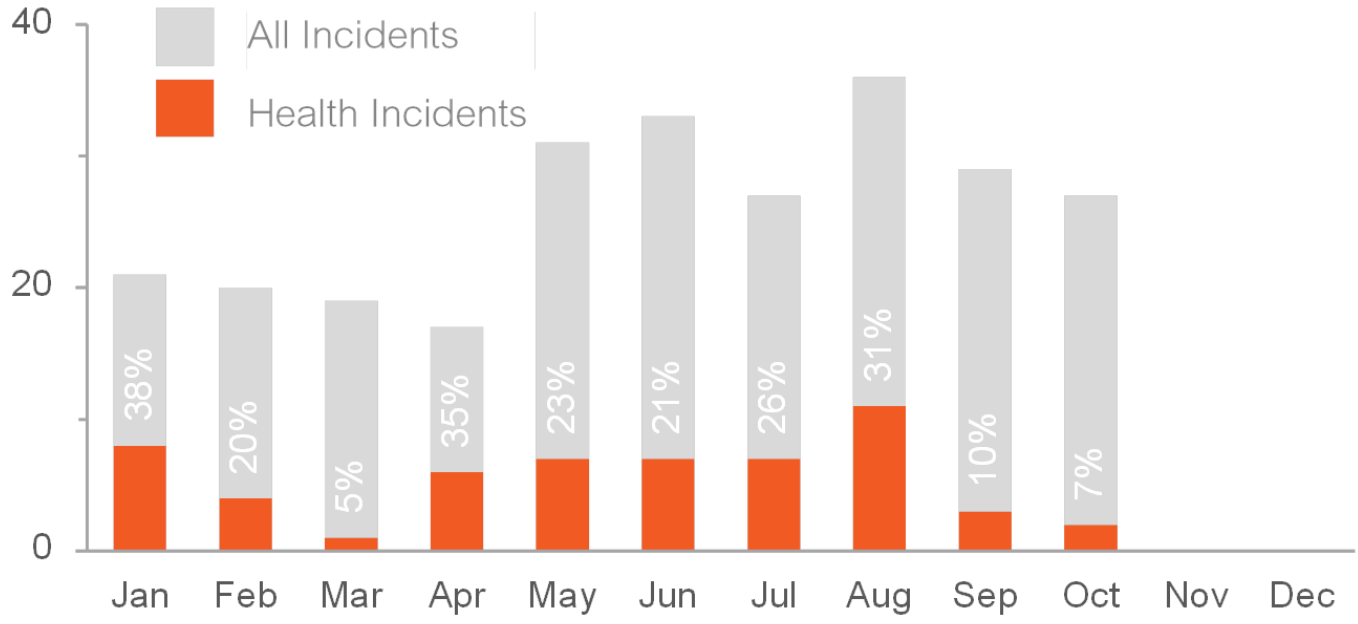
1) Civilian casualties are for the period 1 January to 30 June 2014. 2) A civilian casualty is defined as a civilian killed or injured resulting directly or indirectly from conflict related violence. 3) Some records of casualties were not able to be matched to a district boundary and, therefore, could not be reflected in the map of civilian casualties by district. 4) Data source: UNAMA Human Rights Unit.



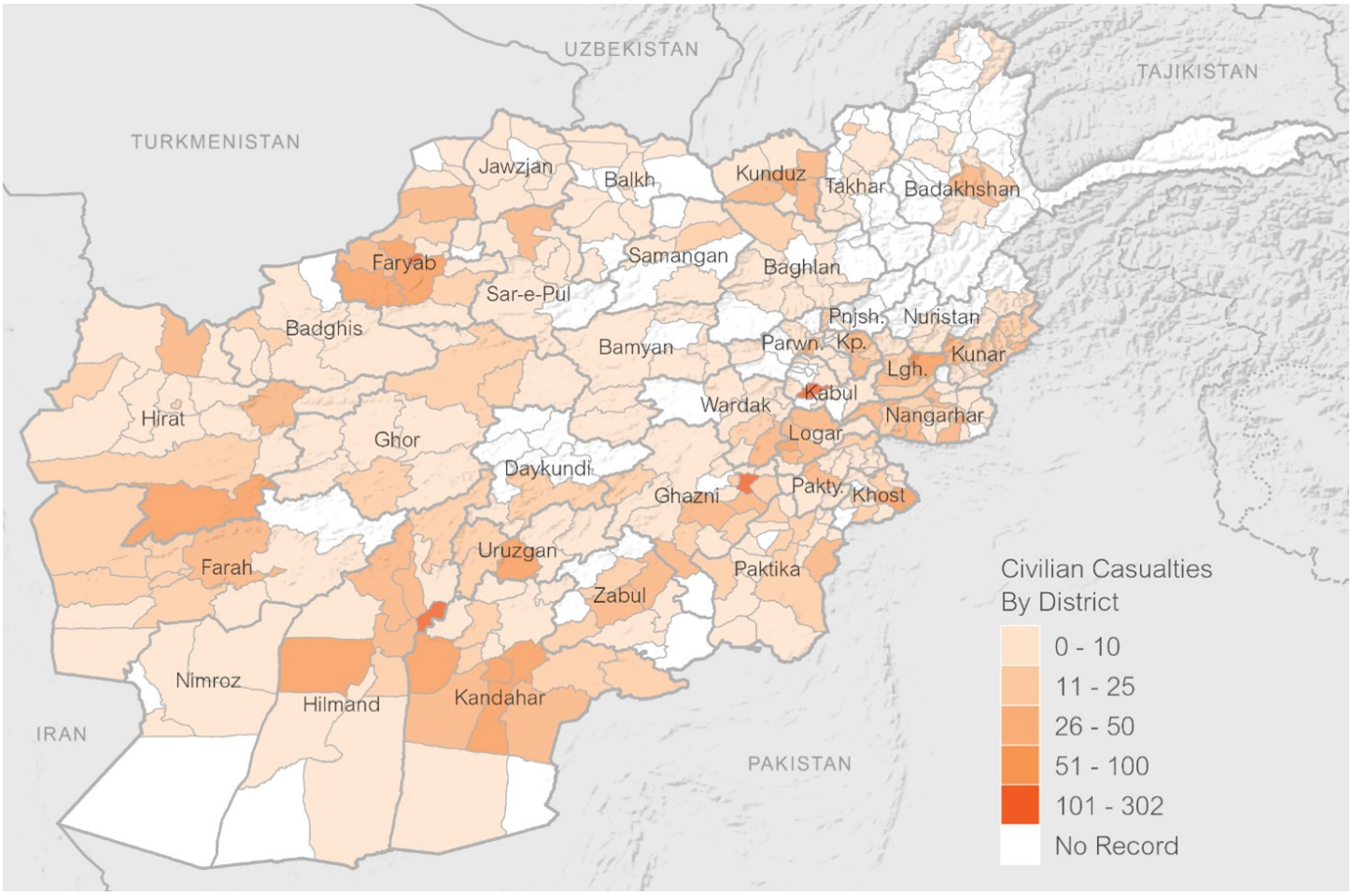
Incidents against Humanitarian related Workers and Assets



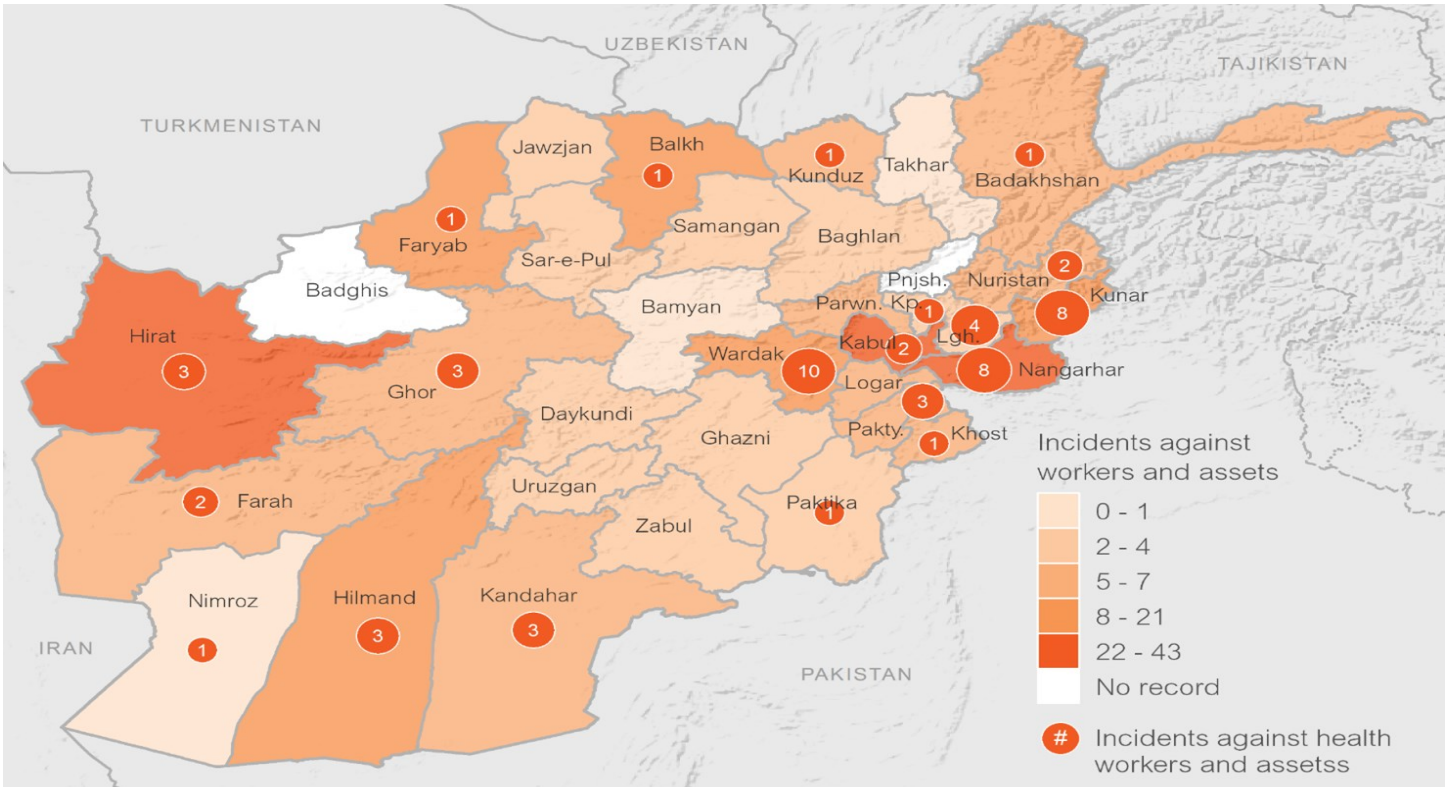
Incidents against Health Workers and Assets in 2014



Security incidents Jan to June 2014



Incidents against health workers and assets January to October 2014



Afghanistan Protection Cluster Coordinator (APC/UNHCR)

The Protection of Civilians Working Group (PCWG) under the Afghanistan Protection Cluster monitors and advocates for reducing, and ultimately eliminating, impacts of conflict on civilians in Afghanistan. As of the end of October 2014, over 131,000 IDPs have been displaced due to conflict. This represents an increase of 16 % over the same 10 month period in 2013. The cumulative total of people displaced by conflict is possibly over 782,000.

From April to September 2014, headlines of conflict were occurring all over the country, namely in Helmand, Kunduz, Faryab, Logar, Ghazni, Kapisa and cross-border shelling in the eastern region of Kunar province. Due to such offensive insecurity incidents, 25 provinces out of 34 were affected in some way by displacement. Furthermore, since June 2014, 284,000 refugees from Pakistan arrived in Khost / Paktika from North Waziristan.

Consequences of displacement:

- Humanitarian access to populations in need and the ability of timely response to these displacements is hindered.
- Access to services, including healthcare, can also be affected.
- An increasing trend of IDPs seeking refuge in urban centers brings further burdens as these areas are already over-stretched in terms of services, including health facilities.
- IDPs suffer multiple displacements due to repeated conflicts or incidents and it is very difficult for them to find durable solutions.
- Displaced populations face socio-economic, impacts, including impacts to their physical and mental wellbeing. They may lose their assets of livelihood, resulting in a lower income level, or they may suffer mental and physical trauma.
- Displacement increases vulnerabilities, family separation, women headed household and child headed households.

- **Casualties in January to June 2014:**
- Based on UNAMA mid-year report, the level of causalities has increased compared to the same period last year:
- 4,583 civilian casualties (1,564 deaths, 3,289 injured), 17% increase
- 440 women casualties (148 deaths, 292 injured) – 24% increase
- Child casualties:

⇒ 295 deaths, 776 injured 34% increase; average 40 children injured / killed every week

⇒ Ground engagements are up by 110%, leading cause of child casualties and cause them for moving to urban centers which affect more and more people in particular women and children.

⇒ IEDs killed 83 children and injured 183, 7% increase comparing to last year.

Ground engagements:

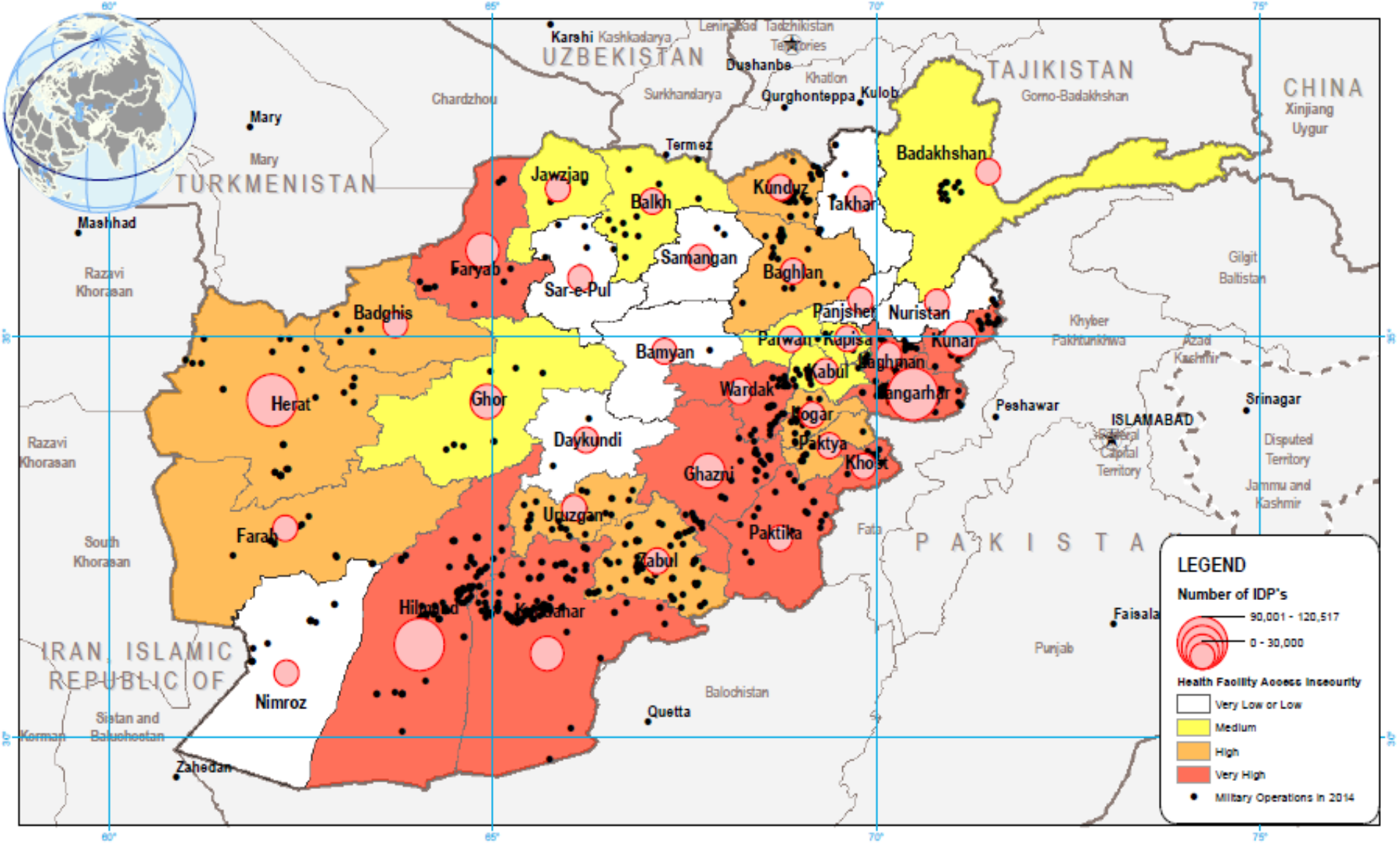
In 2013, improvised explosive devices (IEDs) caused the largest amount of fatalities. In 2014, however, ground engagement between government and non-government forces caused the most civilian casualties. Ground engagement became the biggest killer of women and girls (256 civil casualties) and accounted for a 61% increase in female casualties in 2014.

IEDs & ERWs were the second leading cause of civil causalities. They actually caused the highest number of casualties recorded in first 6 months of any year since 2009.

With regards to unlawful indiscriminate use, particularly in markets, there was a 33% increase of pressure plate IEDs (anti-tank) which caused 149 female casualties (58 deaths, 91 injured) and 266 child casualties (83 deaths, 183 injured).

Explosive Remnants of War (ERW) caused 97 incidents in 2014, 206 casualties in total of which 76% were children.

Afghanistan Protection Cluster
Number of IDPs per province, military operations and health facility access in 2014



Disclaimer: The Boundaries on this map are not necessarely endoresed by UNHCR or the Afghanistan Protection Cluster.
Data Source: Health Cluster, UNHCR, Protection Cluster and/or Sub-Cluster members, CSO, OCHA.

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Handicap International (HI) Presentation

As a member of the Protection of Civilians Working Group (PCWG), HI insists on ensuring follow up services after for trauma care patients. Since 2009, civil casualties have increased every year. WHO reports that worldwide, for every violent death, four more are left with a permanent physical impairment and are in need of follow-up care.

Victim assistance addresses the needs of people with disabilities including emergency healthcare, physical rehabilitation, psychological and psychosocial support services.

In Afghanistan, physiotherapy is available in 81 districts, funded under the BPHS. Physical rehabilitation centers (comprehensive orthopedic centers) are present in only 13 provinces in Afghanistan, providing artificial limbs, wheel chairs, crutches etc. These physical rehabilitation centers are only supported by NGOs or the ICRC, and currently, the EPHS, a healthcare funding mechanism has provided little information on these centers will be financed in the future.

Gaps in the provisions of services are high in rural areas and regions where insecurity and persisting violence is high. As per Sphere standards under essential health services**,** "*surgery provided without any immediate rehabilitation can result in a complete failure in restoring functional capacities of the patient*" and "*early rehabilitation can greatly increase survival and enhance the quality of life for injured survivors*".

Other Protection of Civilians (PoC) considerations:

- Health facilities: Intrusions commandeering non-respect of the civilian character
- Safety and security of humanitarian personnel, safety of women and children rights
- Executions, targeted killings of civilians, community and religious leaders
- Abductions/kidnappings
- Attacks against civilians
- Destruction of civilian infrastructure
- Shelling/airstrikes
- Denial of fundamental freedoms of people, in particular, children, women and elderly

Impact of conflict on health:

Healthcare provisions are becoming uneven and unstable. Violence usually affects curative interventions as some health services are disrupted more than others. A lack of capacity resources, for example female staff members, affects preventive healthcare and health promotion.

The 'Afghanistan Balanced Scorecard' reported that in 2010, the average score for quality of care was around 70.4%. Based on the data from different sources, the BPHS/EPHS cover 65% of the total population of the country. If this information is accurate, we again have 35% who are left aside.

Impact on health workers:

- Death and outward migration reduces the availability of human resources. The latest UNAMA civilian casualty figures indicate a 15% increase in civilians killed or wounded in the first eight months of 2014, compared to the same period of the previous year. Health workers as part of civilians also come under the percentage.
- Some human resources capacities are more affected than others by protracted turmoil. In recent months, a majority of female health workers resigned or were unable to keep their posts, meaning less access for women
- Health workers move to secure areas or abroad
- In some conflict situations, health workers are targeted (60 incidents against health workers were reported in 2014)

Conflict affecting health systems in multiple components:

Access for women is much lower as there is only one healthcare professional per 30,000 Afghan women. For example, access is very low in Wardak, Bdghis, Faryab, Ghazni , Kandahar Kunar, Farah.

There is a shortage of trained surgeons, anesthetists and capacity to deal with the amount of civilians injured through conflict situations. Looking to the standard worldwide, 22 healthcare professionals should respond to every 10,000 people. In Afghanistan some areas only have 1 healthcare professional for every 10,000 Afghans.

Context of health care provisions:

- Afghanistan has over 620,000 internally displaced people (IDPs), with more than 110,000 newly displaced in 2013.
- There are more than 5.7 million refugee returnees from Iran and Pakistan over the past decade. (SRP 2014).
- 40% of IDPs move to urban areas, where they join the growing numbers of urban poor.
- There are highly insecure and inaccessible areas where residents live too far away from healthcare services to have accesses.

The increase of healthcare providers during conflict:

- Standard public health services
- NGOs and charities, mainly international
- International agencies, like the UN and the ICRC
- The decrease in specific army health services will hugely impact on civilian health facilities.
- Private sector health facility operators, in many instances unregulated, of various levels of skills no provision of follow-up care.

Conflict affects health system in multiple components:

1. Direct causalities from conflict and indirect impacts through a breakdown in service provisions and health

- Due to conflict situations and insecurity, Afghanistan has a low immunization coverage which has caused injuries and death.
- In 2014, 52 security incidents happened within 100 meters of health facilities, this was a major threat to health workers. Among many other issues, staff workers were not psychologically ready for treating patients.

2. Polio

- Between January 2013 and October 2014, 65 incidents had an impact on the safety and security of polio field workers in Helmand.
- Cross boarder shelling and displacement, for example in Dangam, Marawara, Nari, Sarkani also affects the quality of the polio campaign.
- The Polio campaign has been unable to reach Watapoor district of Kunar province for over 2 years due to insecurity
- In 2014, 16 out of 23 cases of polio were reported from either inaccessible or security compromised areas.
- Two polio cases were confirmed among the displaced children from North Waziristan. Vaccination posts were established at border crossing points.

3. Public Health threats:

According to data available, up to September 2014, there were 98 measles outbreaks. 54 cases (accounting for a 55.1%) were in Farah, Faryab, Gazni, Helmand, Kabul, Kandahar, Kapisa, Khost, Kunar, Nangarhar, Nuristan, Pakitika, Paktia and Wardak.

Acute diarrhea affects approximately 1.7 million per year in Afghanistan, and acute respiratory infection counts for nearly two thirds of a million. Although both these conditions are easily treatable, conflict in Afghanistan prevents healthcare. If the conflict situation becomes more complex, Afghanistan will have a more difficult situation in terms of healthcare.

MSF Presentation

Violence and Access to Health care in Afghanistan

In 2012, MSF International HQ in Geneva launched a three-year project in cooperation with ICRC, with an aim to identify how MSF as a humanitarian organization can respond to violence towards healthcare structures, services and practitioners. MSF collects quantitative and qualitative analysis of violence affecting MSF medical missions in 10 pilot countries, including Afghanistan. The purpose is to improve safe access to healthcare and security of staff and patients during conflicts.

MSF has a plan to start evidence-based advocacy in 2015. A research phase is already over and the team planning to produce a conclusion and way forward to advocate on health protection issues. As part of global advocacy, MSF have published their report on targeted violence on healthcare in South Sudan.

In Afghanistan, MSF provides health services in Kabul, Helmand, Khost and in Kundoz through secondary level structures (hospitals, trauma centers, maternities) in direct support to the MoPH or in a private structure.

Medical Care Under Fire (MCUF) Qualitative Analysis:

Quantitative Analysis is done according to cross-sectional initiatives, including:

- Systematic analysis of security incidents affecting MSF's medical mission from 2009-2013 in four highly insecure contexts (Afghanistan, South Sudan, DRC, Kenya) in 2013.
- Incident reports and semi-structured interviews
- Definition: "*A security incident which negatively impacts MSF's mission personnel, patients or caregivers and compromises or has the potential to compromise the populations' access or use of healthcare, the quality of healthcare available and overall health system resources*."

Exclusion: Incomplete reports/double entries, safety incidents, unprofessional conduct/interpersonal conflict among staff, wrong time, wrong place scenarios.

Medical Care Under Fire (MCUF) Quantitative Analysis:

From 2009 to 2014, 85 incidents were reported and as per the exclusion criteria, 48 of them were classified as MCFU incidents. 48% of these incidents occurred in Khost with majority of them on project site both as armed entry (41.9%) and armed attack (29%) to or on health facilities. Beside this, analysis shows the presence of weapons but not used (41.9%) and Explosive device (25.8%).

- Regarding perpetrators, 50% were unknown, national security forces accounted for 21%, international forces were responsible for 8%, and armed opposition groups were also responsible for 8% of security incidents.
- National staff frequently became victims and international healthcare staff members are at a high risk.

Consequently, these incidents interrupted health services, reduced the quality of care, and harm neutrality in one third of cases.

In 2013, MSF interviewed 800 patients in four locations (Kabul, Kundoz, Lashker Ghah, Khost) to understand types of access barriers based on the experience of MSF/MCUF patients. MSF has conducted this research to draft a narrative on a reality check after 10 years of international aid and political and military agendas. The outcomes are as follows;

Main barriers:

- Costs (32%): many patients are dying due to unaffordable costs which can only be paid by selling their assets and livelihoods.
- Distance (22%): patients emphasized the point that health facilities are too far away to be accessible
- Conflict (18%), many patients raised the problem of conflict as main barrier on access to healthcare.
- 20% of interviewees said they had a family member or friend who died as direct consequence of lack of access to healthcare in last 12 months.
- People are taking dangerous journeys to health care facilities. 75% of patients experienced obstacles preventing travel to MSF hospitals due to active fighting or insecurity. People were forced to watch over injured relatives throughout the night, and were too afraid to risk checkpoints, landmines or bandits on the road.

- Negative perceptions of public system: 4 in 5 people said they had bypassed closest public clinic during previous illness (availability or quality of the staff, services or the treatment) and turned to private sector (unregulated, high cost, quality issues)

Humanitarian Access:

- Ongoing conflict impedes humanitarian workers and medical staff to reach the most vulnerable populations of Afghanistan.
- Negotiated access with all sides in armed conflict must be done to ensure that neutral and impartial care can be delivered.
- Armed groups must not hinder the access of the patients to the hospitals.

MCUF current research phase:

As an operational objective for 2015, MSF will analyze potential outreach strategies and comparative perspectives with other health or aid actors, including, ICRC, Emergency NGO, SCA, IMC, and MCRA. Taking into account factors such as location and violence or conflict related access barriers, the conclusion of analysis may feed specific local conditions for negotiated access and protection.

ICRC Presentation

'Healthcare in Danger' is a major campaign around the world. The objective of the campaign is to ensure the respect and protection of healthcare during armed conflict and other types of emergencies. ICRC wants to address attacks on health facilities in all its forms, including abductions and attacks health workers and medical transportation. Furthermore, ICRC wants to stimulate a change of behavior and patterns among all armed carriers in Afghanistan. The work done over the campaign reinforces protective laws though mobilization and awareness, including conferences, individual organizations and state government.

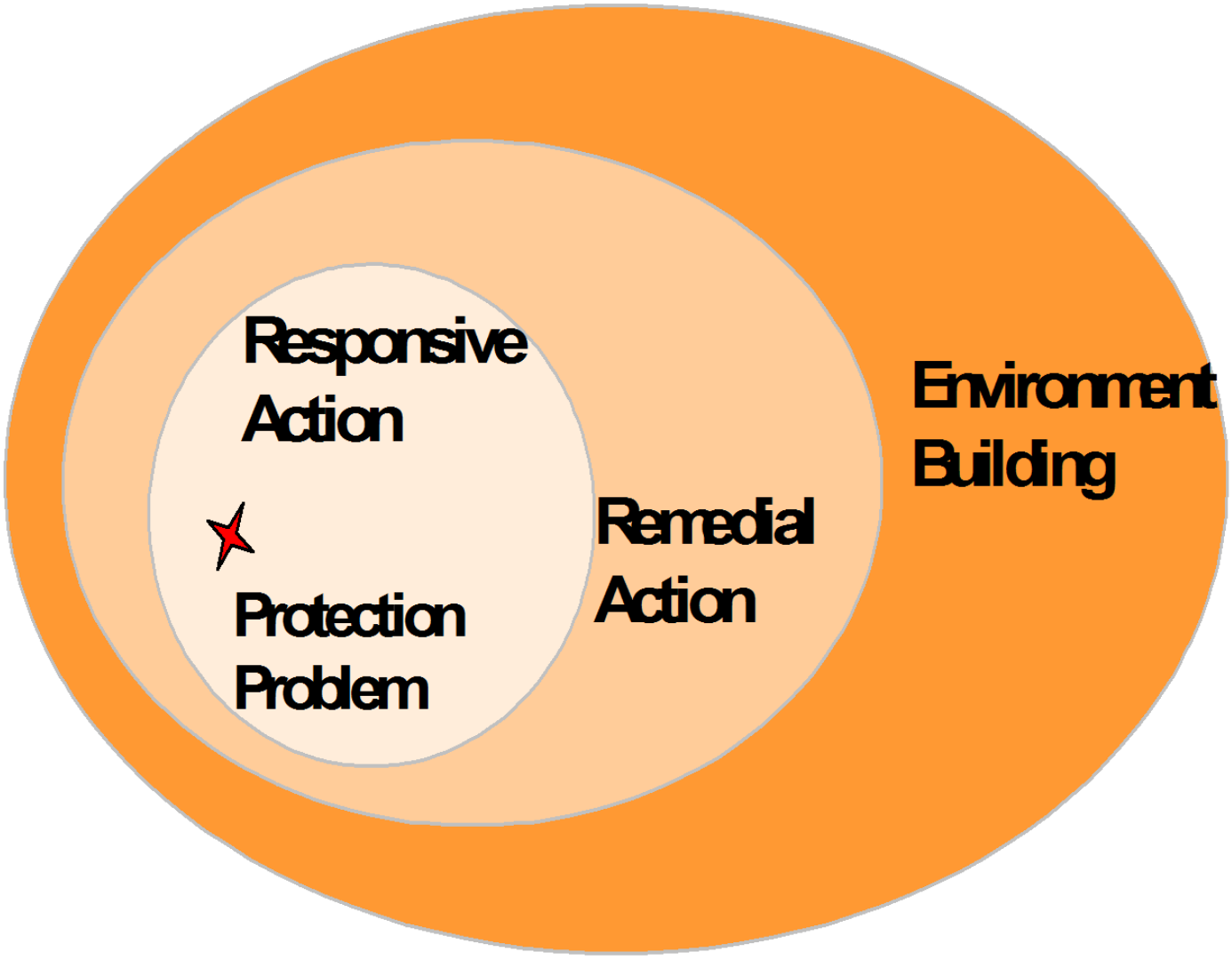
ICRC modes of action:

To help ensure healthcare protection, ICRC interacts with all perpetrators using the following negotiation mechanisms:

Persuasion: remains the main key element in order to change behavior and to maintain positive changes either immediately or on the long term. Persuasion creates a strong network which enables ICRC to address specific issues. For instance, ICRC recently managed to solve an issue between clinics run by MoPH and armed opposition groups who finally committed to cooperating each other.

Mobilization: is part of the general campaign to bring awareness within communities, healthcare workers, Islamic circles and States. It brings together several elements to discuss specifics issue for protecting medical missions and aid workers.

Denunciation: is used more publically in terms of having confidential or bilateral dialogue with all those involved in acts against the national or international humanitarian laws. ICRC uses public communication tools around the subject in parallel with support and substitution as relevant. Actions based on principles of neutrality, independence and impartial delivery of assistance shows perpetrators where the limits are in terms of abuses and constantly reminding the roles of protection.



Responsive Action: any activity undertaken to deal with an emerging or established protection problem and is aimed to alleviating or preventing its recurrence. It is an action to block any kind of violated activities and to transfer the wounded to a health facility for treatment. It is also an action to alert security forces of the services for them and other affected populations. Responsive action also involves communication with the Afghan Government and armed opposition groups to ensure that medical facilities are safe.

Remedial Action: any activity undertaken to restore peoples' dignity and ensure adequate living conditions after they have suffered abuse.

Environment-Building Action: all efforts to establish or foster a social, cultural, institutional and legal environment in which the rights of individuals might be respected.

International Humanitarian Law (IHL):

International Humanitarian Law addresses challenges on delivery and protection of healthcare in armed conflicts. In addition to this legal framework, principles of humanity, legal provisions including domestic law, customary law, and provisions of medical ethics all contribute to the protection of health workers. All wounded and or sick people who refrain from hostile acts during treatment are protected by IHL. This includes any fighters who become wounded, civilians, and maternity cases such as new-born babies and expectant mothers.

Who is protected by International Humanitarian Law (IHL):

Medical personal of the Red Cross and Red Crescent organizations and the personal of other aid societies including members of Armed Forces and National Society are protected. However, the broader scope of IHL protects all those who are working in the area of healthcare, whether they are professional healthcare workers, healthcare personal in facilities or ambulances, personal of health-oriented NGOs, military healthcare personnel and first-aiders.

There are rights and responsibilities under IHL in relation to medical missions and responsibilities for:

Care: The necessity to take all possible measures to provide healthcare and evacuate wounded and sick people. This must be done on a non-discriminatory basis. In Afghanistan, all parties involved in conflict and aid organizations working have to find ways to evacuate and provide health services in difficult circumstances.

Collect: The responsibility to search for, and evacuate victims. Wounded and sick people must be collected without discrimination or delay.

Protect: wounded and sick people are protected by law and should never be attacked. Medical facilities should always provide health services to all. They should therefore be safe and should not be the subject of attacks. ICRC does not provide healthcare directly, but supports selected hospitals and also provide first-aid trainings to health workers, armed oppositions, and civilians, working in remote areas. The aim of these activities is to try to communicate these principles to all beneficiaries.

Respect: Medical staff and patients must not be attacked, arbitrarily deprived of their lives, or ill-treated. Medical vehicles and facilities cannot be subject to attack.

Loss of protection of medical personnel and objects:

Specific protection can be lost by committing 'acts harmful to the enemy', for instance:

- Sheltering able-bodied combatants;
- Storing arms or ammunition;
- Using health facilities as military observation posts;
- Using health facilities as a shield for military action;
- Carrying or using fire arms for non-defensive purposes;
- Transporting healthy troops, arms or munitions;
- collect or transmit military intelligence;

Medical ethics verses the law:

Medical ethics protects the patient confidentiality in terms of medical information and identity. In some cases, however, national or customary law ask for information which conflicts with these ethics.

First challenge: Denunciation of wounded and sick fighters to government authorities is required by law when fighters seek medical care in facilities other than their own. There is a general obligation under IHL to respect medical confidentiality; however this is subject to exceptions under national law. Based on available mechanisms, medical treatment takes priority, after which patients can arrested by national forces.

Second challenge: There is an occurrence of criminalization of that providing medical care to wounded people during conflict. This is in contradiction to IHL which provides for no punishment for action within medical ethics.

Summarized relevant IHL rules:

Care	1. Taking all possible measures to provide medical care
Collect	2. Taking all possible measures to search for, collect and evacuate the wounded and sick
Protect	3. Ensuring that protected persons and objects are not attacked
	4. Protecting against undue interferences
	5. Preventing and repressing interferences with heath
Respect	6. No attacks or other harm inflicted on the wounded and sick, medical personnel, health facilities and vehicles
	7. No other forceful undue interference with medical care
	8. Respecting healthcare personnel's medical duties and ethics

The mentioned points are applicable by respecting the autonomy and dignity of individuals and maintaining confidentiality. There are many other interactive courses in understanding how IHL protect medical missions during conflicts and other emergencies.

https://www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-health-care-in-danger-project.htm

Q: What happens to wounded people who have been arrested?

A: There are still problems, ICRC and MoPH regularly sit together to overcome such problems in future.

In addition to this answer, NGO stated a real life example of a wounded persons being arrested when police entered one of NGO's health facilities and removed a person who had not yet been treated of his bullet injuries. Beside this, there was also a case where police stopped ambulance and removed an injured person.

John Hopkins Presentation- Human Rights

Human rights law addresses access to all legal rights such as healthcare and education. When it comes to protection, both IHL and human rights law share the aim of protecting all persons and are grounded in the principles of respect for the life, well-being and human dignity. The application of human rights law to conflict therefore ensures greater protection of civilians, additional accountability mechanisms for State actors, and remedies for affected populations.

Dialogue with perpetrators, education of combatants, and relationships with community elders, are all central to protection mechanism and strategies. The human rights approach is a very different approach to put pressure on perpetrators to demand human rights during conflicts in a very public way. Humanitarian organizations may not be in a good position to undertake those kinds of activities because access and relationships are very important and can be lost by applying human rights obligation. However, there are other people and entities that can make those commands.

Why focus on human rights?:

Human rights focus on the legal rights of people at any stage whether there is conflict or other emergency situations or neither. Human rights law:

- Applies at all times – in armed conflict and when conflict ends
- Addresses all aspects of interference with health, e.g., reduced access due to insecurity, curfews or decline in human resources.
- Focus specially on vulnerable populations
- Provides extensive requirements and obligations on governments for health services to be offered in a way that enables good quality access:

⇒ Services must, be available, accessible and be of high quality

⇒ Health facilities must be protected

⇒ Services must not be interfered

- Requires the participation by communities; individuals and communities have a meaningful right to participate in the development, implementation and oversight of health programs. Human rights also provide the right to freedom of speech and assembly.
- Makes available accountability mechanisms to ensure the quality of service delivery to beneficiaries, donors and States.

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. **(UDHR 1948*)***

Overview of human rights:

Two main Treaties regarding the protection of health workers:

- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights

The human right to health:

Article 12 of the Covenant on Economic, Social and Cultural Rights provides *"The right of everyone to the enjoyment of the highest attainable standard of physical and mental health".* This requires the:

- Provision of health services
- Determinants of health such as clean water
- Disease surveillance and other public health functions
- Protection from interference by others including forces.

Links to key documents on right to health and conflict:

- General Comment 14 on the Right to the Highest Attainable Standard of Health (2000) http://www1.umn.edu/humanrts/gencomm/escgencom14.htm
- Report of the Special Rapporteur on the Right to Health [on Health in Conflict] A/68/297 (2013). *http://reliefweb.int/sites/reliefweb.int/files/resources/N1342297.pdf*

The impact of conflict on the right to health:

General Comment 14 recognized the widening scope of notions of health, and proposed an approach that *"…takes into account such socially-related concerns as violence and armed conflict."*

- **Conflict impacts on underlying determinants health:** including access to safe potable water, adequate sanitation, food/nutrition and housing.
- **Vulnerability of health care system:** include impact on human resources for health, physical infrastructure, public health programming and etc...
- **Increased risks to population health:** increases morbidity and mortality, acute and chronic malnutrition, mental health etc.
- **Greatest impact on vulnerable groups –** e.g. refugees, women, children and elderly.

Types of obligations:

States have three types of obligations and to be attained first and for most at any stage particularly during conflicts.

- **Respect**: refrain from direct infringement of right to health and not attack, interfere, obstruct, demand priority for soldiers, arrest health workers or place munitions nearby health facilities.
- **Protect**: protect health services from interference by third parties and to assure safe access, assure facility and health personnel security.
- **Fulfill:** adopt proactive measures to realize right to health in all instances.

Four requirements for protection of health systems: (1) Availability:

Goods, services, facilities and programs must be available for all, including those with disabilities and minorities. They should include determinants of health such as water and sanitation.

Violations prevent availability through:

- destruction or closure of health facilities due to attacks
- loss of trained medical personnel who migrate due to systematic violence, assaults or attacks
- destruction, stealing of essential medicines and disruption of supply chains
- Insecurity prevents vaccinations. This was recently found to be true in eastern Afghanistan, (Kunar province / Dangam District) reported by WHO.

Availability in armed conflict –Relationship with armed groups:

"*States should also formulate policies on engaging with third parties, such as non-State armed groups, over their responsibility under human rights law or international humanitarian law, such as the obligation of States to make available health facilities, goods and services and the responsibility of non-State armed groups to refrain from preventing delivery of health care*."

"The obligation to fulfill the right to health by facilitating, providing and promoting conditions conducive to its enjoyment may also be difficult in conflict due to resource constraints or security reasons. States should, however, make available essential and minimum levels of health facilities, goods and services."

(Report of the Special Rapporteur on the Right to Health)

Four requirements for protection of health systems: (2) Accessibility:

- Non-discrimination – with a focus on marginalized people.
- Physical accessibility – distance, time required to access; again focus on vulnerable/marginalized people, women and children
- Impact of insecurity
- Military takeover of health facilities
- Economic accessibility – affordability. This ensures equity in access, including shares of resources
- Information - -access to health information

Accessibility in Conflict –Special Rapporteur on the Right to Health:

"*States in conflict may face unique challenges with respect to the obligation because of the presence of armed groups operating beyond the control of the State. In such cases, States should take concrete steps to provide protection for health-care workers and individuals seeking health-care services*."

Healthcare workers are essential for ensuring availability of healthcare services. States therefore have an immediate and continuous obligation to provide healthcare workers and humanitarian organizations with adequate protection during periods of conflict."

"*States should ensure that movement restrictions for people in conflict areas are legitimate and essential, and provide exceptions for access to health facilities, goods and services which can be exercised with minimal delays. States should also take steps to enable passage of individuals in need of health services in insecure areas*."

"*Acts that do not involve specific targeting of health facilities may also violate the right to health where the acts increase the risk of damage to the facility or decrease patient access to it, such as by locating military outposts or weapons in the vicinity of a clinic*."

Four requirements for health services: (3) Acceptability:

- Cultural appropriateness
- Consistency with medical ethics: medical staff should not be compelled to give priority to soldiers on non-medical grounds. Further, doctors and nurses should not be punished for acting impartially
- Gender sensitivity
- Respect for rights in health care such as confidentiality

Four requirements for health services: (4) Quality:

Health facilities, goods and services must be scientifically and medically appropriate and of good quality. Conflicts often undermine quality but this is not a blanket excuse for failing to meet obligations. The progressive realization of the right to health is a specific and continuous obligation.

Non-state armed groups are not explicitly covered by human rights law but there is an increasing recognition that armed groups should respect human rights and have obligations, including the obligation to:

- refrain from attacking or interfering with humanitarian facilities, vehicles, and personnel
- refrain from harming civilian populations, including through sexual violence or destroying food or water systems

Human Rights obligations: Participation:

- The obligation to assure the individuals and communities has meaningful right to participate in the development, implementation and oversight of health programs.
- Implicates other human rights, e.g., freedom of speech and freedom of assembly.

Human Rights obligations: Accountability:

- An important feature of HRL is the monitoring and accountability of duty bearers.
- Adopting a human rights approach to health care in conflict provides a valuable opportunity to identify additional accountability mechanisms that could be utilized.
- Potential rests in:

⇒ Treaty body issued reports e.g. Human Rights Committee

⇒ Universal Periodic Review and civil society should get involved in it and they have to participate

⇒ Increased reporting by OHCHR

⇒ Reports by the Special Rapporteur on the Right to Health (complaint procedures)

Comparison Human Rights and Humanitarian Law:

Humanitarian Law	Human Rights Law
Applies in armed conflict only	Applies in all circumstances
Applies to parties to the conflict	States are bound; norms apply to non-state actors
Very specific rules of conduct	General standards –but equally strong as IHL
No requirements of participation	Requirements of participation
No reporting requirements	Reporting requirements to UN bodies
ICRC seeks compliance by parties to conflict	ICRC generally not involved
Grave violations are war crimes and may be prosecuted	If widespread and systematic can constitute crimes against humanity

- **Area of special strength of International Human Rights Law (IHL) as compared to human rights law:**

- Rules regarding conduct regarding not attacking or interfering with health facilities, personnel, ambulances are clearly spelled out.
- Non-state actors legally bound in many circumstances.
- Explicit rules on non-interference with medical ethics to become powerful and non-state armed groups are at least to be bound by customary law and human rights law.
- Rules have become so powerfully accepted as to become customary law so apply to all combatants regardless of affirmation.

Areas of special strength of human rights law compared to IHL:

- In situations of insecurity, States have specific responsibilities to make services available and protect them.
- Under either source of law, armed forces may enter health facility, but IHRL is stronger on preventing disruption and interference with care.
- Clearer on requirements on quality and quantity of health care services in conflict including national plan.
- Broader opportunities for accountability through UN mechanisms.

NRC presentation /Islam and International Humanitarian Law

Based on historical perspectives of Islam and International Humanitarian Law, there are two dangers and the approach should be kept in mind.

To take International Humanitarian Law as the yardstick and to pick and choose Islamic verses that fit into that pattern will not be appreciated in Muslim societies, since it suggests that Islam is subservient to humanitarian law. There is a tendency to try get verses of the Holy Quran and Hadith of (Prophet Mohammad peace be upon him) to fit into that pattern. In the Muslim world, people feel that Quran is paramount and International Humanitarian Law should fit in with the Quran rather than the other way around.

Secondly, justifications of International Humanitarian Law tend to cite scriptures, and leave out history, whereas the proof of the scriptures is the practice of them, throughout the ages.

Approach to communication of Humanitarian Principles – and IHL:

For the last two years, NRC has been looking at humanitarian principles of neutrality, impartiality, independence in the light of Islamic teachings and strives to address them through the perspective of Quran and Hadith. We are teaching this module (Humanitarian Principles and Practice) to Madrasa graduates in Jalalabad and in Kandahar. Madrasa graduates are very committed, idealistic, honest and very devout particularly young men but completely marginalized because they are madrasah graduates. NRC would like to get them in to the mainstream and incorporate them into the humanitarian fold:

- Under the aegis of the ECHO-funded Humanitarian Access project, NRC has introduced a Humanitarian Principles and Practice module into the curriculum of MDI (Mahad'ad-Dawa Institute) in Kandahar and Jalalabad
- A hallmark of this module is that it does not seek to translate the humanitarian principles, but approaches them from the angle of Islamic tradition, in a way people can understand / in an Afghan way.
- The same approach to be adopted with International Humanitarian Law, IHL.

IHL and Islam: the tides of history:

From the time of Hazrat Omer Farooq, there have been engagements between the world of Islam and the world of Christianity. The first emigration of Muslims was to a Christian Kingdom Abysinnia and they were welcomed with open arms and given refuge.

There are countless examples of the engagement between the world of Islam and the world of Christianity.

Similarly, the debts owed by Europe to the Muslim world, including engagements with world of Islam (capture of Jerusalem by Umar'al-Farooq and Crusades) with respect to development of IHL may also be acknowledged.

The new tide of history:

With modern weaponry, it has become next to impossible to conduct war, and to observe the Islamic principles of inviolability of those not actively engaged in conflict. It has almost become impossible with modern weaponry (indiscriminate weaponry) to protect innocent people from the ravages of conflict.

The only way to be human, while adhering to Islamic principles of conflict, is to end conflict altogether – pacifism.

The Quoranic model:

"*Only fight against those who fight against you. Do not be excessive*." (Al-Quran, 2:190). Use the power against those who are actively involved in hostility and do not touch those who are not part of the conflict as well their assets in terms of health facilities and public utilities.

From the historical perspective: when automatic weapons came into fashion, there was debate among Islamic scholars as to whether these were permissible as they were too indiscriminate. Can war be humanitarian in the age of modern weaponry?

Rights of prisoners:

The generosity of the believers: "*they give food, despite being in need of it themselves, to the destitute, the orphans and prisoners "(*Al-Quran, Al-Insan, 8)." The treatment of prisoners has traditionally been humane and prisoners are not killed so prisoners have rights as stated in Quran.

Practice of IHL in the Muslim world:

- Seven Pillars of Wisdom:

"*The first rule of Arab war was that women were inviolable…. The lives and honor of children too young to fight with men were to be spared….. Property impossible to carry off should be left in place undamaged"*

The Cross and the Crescent:

When Humanitarian Law was developed in 19th century, it had the symbol of the cross which caused little bit of a reaction in the Muslim world.

- Given that the Muslim world has its own traditions of International Humanitarian Law, why the struggle to get official ratification of IHL from the Muslim world?

- Initial distrust, particularly on the part of the Ottoman Empire, of humanitarian law that was espoused under the banner of the Cross

- This led to the development of Red Crescent societies, which espoused similar principles in the Muslim world.

Protection of health facilities:

The Holy Quran says do not fight first, because fighting should be a last resort.

As for protection of wounded more work has to be done in this area, to establish the Islamic position on this. There might be a tendency to say, once there is a justified casus belli with this person, why should one protect him? When he is restored to full health, he will fight against you?

NRC is engaging in social media activities in terms of storylines and drama on the protection of health utilities:

- At the request of SCA, NRC worked with PACT Communications to develop a radio drama storyline on Protection of Public Utilities – in particular health clinics. This need developed following collateral damage in fighting to one SCA clinic in Wardak.

- Audience research is currently being conducted, to ascertain the impact of this storyline, which underscored the right that medical facilities have to protection from the ravages of war – entirely within the context of local traditions .

The Liaison Office TLO / Presentation

TLO is an Afghan NGO primarily involved research and peace building. TLO has been involved in research in many areas of Afghanistan for the past decade and as part of the research over the last five year it became evident that in the general research that attacks on humanitarians (NGOs / health sector) have increased - more organizations appear to develop specific approach and coping mechanism.

At the same time, TLO has increasingly engaged in research funding by various donors that, among other themes, seeks to understand how the insurgents are operating and to understand in how far they adhere to any codex that would cover humanitarian actions.

Context matters, there appears to be regional dynamics and the knowledge of the local elders and their role appears to be an important conduit to negotiate with the insurgency and other armed groups.

TLO has conducted research for various donors on some aspects on this topic. In the context of this meeting, some of the findings from research being conducted for a project with Geneva Call might be of interest:

- Understanding the level of global knowledge of local elders who could act as interlocutors with armed groups with regards to IHL, Islamic Law and lastly how aspects of Pashtunwali tie into the understanding of protection for humanitarian interventions
- Current practices on the ground and those patterns could be used to facilitate the dissemination of IHL and Islamic law provisions with regards to humanitarian principles
- Ideas and potential that elders see for how to engage groups on IHL ideas

The TLO research, which is going on in three provinces, namely in Logar, Khost and Paktya, will be completed in early January 2015 and will be shared in the final version with colleagues once approved by Geneva Call.

Basic preliminary findings in the Logar Province context:

Approaches and levels of knowledge of IHL, Islamic Law and Pashtunwali vary widely. IHL knowledge or even just a basic understanding of the concept is very limited, if present at all. A starting point can be Islamic law, but here again the level of knowledge varies widely. Unless people have had a formal education, their knowledge is mostly confined to basic Islam law concepts and usually do not include Islamic philosophy on civilian protection or ideas of conduct during war.

When approaching the IHL topic, elders feel most comfortable with local customary law – Pashtunwali but also Tajik communities mentioned their practices in this context. In some areas, elders appear to develop their own approaches based on what they were able to negotiate or find accommodation for with the armed groups.

Tentative Conclusions - IHL, Islamic Law and other practices:

There is a particular interest in IHL in communities that have been caught between the government and the anti-government/armed groups. Elders often struggle to understand IHL, especially if there is no solid grounding in Islamic Law, and if they do not see other parties, like ANSF applying such standards regularly.

Elders and communities surveyed overall have expressed a varying level of willingness to engage with anti- government or armed groups – but this willingness increases with the outlook for better service provision – especially with regards to healthcare.

In Logar, conflict seem to have increased in most respondents' views; the increased number of civilian casualties seems to make communities more willing to engage, to advocate for and to establish some rules of engagement, at least for basic services such as healthcare.

The premise of the Geneva Calls and TLO's approach is to give elders a better understanding of approaches of IHL implementation and to identify common ground for negotiation with armed non-State actors to advocate more effectively for civilian protection and the access to basic services such as healthcare. If the elders are more effective after the training in IHL related concepts, then this would be a positive development that would also be useful for the wider humanitarian sector as it would facilitate more protection for healthcare staff in the three mentioned provinces.

UNICEF presentation - Children in Armed Conflict

To establish how IHL can protect healthcare in armed conflict, UNICEF presented some general dynamics of IIHL which protect children in armed conflict.

General International Developments

Graca Machel Study 1996 – was the first comprehensive human rights assessment of war affected children in conflict situations and contained a comprehensive agenda for action by member states and the international community. It included a proposal for appointment of a special representative on children and armed conflict. The report analyzed preparedness and advocacy in existing of international law on protection for children in armed conflict particularly child soldiers, IDPs and refugees children and the protection of healthcare and health workers.

Following to Graca Machel Study, in 1997 the General Assembly adopted a resolution and recommendations for the appointment of Special Representative of SG for Children and Armed Conflict. Through this recommendation, Olara. A. Otunnu, the first Special Representative, had the following four responsibilities relating to children in armed conflict:

- **Advocate** – building awareness of the needs of war-affected children
- **Catalyst** – proposing ideas and approaches to enhance the protection of children in war
- **Conveyor** – bringing together key actors to promote more concerted and effective responses
- **Facilitator –** undertaking humanitarian and diplomatic initiatives/interventions to unblock difficult political situations.

And thirdly, the adaption of Security Council Resolutions SCR specifically for the protection of children in armed conflict.

There are four other key UN resolutions issued by the UN Secretary-General on child protection and the protection of Schools, Hospitals, Education and Health workers.

Key UN Resolutions:

Year / and resolution issuance	Description
In 2001/Res no 1379	On parties to conflict who *use and recruit children* in armed conflict
In 2005/Res no 1612	Set up of *Monitoring and Reporting Mechanism (MRM).*
In 2009/Res no 1882	parties to conflict *who kill and maim children and who commit rape or sexual violence* against children
In 2011/Rep no 1998	On parties to conflict *who threaten or carry out attacks against schools and hospitals or education and medical personnel*

Monitoring, and Reporting Mechanism (MRM):

The purpose of MRM is to provide for the systematic gathering of accurate, timely, objective and reliable information on grave violations committed against children in situations of armed conflict, as well as in other situations of concern as determined by the Secretary-General.

Such information should lead to well-informed, concerted and effective advocacy and response to protect and care for children and foster compliance with international child protection standards and norms. A key objective of the MRM is to enhance the accountability of State and non-State armed groups of grave violations against children.

Established in 2008, the MRM mechanism for Afghanistan is co-lead by UNICEF and UNAMA. Within the UNICEF office, there are national child protection officers alongside one international child protection specialist dedicated to MRM.

Monitoring should be undertaken by personnel from the Country Task Force Monitoring and Reporting (CTFMR), and partners who have been specifically trained in the MRM. This may include UN Agencies/Missions, NGOs, additional child protection actors, ICRC and Humanitarian clusters while other actors can also contribute to monitoring and reporting such as community stakeholders and journalists.

UNICEF conducts MRM training to partners or NGOs who want to contribute to work of MRM. AIHRC is the only non-UN member of CTFMR. NGOs and other actors can attend MRM task force meeting as observers. The ICRC can have a significant contribution to MRM but are not full member of CTFMR.

The following six categories of violations (grave violations against children) are the primary focus of reporting to the Security Council:

- Killing or maiming of children
- Recruitment or use of children in conflict situations
- Attacks on schools or hospitals
- Rape or other forms of sexual violence
- Abduction
- Denial of humanitarian access for children

In Afghanistan, detention and accusation of children for alleged involvement with armed forces and armed groups is also under scrutiny (grave violation). Perpetrators must be members of either national armed forces, non-state armed groups or International Military Forces. Personal enmity incidents cannot be covered by MRM.

And, each case has to be verified by minimum UN standards and can be credible only if reported by trained entity and should cover the criteria.

Attacks on hospitals as a grave violation-definition:

Attacks include the targeting of medical facilities that cause the total or partial destruction. Other interferences to the normal operation of the facility may also be reported, such as the occupation, shelling, targeting for propaganda, or otherwise causing harm to medical facilities or their personnel. 'Medical facilities' are places where the sick and wounded are collected and provided with health-care services.

SCR 1998 Key Provisions:

The Security Council specifically requested the Secretary-General to also include in the annexes to his reports on children and armed conflict, those parties to armed conflict who attack or threaten or any medical personnel.

The Secretary-General's Annual Report called upon these parties, "*to prepare without delay concrete, time-bound action plans to halt those violations and abuses*" and "*undertake specific commitments and measures in this regard*."

The Council explicitly urged *"parties to armed conflict to refrain from actions that impede children's access to education and to health services*" and requested "*the Secretary-General to continue to monitor and report, inter alia, on the military use of schools and hospitals, in contravention of international humanitarian law, as well as on attacks against, and/or kidnapping of teachers and medical personnel*."

Monitoring Attacks on Hospitals:

Attacks on hospitals are disaggregated in to three sub-categories; 1) targeted/deliberate attacks, 2) indiscriminate attacks/crossfire incidents, 3) looting and destruction.

It is very much important to report on these three categories as not all acts which affect health services are in violation of international law. Such perpetrators cannot be listed in the annexes of the Secretary General's report. For example, circumstances where a clinic damaged in cross-fire or a hospital is used by military are not contained in the criteria for listing those perpetrators in the annexes. However, parties that commit direct and repeated attacks can be listed in the annex of Secretary General under report.

MRM can however report on attacks and interferences of health service providers and patients, including, threats of attacks which are directed towards people and both credible and explicit, military use, or use of health facilities for alternative civilian purposes.

MRM statistics reported on attacks on Hospitals in Afghanistan:

- 2010: AOG (6), ANSF (1), Unknown (4) = 11 verified (7 unverified)
- 2011: AOG (15), ANSF (7), PGF (2), IMF (4), Unknown (6) = 34 verified (38 unverified)
- 2012: AOG (6), PGF (1), Unknown (7) = 14 verified (16 unverified)
- 2013: AOG (32), ANSF (1), IMF (1), Unknown (8) = 42 verified (14 unverified)
- As of 1st Nov, 2014: AOG: (35), ANSF (5), Unknown (7) = 47 verified (4 unverified)
- AOG is listed for attacks against schools and hospitals

Accountability and Response:

The purpose of MRM is to enhance accountability. Information collected must therefore lead to providing a concrete response.

- **Action plans and other commitments:** is an accountability measure to develop action plans with all parties to the conflict whether they are listed in the annex of annual report. ANSF is listed to the annex for the use and recruitment of children in armed conflict, UNICEF, in cooperation with other partners developed an action plan with the Government to stop the recruitment of children in armed forces. The Taliban are also on the list because of attacks on schools and hospitals.
- **Commitments and actions of Security Council and other UN Agencies**
- **Justice Mechanisms:** In Afghanistan, the Country Task Force ensure that the use and recruitment of children in conflict situations is criminalized under Afghan Law.
- **Program Response:** Program responses to both individuals and communities are an instrumental part to the MRM.
- **Advocacy**: MRM's systematic data should be used by partners for advocacy initiatives to persuade key decision makers to develop actions and polices to prevent violations against children.

UNAMA Presentation-Conflict and Protection of the Medical Mission

UNAMA are mandated under United Nations Security Council Resolution 2145 (2014) "*to monitor the situation of civilians, to coordinate efforts to ensure their protection, to promote accountability, and to assist in the full implementation of the fundamental freedoms and human rights provisions of the Afghan Constitution and international treaties to which Afghanistan is a State party*."

UNAMA has field presence in Afghanistan including, eight regional offices, three provincial provinces within the existing structure of Human Rights Team and nearly covering all regions of Afghanistan and try to cover each and every incident through its wide presence and network around the country.

Investigation, source of information and documenting civilian causalities:

When documenting any civilian casualty, UNAMA needs to cross-check and verify the data with at least three different independent sources, namely, victims, eye witness, medical practitioners and claims of responsibility by parties to the conflict (e.g. AGEs or PGFs).

National NGOs can provide valuable information to UNAMA at field level, including attacks to health personnel and facilities. UNAMA cross-reference first-hand information with NGOs as part of their normal procedure. NGOs can also share field level information with UNAMA at regional and central level.

Status Conclusion:

UNAMA has a comprehensive electronic database covering dates, locations, target types, perpetrators, tactic, sources. Dara is aggregated by gender and age. The database is updated daily with verified incidents by all regional teams.

When it comes to the stage of conclusion, the case should be in compliance to International Humanitarian Law (IHL). UNAMA consider only incidents in light of IHL. Data contradictory to IHL cannot be documented or added to the data-base. Secondly, UNAMA try to conclude incidents as soon as possible, however, sometimes it takes several weeks or months unless verified. Casualty numbers are not counted and added to database.

Incidents January- 30 November 2014:

UNAMA documented 40 incidents of attacks on healthcare facilities with 19 casualties. Tactics include intimidation, adduction, and killings. **Parties responsible:**

- Taliban: 11 incidents with 5 causalities
- AGEs: 9 incidents with 9 casualties
- PGF (ANP, ANCOP, ANA): 9 incidents with 3 civil casualties (hospital attack in April, motive not clear). For details, incidents breakdown can be shared with colleagues of interest.

UNAMA Advocacy:

UNAMA conduct regular meetings, deconfliction with ANSF (MOI, MOD and PICC), raise concerns and share verified accounts of violations relevantly to each department.

Feedback: ANSF sometimes agree and assure UNAMA of remedial and protective measures and other times disagree through written documents.

In cases were perpetrators deny responsibility, UNAMA need to provide convincing evidence to the contrary, including, any negative impact on civilians. UNAMA as member of Afghanistan's Protection Cluster strives to resolve or to avoid reoccurrences of such incidents.

In terms of AGEs, UNAMA has no direct communication with them but anyhow launching its annual report with chapter to Taliban in terms of incidents and their attacks at its end. UNAMA received written feedback from them which is also published in UNAMA report.

UNAMA also publish a Protection of Civilian report twice a year which contains a specific section on the protection of health facilities. These finding can be used for public awareness.

Government Obligations:

Afghanistan is a party to the four Geneva Conventions of 1949 and to the Additional Protocol II of 1977 which protect civilians in non-international armed conflict and prohibit attacks against civilians and objects indispensable to the survival of the civilian population. Afghanistan ratified Additional Protocol II 1977 on 10 November 2009. It entered into force on 24 December 2009.

Common Article 3 the four Geneva Conventions of 1949 establishes minimum standards that parties, including that State and non-State actors, shall respect in non-international armed conflict.

Treaty Bodies:

The human rights treaty bodies are the committees of independent experts that monitor the implementation of the United Nations human rights treaties by State parties They do this by reviewing reports which are submitted periodically by States regarding actions taken to implement treaty provisions. NGOs as observers can also have an input through active advocacy which reflects the concerns of the country.

Ways of NGO engagement:

- Promoting the **ratification** of a treaty body
- Monitoring State parties' compliance with their **reporting** obligation
- Submitting written and material to HRTB through **"shadow" reports** (often coordinated by all NGOs working in a topic in one country)
- Follow up on HRTB **concluding observations**

Acceptance of individual complaints and inquiries:

Individual complaints can only be registered through the Convention on the Rights of Persons with Disabilities as Afghanistan ratified the Treaty on the 8th September 2012. The source of information for treaty bodies can be UN agencies, NHRIs, NGOs, CSO and other professional associations.

Below the access link for registering the complaint to treaty bodies

http://www.ohchr.org/Documents/Publications/NgoHandbook/ngohandbook4.pdf

Q: What mechanisms are being used and how the accuracy of the data is assured?

A: first of all, UNAMA field offices collect the information from credible resources regarding any incidents that comes under the criteria and once the case is determined, the information is cross-checked with relevant sources namely UNICEF, WHO, MoPH or even with ANSF/ ISAF for verification. After that the information can be documented or added to the UNAMA data-base and is followed as advocacy point relevantly.

Q: How does UNAMA analyze attacks, on health facilities or the occupation of health facilities during militarization?

A: On 26 December, in Nuristan province, DuAb district, ANP personnel, who had forcefully occupied a 20-bed district hospital, agreed to evacuate following the effective intervention of UNAMA and other humanitarian organizations.

Overall view of the context in Afghanistan by ACBAR

After more than three decades of violent conflict, Afghans are longing for peace. With the current international military mission coming to an end on 31 December 2014, the context for peace talks may be changing. However, humanitarian principles are in real danger. The reconciliation context is complex and Afghanistan may be defined as an on-going civil war. 2013 was one of the most violent years since the current phase of the Afghan war started; more civilians have been injured and almost as many have been killed.

2014 was a very volatile year with a total of 5904 security incidents reported in the first quarter of 2014. The humanitarian space is shrinking and in some cases, not even respected by all actors of the conflict, including GoA, AOGs and criminals. Indeed, Afghanistan leads in absolute number of attacks on NGOs; in 2013 NGOs were impacted in 229 security incidents, and 232 in already 2014.

Understanding the context is crucial for NGOs as 52 aid workers were killed and 54 injured during 2014.

Medical NGOs as humanitarian organizations, are working impartially and independently to deliver much needed aid to the Afghan people, irrespective of ethnic identity, religion or political beliefs.

Insecurity incidents Oct, 2013 to Oct, 2014

The following table illustrates targeted attacks, collateral impacts (IED, SAF, Rocket) Aid workers' abduction and cases of intimidation and the occupation of health facilities, as reported by INSO and other reliable sources.

Responsible	Facilities	Staff	Vehicles
AOGs	26	7	15
IMF	1	2	0
ANSF	15	7	0
Criminal	3	8	3
GOA	1	1	0

Wrap up of Day 1 and points to be discussed on Day 2 of the workshop

Based on the update from medical NGOs and UN agencies, it is important to conclude that NGOs should stay impartial and independent. They should not be subject to attack or collateral damage. Healthcare services should not be criminalized and health workers should not be prosecuted lose their legal protection, or funding sources.

NGOs are keen to respond to crisis caused by conflict but health facilities can close staff are threatened, killed or abducted, not least because NGOs cannot accept the loses of human capacity if they are not protected.

It is therefore necessary to have a strong data collection mechanism emplace for healthcare providers to target the right stratum of affected populations. Data collection in this manner will allow NGOs to share, collect and protect.

Participants all agreed on sharing their advocacy inputs and awareness raising in order to facilitate access and resilience, in addition to prompting dialogue with different key actors involved in conflict and the protection of health by having a strong advocacy structure, NGOs will be able to address relevant advocacy issues and can assure the right to health and protection of healthcare and staff.

WHO Presentation

WHO collects data on healthcare in Afghanistan, This includes but is not limited to

- **Data on weapon wounded individuals:** 'Weapon wounded' refers to the number of individuals that have sustained a weapon related injury that may have been caused by conflict, criminal, or accidental circumstances.
- **Data on incidents against health workers and assets in 2014:** this includes health facilities, health workers, mobile health teams, and ambulances. It involves incidents occurring due to politically or economically motivated violence, in addition to, exposure to incidental violence which directly affects humanitarian personnel, equipment and facilities. It also includes, incidents relating to violence against humanitarian personnel, assets and facilities. This can be in the form of intimidations, abductions, arrests, injuries, deaths, damaged property, and stolen assets.
- **Data on regional security incident trends**: including abductions, air strikes, armed clashes, assassinations or attempted assassinations, IED detonated or discovered mine/UXO incident, stand-off attacks, or suicide attacks.
- **Data on civilian casualties and trends**, civilian casualties are defined as any civilian killed or injured resulting directly or indirectly from conflict related violence.

Available information systems and data bases

- UNAMA database on civilian casualties and violence against civilian institutions
- UNICEF database on child protection and violence against civilian institutions
- HMIS (weapons, injuries and death) and the health sector database of MoPH
- Incidence tracking system of WHO (preliminary)
- Incidence tracking on violence against health workers by MSF and ICRC

When analyzing the current flaws in the system currently used to collect data on the protection of health workers, they are issues concerning, duplication of work and efforts. Furthermore notification of incidents can be internment or slow and there is a risk that data quality may be unreliable. They may also be issues regarding inadequate analysis efforts and poor information sharing.

Q: How did you analyze this information to give updates or think about causes of conflicts? For example did you do any analysis on why some regions have higher incidents of attacks against health workers? Could it be used to make assumptions about conflicts occurring both in Afghanistan and in border areas?

A: One of the challenges is, there is no regular system for data collection, we have some data but it not a usable form. The idea of this workshop is to find a way to get a system in place and through that we can answer more questions and do more.

Q: *How reliable is HMIS data?*

A: From a statistical point of view, although it is a new tool, it is a good start as it is discovering about 20% of incidents. Next year external monitoring will take place to check on the ground if health facilities are open. WHO have designed an assessment covering 14 provinces where BPHS public facilities are active in order to gain knowledge of rationalization and functionality.

Q: *What about the others not reporting to HMIS? : How do you overcome the challenge of civilians who do not want to visit health facilities known to use the HMIS for fear they will be targeted due to being associated with government. To my understanding some organizations are not using the HMIS for this reason. Do you allow for confidentially issues on data discrepancies?*

A: We assume HMIS is coming from NGOs produced on district level. In the future we should find a method to allow for this, for example, more communication with the HIMS department as this is a big concern to our functionality, WHO is in negotiation to integrate emergency data.

John Hopkins Presentation on Data Collection

Data collection in Afghanistan:

Afghanistan's current system of data collection:

- UNAMA investigates attacks on healthcare under their civilian protection mandate – 40 cases in 2014.
- UNICEF leads investigations under monitoring and reporting mechanisms created by the Security Council/Children in Armed Conflict mandate – 47 cases in 2014.
- INSO, ICRC, aid groups collect security incident reports for internal purposes.
- MSF study shows that these reporting methods do not capture large number of cases.

Monitoring and reporting is a foundation for raising awareness, assessing effectiveness of prevention strategies, and putting pressure on relevant actors to change conduct. Data collection of violence and interference with healthcare services can raise awareness of major problems in need of address. The collection of evidence also helps assess the effectiveness of security strategies and puts pressure on key actors by invoking formal accountability mechanisms.

Global mandates for data collection- Collection of data on obstruction, threats and physical attacks on health workers:

The World Health Assembly (2012) calls for WHO leadership at the global level in developing methods for *systematic collection* of data on attacks on health facilities, health workers, health vehicles, and patients in complex humanitarian emergencies, in coordination with relevant United Nations bodies, other relevant actors, and the intergovernmental and nongovernmental organizations, avoiding duplication of efforts.

The General Assembly (December 2014) urges Member States (not just UN agencies) in co-operation with relevant international organizations as well as relevant non-State actors, to develop effective preventive measures to enhance and promote the safety and protection of medical personnel and promote respect for their respective professional codes of ethics.

Incident reporting form from Johns Hopkins:

John Hopkins has tried to respond to this problem by developing an electronic incident reporting form which can be used around the world. This form is going to be tested in Syria.

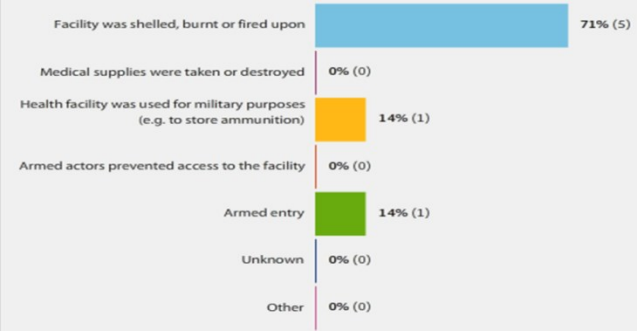
Using this form, John Hopkins aims to cover four major areas based on humanitarian and human rights law:

1. Health facilities
2. Personnel
3. Transports
4. Patients and others

John Hopkins has also included the collection of data of acts which fall short of violence but which still amount to interference with healthcare. This includes threats, insecurity or interference that limit access, cause the misuse facilities, or transports outside humanitarian function.

The initiative uses a '*Magpi*' platform for mobile devices an application commonly used to collect health data. It is very easy to use and is adaptable. www.magpi.com. It uses 'skip logic' meaning that a participant will only be asked further questions relevant to the answers they have already given. This makes it efficient to use, and even though it is comprehensive it can be used fairly quickly. Security features on the system use 'encryption' and there is no preservation of sent records on mobile devices. Additionally, dissemination of the information gathered from individual reports can be controlled, for example, by partial or full aggregation. Quality control options allow managers to see how the form is being used in the field and an in built database allows for reports to be generated quickly. Both witness and victims can complete the form. Targeted questions are used i.e. closed-ended questions as well as open-ended answers to allow for qualitative analysis.

Example of report generated by the John Hopkins Form



Potential pilot in Afghanistan?

This is a potential tool for data collection in Afghanistan.

The form could be piloted in Afghanistan, perhaps under the leadership by WHO and OCHA (due to their data collection mandates). A few NGOs could do a pilot in selected areas. This would require a focal point within organization, training in use of form, designation of individuals to collect data. Center for Public Health and Human Rights at Johns Hopkins would support and train NGOs on the tool and ACBAR might offer modest support in terms of coordination.

Q: Although this is a very interesting concept I have three main questions. First, how does the form allow for neutrality if both witness and victims can complete the form? Second what software does it use as not everyone will have a smart phone? What about questions of access, e.g. no internet, computers?

A: This form was not designed as open source as John Hopkins wanted the data collectors to be authorized for the purpose of accuracy and credibility. Therefore, even through both victims and witness can use the form, it is up to the discretion of mangers to decide how that will take place and who will collect it

Duplication of incidents is not a problem as it means that there is confirmation of an incident. The database is formed in a way which means it would be easy to see multiple reports and produce accurate reports without double counting.

With regards to access, the form works on any kind of mobile device including text. The data will need to be transferred at some point, but if there is no internet, information can be stored on the device until the user reaches a place where there is internet. The form also has security safeguards in place to ensure the data is safe until this point. The form can also be used on paper.

Q: What are the security implications? What justifications are there for collecting this data when it could put our staff at risk?

A: You do not collect data for data's sake and you do not want to be collecting data that puts staff at risk. There should be an assessment on whether the data will be helpful and what the risks are in each case. It does seem that they are certain circumstances in Afghanistan where this data could be helpful to assess the effectiveness of current strategies and to understand 'hotspots' where they are problems. There are lots of reason for this type of data collection but it really is up to you as the people of Afghanistan to decide if this will be helpful. The form also has security features to protect against discovery of data in the field.

This is not a total answer and there also needs to be in depth discussions with staff and communities.

Conclusion

WHO stated that they will take a lead to begin a working group or forum in order to establish an integrated mechanism of data collection to enable a joint repose to health protection. However, WHO will not release information which could be harmful to others. As the health cluster works closely with the MOPH, WHO suggested they could take a role in terms of capacity building the MoPH**.**

Next Action Points:

By January-February 2015:

- The establishment of a protection of civilian working group, with John Hopkins, ICRC, MSH.
- The development of TORs for the working group with very specific and detailed kinds of information.

By March 2015:

- A reporting tool is prepared and shared
- Existing data from organizations (e.g UNAMA, WHO, UNICEF will be extracted)
- Establishment of MoR (same figures- MRM) Task Force country (open to NGOs)
- Verification of data

Advocacy for the Protection of Health Services

Advocacy towards the Government:

Key Targets:

- Ministry of Interior
- Ministry of Defense
- Heads of ANA, ANP, ALP, NDS at national, regional and provincial level
- Security Council and Security Advisor to the President
- Security Cell of the National Assembly
- NATO civilian representative
- Resolute Mission or US commander

Key Messages:

♦ Respect IHL: This means: no threats against patients and personnel, no misuse of assets and supplies, no search of facilities, no entrance with weapons.

♦ Respect of IHL by PGF is the only way the other parties to the conflict will also respect IHL themselves. This allows for PGF members to be protected if/when treated, for their families to be protected and their communities as well.

♦ Since international military hospitals are closing, PGF need more than ever public civilian health facilities to work properly and are safe and this depends on respect of IHL.

♦ It is against Afghan and Islamic culture to kill a person who is wounded, and it is even obligated to provide help to people who need it, in particular health.

Possible solutions:

♦ Increase training for the staff (e.g. better curriculum, longer time spent teaching IHL and protection of civilians).

♦ Reinforce the military and police justice system and implement it for people who do not respect their obligations.

Advocacy towards Non-State Armed Actors:

Key Targets:

The panel identified key targets to focus advocacy efforts towards. This included, local level Taliban, Al Qaida, Akani, foreign fighters and shadow-governments and criminal groups in the regions.

Key Messages:

♦ The importance of advocating the right to health for all Afghans. Medical ethics dictate that health care facilities are available to all, regardless of political affiliation.

♦ The importance of raising awareness of the IHL which protects health service providers.

♦ The importance of raising awareness of the fact that healthcare providers operate under humanitarian principles of neutrally, impartially and independence.

♦ The importance of raising awareness of the fact those health care providers operate under the basis of full transparency, meaning that projects are open to scrutiny.

♦ Advocacy surrounding the protection of ordinary vehicles used to transport the wounded. Although marked ambulances are protected by law, in many cases people use ordinary vehicles to transport wounded persons. There should therefore be advocacy to inform Non-State actors to leave these vehicles alone, even though they are not necessarily protected by law.

Key methods to engage in advocacy towards Non-State Armed Actors:

- Meetings with Shuras
- Engagement with top commanders (issues with efficiency)
- Using local staff members to pass on messages means that they may be more welcomed from somebody they know
- Using the Islamic approach
- Using concepts from Pastoonwali

It is important to ensure consistent messages are passed to all relevant parties. Messages passed to the Government must be exactly the same as those passed to the opposition. This is because under International Human Rights Law, an opposition party in control of an area has the same responsibilities and obligations as if they were the Government.

Advocacy towards media and citizens

Key messages:

- Messages to raise awareness of tools to provide legal protection to health facilities, staff transport and others. All parties should protect these laws and accessible accountability measures.
- Messages to advocate against attacks on health facilities as neural entities. Health services should not be attacked as counter terrorist measures.
- Raising awareness of communities caught between the fighting
- Raining awareness of the importance of proving accurate information to the media and all relevant parties. Media should play and impartial role. Health should play a neutral part.

Key Advocacy Strategies

- Maintaining, relations with the media, and all relevant parties
- Effective and accurate data collection
- More campaigns

The workshop then discussed suggestions for advocacy to persuade the Afghan Government to tackle insecurity affecting the protection of health. This included:

- Asking ICRC to train the Afghan police and forces in the protection of health services, e.g rules concerning entering health facilities with weapons.
- There was a campaign in South Sudan to inform people about not entering health facilities with weapons. There could a campaign in Afghanistan on the topic to inform the both the AOG, international and Afghan forces on these laws and IHL training. The campaign could also highlight information on attacks, killings, abuse doctors, stealing materials.
- ACBAR should continue to release statements when they are attacks on health care services.
- Using the media as a platform to disseminate information.
- There needs to be a unified call for sanctions and systems by the NGO and CSO community. The Government should ensure that laws are followed.

Concluding remarks from John Hopkins on the Safeguarding Health in Conflict Coalition:

They are two kinds of things that the Safeguarding Health in Conflict Coalition does, one is to advocate on a global level, for strengthening mechanisms to protect health. For example what UNICEF is doing in Afghanistan, regarding collecting data and conducting investigations into attacks on healthcare services, would not have happened if there had not been a global movement to protect schools. That global coalition is what forced the UN Security Council to oblige UNICEF to strengthen their monitoring and evaluation systems on attacks on schools and hospitals. It was by luck that the original language of the resolutions from years ago said 'schools and hospitals'. However, it was the people in the education world that forced the UN Security Council to act. The coalition web site is www.safeguardinghealth.org. Everyone is welcome to receive the monthly newsletter by email by signing up at the website.

The Coalition wants to use this as a model to strengthen mechanisms to get the problem on attacks on healthcare on the international agenda. The second thing the Coalition aim to do is to support people working at the national level. We want to support people working in Afghanistan. ACBAR is a member of the coalition, and one of the things we do is try to amplify the voices of people at the national level. For example, we post ACBAR statements on our website and newsletters so the world can see. We support members on data collection. We would like to support participants in this workshop and other NGOs working in Afghanistan. They are other groups working in Afghanistan who are members and we are always looking for members. It has been a pleasure and thank you.

There will be a feedback/ follow-up workshop in June, which the MoPH and the World Bank will be invited to.

ANNEXES

Annex 1: Briefing paper ACBAR—ISAF withdraw and impact of civilian health facility

Annex 2 : List of acronyms

Annex 1

Briefing Paper published by ACBAR - September 2014

Impact of Transition on Health Care Delivery

The security transition in Afghanistan is entering its final phase in 2014, with partial withdrawal of foreign operating forces planned for December 2014 and completed for US forces for the end of 2016, accordingly with NATO's time-line and President Karzai's demand. Already, since mid-2013, the Afghan Government has assumed the lead of all combat operations in the country, after the final transfer of the security responsibility to the Afghan Military Forces took place. In this context, ACBAR would like to focus on the lack of support for ANSF and the consequent impact on civilian health care system.

Increased conflict related civilian casualties:

The conflict between pro-government forces and armed opposition groups is escalating, as the number of civilian and Afghan military casualties in 2013 shows. Indeed, last year saw a record high number of civilian casualties. According to the UN Mission in Afghanistan (UNAMA), 2,959 civilians were killed in 2013 and 5,656 injured, a 14% increase in total civilian casualties compared to 2012, consistent with the numbers of 2011 which were themselves a record. UNAMA specifies that "*increased ground engagements […] with civilians caught in the crossfire was a new trend […] causing 27 percent of all civilian deaths and injuries in 2013*", the second leading cause of civilian casualties country-wide, and a 43% increase compare to 2012. UNAMA further explains that "*this 'fog of war' dynamic reflects the changed nature of the conflict in Afghanistan in 2013 which was increasingly being waged in civilian communities and populated areas with civilians caught in the cross fire*".

As OCHA states "*2013 witnessed a significant increase in reported weapon-wounded patients [77% increase compared to 2012], as a direct impact of the conflict, challenging an unprepared health system. Several security incidents resulted in mass casualties, which exposed the unpreparedness of health services to respond at scale to trauma victims*."

As a result of this increased level of insecurity combined with poor access to health services in the most affected provinces, the access to emergency trauma care and health services are considered the number one priority by the CHAP 2014.

Record high casualties in the Afghan military forces:

At the same time as civilian casualties rose, record high numbers of national security troops killed in combat in 2013 were reported by the US Department of Defense in November 2013. This report said that the number of Afghan security forces saw an 80% increase in number of troops killed during the summer 2013, compared to the same period in 2012. According to a Washington Post article from 2013, "*About 250 Afghan soldiers and police officers die every month, a toll far higher than that suffered by Western troops in their deadliest period*". Moreover, the report points out, the high number of casualties and the limited ability of the army to evacuate the injured "*adversely affect moral, retention and recruiting*", with 34% of attrition rate during the same period.

Because of the security transition, Afghan military forces face reduced air support from the international military forces. The Afghanistan Analyst Network (AAN) published an article on the subject stating that: "*if Afghan troops are wounded in a fight, their best chance for survival is medical evacuation (MEDEVAC). This is a mission of critical importance in a country like Afghanistan, where transport by road is problematic, thanks to a combination of poor infrastructure and the ongoing threat of roadside bombs*".

However, as reported by a Washington Post's article from 2013: *"For the past decade, the Afghan army has relied on hundreds of American helicopters to pluck wounded soldiers from remote battlefields and outposts. Now, the U.S. helicopters are leaving Afghanistan just as the country's army embarks on its toughest fight, assuming formal responsibility for security this summer. The Afghan air force has 60 helicopters, but many are out of commission at any given time, and none is dedicated solely to casualty evacuation American officials acknowledge that Afghan pilots will be able to evacuate only a fraction of wounded soldiers and police officers. Last year [in 2012], the United States evacuated 4,700 Afghan soldiers by air, compared with the Afghan air force's 400".*

Furthermore, according to a US Colonel cited in this article, *"there is no way the Afghan air force will be able to cover what we've been covering".*

On the air coverage, AAN also added that, "*while there are plans to purchase an additional 30 Mi-17 helicopters from Russia, those are not going to be nearly enough to fill the gap left by the departure of coalition airpower*".

Increase reliance on the civilian healthcare system by the Afghan military:

Thus, confronted with increased casualties in their rank, Afghan troops increasingly depend on ground evacuations for their injured. However, because of the complicated geography of the country and the high security threats on any ground transportation, according to new data from NGOs, the ANSF often have to make use of civilian health services, instead of military ones, in order to try to save the lives of their recruits. Recently, a number of armed Afghan Local Police came to a CHC along with a patient. Before entering the clinic, the NGO guard prohibited the ALP from carrying their weapons inside the clinic, and asked them to put the weapons aside. The ALP officers refused, and insisted that they be allowed in the clinic with their weapons. The verbal discussion quickly deteriorated and the ALP officers attacked the clinic guard, physically assaulting him and eventually breaking his leg in a violent altercation. The guard has been admitted to the provincial hospital for treatment.

This increases the burden on an already fragile, hard-pressed and unprepared civilian health system and on the NGO's implementing health care. Still in the Washington Post article, an unnamed US official is quoted saying that there was no "*proper trauma care in place*" in the country to take care of the increasing number of civilian casualties. Moreover, they often do not respect the immunity of the health services, by entering facilities with armed weapons and forcing medical staff to prioritize their patients. The priority for medical care should be based on need and not on threats. Finally, in their search for health services; looting cases, in-facilities search operations; harassment, threats and intimidation have been regularly reported.

Indeed, according to UNAMA, "*attacks against healthcare facilities and personnel increased in 2013*". They documented 32 incidents, compare to 20 in 2012. The majority of incidents involved "*threats, intimidation and harassment, followed by abductions and targeted killings of medical personnel*". UNAMA received multiple allegations of occupations, looting and search operations by all parties to the conflict, in direct contravention with international humanitarian laws that prohibits attacks against staff and facilities.

As the Safeguarding Health in Conflict Coalition said at the occasion of the releasing of their report 'Under Attack: Violence Against Health Workers, Patients and Facilities', "*When health workers and hospitals are attacked, people can't get medical care and trained professionals flee areas where they are urgently needed*".

A complex context for Non-Governmental Organizations:

After more than three decades of violent conflict, Afghans are longing for peace. With the current international military mission coming to an end on 31 December 2014, the context for peace talks may be changing. However, humanitarian principles are in real danger. The reconciliation context is complex and Afghanistan may be defined as an on-going civil war; comparing 2013 with 2011, the most violent year since the current phase of the Afghan war started, more civilians have been injured and almost as many have been killed. 2014 is already a very volatile year with a total of 5904 security incidents reported in the first quarter of 2014. Of these, 3059 incidents were attributed to the armed opposition, 2234 to the Afghan Security Forces, 200 to the International Forces and 411 to armed criminal groups. The humanitarian space is shrinking and sometimes, not even respected as space is contested by all actors including GoA, AOGs and criminals. Indeed, Afghanistan leads in absolute number of attacks on NGOs; in 2013 NGOs were impacted in 229 security incidents, and so far in 2014, 79 incidents.

Understanding the context is crucial for NGOs as 30 aid workers were killed and 73 injured during 2013 while 14 aid workers have been killed so far during the first 5 months of 2014 in Afghanistan.

The need for protection of the health care sector and respect of International Human Rights and Humanitarian Law

As a coalition of humanitarian and development organizations, our obligations are toward the Afghan population that we serve, support and aim to protect from risks. This means in particular, ensuring the safe and unhindered access of the people to healthcare, an essential and basic service. Respect and protection of medical personnel, facilities, including vehicles, and patients is essential in order to allow for the provision of timely, often life-saving, medical assistance to civilians, as it is their right.

Deliberate attacks on health facilities and failure to provide access to patients and protection against damage are often in violation of international laws Attacks, abdications of responsibilities of access and protection of facilities, personnel and vehicles performing their exclusively medical tasks are strictly prohibited under international human rights humanitarian law. The Safeguarding Heath in Conflict Coalition's report underlines that: "*In compliance with international humanitarian law, parties to an armed conflict must ensure the respect and protection of patients as well as health workers, facilities and transportation. It is also an obligation under human rights law for governments to ensure access, without discrimination, to primary health care and 2nd level Health care*".

The ICRC also states the following: "*Health-care personnel must not be hindered in the performance of their exclusively medical tasks. They must not be harassed or punished for performing activities compatible with medical ethics, compelled to perform acts contrary to medical ethics, or forced to refrain from acts required by medical ethics. […] Medical vehicles must not be attacked, stolen or otherwise interfered with, regardless of whether they are military or civilian." " Healthcare facilities must be spared the effects of conflict, including forcible interference with their functioning by , for instance, depriving them of electricity and water.*"

Humanitarian organizations as medical NGOs are working impartially and independently to deliver much needed aid to the Afghan people who need it the most, irrespective of ethnic identity, religion or political beliefs.

In the current context, where Afghanistan still faces major challenges such as the high vulnerability to natural disasters, one of the worst levels of poverty in the world, an increase in crime and an intensification of a conflict that has been ongoing for more than 30 years, NGOs – both local and international – play, and will continue to play, a critical role in providing relief and development aid to people in need, in all 34 provinces of Afghanistan, often in areas where other service providers have limited or no access.

ACBAR - the Agency Coordinating Body of Afghan Relief and Development - calls upon ANSF to end all forms of violence against health facilities and to the medical staff. ACBAR highly request from ANSF to create an internal mechanism of protection of civilians in armed conflicts. ANSF should conduct training for military personals on civilian protection according to Geneva Conventions. ACBAR also reiterate its strong condemnation of any attack, intimidation, violence or threats against medical staff. We appeal for the organization of army medical support for the soldiers (Roll 1 in each provinces and Roll 3 in each region) and to follow the humanitarian law – the protection of the health facilities.

Annex 1: List of Acronyms

Acronyms	*Full Name*
AAP	Accountability to Affected Populations
AB	Advisory Board
ABP	Afghan Border Police
ADF	Afghanistan Development forum
ACTA	Afghan Coalition for Transparency and Accountability
AGE	Anti-Government Element
AHF	Afghanistan Humanitarian forum
AIHRC	Afghanistan Independent Human Rights Commission
ALNAP	Active Learning Network For Accountability and Performance in humanitarian Action
ALP	Afghan Local Police
AMP	Aid Management Policy
ANA	Afghan National Army
ANDMA	Afghanistan National Disaster Management Authority
ANDS	Afghanistan National Development Strategy
ANP	Afghan National Police
ANSF	Afghan National Security Forces
AOG	Armed Opposition group
APPF	Afghan Public Protection Force
APC	Afghanistan Protection Cluster
APPRO	National Action Plan For The Women Of Afghanistan
ARCS	Afghan Red Crescent Society
ART	Anti-Retroviral Therapy
ARTF	Afghanistan Reconstruction Trust Fund
ARV	Anti-Retroviral
AVRR	Afghan Volunteer Return and Reintegration
AWG	Advocacy working Group
AXO	Abandoned Explosive Ordnance
BAAG	British And Irish Agencies Afghanistan Group
BCPR	Bureau For Crisis Prevention recovery
BA	Bachelor Of Arts
BCS	Border Crossing Station
BEMOC	Basic Emergency Obstetric Care
BMI	Body Mass Index
BPHS	Basic packages of health services
BPRM	Bureau of Population, Refugees, and Migration
BTS	Blood Transfusion service
BVW	Basic Veterinary Worker
CAS	Close Air Support (Air Strike)
CBE	Community Based Education
CBO	Community-based organization
CBRR	Cross Border Return and Reintegration
CCM	Convention on Cluster Munitions
CEO	Chief Executive Officer
CCW	Certain Conventional Weapons
CCA	Close Combat Attack

CDC	Community Development Council
CE-DAT	Complex Emergency Database
CEDAW	Convention On The Elimination Of All Forms Of Discrimination Against Women
CEMOC	Comprehensive Emergency Obstetric Care
CERF	Central Emergency Response Fund
CFR	Case Fatality Rate
CFW	Cash For Work
CHAP	Common humanitarian Action Plan
CHF	Common humanitarian fund
CHW	Community Health Worker
CIHL	Customary International Humanitarian Law
CM	Capability Milestone
CMT	Core Management Team
CMR	Crude Mortality Rate
CPAN	Child Protection Action Network
CPIA	Country Policy and Institution Assessment
CRC	Convention On the Rights Of The Child
CRED	Centre for Research on the Epidemiology of Disasters
CRISE	Centre for Research on Inequality, Human Security and Ethnicity
CRPD	Convention On The Rights Of Person With Disabilities
CSO	Civil society Organization
CSTC-A	Combined Security Transition Command Afghanistan
CTC	Cholera Treatment Center
CVO	Chief Veterinary Officer
DA	Department of Army
DAC	Development Assistance Committee
DDA	District Development Assembly
DDMC	District Disaster Management Committee
DFID	Department for International Development (UK)
DMC	Department of Mine Clearance
DOD	Department Of Defense
DORR	Directorate of Refugees and Repatriation
DRR	Disaster Risk Reduction
ECB	Emergency Capacity Building
ECHO	European Commission Humanitarian Office
EE	Emergency Essential
EFA	Education For All
EITI	Extractive Industries Transparency Initiative
EM	Environment markers
ENA	Emergency Nutrition Assessment
ENNA	European NGOs Network For Afghanistan
EOF	Escalation Of Force
EPHS	Essential Package of Health Services
EPI	Expended Programme On Immunization
ERC	Emergency Relief Coordinator

ERP	Emergency Response Plan
ERF	Emergency response fund
ERW	Explosive Remnants of War
ETAT	Emergency Triage Assessment And Treatment
EU	European Union
EVIF	Extremely Vulnerable Individual
FANTA	Food And Nutrition Technical Assistance
FAO	Food And Agriculture Organization Of United Nations
FCN	Foreign Country National
FI	Food Items
FSM	Field Site Monitoring
FSN	Foreign Service National
FTE	Full Time Equivalent
GAD	Gender Age Diversity
GAVI	Global Alliance for Vaccines and Immunizations
GBV	Gender Based Violence
GDP	Gross Domestic Product
GHI	Global health initiative
GIROA	Government of the Islamic Republic of Afghanistan
GMO	Genetically Modified Organism
GOA	Government of Afghanistan
GSV	Go and See Visit
HAP	Humanitarian Accountability Partnership / or Humanitarian Assistance Program
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
HE	Hygiene Education
HF	Health Facility
HFSN	Health and Fragile States Network
HFU	Humanitarian Financing Unit
HIP	Humanitarian Implementation plan
HIS	Health Information System
HLP	Housing, Land and Property
HLTF	High Level Task Force
HRA	High Return Areas
HRL	Human Rights Law
HRFM	Human Rights Field Monitoring
HRW	Human Rights Watch
HSR	Human Security Report
IASC	Inter-Agency Standing Committee
ICC	International Criminal Court
ICCPR	International Covenant On Civil And Political Rights
ICERD	International Convention On The Elimination Of All Forms Of Racial Discrimination
ICESCR	International Covenant On Economic Social And Cultural Rights
ICLA	Information Counselling and Legal Assistance
ICRC	International Committee of the Red Cross
ICVA	International Council Of Voluntary Agencies
IDF	Indirect Fire (Rockets Mortars)

IDLG	Independent Directorate for Local Governance
IDLO	International Development Law Organization
IDP	Internally Displaced Person
IEA	Islamic Emirate Of Afghanistan
IEC	Independent Election Commission
IED	Improvised Explosive device
IFE	Infant Feeding In Emergency
IFPRI	International Food Policy Research Institute
IFRC	International Federation Of Red Cross And Red Crescent Societies
IFAD	International Fund For Agriculture Development
IGC	International Grains Council
IHL	International Humanitarian Law
II	Implementation improvements
IM	International Military
IMAI	Integrated Management Of Adult illnesses
IMCI	Integrated Management Of Childhood illnesses
IMF	International Military Forces
IMPAC	Integrated Management Of Pregnancy And Childbirth
INEE	Inter-Agency Network For Education In Emergencies
IOM	International Organization for Migration
IPC	Infection Prevention And Control
IRS	Indoor Residual Spraying
ISA	Independent Services Authority
ISAF	International Security Assistance Force
ISPO	International Society For Prosthetics And Orthotics
IYCF	Infant And Young Child Feeding
JCMB	Joint Coordination Monitoring Body
JIU	Joint Inspection Unit
JICA	Japan International Cooperation Agency
LAS	Land Allocation Sites/ Land Allocation Scheme
LBW	Low Birth Weight
LEGS	Livestock Emergency Guidelines And Standards
LICUS	Low-income countries under stress
LFEW	Livestock Female Extension Worker
LLIN	Long Lasting Insecticide Treated Net
LoLM	Law on Land Managment
M&R	Monitoring and Reporting

MA	Managing Agent
MACCA	Mine Action Coordination Center of Afghanistan
MAIL	Ministry of Agriculture, Irrigation and Livestock
MAPA	Mine Action Programme of Afghanistan
MBT	Mine Ban Treaty
MDGs	Millennium Development Goals
MEC	Monitoring and Evaluation Committee
MISP	Minimum Initial Service Package
MOBTA	Ministry of Border and Tribal Affairs
MOD	Ministry of Defense
MOE	Ministry of Education
MOEC	Ministry of Economy
MOF	Ministry of Finance
MOFA	Ministry Of Foreign Affairs
MOCY	Ministry of Culture and Youth Affairs
MOIC	Ministry Of Information And Culture
MOHRA	Ministry of Haj and Religious Affairs
MOYC	Ministry Of Youth And Culture
MOI	Ministry of Interior
MOJ	Ministry of Justice
MoLSAMD	Ministry of Labour, Social Affairs, Martyrs & Disabled
MOPH	Ministry of Public Health
MORR	Ministry of Refugees and Repatriation
MOWA	Ministry of Women's Affairs
MPA	Master Of Public Administration
MRRD	Ministry of Rural Rehabilitation & Development
MUAC	Mid Upper Arm Conference
MUDA	Ministry of Urban Development Assistance
NATO	North Atlantic Treaty Organization
NAPWA	National Action Plan for Women of Afghanistan
NCD	Non Communicable Diseases
NCHS	National Center For Health Statistics
NDS	National Directorate of Security
NFI	Non Food Item
NGO	Non-governmental Organization
NICS	Nutrition In Crisis Information System
NHLP	National Horticulture And Livestock Project
NPP	National Priority Program
NRVA	National Risk And Vulnerability Assessment
NSC	National Security Council
NSP	National Solidarity Program
NTAP	National Transparency Accountability Program
OAU	Organization Of African Unity
OCHA	UN Office for the Coordination of Humanitarian Affairs
OECD	Organization For Economic Cooperation And Development
OER	Office of Emergency Response
Off Budget	Budget From Donor Based On Bilateral Agreement
OHCHR	Office of the High Commissioner for Human Rights
On Budget	Budget From Donor through GIROA

ORS	Oral Rehydration Salts
OSD	Office of the Secretary of Defense
PAHO	Pan American Health Organization
PDMC	Provincial Disaster Management Committee
PEP	Post Exposure Prophylaxis
PGM	Pro-Government Militia
PHC	Primary health care
PHT	Provincial Humanitarian Team
PLHIV	People Living With HIV
PLWHA	People Living With HIV And AIDS
POR	Proof of Registration
POUWT	Point Of Use Water Treatment
PRT	Provincial Reconstruction Team
PSN	Person in Need
Q&A	Quality And Accountability
RAF	Rapid Assessment Form
RADP	Regional Agricultural Development Program
RH	Reproductive Health
RHT	Regional Humanitarian Team
RMU	Risk Management Unit
RMLSP	Rural Microfinance And Livestock Support Project
RNI	Reference Nutrient Intakes
RPG	Rocket Propelled Grenade
RPA	Remotely Piloted Aircraft
RSD	Refugee Status Determination
SAF	Small Arms Fire
SSAR	Solution strategy for Afghan refuge
SCM	Supply Chain Management
SEEP	Small Enterprise Education And Promotion
SIGAR	Special Inspector General for Afghanistan Reconstruction
SGBV	Sexual and Gender Based Violence
SGP	Small Grant Program
SKAT	Swiss Center For Appropriate Technology
SLRC	Secure Livelihoods Consortium
SMC	Sanitary Mandate Contract
SOPS	Standard Operating Procedures
SOM	Senior official meeting
SRC	Strategic Review Committees
SRP	Shelter Response Plan
SWG	Sub Working Group
TA	Technical assistance
THET	Tropical Health Education Trust
TMAF	Tokyo Mutual Accountability Framework
TOT	The Terms of Trade
U5MR	Under Mortality Rate
UCT	Unconditional Transfer
UDHR	Universal Declaration Of Human Rights
UK	United Kingdom
UN	United Nation

UNAMA	United Nations Assistance Mission in Afghanistan
UNCRPD	UN Convention on the Rights of People with Disabilities
UN-DDR	United Nation Disarmament Demobilization and Reintegration
UNDP	United Nations Development Program
UNDSS	United Nations Department of Safety and Security
UNFCCC	United Nation Framework Convention On Climate Change
UN-HABITAT	United Nation Human Settlements Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNISDR	United Nation International Strategy For Disaster Reduction
UNITAID	International Drug Purchasing Facility
UNODC	United Nation Office For Drug Control
UNOPS	United Nations Office for Project Services
UORS	Urgent Operational Requirements
USAID	United States Agency for International Development
USFOR-A	United States Forces-Afghanistan
USSOF	United States Special Operations Forces
UXO	Unexploded Ordnance
VCA	Vulnerability And Capacity Analysis
VDC	Village development committee
VFU	Veterinary Field Unit
VIP	Ventilated Improved Pit
VRF	Voluntary Repatriation Form
VT	Vocational Training
WASH	Water Supply sanitation And Hygiene Promotion
WB	World Bank
WBM	Web Based Monitoring
WEDC	Water Engineering And Development Center
WFH	Weight For Height
WFP	World Food Programme
WHA	World Health Assembly
WHO	World health Organization
WIT	Water Inspection Team
WMC	Water Management Committee
WP	Water Point
WSP	Water Safety Plan

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Afghan Relief & Development

DO NOT FORGET AFGHANISTAN
THE WORLD IS GRADUALLY FORGETTING