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# The medical profession and international humanitarian law <sup>1</sup>

by Jean Pictet

## 1. INTRODUCTION

International humanitarian law, whose purpose is to attenuate the evils of war, has been intimately bound from its earliest days to doctors and all others whose mission in life is to heal—the noblest of all professions. The fact is that this law originated from the need to make up for the deficiencies of military medical services and protect those wounded in war. Since then, the law has gone far beyond that framework and has extended its protection and solicitude to many other victims of conflicts and also, in peacetime, to victims of day-to-day life—sick people. An essentially medical element was the basis of the law, and continues to be a major element, referred to by some as “medical law”.

The initiator of humanitarian law was the International Committee of the Red Cross (ICRC), which is closely associated with medicine, since the Red Cross and doctors have the same aim: to fight against suffering and death. Co-operation between them can never be too close.

The role of the doctor in time of conflict, like that of the Red Cross delegate, is becoming more and more difficult. It is my duty to call attention to this, for our epoch is marked by a hardening of hearts and a weakening of international morality. Nowadays, nations go to war with intensified passion, and the infliction of

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<sup>1</sup> Address at the conference on «The Right to the Protection of Health» (Turin, 20-22 May 1983), under the auspices of the Institute of International Humanitarian Law of San Remo.

suffering has come to be a political weapon. Accordingly, we must recognize that the relief mission demands ever-increasing courage from those who serve this cause. In a maddened world, fidelity to our duty may demand that we risk our lives. The doctor, more than ever, must therefore be ready to accept such risks. His job also demands a deeper inward preparation—and it is for this reason that knowledge of the texts and principles of international humanitarian law is indispensable.

Let us begin with a glance at the past.

The roots of humanitarian law are embedded in prehistory. What is described as the law of the jungle prevailed in primitive societies, but we know that even then there were attempts made to attenuate unnecessary suffering. We know for example that the wounded in Neolithic battles were treated, for many skeletons show evidence of the reduction of fractures and even of trephination.

In antiquity, examples of humanity shown by kings were isolated gleams of light in the prevailing darkness, but, very slowly, these examples became the rudiments of custom. For instance, Cyrus gave the same care to wounded Chaldeans as to his own soldiers. In India, the emperor Asoka ordered his troops to respect the enemy wounded and the religious sisters who cared for them. Much later, during the Crusades, Saladin allowed European doctors to come and treat their wounded compatriots and then to return freely to their own side. He even sent his own doctor to the bedside of Richard the Lion Hearted. These are just a few of the precursors of the law.

In the Middle Ages, only a handful of military chiefs could bring their own doctors with them, and it is painful to think of how the troops were exploited by quacks and other fakers. The wounded were left in their agony and those of the enemy were commonly finished off.

Only with the dawn of modern times did the practice arise of sparing and treating the enemy wounded, along with the development of medical services in the armies. From the 16th century onward, respect for the wounded was the result of “cartels”, the name then given to agreements between opposing commanders. This practice reached its peak in the 18th century. At that time the rules were roughly as follows: hospitals were immune from attack and were marked with special flags; wounded and sick enemy soldiers were treated in the same way as those in the army which captured them, and were sent back after they recovered; doctors and their assistants, and chaplains as well, were not taken prisoner

but sent back to their own lines. Thus, after the battle of Fontenoy in 1747, more than 6000 wounded, on both sides, were evacuated to well organized hospitals and treated by qualified personnel, so that only 583 of them died.

The 19th century however saw a return to the use of mass armies and a collapse of medical services. The battle of Austerlitz was described by Dr André Soubiran as a “medical Waterloo”.<sup>1</sup> In the campaigns of Napoleon III, sixty per cent of the wounded died.

This was the background for the appeal by Henry Dunant, witness to the tragic consequences of the battle of Solferino. As a result of that appeal, the Red Cross was founded in Geneva in 1863. In the following year, its international committee succeeded in gaining the adoption of a treaty, valid at all times and in all places: the first Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, the corner-stone of humanitarian law. This confirmed the neutral status of doctors and nurses, who were to be protected on the battlefield and returned to their own armies if they should be captured. Wherever the Convention was in force, mortality among the wounded decreased dramatically.

In the ensuing century, humanitarian law was extended to cover other victims of armed conflicts. There are now four Geneva Conventions, dating from 1949, which were supplemented in 1977 by two additional Protocols. It is in these fundamental texts that we can discern the features of a Charter for Military Medicine, which I propose to outline.

## 2. GENERAL PRINCIPLES

The foundation of humanitarian law is the principle of *humanity*, which demands respect for the human person. In contrast to this is war, which is a resort to violence. The latter, however, must not run counter to the imprescriptible rights of the individual.

It follows from this that belligerents must not inflict on their adversaries harm out of proportion with the object of warfare, which is to destroy or weaken the military strength of the enemy.

War is a means, the ultimate one, for a State to bend another to its will. It consists in employing the necessary constraint in order to

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<sup>1</sup> Dr André Soubiran: *Napoléon et un million de morts*, Paris, 1969.

obtain this result. All violence which is not indispensable for achieving this object is therefore without purpose. It then becomes merely cruel and stupid.

To achieve its object, which is to conquer, a State engaged in a conflict will seek to destroy or weaken the enemy's war potential at the cost of the least loss to itself. This potential consists of two resources: manpower and material.

To wear out human potential, by which we mean individuals contributing directly to the war effort, there are three means: to kill, to wound or to capture them. There is no difference between these three methods with respect to military efficacy. To be cynical about it, all three are equally capable of destroying the enemy's vital capacities.

Humanitarian reasoning is different, for humanity requires that capture be preferred to wounding; that wounding be preferred to death; that non-combatants be spared; that wounds be no more serious than necessary, so that the victim may be operated upon and healed; that they cause the least possible pain; that captivity be made as bearable as possible.

Military commanders can understand this language, and they have often understood it, since they are not asked to renounce their duty as soldiers and patriots and can attain the same results while causing less suffering. To prolong, by neglect or mistreatment, the suffering of an enemy who has been put *hors-de-combat* is, even from the most realistic point of view, pointless.

It is on the basis of this principle that the Geneva Conventions require that persons who are *hors-de-combat* and those who do not participate directly in hostilities must be respected, protected and humanely treated.

Against the most formidable array of force in the world, that is against war, the Red Cross has erected barriers; barriers which are still fragile for they are constructed of words, under the name of humanitarian law.

The principle of Geneva specifies three duties towards the victims of war—to respect them, to protect them and to treat them humanely, three complementary concepts. It would be dangerous to offer a detailed definition of humane treatment, because one could never catch up with the imaginations of scoundrels. To decide what is humane is a matter of common sense and good faith. Let us limit ourselves at this point to defining it as the minimum treatment which must be accorded to the individual to enable him to lead an acceptable life.

The principle of *inviolability*, according to which the individual has a right to the respect of his life and his physical and moral integrity, requires that no person who suffers should be abandoned but must be given the care required by his condition.

It was in obedience to that imperative that the First Geneva Convention was concluded in 1864. All the other obligations in the Convention derive from it. It is not enough only to respect the wounded and sick, they must also be treated, otherwise they may die. When we speak of suffering, this does not refer only to pain but also to all impairment of health, even if it is not felt.

Although it was conceived for soldiers in wartime, the principle of humanity is all the more valid for civilians in peacetime. In the latter case, it assumes the more positive form of maintaining health and preventing disease.

International medical circles have proposed a rule that all persons who are wounded or sick have the right to be cared for. No principle of this kind has yet been included in the Universal Declaration of Human Rights, in view of the embryonic state of medical assistance in so many of the developing countries.

Another fundamental idea for our present purposes is that of *neutrality*, which implies that medical and rescue services are never to be construed as interference in the conflict; they stand above the fighting.

The concept which is the basis of the First Geneva Convention is that relief given even to adversaries is always legitimate, that it never constitutes a hostile act and is never a violation of neutrality.

The First Convention of 1949, on the subject of assistance which may be given to a party to a conflict by an aid society from a neutral country, specifies that "in no circumstances shall this assistance be considered as interference in the conflict" (Article 27). Even more indicative is Article 70 of the additional Protocol I of 1977, which states that offers of humanitarian and impartial relief "shall not be regarded as interference in the armed conflict or as unfriendly acts".

### 3. PROTECTION OF THE WOUNDED AND SICK

The First Geneva Convention of 1949, a revised version of the Convention of 1864, provides that the military wounded and sick,

who are thus defenceless, shall be safeguarded in all circumstances. They on their part must give up fighting.

In 1864, there were references to the “neutrality” of the wounded. Since that time, the references have been to “respect and protection”, respect being a negative idea—do not shoot the wounded soldier—and protection a positive idea—defend him, relieve him and help him. The keystone in the situation is this: one may kill only a soldier who is himself capable of killing. The abandonment of aggressivity should suspend all aggression.

Protocol I of 1977 provided useful clarification concerning the safeguard of enemies *hors de combat*. In addition to those who surrender, any person who “has been rendered unconscious or is otherwise incapacitated by wounds or sickness, and therefore is incapable of defending himself”, is deemed *hors de combat* (Article 41, par. 2 c).

The Convention protects the wounded person before his capture, when he is still with his own army or in no-man’s-land, and also afterwards, when he is a prisoner. The wounded soldier who has fallen into the hands of the adversary, is simultaneously both the wounded person who must be treated as if he were not an enemy, and the captured combatant, who becomes a prisoner of war. He is therefore protected, until his recovery, by two Conventions at the same time, the First and the Third, with primacy given to the First if they overlap. After he has recovered, his treatment is governed by the Third Convention, which offers equivalent guarantees with respect to medical care.

An army which must leave behind its wounded as it retreats should leave with them, as far as possible, medical personnel and material to provide for their care. This was one of the great innovations made in 1864—made possible by the neutralizing of medical personnel, with provisions for their return to their own units.

The wounded must be searched for and collected, as must the dead. The dead must not be buried until after a medical examination and identification. Local armistices may be concluded and special arrangements made to evacuate the wounded from an encircled zone.

Enemy soldiers who are *hors de combat* must be treated like those of one’s own army. This great principle of *non-discrimination* has been a part of the Geneva Conventions from the beginning. Until 1929, the Convention forbade only distinctions based on nationality. In 1949, other distinctions were forbidden, “founded on sex, race, nationality, religion, political opinions or any other

similar criteria". The last five words quoted clearly show that all kinds of discrimination are forbidden, and that those enumerated in the text are cited only as examples. It is quite apparent that they were implicitly forbidden earlier—but the tragic events of the Second World War made it advisable to list them explicitly.

Non-discrimination is an indissociable aspect of Red Cross action and has long been a principle of medical ethics. It is a relatively modern humanitarian achievement, however, since it was not a part of the original Hippocratic oath.

In exceptional circumstances, however, it may be necessary to make a distinction, when, for example, a doctor or nurse, lacking sufficient medicaments, can save only some of the sick who need them. This can be a tragic situation, comparable to that on a life raft, which will sink with its human load if other shipwrecked people try to climb onto it. Can we take an oar and smash the hands of human beings, children perhaps, who arrive too late?

I have known cases in which doctors have treated only the wounded, sick or starving people who still had a chance to survive, leaving the others to die. These are what we call cases of conscience, because the choice must be made by the person responsible, who has to decide, with his own mind and heart, the chances of those in front of him. Who can claim to determine the standards of absolute justice in such cases?

In the light of these considerations, we can see that the principle of non-discrimination cannot be construed in absolute terms, but needs to be qualified. Thus, the current Geneva Conventions forbid only "adverse" distinctions. This is not a very happy choice of words, for it is clear that we would be doing a disservice to all those to whom we do not accord the benefits given to others. But, even if the language is awkward, the idea it seeks to express is right: there are indeed legitimate and even obligatory distinctions.

When misfortune has destroyed equality among human beings, the application of humanitarian principles tends to restore the balance. To restore everyone to the same level implies giving the first and most effective attention to those in the greatest need. This is only common sense. We cannot remedy an inequality except by another inequality. There are therefore distinctions we are obliged to make: those which are based on degrees of suffering, distress or weakness—but only these.

The Geneva Conventions of 1949 are not silent on this point, as had been their predecessors. For instance, they specify that women

should be treated with all the regard due to their sex. Likewise, it is normal to give special attention to children and old people.

Together with quantitative inequality of treatment, the Conventions provide even more clearly for inequality in terms of time. It is specified that, "Only urgent medical reasons will authorise priority in the order of treatment to be administered" (Article 12). If, for example, the military medical service in a given case has to deal with a great influx of wounded, the doctors, without any consideration of nationality, will first treat those for whom a delay would be fatal or at least very injurious, before turning to those whose condition does not require immediate action. Likewise, the distribution of food and medicaments should correspond to the relative needs of each person.

#### 4. MILITARY MEDICAL PERSONNEL

Doctors and other medical and religious personnel shall be respected and protected in all circumstances. They shall not be prevented from discharging their duties. For these purposes, they must wear on the left arm an armlet bearing the distinctive emblem of the red cross or, in Moslem countries, red crescent. They must also carry identity cards.

Who is entitled to such protection by the First Convention? First and foremost, the military medical personnel, both those treating the sick and wounded and those with administrative responsibilities; next, those members of the personnel of National Red Cross or Red Crescent Societies who are assisting and are attached to the military medical services and only such persons.

The granting of such extensive privileges to doctors and nurses is not for their personal benefit. It is accorded only because they are caring for the victims. It is through them that the wounded and sick are benefited. The doctors are protected because they are healers—and this is the finest tribute that can be accorded them.

The immunity given to medical establishments and personnel requires that such personnel must absolutely abstain from any direct or indirect interference in the hostilities. Being regarded by the enemy as "neutrals," in the higher interest of the wounded, they are obliged to act as such.

During the Second World War, members of the medical personnel in occupied territories sometimes concealed combattants in

hospitals and helped them carry out military missions, such as intelligence activities and sabotage. By acting in this way, they were certainly serving powerful and highly honourable patriotic purposes—but they were nevertheless violating the rules of humanitarian law and in so doing running the risk of provoking sanctions against a countless number of innocent beings. The adversary might very well be tempted to refuse protection to the whole hospital, and if such abuses were repeated, to the whole medical service.

One cannot serve the medical mission and also fight. The choice must be made. Open or clandestine resistance to the enemy may well be legitimate and heroic. We do not dispute this, but it is incompatible with the relief mission. If in the general interest, humanitarian institutions are to survive and continue their work in occupied countries, their members' conduct must be irreproachable to maintain the full confidence of the authorities. There might be an exception to this principle, if we are dealing with a faithless enemy with no respect for the law, who systematically violates the law and gives no protection to the persons for whom the Conventions require respect.

One of the problems which gave rise to animated discussion in the course of the 1949 revision was the *retention of medical personnel who fall into the hands of the adverse party*. According to the traditional concept, such personnel should be immediately released and sent back to their own side. During the Second World War, however, the belligerents agreed to have a considerable number of their medical personnel remain in POW camps to care for their compatriots. It was the general opinion that prisoners recovered better from their wounds when treated by medical personnel from their own country. The British and United States representatives proposed the complete renunciation of repatriation of doctors and nurses; they would simply be prisoners of war, but would be assigned to medical work.

A compromise was finally reached: medical personnel would not be retained except to the extent that the state of health and the number of prisoners of war made it necessary. They would not become prisoners of war, but would have all the rights of such prisoners. This solution had the disadvantage of all such compromises: it produced confusion. In any case, we recognize that the authors of the Conventions of 1949 wanted on the one hand not to assimilate medical personnel to combatant prisoners of war but instead maintain the special and traditional immunity inherent in

their professional status and position of being separate from the fighting and, on the other hand, to assure for them the benefits of the Third Convention, which they regarded as providing the best protection for persons in the hands of their enemy.

Although they thus legally escape being designated as captives, by the simple fact that they are not prisoners of war, medical personnel do in fact find that their freedom is somewhat limited. This situation inevitably results from the fact that they are of enemy nationality and from the need of the Detaining Power to ensure its military and political security. The Convention also provides that they shall be subject to the internal discipline of the POW camp.

Under Article 28 of the First Convention, medical and religious personnel "shall continue" to carry out their medical and spiritual duties on behalf of the prisoners. These words indicate that even though their capture and retention place medical personnel in a new situation, their special function—caring for wounded and sick soldiers—remains unchanged and they must continue their work, without interference and with unbroken continuity.

This function must henceforth be exercised under the terms of the laws and military regulations of the Detaining Power and under the authority of its appropriate services. The Convention nevertheless specifies an important limitation on this subordination by stating that doctors and other medical personnel shall carry out their duties "in accordance with their professional ethics". Although they are subject administratively to their captors, this subjection is not unlimited. The constraint of the Detaining Power ends where the domain governed by professional requirements and individual conscience begins. One may not, for example, forbid a doctor to treat a patient or compel him to use a treatment which he considers wrong.

Retained medical personnel in prisoner-of-war camps must be granted the privileges necessary for their work; they may not be required to do any work apart from their medical duties; they must be allowed to visit hospitals and labour units.

At least once a month, all prisoners must be given complete medical examinations, with particular regard for their fitness to work.

All measures must be taken to ensure hygiene in POW camps, the prevention of epidemics, the isolation of cases of infectious diseases, transfers of seriously sick prisoners to hospitals or specialized institutions and the supplying of necessary prostheses.

Similar requirements are effective for civilian internees, whose situation under the Fourth Convention is comparable.

Mixed Medical Commissions of three members, including two from neutral countries appointed by the ICRC, shall visit prisoners, with full authority to make decisions concerning those whose state of health justifies the measures provided in the Third Convention for seriously wounded or sick prisoners—either direct repatriation or hospitalization in a neutral country. A model agreement, annexed to the Convention, specifies the disabilities and diseases to be considered and serves as the basis of the work of the Mixed Medical Commissions.

## 5. THE MEDICAL MISSION

Private doctors, first-aid workers and members of the general public, under certain conditions, may participate in relief activities. As stated in Article 18 of the First Convention: “The military authorities may appeal to the charity of the inhabitants voluntarily to collect and care for, under their direction, the wounded and sick, granting persons who have responded to this appeal the necessary protection and facilities.” Another provision in the same article authorizes the inhabitants and relief society to collect and care for the wounded spontaneously, without distinction of nationality, even in occupied areas.

Recent developments in methods of warfare, far from making these provisions illusory, have given them new timeliness, due notably to the evolution of resistance movements and the parachuting of troops. There may be isolated wounded persons anywhere in a country, and civilians must be able to come to their assistance without interference.

During the Second World War, occupation authorities ordered inhabitants, including doctors, on pain of the most serious punishments, to report the presence of any suspected enemy and of any partisan. There were very few doctors who obeyed this order, because doing so would have prevented the wounded and sick from coming to a doctor to be cared for.

Representatives of some States in 1949 wanted the Convention to state that the inhabitants were forbidden to remove the wounded and sick from the control of military authorities. Others opposed this, fearing to legitimize measures which occupying authorities might take to force doctors and the general population to denounce

wounded enemies or members of resistance movements, which they said would violate medical secrecy. Finally, it was decided not to mention the matter at all.

The question was raised again at the Diplomatic Conference in 1974, which met to draft the two Protocols additional to the Geneva Conventions. This time it was spelled out in black and white that no person engaged in medical activities should be compelled to provide information about wounded or sick persons treated if he believed that such information would be harmful to those persons or to their families. This means that health personnel are not obliged to denounce people who come to them for help.

After all the tragedies and all the discussions in medical circles, a solution had finally been arrived at, based on the freedom of the doctor. So far so good.

Unfortunately, in its final session, the Conference qualified its decision and decided to make an exception, so that the doctor would have to provide the information in question if required to do so by the laws of his own country. This modification is regrettable, for it tends to deprive the clause, obtained after so much difficulty, of much of its substance. The clause remains fully effective, however, vis-à-vis the enemy and the Occupying Power.

Another related problem, equally painful, remains to be dealt with. In a number of countries, during and after the Second World War, men and women were killed, mistreated or imprisoned because they had given care to resistants or to parachutists. In addition, after the liberation of some countries, doctors and nurses who had worked for the medical services or the Red Cross Society of the occupying power were subject to prosecution under rigid laws which defined as high treason any engagement in the enemy army and treated them on the same basis as those who took up arms against their country. The 1949 Convention states that, "No one may ever be molested or convicted for having nursed the wounded or sick" (Article 18). The 1977 Protocol goes further: "Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom" (Article 16, par. 1). I would like to draw attention to the fact that medical ethics have thus in a sense become a part of international law.<sup>1</sup>

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<sup>1</sup> In international terms, we may recall the principles of medical ethics embodied in the Oath of Geneva of 1948, adopted by the World Medical Association, a revised version of the Hippocratic Oath, and the International Code of Medical Ethics, which completed it. A new draft code is currently under consideration by the World

Other provisions in the 1977 Protocols, also requested by medical circles, provide better protection than before for the individual and for the medical mission. One article, for example, forbids subjecting protected persons to any medical procedures not indicated by their state of health and not consistent with generally accepted medical standards. The purpose was to condemn pseudo-medical experiments, of evil memory, and also the removal of organs for transplantation, a relatively new problem. In the same spirit, blood donations are hedged about with precautions. In other words, people in the power of an enemy are not to be treated as experimental guinea pigs nor as sources of biological spare parts. Finally, it is specified that persons engaged in medical activities may not be forced to perform acts contrary to humanitarian law or medical ethics—a very important provision.

It is useful to recall at this point that medical personnel who violate humanitarian law are subject to punishment. What are designated as grave breaches—commonly called war crimes—are accordingly dealt with very severely. These include endangering the physical or mental health or integrity of any person by a wilful act or omission, biological experiments, torture and punitive treatments and the perfidious use of the red cross emblem if this results in death or serious injury to human beings. It is also forbidden to leave persons, wilfully, without access to medical attention and care or to expose them to risks of contagion or infection.

The wishes of patients, even those in captivity, must be respected. Before undertaking an operation or treatment the doctor must try to obtain the patient's consent, in writing if possible, unless the patient is incapable of giving such consent.

Some medical circles have raised the question whether doctors have the right to carry out research in domains threatening the lives or integrity of individuals. Can they do work designed to make weapons more cruel or more deadly? Can they say how far torture may be proceeded with? In the spirit of the law of Geneva, I reply with a categorical no—and I add that from the moment when they engage in such criminal activities they have lost the right to call themselves doctors.

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Health Organization. In addition, in 1957, the ICRC, the International Committee of Military Medicine and the WHO drafted "Rules of medical ethics for wartime," and the World Medical Association adopted "Rules to assure relief and services to the wounded and sick in times of armed conflict."

## 6. HOSPITALS AND MEANS OF TRANSPORT

If we intend to protect the wounded and the persons caring for them, it is obvious that immunity must be given to the buildings sheltering them, the medical units to which they belong, the vehicles which transport them and the medical material used.

Both fixed establishments and mobile medical units must be respected at all times, whether or not they contain wounded or sick persons. If they fall into the hands of the adverse party, their personnel must be allowed to continue their activities so long as the capturing Power has not itself ensured the necessary care of the patients.

The protection accorded to both fixed and mobile elements comes to an end if they are used to commit what the Conventions call "acts harmful to the enemy." Such acts have the aim or effect, by favouring or impeding military operations, of being detrimental to one of the belligerents. They may consist, for example, of hiding able-bodied combatants, concealing weapons or installing a military observation post in a hospital.

The Conventions enumerate acts which are not to be considered as harmful. For example, medical personnel may be armed and in case of necessity may use their weapons to defend themselves or the wounded for whom they are responsible. Such arming of medical personnel has often been misunderstood and wilfully misinterpreted. We should stress that only purely defensive weapons are referred to—light arms such as pistols. They are not intended for use in resisting an illegal attack, and in such instances the unit should surrender since its means of defence are insignificant. The weapons are intended only to maintain order and discourage looters. Of course this does not mean that doctors are expected to be totally passive and let their throats be cut by barbarians with no respect for any standards. As we can see, the weapons in questions do not modify in any respect the essentially neutral and peaceful character of a medical unit.

Until 1949, medical material had to be restored to its army of origin. This is no longer the case. The change was due to the modification agreed upon with respect to the possible retention of medical personnel. It may not be confiscated however as long as it is needed for the care of the wounded.

A similar situation prevails for land vehicles. They are protected at the front, but if captured they need not be returned.

*Medical aircraft* belong in the same category. Before 1949, it was sufficient for their protection that they be painted white and be marked with red crosses. At the 1949 Diplomatic Conference however it was recognized that this was insufficient, since planes were commonly fired at before they could be seen. Accordingly, protection for medical aircraft was made to depend upon an agreement between the belligerents about their flight schedules—the route, time, altitude, speed, etc. Since it is very difficult to reach such agreements in wartime, especially in cases of emergency, this virtually clipped the wings of medical aviation and left it grounded, unless it was possible to provide it with an escort of fighter planes. This was naturally a great misfortune for countries which did not have control of the air, for planes are a wonderful means of quick transport for the wounded. It became the practice to take them by helicopter from the place they fell directly to the hospital, to save them from the long, painful, and often fatal transport by land. During the war in Vietnam, large American transport planes carried the wounded directly to the United States and treated them en route in virtual airborne operating rooms.

The question was considered again in 1974, and science provided the remedy for the evil it had caused. It was recognized that one could easily identify planes in flight before firing at them—since this was already being done in the case of warplanes, which could be instantly recognized as friendly or hostile. Accordingly, a technical annex was joined to Protocol I of 1977 creating a system of three types of signal: a flashing blue light, a radio signal and a secondary radar system, as part of the international communication procedures.

A rebirth of immunized medical aviation has therefore become possible, and let us hope it will soon be a reality.

At sea, it is *hospital ships* which must be considered. These are used in several situations: in maritime warfare, they follow the fleet and collect the shipwrecked and wounded after combat; in inter-continental wars, they are means of evacuation and transport; in amphibious warfare, they serve as floating hospitals, providing complete treatment for soldiers taken aboard.

Providing the adverse party with information about their characteristics and signals confers protection on these hospital ships and makes them immune to capture under all circumstances, whether or not they carry wounded. This protects them in their totality, including their medical personnel, crews and material. This gives them a specially privileged status in warfare, in which ships

are rare and hospital ships even more so. Without their crews, hospital ships would be no more than drifting derelicts. They are therefore protected as total entities.

Even though they belong to navies, hospital ships are not warships. They are separated from the conflict. The adverse party may stop them, order them to follow a particular course, etc. If hospital ships venture into the midst of a naval battle, they do so at their own risk.

Hospital ships, under the penalty of losing their protection, obviously cannot commit acts "harmful to the enemy", such as transporting war material, except for weapons taken from the wounded or shipwrecked, and the weapons of the vessels' personnel, used for their own defence and that of the wounded.

## 7. CIVILIAN MEDICAL PERSONNEL

The Fourth Geneva Convention dating from 1949 finally accorded to civilians guarantees which had been so tragically lacking during the Second World War. In the domain with which we are now concerned, it extended to wounded and sick civilians the principles originally conceived only for the military wounded, of which I have spoken.

Civilian hospitals are accordingly protected in the same way as military hospitals, on the condition that they correspond to the definition of the Convention and are duly recognized by the State. Civilian hospitals, if authorized by the State, will be identified by the red cross emblem, which had not previously been the case.

The Convention grants to the personnel of civilian hospitals a protection similar to that given to military medical personnel. This is also the case for the transport of civilian patients, which must however be carried out by organized convoys.

In 1949, the Diplomatic Conference refused to extend the special protection of the Convention and the use of the red cross emblem to all civilian medical personnel, on the ground that such an extension to poorly defined groups, not officially organized and not under strict control, would increase the danger of abuse of the distinctive sign and thus weaken the protection which all civilians should enjoy.

The Diplomatic Conference of 1974, however, took the great step forward at which its predecessor had balked twenty-five years earlier. It recognized that the 1949 solution was embryonic and very

inadequate. The whole territory of a country is now affected by a conflict and civilians are afflicted just as much as, if not more than, the soldiers. Medical personnel must be free to go everywhere, often into danger zones, and care for the wounded without distinction. Under the additional Protocol of 1977, civilian medical personnel as a whole now benefit from the immunity originally provided in 1864 for the army medical services. Substantial guarantees were provided to prevent the abuses which had been feared earlier. To have the right to the protection and the use of the red cross emblem, civilian military and para-military personnel have to be authorized and controlled by the State.

How was such a considerable extension deemed possible? It is undoubtedly due to the fact that a real civilian medical service has been created in many countries and, even more important, that this civilian service has often become merged with the military medical services, so that in wartime there is only one medical service.

In our time, wartime medical personnel and peacetime medical personnel are recruited from the same sources and are receiving the same training.

We are thus in the presence of an irreversible evolution. We must insist however that government control be exercised with unceasing vigilance, because it is essential at all costs that the authority of the emblem and respect for it be assured. We must never forget that *many human lives depend on this*.

Other special provisions for the benefit of civilians should also be mentioned. In a conquered country, the occupation authorities are responsible for the maintenance of public health. All categories of medical personnel and all relief societies must be allowed to carry on their work.

The Convention also provides for agreement on the creation of hospital and safety zones for the wounded, the sick, certain categories of the civilian population and, of course, the necessary medical personnel.

There has been much talk of such zones, but very few of them have actually been created. If such places of refuge should become widespread, there would be a danger of weakening security in other parts of the national territory. However, it is conceivable that zones of this kind could be established in urgent cases, with very specific boundaries.

The Fourth Convention also provided for various exceptions to blockades, thus directly challenging this powerful form of economic warfare. This proposal encountered strong resistance by some gov-

ernments. It was finally decided that these exceptions would be limited with respect to the nature of the shipments and the categories of recipients. Only shipments of medicaments and medical material are assured for the whole population. Food and clothing are allowed free passage only for children and pregnant women. These exemptions from blockade are subject to conditions and to guarantees of control.

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In what has gone before, I have evoked only the letter of the Geneva Conventions, but the spirit is more important than the letter. The spirit of the Geneva Conventions is the very spirit of the Red Cross itself, which is much older and much broader than the texts. The First Geneva Convention embodied a noble humanitarian idea, going far beyond what it specifically stated, that all the wounded must be cared for without distinction of nationality. It follows from this that relief given even to adversaries is never a hostile act and is never an interference in the fighting.

It is clear that if we look at it from an exclusively egoistic and purely utilitarian point of view, the Geneva Convention may seem to be an aberration. Is not the very essence of war to attack enemy soldiers? If only the most immediate military interests—although they were poorly understood—had prevailed in 1864, it would have been considered that wounded enemies who might recover were still dangerous adversaries. Therefore, the medical service which strengthened the military potential by “recuperating” the combatants would not have been protected.

Accordingly, the Geneva Convention would never have existed, and all those who cared for the enemy wounded would have been traitors. However, this concept did not prevail and the States, in signing the Geneva Conventions, agreed to sacrifice national interest to the demands of conscience. This is indeed the miracle of the Red Cross.

In conclusion. I express a wish: let the white flag with the red cross never be struck, anywhere in the world. If this were done, we should soon see, hoisted in its place, another emblem which is also well known—and respected in its own way—the black flag bearing a skull and crossbones. Let us not forget that the flag with the red cross, which has floated for more than a century over all the battlefields of the world, and everywhere else where there are

suffering people, is not only the banner of those who fight with their bare hands to deprive death of its prey; it is also the emblem of peace itself.

**Jean Pictet**

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## **The Red Cross Contribution to the Development of Medical Equipment**

**By A. Musy**

Right from the very beginning, the founders of the Red Cross were interested in improving military medical equipment; this remained a concern of the movement for many years (1863-1925). Later, attention was devoted to standardizing this equipment (1925-1934). Then, at a third stage, the Red Cross concentrated on studying and developing military medical equipment (1934-1938).

Afterwards, mainly as a result of World War II, this study was interrupted and a few years later, in 1957, the ICRC ceased to be concerned with such questions because many national and international bodies had been specifically set up to deal with them.

Nevertheless, "the preparation and development of medical personnel and medical equipment" are mentioned in the ICRC Statutes as one of the important tasks of the International Committee (Article 4, paragraph f).

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One of the bloodiest battles of the Nineteenth Century, the battle of Solferino, took place in June 1859. The wounded who could be moved were taken to Castiglione. Henry Dunant, who happened to be in the area on private business, was so moved by the pitiful condition of these people that he forgot the original reason he was there and set about relieving the suffering of the French and Austrian wounded.

Helped by the village children and a few women, he applied dressings, bought food, shirts, bandages and tobacco, and tried to bring comfort to a few of the huge number of injured men.

The rest is history. Obsessed by what he had witnessed, Dunant wrote his book "*A Memory of Solferino*", published in 1862, not only describing what he had seen and done, but proposing "the formation of relief societies for the purpose of having the wounded cared for in time of war by zealous, devoted and properly trained volunteers".

In his book, Dunant included suggestions for technical improvements to relieve the casualties: "If there had been available for the wounded improved means of transportation better than those now existing, there would have been no need for the painful amputation which one light infantryman of the Guard had to undergo at Brescia. The need for that operation arose from deplorable lack of attention when he was being carried from the regimental flying ambulance to Castiglione."

In a commentary, he pointed out that a number of surgeons had recently made special studies relating to the transport of casualties: "Dr. Appia has designed a versatile, light and simple apparatus which reduces jolting for fracture cases. Since the war in Italy, Dr. Joubert has invented a stretcher bag as simple as it is ingenious, the advantages of which are remarkable enough for a number of them to have been taken along by the French expeditionary troops in Mexico and Cochin China. Various governments have realized the usefulness of the stretcher bag and have adopted it. And it is even beginning to be used widely in France in civil administration bodies, large industrial units such as factories, construction sites, mining companies, etc..."<sup>1</sup>

Prompted by Dunant's wish for relief societies to be created, the *Société genevoise d'utilité publique* (the Public Welfare Society of Geneva) organized an international conference in 1863 to study ways of reducing the inadequacy of the army medical services. In his opening address, Gustave Moynier outlined what such a relief society might do.

"I shall summarize briefly what the aim of this project is. A committee will be set up in each of the European capitals... In peacetime, it might well study the service to be provided in wartime and how best to use the resources to be made available to it, if necessary; it would prepare instructions for untrained volunteer nursing staff who would offer their help; it would encourage the invention of improvements for medical equipment or methods of transport, etc.

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<sup>1</sup> H. Dunand: *A Memory of Solferino*, *passim*.

Once war had broken out, each committee would organize relief services for the army of its own country; it would appeal for gifts in cash or kind; it would collect such items as dressing, stretchers and all kinds of supplies..."<sup>2</sup>

In making these proposals, Gustave Moynier showed his insight, for during the subsequent seventy-five years the subject of stretchers and dressings recurred regularly in the agenda of International Red Cross Conferences.

While the draft agreement mentioned that the different committees and sections would concern themselves with improvements to be made in the fitting out of ambulances and hospitals and means of transport for casualties, Article 4 of the resolutions adopted by the Conference was less precise: "In peacetime, the Committees and Sections shall take steps to ensure their real usefulness in time of war, especially by preparing material relief of all sorts and by seeking to train and instruct voluntary medical personnel"<sup>3</sup>

In a Communication following the Proceedings of the 1863 Conference, the Committee stated: "... that, in the interest of making improvements in medical equipment, it would be advisable to have a depot somewhere for all models in use (ambulance wagons, transport, items and apparatus relating to dressings, hospital furniture, etc.), a kind of permanent exhibition or museum, where a comparative study could be made of the procedures used in the various armies."<sup>4</sup>

The Committee, a private body, proposed that governments should hold a diplomatic conference. This took place in 1864 and produced the Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, signed on 22 August 1864 (120 years ago), by twelve governments.

During the First International Red Cross Conference in Paris, in 1867, attended by the National Societies already established, an exhibition of medical equipment was organized on the occasion of the Universal Exhibition. Visitors could see small-scale models of ambulance wagons and field hospitals, together with assorted instruments, stretchers, and portable medical kits. They were also shown the original packets of individual (field) dressings as carried by Austrian troops. Experts appointed by their National Societies

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<sup>2</sup> *Proceedings of the 1863 International Red Cross Conference*, ICRC, Geneva, second edition, 1904, p. 13.

<sup>3</sup> *Ibid.*, p. 116.

<sup>4</sup> *Communication from the International Committee* Following the Proceedings of the 1863 International Conference. Geneva, 1864, p. 37.

met over a period of three months, in a total of thirty meetings, to carry out tests and comparative studies of the equipment exhibited. One of the subjects under discussion was the "model equipment" which the Conference recommended should preferably be adopted by the various relief societies.

Lectures and debates dealt with technical improvements made in bandages, surgical instruments and operating tables, and with forms of transport, ambulances, field kitchens and stretchers.

It was decided to hold a public competition for improved methods of transporting the wounded. Among other subjects of discussion were the best means of disinfecting battlefields, the composition of a standard list of medicines, the most satisfactory designs of artificial limbs, the preparation of a manual of instruction in the use of the equipment adjudged as generally most suitable, and the best way to build a field hospital.

Most of the subjects dealt with more than one hundred years ago are still relevant and provide food for thought in modern times.

At the Second International Red Cross Conference, in Berlin in 1869, there were no technical discussions on medical equipment, but three resolutions of interest in this connection were adopted by the Conference.

The first remains extremely topical to anyone who knows the difficulty, even today, of persuading donors to send only equipment which is useful: "Gifts of supplies, before being sent to a theatre of war, shall be subjected to careful examination."<sup>5</sup>

Another resolution dealt with standardization before the word existed: "Medical service equipment shall be acquired, so far as possible, following the models adopted by the State."<sup>6</sup>

A third mentioned the peacetime activities of the relief societies: "Relief committees must in peacetime inform themselves of all new inventions, experiments and proposals which concern military hygiene and sick care during war;"<sup>7</sup>

... should make the acquisition of easily transportable tents or huts and of stretchers for the use of the wounded and sick in war and peace:<sup>8</sup>

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<sup>5</sup> Second International Red Cross Conference, Berlin, 1869. Summary of the discussion, Chapter I, para. 5.

<sup>6</sup> Ibid., para. 6.

<sup>7</sup> Ibid., Chapter III, para. 19.

<sup>8</sup> Ibid., para. 17.

... should make preparations for setting up the military hospitals which they intend to establish or administer during wartime.”<sup>9</sup>

On 27 April 1869 the Berlin Conference also decided to have an *International Bulletin* issued. This later became the *International Review of the Red Cross*: “The Conference considers it indispensable to establish a periodical which will enable the Central Committees in the various countries to keep in touch with each other and which will inform them of events, official or otherwise, which they should know about.... Part of the publication could be devoted to advertisements, reviews of special articles or books, and the description of equipment or inventions dealing with aid for wounded and sick army personnel.”<sup>10</sup>

In October 1869 the first edition of the *International Bulletin* made its first appearance. From then on it never stopped to publish proceedings of conferences, descriptions and diagrams of equipment and inventions dealing with aid for the wounded. In this way it greatly assisted in the development of medical equipment.

Shortly after, during the Franco-Prussian War of 1870, Henry Dunant, in co-operation with Dr. Cheron of Paris, started to manufacture anti-haemorrhagic field-dressings. The fact is little known.<sup>10bis</sup>

The third International Red Cross Conference was held in Geneva in 1884 and was no longer attended by “Societies or associations for the relief of military wounded or sick”, but by National Red Cross Societies. This Conference is of special interest, since it first put forward the concept of standardization. The idea seems to have come from the Comte de Beaufort, Secretary-General of the Council of the French Red Cross, who asked:

“Would it not be possible to set up an International Commission for model equipment, with an international store? The scientific authorities should be included. In the store as arranged by the Commission it would be possible to examine everything of approved design. Let me make clear that I am not trying to repeat the proposal for an international museum made at the Paris Conference in 1867. What I am hoping for is something much more modest—I would be quite happy with, say, a room full of models of practical and necessary equipment for present-day use. The scien-

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<sup>9</sup> Ibid., para. 25.

<sup>10</sup> Ibid., Chapter IV, para. 2.

<sup>10bis</sup>. See André Durand: «Le livre d’Henry Dunant écrit en collaboration avec le docteur Chéron», in *Bulletin de la Société Henry Dunant*, N° 6, 1981, p. 1-13.

tific authority of such a Commission would serve not only the Red Cross but also governments and armies. The great advantage would be that gradually the equipment adopted would be the same in every country, and this would indisputably represent a laudable step forward.

The Committees and societies should be able and authorized to borrow the models from the international store in order to copy them and thus acquire supplies in advance.

Perhaps the International Committee of Geneva, to which the Red Cross movement is already so greatly indebted, might consider the idea. I hope that it will add this further benefaction to so many others made to mankind in the past.

I am convinced that in this way, in spite of the genuine difficulties which exist, the Societies will be able to attain the desired objective and provide themselves, in time of peace, with the equipment they need, equipment that will always render the greatest service. Otherwise, in time of war, doctors and surgeons will find they have nothing. They will be like soldiers with no weapons; they will have only their goodwill to offer and will experience a great deal of disappointment..."<sup>11</sup>

Another Frenchman, Albert Ellissen, was not exactly of the same opinion: "I think that an international commission for models could never succeed in getting all countries to adopt standard models. It is impossible to compel a nation to take one type of equipment or another. The essential is to adopt principles on the basis of which it will then be possible to make equipment capable of being used in wartime and of being gradually improved. Nothing would be done if we always awaited the latest news from science and industry..."<sup>12</sup>

Nevertheless, Albert Ellissen favoured uniformity of equipment at a national level and standardization of the dimensions of stretchers in all armies.

On the occasion of this Third Conference, the Swiss Army demonstrated its medical equipment. Experiments in lighting electrically—a new invention—the evacuation of wounded and the burial of the dead, on a battlefield at night, were made in Geneva. One resolution was the starting point for what later became the International Standardization Commission.

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<sup>11</sup> Proceedings of the Third International Red Cross Conference, Geneva, 1884. ICRC, Geneva, 1885, p. 99.

<sup>12</sup> *Ibid.*, p. 105.

“The Third International Red Cross Conference, referring to previous resolutions adopted at Berlin (1869), recommends:

1. That each Central Committee form an album or collection, to show by sketch, print or photograph, the whole of its ambulance equipment, as well as the corresponding material of the military administration in its country, and that it send a copy to each of the other Central Committees, and to the Governments which have acceded to the Geneva Convention. The effect of such exchange would be to generalize what today can be no more than local and thus, as far as it is possible, standardize ambulance equipment.

2. That an international commission be set up to study standards for ambulance equipment.

3. That the dimensions of ambulance stretchers be made uniform in all armies.

4. The Conference postpones to the next Conference the question of organizing international museums for ambulance equipment.”<sup>13</sup>

Another resolution, dealing with hygiene, is worth noting: “The Third International Red Cross Conference recommends that antiseptic bandaging be made the rule in the Medical Services of all armies in the field and in those of all Red Cross Societies. It is desirable that in peacetime the medical personnel should be given the appropriate instruction.”<sup>14</sup>

Three years later, at Karlsruhe in 1887, at the Fourth International Red Cross Conference, there was discussion of the results of antiseptic dressings used in the Serbo-Bulgarian War. One of the resolutions asked the States which had signed the Geneva Convention, and private societies, to take the necessary measures for antiseptic and preservative surgery to be practised in the armies, even in the front line and the combat area.

During this Conference, a gold medal was awarded to Joseph Lister, creator of aseptic methods in the operating theatre.

The notion of a museum of medical equipment was revived. One of those promoting the idea said: “An international museum, or a number of international museums, is what we have to consider. I will begin by saying that in my opinion the need as felt repeatedly by the Red Cross is not so much to have a complete collection of medical equipment containing everything connected with our work, making it possible to study the full range of items, good and bad,

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<sup>13</sup> Ibid., Resolution C, p. 430.

<sup>14</sup> Ibid., Resolution N, p. 433.

more or less practical, more or less worth copying, in other words a complete museum. No, what the Red Cross needs, gentlemen, is sound model designs for the equipment it wishes to have made in time of peace; but they should be designs acknowledged as being really and fundamentally superior, proved in practice and adopted by a committee composed of the most competent men available. Gentlemen, my wish is a modest one: to see a small international museum in which will be collected and kept, as standard models, outstanding items of equipment, extremely practical and of real use, a museum in which each object must, before it is admitted, have been approved by a committee after mature reflection and after being considered worthy of recommendation by the Committees in the various countries.”<sup>15</sup>

A. Ellissen, who as we saw, was not in favour of the formation of a Model Commission in 1884, made a proposal of his own, for “an album of equipment, to be constituted by each Committee and circulated, instead of a museum”.

Two competitions were proposed, one dealing with arrangements for transporting casualties, the other with “the internal arrangement of an improvised hospital, prepackaged, for fifty patients”.

The Fifth and Sixth International Red Cross Conferences, in Rome in 1892 and in Vienna in 1897, included debates on the question of materials for antiseptic dressings and on the novel concept of sterilization. In speaking of the steam autoclaves that should be installed everywhere, a far-sighted delegate at the 1892 Conference gave his view that “this microbe oven will be almost as useful as the bread oven accompanying the troops”.<sup>16</sup> One of the resolutions expressed the wish for the system of sterilization by autoclaves to be adopted in parallel with antiseptic procedures.

In Vienna, in 1897, a more precise resolution was adopted and the following measures were recommended:

“1. The accumulation in military and Red Cross Society stores of light, absorbent, sterilized dressings; and of which at least a part should be antiseptic.

2. Periodical disinfection of accumulated material by fixed dry-heat cabinets in the warehouses of our Societies.

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<sup>15</sup> Proceedings of the Fourth International Red Cross Conference, Karlsruhe, 1887, p. 31.

<sup>16</sup> Proceedings of the Fifth International Red Cross Conference, Rome, 1892, p. 378.

3. Periodical inspection to make sure that dressings continue to be aseptic and antiseptic.

4. Acquisition of sterilizing apparatus of different sizes in sufficient quantity to deal with all wartime needs; they should be of the following varieties:

(a) Very light, small apparatus for sterilization by boiling, which could be added to all the kits of instruments which they are to sterilize (for first-aid posts);

(b) Medium-size autoclaves (for the sterilization by steam under pressure of instruments and dressings) which could be carried by mulepack (for field ambulances);

(c) Larger and heavier autoclaves for field hospitals;

(d) Fixed autoclaves for evacuation hospitals.”<sup>17</sup>

At the Eighth International Red Cross Conference, held in 1907 in London, the delegates not only discussed the importance of sufficient supplies of medical equipment but also attended a demonstration of cases for individual dressings (field dressings) in their protective covers. One of the participants asked:

“Could not the Conference express the wish that, to ensure that antiseptic solutions would be easily recognizable from a distance, the colours should be the same in every country, to prevent mistakes and, sometimes, deaths?”<sup>18</sup>

This question does not appear to have been acted upon. A resolution was adopted, however, voicing the following request:

“The Eighth International Red Cross Conference recommends that Red Cross Societies be invited to send each other, in future, in the form of printed communications, the results of their experiences, as well as communications on military medicine which they may receive from their respective governments.”<sup>19</sup>

In the same year—1907—at the Congress on hygiene and demography, in Berlin, the Spanish army physician Colonel Van Baum-berghen again mentioned the idea of standardizing army medical equipment.

The Ninth International Red Cross Conference in Washington in 1912 considered it desirable “that the material necessary to each Red Cross Society in time of war should be as simple as possible; that it should be prepared and stored in such a way as to be easily

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<sup>17</sup> Proceedings of the Sixth International Red Cross Conference, Vienna, 1897. p. 248.

<sup>18</sup> Proceedings of the Eighth International Red Cross Conference, London, 1907. p. 132.

<sup>19</sup> *Ibid.*, Resolution XIII, p. 169.

available for use in time of war by the official Medical Services.”<sup>20</sup>

The First World War (1914-1918) was, for many National Societies, the occasion for using the equipment collected. It was no longer a matter of testing a particular dressing package or stretcher attachment: the new equipment was to suffer and show its weaknesses. For want of being standardized, the French stretchers, for example, proved difficult to fix in American medical vehicles.

Some National Red Cross Societies grew considerably during this conflict. After the war they had very important resources. The American Red Cross proposed the creation of what became, in 1919, the League of Red Cross Societies. Experience and energies could be pooled in the sphere of public health and in disaster relief, thus enabling National Societies “to continue in time of peace the work undertaken with such success in time of war.”

The Tenth International Red Cross Conference was held in Geneva, in 1921, almost ten years after the Washington Conference. Acknowledging the experience gained during the First World War, “The Tenth International Red Cross Conference requests the International Committee of the Red Cross to ask the Red Cross of each country which has taken part in the Great War to be good enough to indicate the results of its experience of equipment used either in hospitals and for transport of wounded and sick, or in offering them medical assistance.

A committee of the International Committee of the Red Cross should collect the reports, inform each Red Cross Society and each government of particulars acknowledged to be useful, and consider the desirability of organizing an exhibition on the subject.”<sup>21</sup>

The idea of this committee was revived at the Twelfth International Red Cross Conference which met—again in Geneva—in 1925; the same year saw the establishment of the International Institute for the Study of Medical Equipment.

In correspondence preceding the Twelfth Conference, the ICRC mentioned for the first time the word standardization, in the following circular:

“The attention of the International Committee of the Red Cross has been drawn to the major drawback in the transport of the

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<sup>20</sup> Proceedings of the Ninth International Red Cross Conference, Washington, 1912. Resolution I, p. 317.

<sup>21</sup> Proceedings of the Tenth International Red Cross Conference, Geneva, 1921. Resolution XIII, para. 3, p. 216.

severely wounded as being the diversity of dimensions and methods of suspensions of the stretchers in use in the different armies and Red Cross Societies. In effect, whether in the case of international relief operations in aid of disaster victims or in time of war, when medical services of different nationalities are engaged together in collecting and evacuating a casualty, it may well happen that this person, being carried on one type of stretcher, has to be transferred to a different type in order to be placed inside an ambulance belonging to another medical service; it may then be necessary for the patient to be put into a hospital train, requiring him to be moved to yet another stretcher suitable for fixing within the train. The condition of some injured persons demands that they be moved as little as possible; yet because a particular stretcher cannot be used in a vehicle of another service, the patient has to be transferred, with consequent pain, even death. Moreover—and in some cases this is also important—such transfers give rise to much waste of time and effort and to serious complications in co-ordinating relief methods.

At a time when a large number of nations and Red Cross Societies are replenishing their stocks, and when the growth of medical aviation is bound to entail the creation of new equipment, when co-operation among relief services is spreading, both nationally and internationally, it seems appropriate to study the *standardization*, not of the various types of stretcher, but of some of their dimensions and of a suspension system capable of being used in any type of vehicle. International regulations might even, at a later date, define the conditions required for designing future stretchers, which should be interchangeable.

For the purpose of studying the possibility of universal adoption of standard size and launching an international competition for the invention of a universal system for attaching any kind of stretcher in any kind of vehicle, the International Committee of the Red Cross wishes to assemble equipment and documentation to enable the most exhaustive technical study to be made by a commission of experts nominated by the medical services and the Red Cross Societies. The ICRC will organize an exhibition of the items and documents that it receives.<sup>22</sup>

Before the Conference ended, the commission was already at work, defining the criteria to be met by field dressings and by

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<sup>22</sup> Proceedings of the Twelfth International Red Cross Conference, Geneva, 1925, pp. 3-4.

casualty cards, and noted the first subjects to be discussed in the future Institute for the Study of Medical Equipment.

The Twelfth International Red Cross Conference adopted the following resolutions: "The Conference considers that it would be useful to set up, in Geneva, an International Institute for the Study of Medical Equipment. The International Committee is instructed to study the programme for such establishment and its budget, and is requested to present a report and proposals to the National Societies at the earliest date possible."<sup>23</sup>

It requested the International Committee: "To collect all information and documents relative to the standardization of medical equipment;

To hold competitions for items to be standardized;

To set up a Standing International Technical Commission to judge the items presented in competition and to investigate standard types which would later be adopted by the International Red Cross Conference;

To investigate methods for standardizing the coding of wounds.

The Medical Services of National Red Cross Societies are earnestly requested in future to leave at the disposal of the International Committee of the Red Cross any exhibits of articles which the Commission is endeavouring to standardize. These might constitute the first collection of the International Institute for the Study of Medical Equipment."<sup>24</sup>

The International Institute for the Study of Medical Equipment was inaugurated on 19 November 1925 with equipment received from thirty nations. Three years later, the Institute possessed no fewer than 150 different types of stretchers.

The Standardization Commission, composed of technical experts belonging to the medical services of eleven countries met three times between 1925 and 1928 and examined:

- stretchers;
- stretcher suspension systems;
- field dressing packages;
- identity discs;
- medical records;
- detailed coding of wounds;

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<sup>23</sup> Ibid., Resolution III, para. 1, p. 168.

<sup>24</sup> Ibid., Resolution XIV, p. 173.

- transporting casualties by pack animals;
- a neutrality armlet.

Apart from the growth of medical aviation, the agenda for the Thirteenth International Red Cross Conference, in The Hague in 1928, once again included the standardization of medical equipment.

In the meetings of the commission responsible for this matter, the French General Marotte defined what he meant: "The word 'standardization' is a somewhat barbarous neologism, but it has been sanctified by use and every country has incorporated it into the language. To standardize is to search for and exactly describe the essential characteristics of an agreed ideal design intended to serve as a model."<sup>25</sup>

Colonel Van Baumberghen, whom we have already quoted, was won over to the idea: "Among the large quantity of significant information provided by the last war, what is most striking is the need to standardize, as far as possible, methods of treatment and systems for transporting casualties."<sup>26</sup>

The commission of experts reported the results of its work. A definitive agreement was reached on the dimensions of stretchers, of stretcher harnesses, and of field-dressing cases; the material for identity discs and the details to be entered on it; the front-line medical record, the evacuation record and the hospitalization record; and the definition of the casualty litter for use with pack animals.

In its resolution XI,

"The Thirteenth International Red Cross Conference notes with lively satisfaction the measures taken by the International Committee of the Red Cross to set up an International Institute for the Study of Medical Equipment,

notes that, thanks to the strict economy which has characterized these measures, the Institute has already been created at Geneva, where it constitutes an agency, absolutely unique of its type, and capable of rendering very appreciable services,

congratulates the governments and Red Cross Societies which, without waiting for the Thirteenth Conference, have subscribed for this purpose to the International Committee, and

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<sup>25</sup> Proceedings of the Thirteenth International Red Cross Conference, The Hague, 1928, p. 127.

<sup>26</sup> *Ibid.*, p. 142.

recommends the governments of all States signatory to the Geneva Convention, and all National Red Cross Societies, to allocate regular subventions to the International Committee of the Red Cross to meet the expenses of the Institute, and to send copies of all items of medical equipment, suitable for inclusion in the Institute's collections or for submission in the competitions organized by the International Standardization Commission.

Considering the great advantage of the Institute, and taking into account its special aim and the fact that it is of interest to all countries, the Conference earnestly requests the governments of States signatory to the Geneva Convention to be kind enough to consent, by reciprocal concession, to exonerate from all transport charges and entry dues, medical equipment intended for the International Institute for the Study of Medical Equipment, sent by Central Committees of the different Red Cross Societies and by Army Medical Services and material sent by the Institute to rapporteurs, for purposes of study.”<sup>27</sup>

In 1930, General Marotte, who was a member of the Standardization Commission, addressed those attending the Fourteenth International Red Cross Conference in Brussels: “You can do a lot for us. When you get home and report on your mission, stress the importance of this question, the special aim we have, which is really in the interests of all countries of the world, and urge your governments to send us the material we need for our studies.”<sup>28</sup>

In order to understand this remark it is necessary to know that, apart from stretchers, the other items of study had not aroused the desired interest. The competitions concerning identity discs, medical records and the manufacture of prototypes conforming to the decisions on standardization were not a success.

From 1929 onwards, the Standardization Commission had been working in connection with the Standing Committee of the Congresses of Military Medicine and Pharmacy and with the Health Division of the League of Nations on the subject of the coding of wounds.

In Tokyo, in 1934, the Fifteenth International Red Cross Conference recommended “the world-wide use of the manual published in French by the League of Red Cross Societies under the title “Hygiène et médecine à bord” and expressed the hope “that the

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<sup>27</sup> Ibid., Resolution XI, p. 179.

<sup>28</sup> Proceedings of the Fourteenth International Red Cross Conference, Brussels, 1930, p. 165.

League study “(a) the standardization of medical chests, and draft plans for the publication of a similar but smaller manual to be used in aerodromes, air ambulances and aeroplanes; (b) the standardization of chests to be used by air services.”<sup>29</sup>

It should be recalled that when the League was founded, it had been stated that it would concern itself with public health matters, while the ICRC would engage in activities related to conflicts.

Resolution XXXV of the Tokyo Conference also gave a wider definition of the activities of the Standardization Commission: “The XVth International Red Cross Conference, considering the interest of comparative study of medical stores to Army Medical Services and to National Red Cross Societies,

approves the modifications in the statutes of the Standing International Commission on the Standardization of Medical Stores, and resolves to change the title of this Commission, which will henceforth be known as the Standing International Commission for the Study of Medical Stores,

instructs this Commission, in addition to the work which it may undertake looking directly towards standardization, to endeavour to comply with the requests which may be addressed to it, through the intermediary of governments, for investigations and information on particular points,

expresses the hope that the governments of States which are party to the Geneva Convention, and the National Red Cross Societies, which are not represented on the Commission, will promote such studies by sending in appropriate material and granting subventions.”<sup>30</sup>

The Conference also adopted numerous resolutions on the standardization of:

- field stretchers;
- stretcher harnesses;
- field-dressing cases;
- identity discs;
- front line medical records;
- medical records of hospitalization;
- medical record wallet;
- detailed coding of war wounds;
- casualty litter for use with pack animal;

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<sup>29</sup> Proceedings of the Fifteenth International Red Cross Conference, Tokyo, 1934. Resolution XXVII, p. 237.

<sup>30</sup> Ibid., Resolution XXXV, pp. 259-260.

- identity documents;
- adaptation of a standard field stretcher for use with a wheeled base;
- adaptation of a field stretcher as an operating table and a bed;
- adaptation of a standard field stretcher for use in aircraft;
- medical vehicle;
- adaptation of a standard stretcher for use on skis or a sleigh;
- transport of wounded or sick persons by cable-car;
- transport in mountains;
- disinfection and decontamination of stretchers and vehicles that have been exposed to the effects of poison gases;
- device intended to adapt the standard stretcher to requisitioned vehicles;
- identification markings for equipment belonging to National Red Cross Societies;
- haemostatic bandages.

Like the Washington Conference in 1912, on the eve of the First World War, the Sixteenth International Red Cross Conference, which met in London in 1938, one year before the Second World War, made recommendations prompted by the extremely tense political situation at that time.

It recommended the National Societies: "... to organize their emergency services in order to be ready at all times to second quickly and efficiently the public bodies in their respective countries"

and specially draws their attention to the necessity of:

"Completing the training of Red Cross nurses and voluntary aids on those points which are recognized as necessary in order to prepare them for the duties, whether medical or social, which may devolve upon them;

Enrolling sufficient personnel and training the relief personnel which will deal with the victims of aerial attacks;

Having at its disposal relief material suitable for any eventuality;

Organising in advance, as far as possible, a transport service capable of being adapted to all needs and, if necessary, aerial relief, the importance of which becomes daily more evident."<sup>31</sup>

<sup>31</sup> Proceedings of the Sixteenth International Red Cross Conference, London, 1938. Resolution XVI, p. 105

- Resolutions were adopted on the standardization of:
- Restraining devices for the transport of fracture cases;
  - Individual medical equipment for medical service Personnel (stretcher-bearers, nurses);
  - Transport of wounded and sick persons by train;
  - Lighting in forward medical units;
  - Disinfestation of troops in forward areas.

In a report from the Standardization Commission to the Conference, the French representative, General Marotte, the only member who had taken part in all the Commission's meetings since its creation in 1925, recalled the advances made. He distinguished two periods.

The first, which he called the "period of pure standardization", had regarded the stretcher as the chief and indeed only object of consideration. The second period, which he called the period of medical equipment study, began in 1934 after the Commission had had its responsibilities extended by the Tokyo Conference. In this period, 26 resolutions on standardization were approved and more than 80 different subjects, all of them concerning equipment capable of use in time of war, were dealt with between 1926 and 1938.

During the ten years following the London Conference of 1938, a period during which the Second World War took place, there was no question of a Standardization Commission. In its report published in 1948, the ICRC pointed out that during the Second World War medical equipment was still far from being standardized. "At all points on the front, heterogeneous medical units were to be found side by side, and never had the differences in the design of their equipment, and especially their carrying equipment, appeared so marked and so disadvantageous to the interests of the wounded."<sup>32</sup>

At Stockholm, in 1948, in one of its resolutions: "The Seventeenth International Red Cross Conference expresses the hope that the World Health Organization will undertake to be responsible for the uniformity of medical equipment both for military and civilian needs, on the basis of experience acquired and with the co-operation of international Red Cross organizations, in particular the Standing International Commission for the Study of Medical Equipment."<sup>33</sup>

<sup>32</sup> André Durand: From Sorajevo to Hiroshima, p. 266.

<sup>33</sup> Proceedings of the Seventeenth International Red Cross Conference, Stockholm, 1948. Resolution L, p. 102.

The ICRC at once forwarded this resolution to the World Health Organization and contacted it in order to establish the base for possible collaboration between the two institutions in relation to medical equipment.

On 18 March 1949, in a letter from its Director-General, the World Health Organization informed the International Committee of the recommendations made by the WHO Executive Board, the tenor of which was as follows:

“1. The International Committee of the Red Cross is requested to continue its work relating to standardization of medical equipment for civilian and military needs.

2. The World Health Organization will collaborate with the International Red Cross bodies in this activity by providing them with any information it may possess on the subject”...<sup>34</sup>

The World Health Organization thus left to the ICRC the responsibility of continuing its work in the sphere of medical equipment.

The Board of Governors of the League of Red Cross Societies, meeting in Monte Carlo in 1950, stressed the need for closer co-operation between the League and the ICRC in the study of medical equipment; but it recommended that the National Societies make any proposals for standardizing equipment through the national organizations for standardization.

In view of the WHO's refusal and the wish expressed by the League, a joint League-ICRC committee was set up, with the addition of four outside experts, and met in January 1952. The meeting was the 14th of the Standing International Commission for the Study of Medical Equipment, which had not met since 1938.

In his opening address, the French General Jame drew attention to two new facts that had arisen since the previous meeting and that he thought likely to alter the Commission's activities:

“First of all, the nature of modern warfare means that medical equipment is no longer solely the province of army medical services, but also of civilian medical services. Secondly, there exists today a large number of international organizations studying the problems which were for a long time considered only by the Commission”...<sup>35</sup>

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<sup>34</sup> Proceedings of the Eighteenth International Red Cross Conference, Toronto, 1952. Document No. 5, p. 2.

<sup>35</sup> Minutes of the Fourteenth Session of the International Commission for the Study of Medical Equipment. p. 2.

Mr. Robert Tissot, secretary of the Medical Division at the ICRC, pointed out that, in a survey carried out in the spring of 1950, the matters that had seemed of greatest concern to army medical services and the Red Cross Societies had been the standardization of stretchers and of blood-transfusion apparatus. These two important questions had been taken into consideration by the International Standardization Organization (ISO), with which the League and the ICRC had made contact. This body had stated its willingness to examine the subjects which the Commission would propose to it. The work of the ISO and that of other organizations, national and international, in the same field, was to be taken into account when the Commission's programme of study came up for discussion.<sup>36</sup>

In July and August 1952, the Eighteenth International Red Cross Conference, held in Toronto, voted the following resolutions:

“The XVIIIth International Red Cross Conference

notes the action taken on Resolution L adopted by the XVIIth International Red Cross Conference and the opinion expressed with regard to this resolution by the World Health Organization,

approves the report presented by the reorganized Standing International Commission for the Study of Medical Equipment, as well as the new regulations of this Commission, whose title will henceforth be ‘International Commission for Medical Equipment’,

insists that the matter of blood transfusion equipment be studied as a question of primary importance.”<sup>37</sup>

In December 1952, the new Commission began work.

From the start of the meeting, it bore in mind the large number of international organizations studying the problems about which the Commission had long been the only body to concern itself. The question of stretchers was being examined by the ISO and that of blood-transfusion equipment by the ISO and the International Society of Blood Transfusion. The meeting did not come to any important decision apart from resolving to keep in touch with the ISO, which was already working on matters likely to be of interest to the Commission.

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<sup>36</sup> *Ibid.*, p. 3.

<sup>37</sup> Proceedings of the Eighteenth International Red Cross Conference, Toronto, 1952. Resolution XXIX, p. 160.

After the 1952 meeting, the work of the Commission did not seem to have attracted any interest from the ICRC or the League or from the National Societies. There was no reason at all to maintain this Commission, whose purpose was to report the work done and the results obtained by better equipped technical bodies in touch with many civilian and military bodies.

The Nineteenth International Red Cross Conference, held in New Delhi in 1957, therefore took the advice of the League and the ICRC and adopted the following resolution:

“The XIXth International Red Cross Conference, having taken cognizance of the joint report of the International Committee of the Red Cross and the League of Red Cross Societies on the International Commission for Medical Equipment, considering that these two organizations have reached the conclusion that whilst the work of this Commission had proved extremely useful in the past, this is no longer the case, other specialized organizations now being in a better position to undertake these tasks, recommends that the Commission be dissolved, further recommends that the International Committee and the League continue to follow problems connected with medical equipment for civilian and military use and inform National Societies of progress in these fields, at the same time remaining in close contact with the competent international technical organizations and national health authorities.”<sup>38</sup>

So, after a fruitful period of work on improving army medical equipment, from 1863 to 1925, and then on standardizing it, between 1925 and 1938, this Red Cross activity officially ceased in 1957.

**André Musy**  
*Medical Division, ICRC*

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<sup>38</sup> Proceedings of the Nineteenth International Red Cross Conference, New Delhi, 1957. Resolution XXI, p. 172.

## **Medical Supplies for Emergency Medical Actions**

*The following circular letter was sent by the ICRC and League chief medical officers to all the National Red Cross and Red Crescent Societies with a view to rationalizing consignments of medicaments and medical material for emergency medical actions. The circular letter contains practical advice and precise rules to be observed when selecting and packaging emergency relief medicaments.*

*The success of emergency action in cases of natural disaster or armed conflict depends of the degree of preparedness of personnel and material: it is not necessarily proportional to the number of volunteers or the volume of relief supplies hastily dispatched.*

*The sending of material and medicaments is not an end in itself: it is an integral part of the whole action and as such must be adapted in quantity and quality to the needs of the users. In either respect, inappropriate consignments are not only a waste but can also disrupt emergency relief work by causing users to lose valuable time.*

*Medicaments in particular can present a real danger to patients if they are not administered to the right people at the right time and in the correct dosage.*

*In order to carry out their difficult task in emergency situations, national medical teams and those sent in to reinforce them must have a sufficient quantity of essential medicaments and medical material readily available, and every effort must be made to see that their stocks are regularly replenished.*

*Donations well organized according to ICCR and League directives would help attain this goal and would make it easier to overcome transport, storage and distribution problems. The appropriate selection and packaging of consignments, with a standardized system of labeling, would help avoid the distribution problems so often encountered by emergency teams. In this way, the unfortunately classic*

*situatiuon of a warehouse filled to overflowing with tons of hastily sent and not assorted medical supplies, in which the medical teams have not hope of locating the particular medicaments they urgently require, should no longer arise.*

**Dr. R. Russbach**  
*ICRC Chief Medical Officer*

### **CIRCULAR**

#### *Medical Supplies for Emergency Medical Actions*

To be effective in emergency situations the medical supplies have to be adapted to the needs in quantity and quality. Inappropriate supply of drugs and medical material is not only a waste but could also be dangerous for the population in need of medical treatment and disrupt the medical action.

ICRC/LORCS have established the following procedures which should always be applied when sending medical supplies for emergency actions:

1. During disaster relief operations, donating Societies should send only the standard drugs and medical material listed by ICRC and LORCS: <sup>1</sup>

for the LORCS: League Standard Drug List (which also includes clinic equipment).

for the ICRC: Standard Emergency Units.

The two lists are required because of the differing types of actions and needs, e.g. natural disaster (LORCS) and armed conflict (ICRC). The guidelines below are, however, common to both ICRC and LORCS.

2. All donated drugs should be labelled according to their generic names.
3. Expiry date of drugs must be later than 6 months after the estimated date of arrival in the country of use.
4. Instructions and labels of packs should be in the appropriate language for the receiving country and/or in English, French or Spanish.
5. Doctors' samples and other ill-assorted drugs in small amounts are not acceptable.

6. To facilitate the identification of drugs and medical equipment, a green band 5 centimetres (2 inches) wide should be marked on at least two sides of each package. In addition contents should be listed on the outside of all packages in the appropriate language. This will facilitate customs clearance and storage.
  7. Before dispatching drugs and supplies from one National Society to another in time of natural disaster, the donating Society should inform LORCS about the planned consignment and obtain its approval to ensure that the type and quantity corresponds to the needs of that particular action, in order to avoid wastage of time, money and labour. In the case of man-made disasters (armed conflicts), all medical relief supplies are channelled through ICRC and have to be approved by its medical division before dispatch.
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# INTERNATIONAL COMMITTEE OF THE RED CROSS

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## **Visit by the Prime Minister of India to the ICRC**

The Prime Minister of India, Mr. Rajiv Gandhi, visited the ICRC on 17 June. He was accompanied by Mrs. Gandhi and various officials: Mr. Romesh Bandhari, Foreign Secretary, Ministry of External Affairs, Mr. Arun Singh, Parliamentary Secretary, Mr. C. R. Gharekhan, Additional Secretary, Prime Minister's Office, Mr. Thomas Abraham, ambassador to Bern, and Mr. M. Dubey, ambassador and permanent representative for India to Geneva.

The Prime Minister was welcomed to the ICRC by Mr. Alexandre Hay, President of the International Committee, together with some of his close staff members. In reply to the welcoming address by the President of the ICRC, the Prime Minister of India made the following very kind remarks about the International Committee: «There is very little difference in points of view among nations when it comes to basic principles and humanitarian values but sometimes, due to circumstances, it becomes difficult for nations to stand up for those values. It is at such times that international and multinational organizations must use their influence to bring people together again and to overcome these differences. The ICRC has a very good record on just such matters. Its work, so beneficial in times of disputes, and its mediation in bringing parties together when this would seem impossible are recorded in history. We are always ready to co-operate with you and we shall try to help you on such issues. We congratulate you on the work you have been doing.»

During a private interview, various humanitarian matters of mutual interest were discussed by the Prime Minister of India and the President of the ICRC.

## **Missions by the President of the ICRC**

### **Principality of Liechtenstein**

The President of the ICRC, Mr. Alexandre Hay, accompanied by Mrs. Hay and Mr. F.-P. Küng, ICRC Delegate General for Europe and North America, spent 7 and 8 June in Liechtenstein. On 8 June, they attended the Annual General Meeting of the Liechtenstein Red Cross, which marked that Society's fortieth anniversary. It was a rather special and not unemotional occasion, as Princess Gina, the President of the National Society, officially resigned her office in favour of Princess Maria-Aglaë.

Mr. Hay gave a speech in which he paid tribute to Princess Gina, who had been President of the National Society since its foundation immediately after the Second World War. He emphasized the importance of the Society within the Red Cross and Red Crescent Movement, attributable not least to its unflagging interest in everything concerning the Movement. He thanked the Society for its important contributions.

On 7 June, Mr. Hay was guest of honour at a dinner given by Liechtenstein's International Press Club. Also present were Prince Franz Josef II and Princess Gina, various prominent Liechtensteiners and National Society members, the Secretary-General of the League, the President of the Austrian Red Cross, and about thirty journalists from Liechtenstein, Austria, Germany and Switzerland. Mr. Hay gave a speech on the ICRC, which went down very well and stimulated a lively discussion.

Apart from these events, the Delegate General for Europe met Mr. Brunhart, the head of the government of the Principality, Prince Nicolas, Liechtenstein's permanent representative at the Council of Europe, and three members of parliament. The discussions were concerned mainly with the ratification by Liechtenstein of the Additional Protocols.

## **Federal Republic of Germany**

Mr. Alexandre Hay, President of the ICRC, carried out a mission to the Federal Republic of Germany from 10 to 14 June. He was accompanied by Mr. J.-P. Hocké, Director for Operational Activities, and Mr. P. Küng, Delegate General for Europe and North America.

The representatives of the ICRC had talks with a considerable number of members of the government and political personalities: the President of the Federal Republic, Mr. von Weizsäcker, Chancellor Kohl, the Minister for Economic Co-operation, the Minister of State for Foreign Affairs, the President of the Bavarian Council, representatives of political parties and members of parliament.

Various subjects were dealt with in the talks: the Additional Protocols and their ratification, respect for international humanitarian law, the moral support which the ICRC expects from the states party to the Geneva Conventions in the event of infringements thereof, the ICRC's activities in connection with current armed conflicts, etc.

Much of 12 June was devoted to talks with the German Red Cross. In addition to the points discussed with the authorities, subjects specific to the Red Cross world were dealt with.

The few days in the Federal Republic of Germany were very tightly packed; even mealtimes were used for interviews and discussions. There was a breakfast with members of parliament, a lunch with the press, and a dinner given by the Swiss embassy, which was attended by a minister of state, a former minister, and the President of the German Red Cross in the Federal Republic of Germany, Prince Botho zu Sayn-Wittgenstein-Hohenstein, and also by the Vice-President and the Secretary General of the National Society.

Every detail of this visit to the Federal Republic of Germany had been meticulously prepared by the German Red Cross, and the meetings with the government and political circles and the members of the National Society were marked by friendly understanding and indeed warmth.

## **United States of America**

The President of the ICRC, Mr. Alexandre Hay, visited New York and Washington between 17 and 21 June. He was accompanied by Mr. J.-P. Hocké, Director for Operational Activi-

ties, Mr. J. Moreillon, Director for General Affairs, and Mr. M. Veuthey, delegate to the international organizations.

The mission had three principal objectives: the possibility of the United States' ratifying the Additional Protocols, the presentation of the plan for the development and financing of the ICRC in the next five years, and an account of the main ICRC operations in current armed conflicts.

The principal elements of the visit, which had been planned quite a long time ago, were talks with the authorities of the USA: President Reagan, Secretary of State Schulz, Under-Secretary Taft of the Defence Department, plus members of Congress and Senators.

Also in the visit programme were a meeting with the Secretary-General of UNO, Mr. X. Pérez de Cuéllar, discussions with the American Red Cross, and participation in a seminar on international humanitarian law, which had been organized for diplomats by the American University in Washington.

All the subjects on the programme were discussed with the American authorities in a frank, relaxed manner. President Reagan himself was pleasant and indeed friendly. The ICRC's requests for moral, political and financial support for its current operations and future development were well received. Relations with the American Red Cross, based on a constructive approach of mutual trust, were even further improved by the talks.

At the time of the ICRC visit to the USA, a number of American hostages were being held in Beirut following the hijacking of an airliner, and this was the matter of primary concern to the Government, the public and the press. The talks with the President of the ICRC were therefore followed with great attention, and his presence was the object of lively interest on the part of the press.

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## *External activities*

*May – June 1985*

### **Africa**

#### **Missions by the delegate-general**

In May and June Mr. Jean-Marc Bornet, ICCR delegate-general for Africa, conducted a series of missions taking him first to Mozambique and then to Zimbabwe, the Republic of South Africa and Angola.

From 13 to 20 May the delegate-general visited *Mozambique*. He was received in Maputo by the President of the Republic, Mr. Samoa Machel, and had discussions in particular with Dr. Fernando Vaz, the Deputy Minister of Health.

From 20 to 24 May, in Harare (*Zimbabwe*), Mr. Bornet discussed with the Minister for the Interior the question of protection for people detained for security reasons.

The delegate-general then went to the *Republic of South Africa*. In Pretoria, he took stock with the ICRC delegates in South Africa and in Namibia/South West Africa of the ICRC's role and activities in this region, particularly as regards the current internal disturbances and tensions in this part of the African continent.

In *Angola* from 5 to 12 June, Mr. Bornet together with the delegation reassessed the ICRC's aid programmes for the post-harvest period, i.e. from September onwards. The delegate-general also met senior members of the "Angola Red Cross" and reviewed with them the various aspects of the ICRC's co-operation with this Society.

### **Angola**

ICRC relief work on behalf of displaced persons on the high plateaux in the provinces of Huambo, Benguela and Bié (a region

known as the "Planalto") continued during May and June, when 1,154.9 tonnes and 831.2 tonnes of food respectively were distributed to some 100,000 people. In June, on account of improvements in the nutritional state of the people affected, thanks to the harvest season and the aid provided by the ICRC, distributions of relief supplies were temporarily reduced, with priority being given to preparing programmes for the next difficult period expected to begin in September.

Because of insecurity, the roads and railways linking up the operational areas in the Planalto were impassable and the ICRC continued to airfreight all relief supplies, brought by sea to Angola, from the coast to the provinces in the interior of the country. During the first half of the year 21 ships unloaded 13,158 tonnes of food and 132 tonnes of other relief supplies, equipment and vehicles, in the ports of Luanda, Lobito and Namibie: three wide-bodied aircraft maintained an airlift to transport 7,432 tonnes of food to the towns of Huambo, Kuito and Benguela: from there, carrying out 6,514 flights, six light aircraft supplied the various distribution points in the townships.

In the medical sphere, ICRC teams regularly conducted surveys to assess the food situation of people being assisted. Since 1 January 1985, between 5,000 and 12,000 undernourished children received food and care in the 22 special feeding centres: also, relief supplies in the form of blankets, clothing and soap were given to relatives accompanying them, the number of people varying between 73,000 and 95,000 per month. With the exception of two centres in the provincial capitals of Huambo and Bié, by the end of June most of these centres had been temporarily closed for the reasons given above.

In addition, during the first six months of the year ICRC medical teams gave about 10,000 consultations in the townships in the operational areas and some 80,000 patients were examined by Angolan medical staff. Moreover, the ICRC supplied medicaments and medical items to hospitals and dispensaries where it could monitor their use. Finally, it evacuated 612 war wounded and seriously ill people to hospitals in the provinces and accompanied 817 patients home when their treatment was finished.

### **Republic of South Africa**

ICRC delegates based in Pretoria carried out a certain number of missions throughout the country during which contacts were

made with local authorities at all levels. On the basis of the results of these missions the ICRC decided to increase its personnel in the main regions of South Africa, including the homelands; the delegates' main task will be to provide maximum protection for victims of the current situation in that country, in co-operation with the local authorities and branches of the National Red Cross Society.

The delegation in Pretoria also continued its aid programmes for detainees and their needy families. During the first half of the year assistance (food parcels, travelling expenses for people visiting their relatives in detention) worth a total of 211,700 Swiss francs was provided.

### **Ethiopia**

During May and June there was a marked increase in assistance provided in the course of the joint relief operation by the ICRC and the Ethiopian Red Cross for people affected by the drought and the conflict situation in Ethiopia.

In May the ICRC distributed monthly food rations to 653,116 people at 45 distribution points in Ertrea, Tigre, Gondar, North Wollo and Hararge. This represented a total of 8,993 tonnes, i.e. some 2,200 tonnes more than in April. In addition 557 tonnes of seed were given to 41,029 families.

In June the number of beneficiaries of ICRC aid increased further, with 10,877 tonnes of food being distributed to 719,489 people; furthermore, 691 tonnes of seed were supplied to 31,019 families.

The increase in the number of people assisted reflects the continuing disastrous food shortage and the increasing needs in the famine-stricken areas, particularly in North Wollo, Eastern Gondar and Tigre. In the latter province the airlifting of relief supplies became absolutely necessary, since road convoys could not reach Mekele, Axum and Adwa because of the inadequacy of transport facilities and the prevalent insecurity. The quantities of food supplies necessary (for immediate distribution and to build up stocks) were flown in by four or five wide-bodied aircraft from Addis Ababa and Asmara. In addition, townships with landing strips were supplied by a fleet of five light aircraft.

As regards medical work, ICRC teams continued to conduct rounds of surveys to monitor the hygiene and food situation of the people affected. Health centres, clinics and dispensaries were pro-

vided with medicaments and medical equipment. This aid came to 399,646 Swiss francs for the first half of the year. In addition, ICRC medical teams endeavoured to combat a diarrhoea epidemic which broke out in Maychew and spread to Axum, Adwa, Areza and Barentu; by the end of June, the epidemic was under control and the number of cases rapidly decreased.

## **Uganda**

During the first half of the year the delegates based in Kampala visited 40 places of detention (police stations and prisons) and saw 8,732 detainees, 1,676 of whom within the competence of the ICRC. Relief supplies were distributed during these visits.

In addition, the ICRC continued to assist displaced people housed in the transit camps in Busunju, Kibizi and Nakazi. Similarly, food was supplied for displaced people in Kampala and clothing distributed to refugees arriving in the camps run by the United Nations High Commissioner for Refugees. In all, 560 tonnes of relief supplies (food, clothing) were provided in this way between January and the end of June.

## **Zaire**

During May and June ICRC delegates continued visiting places of detention both in Kinshasa and in the provinces (Mbuji Mayi, Kalemie). They saw a total of 128 detainees and gave them various relief items.

## **Latin America**

### **El Salvador**

In May, ICRC delegates registered 133 new detainees during 200 visits to places of detention under the jurisdiction either of the Ministry of Justice or the Ministry of Defence; in June, they saw 106 new detainees during 156 visits. On three separate occasions in June, through the intermediary of the ICRC, the FMLN released groups of soldiers it had captured—a total of 26 military personnel and two civilians—and the delegates accompanied them to their place of residence.

Food aid to the civilian population affected by the fighting increased in May to almost 1,105 tonnes for 124,000 people; in

June, 1,026 tonnes of relief supplies were distributed to 117,700 beneficiaries.

ICRC and Salvadorean Red Cross medical teams, based in San Salvador and San Miguel, gave 13,871 consultations (including 2,213 dental examinations) in visits to the field. In addition, they carried out a dozen nutritional surveys in the villages being assisted. Medicaments and medical equipment were distributed to hospitals, health centres and schools in accordance with their needs or were handed over to mobile clinics.

Furthermore, the ICRC Chief Medical Officer from the ICRC and the deputy delegate-general for Latin America were in San Salvador from 17 to 20 June to reassess all the ICRC's material and medical aid activities.

For the dissemination of knowledge of the essential rules of humanitarian law and the principles of the Red Cross, ICRC delegates gave 24 lectures and explanatory talks to some 3,500 people (officers, privates, members of the police, volunteer workers from the Salvadorean Red Cross).

## Nicaragua

In May ICRC delegates visited Bluefields prison where 104 detainees were being held and, in June, the Zona Franca prison where 559 people were being held for security reasons; they interviewed 324 of them without witnesses.

All in all, during the first half of the year 16 visits were carried out to 14 places of detention, i.e. the two prisons in Managua (Tipitapa and Zona Franca), six prisons in the provinces (Chinandega, Matagalpa, Esteli, Juigalpa, Granada and Bluefields), five prison farms in the outskirts of the capital and the Lenin Fonseca hospital. During these visits ICRC delegates had access to 2,083 people being detained for security reasons, of whom 296 were seen for the first time and registered.

During the same period, the assistance (worth 543,000 Swiss francs) supplied to the detainees in the form of monthly food rations came to 152 tonnes. In addition, food worth 181,000 Swiss francs was given to detainees' families in need. Medicaments and medical equipment (cost: 49,600 Swiss francs) were also distributed to prison infirmaries according to needs.

Between 1 January and 30 June, the ICRC Tracing Agency office in Managua registered 737 tracing requests for missing persons; in addition, it exchanged more than 4,000 family messages

between the detainees and their families, and on behalf of displaced people or refugees.

In co-operation with the Nicaraguan Red Cross, the ICRC continued its assistance programme for displaced persons (most of whom were Miskito Indians living in areas along the Atlantic coast); food, blankets, cooking utensils and basic medicaments were transported by ship from Puerto Cabezas (Zelaya Norte province) and Bluefields (Zelaya Sur province) and distributed in co-ordination with the Nicaraguan Institute for Social Welfare (INSS-BI). For the first six months of the year, this operation involved 246 tonnes of relief supplies (worth 397,000 Swiss francs) and brought aid to 7,600 beneficiaries. In addition, the ICRC provided the National Society branches with relief supplies for distribution to displaced persons in various regions (5,000 beneficiaries).

## **Asia-Pacific**

### **Mission by the delegate-general**

Mr. Jean de Courten, ICRC delegate-general for Asia and the Pacific, was in Taiwan from 27 to 29 June and met the Deputy Ministers of the Interior and of the Overseas China Department, the Director of Consular Affairs at the Ministry of Foreign Affairs, the president of the Red Cross and the president of the Free relief Association. Various humanitarian problems of mutual interest were discussed.

## **Pakistan**

The ICRC delegation in Pakistan continued its medical aid programmes as part of its work on behalf of Afghan wounded victims of the fighting in their country.

Throughout the first half of 1985 the ICRC hospitals in Peshawar and Quetta were very busy. The surgical hospital in Peshawar was working at almost maximum capacity: it admitted 908 patients and performed 820 surgical operations as well as providing care for 5,276 out-patients.

A fourth mobile medical team was established towards the end of June at Khar in the Bajaur region. The four mobile medical teams based in Parachinar, Miram Shah, Wana and Khar and composed of staff from the Pakistan Red Crescent, cared for 448 wounded and evacuated 315 of them to the hospital in Peshawar.

The paraplegic centre too, was working to almost full capacity during the first six months of the year and admitted 87 patients, whilst the orthopaedic centre manufactured 224 prostheses. The blood-collecting centre continued to supply the needs of the hospital in Peshawar.

The ICRC surgical hospital in Quetta showed an 85 to 90 per cent occupancy rate. Between 1 January and 30 June it admitted 393 people and provided care for 2,269 out-patients. The two mobile medical teams, based in Chaman and Badini, cared for 266 wounded and evacuated 169 of them to the hospital in Quetta.

Five four-week first-aid training courses were organized in Peshawar during the first half of the year; 82 participants passed their examinations; 65 first-aid workers were also trained in Quetta. Between January and June, 2,278 Afghans followed 108 "short courses" (two days) in Peshawar. In Quetta 326 people took part in 34 courses. In Chaman, where this programme started in March, seven courses, with 61 participants, took place.

The first-aid equipment distributed to first-aid workers trained during the first half of the year came to 284,000 Swiss Francs.

### **Kampuchea**

In May ICRC delegates carried out two surveys in the provinces of Kompong Speu and Kampot. In June they went to the provinces of Kompong Cham, Kompong Chhnang, Kandal and again to Kompong Speu. During each of these trips medicaments and medical equipment were provided, according to needs; they were also supplied to three hospitals and to the blood bank in Phnom Penh. Between 1 January and 30 June the total value of ICRC medical aid to Kampuchea came to 111,000 Swiss francs.

In addition, during the first half of the year, the ICRC dispatched 37 tonnes of medicaments, medical equipment and various relief supplies, either by air from Bangkok to Phnom Penh, via Ho Chi Minh City, or by sea from Singapore.

Moreover, 10,000 first-aid kits, with a card explaining to the combatants the main humanitarian rules, were given to the local Red Cross to distribute in the provinces affected by the fighting.

### **Khmer-Thai frontier**

As part of their activities along the Khmer-Thai frontier the ICRC medical staff continued to care for war casualties and emerg-

ency cases in its hospitals in Khao-I-Dang and Kab Cherng. Between 1 January and 30 June the number of people admitted to the Khao-I-Dang hospital came to 1,542 (including 945 war casualties), an increase of 28 per cent against the same period in 1984. After an influx of wounded during the month of March to the Kab Cherng hospital, requiring extra surgeons to be sent, work there decreased and the ICRC provisionally suspended its surgical activities keeping open only one first-aid post run by a nurse. Since 22 June patients being treated and newly arrived serious casualties have been transferred directly to the Khao-I-Dang hospital. During the first half of the year the number of patients treated in Khab Cherng came to 520, including 255 war casualties.

During the first six months of the year 27 medical co-ordinators, doctors, surgeons and anaesthetists and 23 nurses were seconded to the ICRC for this work by 11 National Red Cross Societies (Canada, Denmark, Federal Republic of Germany, Finland, Great Britain, Iceland, Ireland, Japan, Netherlands, New Zealand and Norway).

The ICRC blood bank in Khao-I-Dang continued to supply the needs of the surgical hospitals and of voluntary agencies working on the spot, thanks to regular consignments from the Red Cross Societies of Australia and Japan (respectively, 2,607 units of blood for a total of 172,100 Swiss francs and 594 units equivalent to 35,640 Swiss francs during the first six months of the year).

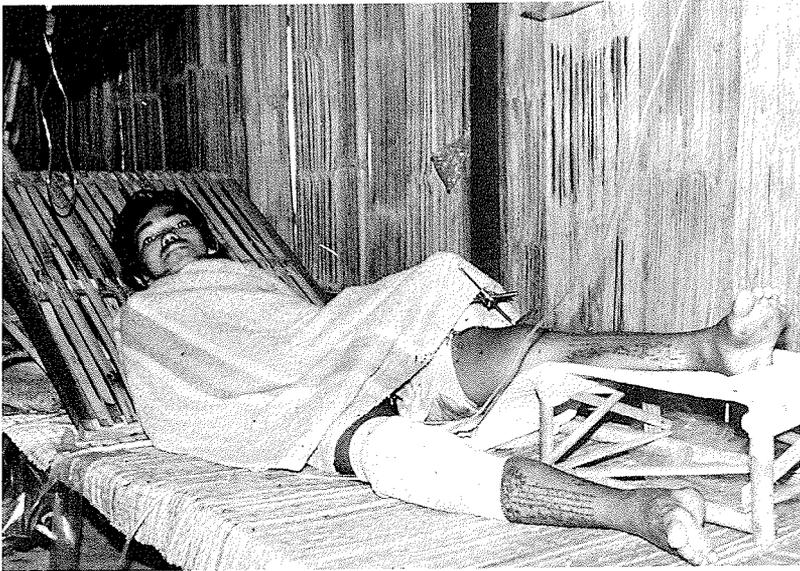
In emergency phases the New Zealand Red Cross also sent consignments (329 units to a value of 21,700 Swiss francs).

In addition, ICRC delegates continued to visit Vietnamese detainees in Aranyaprathet prison; mail and tracing request forms were distributed to them. Between January and June 192 detainees were registered.

Mainly because of the frequent movement of the refugee camp population the work of the ICRC Tracing Agency considerably increased. During the first half of the year 15,536 family messages were forwarded for Khmer refugees and 4,028 messages for Vietnamese refugees and their families. Moreover, the Agency handled 406 tracing requests concerning Vietnamese refugees and 6,187 relating to Khmer nationals; it also carried out 2,305 transfers.

The relief supplies distributed by ICRC delegates in the refugee camps and Aranyaprathet prison (bedding, cooking utensils, clothing, hygiene requisites) came to a total of 328,250 Swiss francs in the first six months of the year.

SOME ASPECTS OF ICRC MEDICAL ASSISTANCE

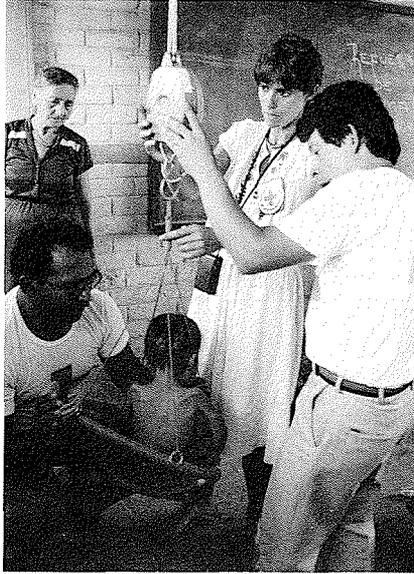


Khmer-Thai border: medical care for war wounded



Angola: Bomba Alta prostheses workshop and orthopaedic centre for the re-education of amputees

In El Salvador:  
Joint action by the ICRC and the Salvadoran Red Cross



Medical consultation for children



Health education

## Middle East

### Lebanon

The fighting which broke out on 19 May in and around the Palestinian camps of Sabra, Chatila and Bourj Brajneh (southern suburbs of Beirut) and the tense situation prevailing in the area of Jezzine (a township on the heights to the east of Sidon) were causes of considerable concern for the ICRC delegation in Lebanon during the months of May and June.

From 20 May onwards, ICRC delegates and relief workers from the Lebanese Red Cross tried to get into the camps to evacuate the wounded; nevertheless, despite an urgent appeal to all the parties for a cease-fire and for them to respect the Red Cross emblem, for security reasons it was particularly difficult to get access to the camps. At the height of the battle the ICRC and the Lebanese relief workers could enter the camp only seven times and evacuated 188 wounded. Ten ICRC delegates—including four members of the medical staff—, some forty relief workers from the Lebanese Red Cross and about twenty vehicles were kept on stand-by throughout the fighting, which ended on 18 June. After the cease-fire which came into force on that date, four more evacuations were carried out. All in all, 300 people were evacuated, 250 of whom were seriously wounded. Medical equipment worth 200,000 Swiss francs was distributed to dispensaries and hospitals in the camps, and to places both in West Beirut and the suburbs where the wounded were being tended.

During the first six months of 1985 the ICRC distributed 1,503 standard medical kits (value: 557,000 Swiss francs) mainly to hospitals and dispensaries in Beirut, the suburbs and southern Lebanon; 300 dressing material sets, 50 pediatric sets, 40 suture material sets, 20 minor surgery sets, 60 stretchers, 500 units of blood and 250 units of plasma were supplied by the Red Cross Societies of Denmark, the Federal Republic of Germany, Norway, Sweden and Switzerland, often at very short notice owing to the emergency situation on the spot. In addition, between January and June the ICRC supplied medicaments and medical equipment worth 495,000 Swiss francs to various branches of the Lebanese Red Cross throughout the country.

Moreover, increasingly hazardous conditions in certain parts of southern Lebanon induced 15,000 people to move to Jezzine and Marjayoun and several thousand others to east Beirut; at the same

time many families had to leave their homes to take refuge in West Beirut because of the clashes along the "green line" dividing the capital. ICRC delegates regularly carried out rounds to assess the needs of the displaced people and provide them with assistance. In May, relief supplies distributed to 51,400 people in Marjayoun, Jezzine and east and west Beirut came to 211 tonnes (value: 596,000 Swiss francs). All in all, during the first half of the year, the ICRC provided 607 tonnes of relief supplies (i.e. 61,850 blankets, 21,349 family parcels, 2,517 cooking utensils and various other relief items) to a total of approximately 1,640,000 Swiss francs. In addition to these distributions, the ICRC sent the Lebanese Red Cross 147 tonnes of relief supplies worth 421,400 Swiss francs.

As regards protection, the ICRC regularly visited the prisoners transferred—in violation of Articles 49 and 76 of the Fourth Geneva Convention—at the beginning of April from Ansar camp (southern Lebanon) to Atlit camp (Israel). Bearing in mind the number of people released in the meantime, there were still 735 people detained in Atlit at the end of June. A total of four complete visits to Atlit were carried out during the first six months of the year, plus five other visits to register new detainees.

Furthermore, ICRC delegates continued to visit Israeli detention centres in Nabatiyeh, Tyre and Mar Elias: during 31 visits between January and 10 June, the date when the Israeli army officially withdrew from southern Lebanon, they registered 22 new detainees.

The ICRC tracing offices throughout Lebanon have enabled thousands of people to re-establish contact with dispersed members of their families; during the first half of 1984 these offices dealt with 28 requests for news, organized two repatriations, 368 transfers and two family reunifications and exchanged 93,476 family messages.

### *Exchange of prisoners*

On 20 May, 1,150 Palestinian and Lebanese prisoners held by Israel and three Israeli soldiers held by the Popular Front for the Liberation of Palestine/General Command (PFLP/GC) were released simultaneously under the auspices of the ICRC.

Austrian diplomats negotiated the terms for this exchange. Both parties requested the ICRC to meet all the prisoners about to be released, in order to ask their opinion of the various destinations offered them, and entrusted the organization and supervision of the operation to the ICRC. In this way 605 Palestinian prisoners returned home to the West Bank, the Gaza Strip and other Arab

localities in Israel, while 151 Palestinian and Lebanese prisoners were released at Kuneitra to return to Lebanon via Syria. Simultaneously, 394 other prisoners and the three Israeli prisoners were released at Geneva airport and flew on to their respective destinations. The part of this release operation which took place in Geneva was made possible thanks to the co-operation of the Swiss and Geneva authorities.

#### *ICRC activities following the hijacking of an aircraft*

On 14 June an airplane belonging to the American airline company TWA, was hijacked after take-off for Rome from Athens airport. After it had landed, first at Beirut and then in Algiers, on 14 and 15 June, the Algerian and American authorities, with the hijackers' consent, requested the ICRC to intervene. A team of six people from the ICRC (including the delegate-general for the Middle East and one doctor) left Geneva for Algiers, where the delegates were able to board the aircraft and interview the passengers and the hijackers, and obtained the release of three hostages.

The ICRC did not take part in the negotiations themselves, since the conditions for its intervention, i.e. being the only intermediary between the parties involved, were not fulfilled. However, after the aircraft had left Algiers for Beirut, it stated its willingness to facilitate and expedite the release of the hostages once agreement had been reached between the parties. Thus, during the night of 25 to 26 June an ICRC delegate and a doctor visited in the Lebanese capital the 37 passengers and crew members being held hostage. They interviewed them without witnesses and registered them. The registration cards were sent to the American Red Cross to be forwarded to the hostage's families. Finally, on 30 June, with the agreement of all the parties, the ICRC organized the transfer of 39 passengers (one of whom had meanwhile been released at the request of the ICRC) and crew members from Beirut to Damascus on board 12 ICRC vehicles. In the Syrian capital, the released hostages were handed over to the Syrian authorities and American representatives on the spot, and were then repatriated.

#### **Conflict between Iran and Iraq**

The ICRC continued to follow with concern the dramatic development, in particular the indiscriminate bombardment of civilian targets, in the war, now in its fifth year, between Iran and Iraq. On 28 May Mr. Alexandre Hay, President of the ICRC,

publicly denounced the bombardment of civilians as one of the very gravest violations of international humanitarian law and solemnly called on the belligerent parties to put an end to this practice.

In *Iraq* ICRC delegates continued regularly to visit Iranian prisoner-of-war camps and distributed some relief supplies in the form of recreational items. Since the hostilities started, the ICRC has registered 10,193 Iranian prisoners of war in Iraq.

In addition, ICRC delegates visited eight camps in May in the region where displaced people of Khuzistan origin (Arabic-speaking Iranians) were being housed. During these visits they distributed forms for family messages and collected them when filled out, for forwarding to relatives in Iran.

At the beginning of the year, a mixed medical commission, composed of one Iraqi doctor and two ICRC doctors, submitted to the Iraqi authorities the cases of more than one hundred sick or wounded Iranian prisoners of war eligible for repatriation. On 2 May, 119 cases had been accepted and Iraq requested the ICRC to organize their repatriation in various stages together with that of 55 Iranian prisoners of war captured in January and 18 other prisoners whose release had been announced by the Iraqi authorities back in March. The first group of 30 prisoners of war were released by Iraq on 27 May; accompanied by four ICRC delegates and doctors, they were flown from Baghdad to Ankara and thence, accompanied by two ICRC delegates, on board another aircraft to Tehran. During this operation, the Turkish authorities and the Turkish Red Crescent provided the medical facilities at Ankara airport for the transfer of the prisoners.

The ICRC Tracing Agency continued to forward family messages between prisoners of war of the two belligerent parties and their families. A total of 841,735 messages were transmitted during the first half of 1985.

In *Iran* the ICRC continued its activities in connection with exchanging family messages between prisoners of war and their relatives, and maintained the dialogue with the Iranian authorities to obtain permission to resume visits, suspended in October 1984, to prisoner-of-war camps. At that time the number of Iraqi prisoners of war registered in Iran was 45,541.

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## In Bulgaria

### Eleventh Festival of Red Cross and Health Films

Every two years since 1965, the city of Varna in Bulgaria has played host to the International Festival of Red Cross and Health Films. The eleventh festival was held this year from 7 to 15 June. For the final competition the jury selected 194 films from 58 countries, made by 27 National Red Cross and Red Crescent Societies and seven international organizations.

The festival, organized by the Bulgarian Red Cross, under the patronage of the League, the ICRC and the WHO, was attended by almost 500 guests including many high-ranking members of National Societies and heads of their information services. Mr. Enrique de la Mata Gorostizaga, President of the League, and Dr. Ahmed Abu-Goora, President of the Standing Commission of the International Red Cross, were at the opening ceremony. Mr. Maurice Aubert, Vice-President of the ICRC, accompanied by Mr. Alain Modoux, head of the ICRC Information Department, represented the International Committee at the closing ceremony.

There was a large public attendance, with over 100,000 people coming to the various showings.

In accordance with now established practice, the films in the competition were divided into four categories: A. Red Cross films; B. short to medium-length films on health; C. feature films; D. television programmes and films.

The Grand Prix in the category of Red Cross films, "The Golden Ship", from the President of the Bulgarian Red Cross, went to "A message from Aaland", which is a co-production by the League, the ICRC and the Finnish and Swedish Red Cross Societies. The League's Grand Prix was awarded to the American Red Cross for its "Light the Darkness", which consists of extracts of recent ICRC and League films. The main prize for feature films

went to "Saints Innocents", by Mario Camus (Spain), and the main prize in the television section to a Canadian film called "The Last Right". Numerous other prizes were awarded.

The Varna film festival provides the National Societies, the League and the ICRC with an excellent opportunity to have a look at new audio-visual productions, and to establish or keep up personal and professional friendships. As the President of the Bulgarian Red Cross, Mr. Kiril Ignatov, said at the opening ceremony, "This international festival serves the humanitarian cause of protecting health and contributing to peace and progress in the world."

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## **Thirtieth award of the Florence Nightingale Medal**

GENEVA, 12 MAY 1985

CIRCULAR NO. 535

*To the Central committees of National Red Cross and  
Red Crescent Societies*

LADIES AND GENTLEMEN,

In its Circular No. 530 of 24 August 1984, the International Committee of the Red Cross had invited the Central Committees of National Societies to send in the names of nurses and voluntary aids who are active members or regular helpers of a National Society or of an affiliated medical or nursing institution, whom they judged qualified to receive the Florence Nightingale Medal.

The object of this Medal is to honour nurses and voluntary aids who have distinguished themselves in time of peace or war, by their exceptional courage and devotion to wounded, sick or disabled persons or those whose health is threatened.

The International Committee, after a careful study of the candidatures submitted by National Societies, has the pleasure of

announcing that for the thirtieth distribution the Medal has been awarded to the following nurses and voluntary aids. Since the designation, qualification and duties of nursing personnel do not always have an exact equivalent in the various languages, it seemed to be preferable to leave them as indicated by each Society.

Allemagne (Rép. féd.) — GERMANY (Federal Republic) — ALEMANIA (Rep. Fed.)

1. *Frau Oberin Dora Müller*. Diplomierte Krankenschwester. Oberin der DRK-Schwesternschaft «Obersee», Marburg und der DRK-Schwesternschaft Marburg, Marburg.
2. *Frau Generaloberin Gisela Bohken*. Diplomierte Krankenschwester. Präsidentin des Verbandes der Schwesternschaften vom Deutschen Roten Kreuz.

AUSTRALIE — AUSTRALIA

3. *Sister Ella Tyler, SRN., SCM*. Graduate Nurse. State Certified Midwife. Director of Training (South Australian Division). Official First-Aid Adviser to the Australian Red Cross Society.

BOLIVIE — BOLIVIA

4. *Sra. Doña Francisca Nieto Pando*. Enfermera Diplomada. Ninguno se encuentra tramitando su jubilación.

CANADA — CANADÁ

5. *Miss Mary Emily Wilson*. Registered Nurse. Member, Board of Directors, Age and Opportunity Inc. Chairman, Senior Centers Committee. Adviser, Community Health Nursing Interest Group. Adviser, International Youth Year. Vice-Chairman, National Health and Community Services Committee.

RÉPUBLIQUE POPULAIRE DE CHINE — THE PEOPLE'S REPUBLIC OF CHINA — REPÚBLICA POPULAR DE CHINA

6. *M<sup>me</sup> Si Kun-Fan*. Infirmière diplômée. Chef des infirmières de l'Hôpital de la Croix-Rouge de Chaoyang de Beijing.
7. *M<sup>me</sup> Liang Jihua*. Infirmière diplômée. Directrice du département des soins médicaux de l'Hôpital de la Croix-Rouge de Canton.
8. *M<sup>me</sup> Yang Bichun*. Infirmière diplômée. Chef des infirmières de l'Hôpital de la Croix-Rouge de la ville de Lu Zhou.

RÉPUBLIQUE DE CORÉE — REPUBLIC OF KOREA — REPÚBLICA DE COREA

9. *Prof. Young-sook Hong*. Graduate Nurse. Registered Nurse. Professor, Red Cross Junior Nursing College.
10. *Mrs. Ok-young Lee*. Graduate Nurse. Registered Nurse. Director of Nursing, Samchok Provincial Hospital.

ETATS-UNIS D'AMÉRIQUE — UNITED STATES OF AMERICA — ESTADOS UNIDOS DE AMÉRICA

11. *Mrs. Delores L. Angelton, R.N., B.A.* Graduate Nurse of St. Elizabeth Hospital School of Nursing. B.A. Saint Joseph College. National Chairman, Disaster Volunteers American Red Cross.

FRANCE — FRANCIA

12. *M<sup>me</sup> Jeanne Pécheur*. Infirmière diplômée de la Croix-Rouge française. Sage-femme. Présidente du Comité de la Croix-Rouge française de Vittel. Membre du Conseil départemental de la Croix-Rouge française des Vosges. Militante de la Croix-Rouge depuis quarante-cinq ans.
13. *M<sup>me</sup> Suzanne Vallette-Viallard*. Diplôme simple de la Croix-Rouge française.

GRANDE-BRETAGNE — GREAT BRITAIN — GRAN BRETAÑA

14. *Mrs. Diane Ryding SRN*. Graduate Nurse. State Registered. Red Cross Diploma for General Nurse Training, University College Hospital, London. Diploma in Refugee Health Care. Currently working as a member of a League of Red Cross and Red Crescent Societies' medical nutrition team in Bati Camp. Relief operations nurse with Christian Aid and the Red Cross since 1980.

GRÈCE — GREECE — GRECIA

15. *M<sup>me</sup> Popi Kastrakidou*. Infirmière volontaire. Certificat d'auxiliaire volontaire. Inspectrice du «Corps des Infirmières Volontaires».

HONGRIE — HUNGARY — HUNGRÍA

16. *M<sup>me</sup> Rozália Bodoglári*. Infirmière diplômée. Retraitée.
17. *M<sup>me</sup> Erzsébet Jakab*. Infirmière diplômée. Diplôme d'infirmière et d'assistante sociale de l'Institut de Formation d'Infir-

mières et d'Assistantes sociales de l'Université «Tisza Istvan» à Debrecen. Retraitée.

18. *M<sup>me</sup> Ilona Kornreich*. Infirmière diplômée. Retraitée.

JAPON — JAPAN — JAPÓN

19. *Miss Teruko Tatematsu*. Registered Nurse. Red Cross Diploma. Former Director, Nursing Department, Japanese Red Cross Nagoya First Hospital.
20. *Miss Kimiko Kishii*. Registered Nurse. Red Cross Diploma for Relief Nurse, Social Nurse. Relief Head Nurse, Home Nursing Instructor. Executive Director of the Japanese Red Cross Nurses' Doho-kai Society.
21. *Miss Nobu Madamubashi*. Registered Nurse. Red Cross Diploma as Public Health Nurse and Midwife. Red Cross Diploma as Relief Nurse. Director, Nursing Department, the Naha Municipal Hospital.

JORDANIE — JORDAN — JORDANIA

22. *Mrs. Najiyeh Nabulsi*. President, Jordan National Red Crescent Hospital. Member of the Central Executive Committee of the Jordan National Red Crescent Society.

MAROC — MOROCCO — MARRUECOS

23. *M<sup>me</sup> Fatima Alamy*. Infirmière diplômée de la Croix-Rouge française et sage-femme. Secrétaire générale et directrice du Département de secourisme du Croissant-Rouge marocain de Casablanca.

PHILIPPINES — FILIPINAS

24. *Miss Adela Sanchez Banzon*. Registered Nurse. Graduate Nurse. Bachelor of Science in Nursing. Present functions: Administration and Supervision of Nursing Service.
25. *Mrs. Rafaela T. Biteng*. Registered Nurse. Executive Director, Young Women's Christian Association Club of Salcedo, Ilocos Sur.
26. *Mrs. Fe Isaac Saño*. Registered Nurse. Chief Occupational Therapy Department. Coordinator, Rehabilitation Medicine National Orthopaedic Hospital. Editor, Ministry of Health National League of Nurses Newsette.

POLOGNE — POLAND — POLONIA

27. *Sœur Wanda Zurawska*. Infirmière diplômée. Directrice de l'École d'infirmière pour les religieuses.
28. *M<sup>lle</sup> Janina Pohorecka*. Infirmière diplômée. Retraitée.

TCHÉCOSLOVAQUIE — CZECHOSLOVAKIA — CHECOSLOVAQUIA

29. *Mrs. Ilona Pjontková*. Graduate Red Cross Nurse. Retired, she works as a voluntary home nurse.
30. *Mrs. Anna Kašparová*. Graduate Red Cross Nurse. Retired. Member of the Committee of the grassroot organization, Red Cross Hořesedle.
31. *Mrs. Mária Kresánková*. Graduate Red Cross Nurse. Retired. District nurse of the Red Cross in Martin.
32. *Mrs. Marie Holubcová*. Voluntary Red Cross Nurse. Retired. Member of the Committee of the grassroot organization Red Cross Třebíč.

THAÏLANDE — THAILAND — TAILANDIA

33. *Miss Sermsook Changsorn*. Graduate Nurse. State Diploma in Nursing Education. Red Cross Diploma in Ward Management. Diploma in General Nursing, Midwifery and Public Health. Director of Nursing, Chulalongkorn Hospital, Thai Red Cross Society.
34. *Miss Phongsiri Narksang*. Graduate Nurse. Certificate of Operating Room Nursing and Hospital Management. Certificate of Nurse Anaesthetics. Thai Red Cross Diploma in Nursing Midwifery and Public Health. Director of Nursing, Somdetch Hospital, Thai Red Cross Society.

U.R.S.S. — U.S.S.R.

35. *M<sup>me</sup> Polina M. Goussak*. Infirmière diplômée. Retraitée.
36. *M<sup>me</sup> Maria A. Kvitchenko*. Infirmière diplômée. Infirmière en chef de l'hôpital clinique à Achkhabad (Turkménie).
37. *M<sup>me</sup> Antonina J. Dmitrieva*. Infirmière de la Croix-Rouge. Infirmière à l'Hôpital d'enfants de la ville de Pavlodar (Kazakhie).

YOUGOSLAVIE — YUGOSLAVIA

38. *Mrs. Cveta Hadzi-Vasileva*. Trained Nurse. Diploma for Nurses. Retired. Collaborator of the Red Cross of Macedonia.

With the thirtieth award on 12 May 1985, a total of 927 medals have been awarded.

The medals and diplomas, accompanied in each case by a photogravure reproduction of the portrait of Florence Nightingale, will be sent as quickly as possible to the Central Committees. The International Committee of the Red Cross would like to receive acknowledgements of their receipt in due course.

The Committee would be grateful if the Medals could be presented in the course of this year and requests the Central Committees to invest the presentation ceremony with a character of formality in keeping with the founders' wishes.

FOR THE INTERNATIONAL COMMITTEE  
OF THE RED CROSS

**Alexandre Hay**

*President*

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*N.B.* Amongst the 927 Red Cross nurses and voluntary aids awarded the Florence Nightingale Medal the names of two of them have not been included in the ICRC circulars for the corresponding years. These are Miss Evelyn Conyers, from Australia, in 1920, and Dame Ellen Musson, from Great Britain, in 1939.

# MISCELLANEOUS

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## **Symposium on the 1925 Geneva Protocol**

In Geneva on 17 June the ICRC was invited to take part in a symposium organized by the United Nations Disarmament Research Institute to mark the sixtieth anniversary of the conclusion of the 1925 Geneva Protocol for the prohibition of the use in war of chemical and bacteriological weapons. The purpose of the symposium was to study prospects of strengthening and filling the gaps in the prohibition of the use of chemical weapons in armed conflicts.

The symposium was attended by diplomats, international civil servants and academic experts. The ICRC was represented by its vice-president, Mr. Maurice Aubert, and Mr. Yves Sandoz, head of the ICRC Principles and Law Department. Both of them presented papers: Mr. Aubert on "The 1925 Protocol and the ICRC" and Mr. Sandoz on "The 1925 Protocol and International Humanitarian Law".

The exact title of the Protocol is: "Geneva Protocol of June 17, 1925 for the Prohibition of the Use in War of Asphyxiating, Poisonous or Other Gases and of Bacteriological Methods of Warfare". The depositary of the Protocol is the Government of the French Republic; one-hundred-and-three States are presently party to the Protocol.

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## **States Party to the Geneva Conventions of 12 August 1949 and to the Protocols Additional of 8 June 1977**

*Summary as on 30 June 1985*

The January-February 1985 issue of our *Review* included a list, as on 31 December 1984, of the States party to the Geneva Conventions of 12 August 1949 and to the Protocols of 8 June 1977. Without reproducing this list in full, we simply wish to mention the States which became party to these treaties during the first half of 1985.

### **States Party to the Geneva Conventions**

By 31 December 1984, 161 States had become party to the Geneva Conventions of 12 August 1949.

No new State became party to the Geneva Conventions during the first half of 1985. Thus, as of 30 June 1985, 161 States are party to these Conventions.

### **States Party to the Protocols**

By 31 December 1984, 48 States had become party to Protocol I and 41 to Protocol II.

During the first half of 1985, the following States deposited their instruments of accession or ratification:

- 17 January      Kuwait, accession to Protocol I (49th State) and to Protocol II (42nd State); entry into force: 17 July 1985.
- 28 February    Vanuatu, accession to Protocol I (50th State) and to Protocol II (43rd State); entry into force: 28 August 1985.

7 May Senegal, ratification of Protocol I (51st State) and to Protocol II (44th State); entry into force: 7 November 1985.

Thus, by 30 June 1985, 51 States had become party to Protocol I and 44 States to Protocol II.

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## BOOKS AND REVIEWS

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### RENDRE L'HÔPITAL PLUS HUMAIN<sup>1</sup>

In today's world, in which modern technology is developing so quickly, often to the detriment of human values, it seems opportune to stop and think about the quality of life of patients in hospitals and care institutions.

Already several years ago, at the suggestion of the late Professor Eric Martin, then President of the ICRC, the Henry Dunant Institute was asked to study dehumanization in hospitals, to examine the major aspects of the problem and to suggest solutions that would meet with the approval of all concerned.

In autumn 1984, the Henry Dunant Institute published a brochure entitled «Rendre l'hôpital plus humain» (Making Hospitals more humane), which is the work of a commission headed by Professor René Mach and composed of medical experts, practitioners, legal scholars and Red Cross personnel.

The brochure is careful not to form generalizations about the phenomena of hospital dehumanization, but observes that this does exist and is a source of public concern. The brochure limits itself to describing different aspects of the life of hospital patients and presents for each aspect a series of remedies which can be summarized in three key words: information—dialogue—respect.

For many patients, a stay in hospital means separation or even isolation. All the more reason, therefore, that they should receive treatment in the atmosphere of sympathy, understanding, refuge and reassurance they need. Hence the importance of the part played by reception staff, whether professional or voluntary and social welfare personnel. They can ensure that the patient always feels he is being looked after in a caring environment, and that he is given the necessary administrative and therapeutic explanations, be it on his arrival at the hospital or when he leaves.

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<sup>1</sup> *Rendre l'hôpital plus humain*, Henry Dunant Institute, Geneva, September 1984, 39 p., in French and German.

The brochure also advocates that medical studies and internships should not be limited to scientific and medical instruction, but that they should also develop the human side of the doctor-patient relationship. The study also stresses the importance of the role played by chaplains.

The success of a stay in hospital is more a matter of volition than knowledge; it depends very substantially on the active participation of all concerned, whether those giving or those receiving care.

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## ADDRESSES OF NATIONAL SOCIETIES

- AFGHANISTAN (Democratic Republic) — Afghan Red Crescent, Puli Artan, *Kabul*.
- ALBANIA (People's Socialist Republic) — Albanian Red Cross, 35, Rruga e Barrikadave, *Tirana*.
- ALGERIA (Democratic and People's Republic) — Algerian Red Crescent Society, 15 bis, boulevard Mohamed V, *Algiers*.
- ARGENTINA — Argentine Red Cross, H. Yrigoyen 2068, *1089 Buenos Aires*.
- AUSTRALIA — Australian Red Cross, 206, Clarendon Street, *East Melbourne 3002*.
- AUSTRIA — Austrian Red Cross, 3 Gusshausstrasse, Postfach 39, A-1041, *Vienna 4*.
- BAHAMAS — Bahamas Red Cross Society, P.O. Box N 91, *Nassau*.
- BAHRAIN — Bahrain Red Crescent Society, P.O. Box 882, *Manama*.
- BANGLADESH — Bangladesh Red Cross Society, 34, Bangabandhu Avenue, *Dhaka 2*.
- BARBADOS — The Barbados Red Cross Society, Red Cross House, Jemmotts Lane, *Bridgetown*.
- BELGIUM — Belgian Red Cross, 98, chaussée de Vlucrgat, *1050 Brussels*.
- BELIZE — The Belize Red Cross Society, P.O. Box 413, *Belize-City*.
- BENIN (People's Republic) — Red Cross of Benin, B.P. 1, *Porto Novo*.
- BOLIVIA — Bolivian Red Cross, Avenida Simón Bolívar 1515, *La Paz*.
- BOTSWANA — Botswana Red Cross Society, Independence Avenue, P.O. Box 485, *Gaborone*.
- BRAZIL — Brazilian Red Cross, Praça Cruz Vermelha 10-12, *Rio de Janeiro*.
- BULGARIA — Bulgarian Red Cross, 1, Boul. Biruzov, *Sofia 27*.
- BURKINA FASO — Burkina Faso Red Cross, P.O.B. 340, *Ouagadougou*.
- BURMA (Socialist Republic of the Union of) — Burma Red Cross, 42, Strand Road, Red Cross Building, *Rangoon*.
- BURUNDI — Red Cross Society of Burundi, rue du Marché 3, P.O. Box 324, *Bujumbura*.
- CAMEROON — Cameroon Red Cross Society, rue Henry-Dunant, P.O.B. 631, *Yaoundé*.
- CANADA — Canadian Red Cross, 95, Wellesley Street East, *Toronto, Ontario M4Y 1H6*.
- CAPE VERDE (Republic of) — Cruz Vermelha de Cabo Verde, Rua Unidade-Guiné-Cabo Verde, P.O. Box 119, *Praia*.
- CENTRAL AFRICAN REPUBLIC — Central African Red Cross, B.P. 1428, *Bangui*.
- CHILE — Chilean Red Cross, Avenida Santa María 0150, Correo 21, Casilla 246V., *Santiago*.
- CHINA (People's Republic) — Red Cross Society of China, 53, Kanmien Hutung, *Peking*.
- COLOMBIA — Colombian Red Cross, Avenida 68, No. 66-31, Apartado Aéreo 11-10, *Bogotá D.E.*
- CONGO (People's Republic of the) — Croix-Rouge congolaise, place de la Paix, B.P. 4145, *Brazzaville*.
- COSTA RICA — Costa Rican Red Cross, Calle 14, Avenida 8, Apartado 1025, *San José*.
- CUBA — Cuban Red Cross, Calle 23, No. 201 esq., N. Vedado, *Havana*.
- CZECHOSLOVAKIA — Czechoslovak Red Cross, Thunovska 18, *118 04 Prague 1*.
- DENMARK — Danish Red Cross, Dag Hammarskjölds Allé 28, Postboks 2600, *2100 København Ø*.
- DOMINICAN REPUBLIC — Dominican Red Cross, Apartado postal 1293, *Santo Domingo*.
- ECUADOR — Ecuadorian Red Cross, Calle de la Cruz Roja y Avenida Colombia 118, *Quito*.
- EGYPT (Arab Republic of) — Egyptian Red Crescent Society, 29, El-Galaa Street, *Cairo*.
- EL SALVADOR — El Salvador Red Cross, 17 Av. Norte y 7.<sup>a</sup> Calle Poniente, Centro de Gobierno, *San Salvador*, Apartado Postal 2672.
- ETHIOPIA — Ethiopian Red Cross, Ras Desta Damtew Avenue, *Addis Ababa*.
- FIJI — Fiji Red Cross Society, 193, Rodwell Road, P.O. Box 569, *Suva*.
- FINLAND — Finnish Red Cross, Tehtaankatu, 1 A, Box 168, *00141 Helsinki 14/15*.
- FRANCE — French Red Cross, 17, rue Quentin-Bauchart, F-75384 *Paris*, CEDEX 08.
- GAMBIA — The Gambia Red Cross Society, P.O. Box 472, *Banjul*.
- GERMAN DEMOCRATIC REPUBLIC — German Red Cross in the German Democratic Republic, Kaitzerstrasse 2, DDR 801 *Dresden 1*.
- GERMANY FEDERAL REPUBLIC OF — German Red Cross in the Federal Republic of Germany, Friedrich-Ebert-Allee 71, 5300, *Bonn 1*, Postfach 1460 (D.B.R.).
- GHANA — Ghana Red Cross, National Headquarters, Ministries Annex A3, P.O. Box 835, *Accra*.
- GREECE — Hellenic Red Cross, rue Lycavittou, 1, *Athens 135*.
- GUATEMALA — Guatemalan Red Cross, 3.<sup>a</sup> Calle 8-40, Zona 1, *Ciudad de Guatemala*.
- GUYANA — Guyana Red Cross, P.O. Box 351, Eve Leary, *Georgetown*.
- HAITI — Haiti Red Cross, place des Nations Unies, B.P. 1337, *Port-au-Prince*.
- HONDURAS — Honduran Red Cross, 7.<sup>a</sup> Calle, 1<sup>a</sup> y 2.<sup>s</sup> Avenidas, *Comayagüela D.M.*
- HUNGARY — Hungarian Red Cross, V. Arany János utca, 31, *Budapest V*, Mail Add.: *1367 Budapest 5, Pf. 121*.
- ICELAND — Icelandic Red Cross, Nóatúni 21, 105 *Reykjavik*.
- INDIA — Indian Red Cross, 1, Red Cross Road, *New Delhi 110001*.
- INDONESIA — Indonesian Red Cross, Manggala Wanabakti, 9th floor, Jalan Gatot Subroto, P.O. Box 2009, *Djakarta*.
- IRAN — Iranian Red Crescent, Avenue Ostad Nejatollahi, Carrefour Ayatollah Taleghani, *Teheran*.
- IRAQ — Iraqi Red Crescent, Al-Mansour, *Baghdad*.
- IRELAND — Irish Red Cross, 16, Merrion Square, *Dublin 2*.
- ITALY — Italian Red Cross, 12, via Toscana, *Rome*.
- IVORY COAST — Ivory Coast Red Cross Society, B.P. 1244, *Abidjan*.
- JAMAICA — Jamaica Red Cross Society, 76, Arnold Road, *Kingston 5*.
- JAPAN — Japanese Red Cross, 1-3, Shiba-Daimon 1-chome, Minato-Ku, *Tokyo 105*.
- JORDAN — Jordan National Red Crescent Society, P.O. Box 10001, *Amman*.
- KENYA — Kenya Red Cross Society, St. John's Gate, P.O. Box 40712, *Nairobi*.
- KOREA (Democratic People's Republic of) — Red Cross Society of the Democratic People's Republic of Korea, *Pyongyang*.
- KOREA (Republic of) — The Republic of Korea National Red Cross, 32-3Ka, Nam San-Dong, *Seoul*.
- KUWAIT — Kuwait Red Crescent Society, P.O. Box 1359, *Kuwait*.
- LAOS (Lao People's Democratic Republic) — Lao Red Cross, P.B. 650, *Vientiane*.
- LEBANON — Lebanese Red Cross, rue Spears, *Beirut*.
- LESOTHO — Lesotho Red Cross Society, P.O. Box 366, *Maseru*.
- LIBERIA — Liberian National Red Cross, National Headquarters, 107 Lynch Street, P.O. Box 226, *Monrovia*.
- LIBYAN ARAB JAMAHIRIYA — Libyan Arab Red Crescent, P.O. Box 541, *Benghazi*.
- LIECHTENSTEIN — Liechtenstein Red Cross, *Vaduz*.
- LUXEMBOURG — Luxembourg Red Cross, Parc de la Ville, C.P. 404, *Luxembourg*.
- MALAGASY REPUBLIC — Red Cross Society of the Malagasy Republic, rue Patrice-Lumumba, *Antananarivo*.
- MALAWI — Malawi Red Cross, Hall Road, *Blantyre* (P.O. Box 30080, Chichiri, *Blantyre 3*).
- MALAYSIA — Malaysian Red Crescent Society, National HQ, No. 32 Jalan Nipah, off Jalan Ampang, *Kuala Lumpur 16-03*.
- MALI — Mali Red Cross, B.P. 280, *Bamako*.
- MAURITANIA — Mauritanian Red Crescent Society, B.P. 344, Avenue Gamal Abdel Nasser, *Nouakchott*.

- MAURITIUS — Mauritius Red Cross, Ste Thérèse Street, *Curepipe*.
- MEXICO — Mexican Red Cross, Avenida Ejército Nacional N.º 1032, *México 10 DF*.
- MONACO — Red Cross of Monaco, 27 boul. de Suisse, *Monte Carlo*.
- MONGOLIA — Red Cross Society of the Mongolian People's Republic, Central Post Office, Post Box 537, *Ulan Bator*.
- MOROCCO — Moroccan Red Crescent, B.P. 189, *Rabat*.
- NEPAL — Nepal Red Cross Society, Tahachal, P.B. 217, *Kathmandu*.
- NETHERLANDS — Netherlands Red Cross, P.O.B. 30427, 2500 *GK The Hague*.
- NEW ZEALAND — New Zealand Red Cross, Red Cross House, 14 Hill Street, *Wellington 1*. (P.O. Box 12-140, *Wellington North*.)
- NICARAGUA — Nicaragua Red Cross, D.N. Apartado 3279, *Managua*.
- NIGER — Red Cross Society of Niger, B.P. 386, *Niamey*.
- NIGERIA — Nigerian Red Cross Society, Eko Akete Close, off St. Gregory Rd., P.O. Box. 764, *Lagos*.
- NORWAY — Norwegian Red Cross, Drammensveien 20 A, *Oslo 2*. Mail add.: *Postboks 2338, Solli, Oslo 2*.
- PAKISTAN — Pakistan Red Crescent Society, National Headquarters, Sector H-8, *Islamabad*.
- PAPUA NEW GUINEA — Red Cross of Papua New Guinea, P.O. Box 6545, *Boroko*.
- PANAMA — Panamanian Red Cross, Apartado Postal 668, Zona 1, *Panamá*.
- PARAGUAY — Paraguayan Red Cross, Brasil 216, *Asunción*.
- PERU — Peruvian Red Cross, Av. Camino del Inca y Nazarenas, Urb. Las Gardenias — Surco — Apartado 1534, *Lima*.
- PHILIPPINES — Philippine National Red Cross, Bonifacio Drive, Port Area, P.O. Box 280, *Manila 2803*.
- POLAND — Polish Red Cross, Mokotowska 14, *Warsaw*.
- PORTUGAL — Portuguese Red Cross, Jardim 9 Abril, 1 a 5, *Lisbon 3*.
- QATAR — Qatar Red Crescent Society, P.O. Box 5449, *Doha*.
- ROMANIA — Red Cross of the Socialist Republic of Romania, Strada Biserica Amzei, 29, *Bucarest*.
- RWANDA — Rwanda Red Cross, B.P. 425, *Kigali*.
- SAN MARINO — San Marino Red Cross, Palais gouvernemental, *San Marino*.
- SAUDI ARABIA — Saudi Arabian Red Crescent, *Riyadh*.
- SENEGAL — Senegalese Red Cross Society, Bd Franklin-Roosevelt, P.O.B. 299, *Dakar*.
- SIERRA LEONE — Sierra Leone Red Cross Society, 6A. Liverpool Street, P.O.B. 427, *Freetown*.
- SINGAPORE — Singapore Red Cross Society, 15, Penang Lane, *Singapore 0923*.
- SOMALIA (Democratic Republic) — Somali Red Crescent Society, P.O. Box 937, *Mogadishu*.
- SOUTH AFRICA — South African Red Cross, 77, de Villiers Street, P.O.B. 8726, *Johannesburg 2000*.
- SPAIN — Spanish Red Cross, Eduardo Dato, 16, *Madrid 10*.
- SRI LANKA (Dem. Soc. Rep. of) — Sri Lanka Red Cross Society, 106, Dharmapala Mawatha, *Colombo 7*.
- SUDAN — Sudanese Red Crescent, P.O. Box 235, *Khartoum*.
- SWAZILAND — Baphalali Swaziland Red Cross Society, P.O. Box 377, *Mbabane*.
- SWEDEN — Swedish Red Cross, Box 27316, 102-54 *Stockholm*.
- SWITZERLAND — Swiss Red Cross, Rainmattstrasse 10, B.P. 2699, 3001 *Berne*.
- SYRIAN ARAB REPUBLIC — Syrian Red Crescent, Bd Mahdi Ben Barake, *Damascus*.
- TANZANIA — Tanzania Red Cross Society, Upanga Road., P.O.B. 1133, *Dar es Salaam*.
- THAILAND — Thai Red Cross Society, Paribatra Building, Chulalongkorn Memorial Hospital, *Bangkok*.
- TOGO — Togolese Red Cross Society, 51, rue Boko Soga, P.O. Box 655, *Lomé*.
- TONGA — Tonga Red Cross Society, P.O. Box 456, *Nuku'alofa*.
- TRINIDAD AND TOBAGO — Trinidad and Tobago Red Cross Society, Wrightson Road West, P.O. Box 357, *Port of Spain, Trinidad, West Indies*.
- TUNISIA — Tunisian Red Crescent, 19, rue d'Angleterre, *Tunis*.
- TURKEY — Turkish Red Crescent, Yenisehir, *Ankara*.
- UGANDA — Uganda Red Cross, Plot 49, South Street, P.O. Box 494, *Kampala*.
- UNITED KINGDOM — British Red Cross, 9, Grosvenor Crescent, *London, S.W.1X 7EJ*.
- URUGUAY — Uruguayan Red Cross, Avenida 8 de Octubre 2990, *Montevideo*.
- U.S.A. — American National Red Cross, 17th and D. Streets, N.W., *Washington, D.C. 20006*.
- U.S.S.R. — Alliance of Red Cross and Red Crescent Societies, I. Tcheremushkinskii proezd 5, *Moscow, 117036*.
- VENEZUELA — Venezuelan Red Cross, Avenida Andrés Bello, N.º 4, Apartado 3185, *Caracas*.
- VIET NAM (Socialist Republic of) — Red Cross of Viet Nam, 68, rue Bà-Triêu, *Hanoi*.
- WESTERN SAMOA — The Western Samoa Red Cross Society, P.O. Box 1616, *Apia*.
- YEMEN (Arab Republic) — Yemen Red Crescent Society, P.O. Box 1257, *Sana'a*.
- YEMEN (People's Democratic Republic) — The Yemen Red Crescent Society, P.O. Box 455, *Aden*.
- YUGOSLAVIA — Red Cross of Yugoslavia, Simina ulica broj 19, 11000 *Belgrade*.
- ZAIRE — Red Cross of the Republic of Zaire, 41, av. de la Justice, B.P. 1712, *Kinshasa*.
- ZAMBIA — Zambia Red Cross, P.O. Box 50 001, 2837 Brentwood Drive, *Lusaka*.
- ZIMBABWE — The Zimbabwe Red Cross Society, P.O. Box 1406, *Harare*.