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THE ICRC AND TRADITIONAL KHMER MEDICINE

by J. P. Hiegel

In October and November 1979 many Khmers fled from their villages and sought refuge in camps in Thailand or along the Khmer-Thai border. The ICRC and other humanitarian organizations, international or private, had to provide for the needs of a sudden influx of people uprooted from their homes, exhausted by famine, suffering, fear, sickness and the ravages of war. The first priorities in such a situation are to supply the basic hygienic facilities, adequate food, water and shelter of some sort, all indispensable for survival. But disease and death are an ever-present threat and have to be resisted. This, then, was the task of the medical teams sent out by the ICRC and the National Societies of the Red Cross, and of many other groups belonging to other organizations who came to help the refugees. An overall coordination of the medical aid was indispensable; responsibility for this was assumed by the ICRC.

The Khmers and sickness

A difficult problem was raised among the refugees by a number of people suffering from mental disorders. They were rejected by the Khmer population, whose own lives were so fraught with problems on every side that they did not tolerate the "misfits" among them. Their admission to hospitals hindered the medical teams in their work and disturbed the other patients. Some doctors considered setting up a psychiatric service in the Sakaeo camp, and the chief medical coordinator, for whom I was acting as deputy in Bangkok, had to decide on their suggestion.

My training as a psychiatrist and a previous ethnological interest in traditional medicine led me to make another proposal. I felt that people suffering from mental disorders should not be segregated from the Khmer community in the camp by isolating them in a special annexe, and that rather than using Western therapeutical methods with the potential

long-term danger of making them dependent on foreign medical aid, it would be better to call in the traditional healers, themselves refugees in the same camps, and entrust the care of such patients to them. In short, I suggested that a programme of collaboration between Western medicine and traditional medicine should be launched and developed.

Psychosis is a mental disorder and insanity is the visible manifestation of this disorder. Insanity is a form of disturbed relationship between the person concerned, the world and the other people he encounters. There is a merging of psychosis and insanity everywhere and at every time. Every society has had to find its own solutions to deal with the insanity of some of its members, and these solutions differ from one culture to another.

The insanity of some Cambodians in the camps was merely the most obvious aspect of a psychological disturbance which was in fact far more widespread than it appeared. Many of the Khmers suffered morally, without being genuinely or seriously mental patients, but the way in which they expressed their suffering was sometimes disconcerting for Westerners. Some refugees with a painful organic complaint attributed their affliction to supernatural causes, and believed themselves "possessed." Others living in stressful situations had no severe psychotic troubles, but also believed that they were possessed. A Khmer possessed has a certain type of behaviour and attitudes which may appear pathological in the light of Western psychiatric nosology. For this reason some Khmers were "schizophrenic" or suffering from "delusions" from the point of view of Western doctors, whereas in fact they were not.

How collaboration with the traditional healers began

So the ICRC's first concern was to alleviate the refugees' psychological distress and respond to the problem of mental disorder in a manner compatible with the ethnological background. It was also important not to transpose the standard formula of the psychiatric clinic to the Khmer refugee camps simply because it is so sadly familiar to the Western world.

The patients could in fact benefit by the skills of the traditional healers not only in treatment of mental ailments but also in physical medicine, for traditional Khmer therapy has its own definite logic and efficacy.

The ICRC also considered that since humanitarian aid, whilst only of limited duration, may well have long-lasting consequences it was important not to create an exclusive dependence on modern medicines.

Many of the refugees hoped to return to their own country one day, and patients there very often have to rely on traditional medicine because "the other medicine", i.e. Western medicine, is not easily accessible to the majority of the population. Furthermore the Khmers trust their own traditional medicine.

Wider co-operation with the traditional healers was likewise justified by the attitude of a substantial number of Khmers with regard to modern medicine, as shown by the following example. There was a little girl with measles in a camp where a centre of traditional medicine had not yet been established. Measles is generally a benign infection, but it can occasionally have fatal complications. Her mother did not take her to hospital. She did try to treat her, and went around the other refugees in the camp begging for the few medicaments they had, but the child died. The mother felt that her daughter was in danger, but as a Khmer woman she was even more afraid of exposing her child to the eyes of Western nurses, for according to Cambodian popular beliefs the sight of a woman during her menstrual period can endanger the life of a child with measles. In this particular case it was not scientific truth that counted, but the truth as seen by this mother. Deeply rooted beliefs such as this can be indirectly responsible for the death of people belonging to a different culture, if they are not recognized and taken into account.

This actual instance showed that there must be a place in the Khmer refugee camps where their own traditions, customs and beliefs would be respected. It is conceivable that the mother would have taken her little daughter to a traditional medicine centre if one had been available, and that we could then have arranged for the necessary treatment at home by a male doctor and nurse after being informed of the problem. The traditional healers working in collaboration with the ICRC have often persuaded a patient to accept an indispensable modern surgical intervention or form of treatment which they had previously categorically rejected.

Once the principle of co-operation between traditional healers and the ICRC was accepted, traditional medical centres were opened in four refugee camps. They in turn had to be kept supplied with the traditional Khmer pharmaceutical products, which meant that a special dispensary had to be established. In order to do so we selected about 250 substances, derived from plants and other sources, which are used to prepare traditional medicaments in Cambodia and in Thailand.

The traditional medicine centres now have an acknowledged part to play in the camps and the traditional healers are popular among the

Western helpers. Co-operation with the *krou* Khmers and its potential benefits did not get off to a flying start, however; many doctors and nurses condemned it without trial. Had it not been for the support, the caution and authority of the ICRC, the inception and development of this experiment would never have been possible. Its success—and indeed its very origin—is due to the personal qualities, the motivation and courage of those who have participated from the start. Most of the Westerners subsequently overcame their resistance to the idea, for traditional medicine was practised in the centres in broad daylight, and they could see for themselves what it was. The absence of accidents, despite the great number of patients treated every day, also helped it to be accepted. In addition the traditional healers themselves made a distinctly favourable impression upon the Westerners who came in contact with them.

The traditional Khmer healers

In the Cambodian language the term *krou*, which is a phonetic adaptation of the Sanskrit word *guru*, is a general designation for any person who is endowed with a form of knowledge. Thus the traditional Khmer healers are called *krou*. The term does not imply their healing capacity, but shows that the person thus referred to possesses some form of knowledge, and it simultaneously carries an inference of respect. An adjective can be added to the original term *krou*, qualifying his special kind of knowledge.

Thus the *krou thnam* treats his patients using medicaments prepared by mixing various products, mostly derived from plants. Each *krou thnam* is specialized in the treatment of a particular complaint. The *krou bângbât* determines the cause of the complaint and gives treatment by meditation. For talismans and tattooing which offer protection from dangers of natural or supernatural origin the *krou lbien* is consulted. The *krou thmop* specializes in magical therapy; his intervention is required when someone is a victim of black magic or the suffering is caused by an offended spirit. The *krou snê* is an expert at making magic charms. A lover would call on his services, for instance, to obtain the affection of his beloved.

A *krou* acquires his knowledge from a master who transmits his learning and ethics to him. This master can be either an esteemed traditional healer in the village, or a monk, for the pagodas are also places of instruction.

The traditional medicine centres in the camps

In each traditional medicine centre there are about fifty Khmers, traditional healers, assistants, secretaries, interpreters, all refugees, working as one group. This is a new situation for the *krou*, accustomed as they are to practising as individuals. They have agreed not to guard their knowledge jealously for themselves, but to pool it. The group within the centres has a hierarchical structure patterned on traditional Khmer society. The assistants form the basis of the pyramid. They are responsible for keeping the building in order, tending the garden where they grow a few medicinal plants, preparing the plants brought to the centre for use by chopping them coarsely or finely according to custom, or grinding them into powder in a mortar, and looking after the fires on which the mixtures are prepared. Some assistants are simultaneously learning the art of traditional medicine.

The *krou* in the centres are divided into several sub-groups corresponding with the various therapeutical methods applied: medicaments, pulverisation, rubefaction, massage, etc. Each sub-group is headed by one person, chosen by his peers from among the *krou* most experienced in that particular domain and responsible for supervising and checking the work of those with less experience. At the top of the hierarchy there is a chief appointed by the members of the group.

Consultations are given by three or four experienced *krou*. After being registered by the secretaries, the patient speaks to the consultant of his choice, but the others are seated nearby and intervene if there is any doubt as to the nature or gravity of his complaint. The consultant enters the name of the prescribed medicine in the patient's file, and indicates one or several other forms of therapy if he feels they are required. The patient then goes to the different specialists to receive the appropriate treatment.

It must be noted that these patients are not first examined by a Western doctor or nurse. This is justified. Traditional treatment and Western medical treatment are given in separate places. A patient who goes to a centre of traditional medicine is expressing a very clear desire to see a *krou* and not a Western doctor. We have to respect his desire, for his refugee status does not give us any rights over him. He remains free to choose and responsible for his choice.

Collaboration between Western doctors and *Krou* Khmers

The Western nurses or doctors do not make a systematic examination of patients after they have consulted the *krou*, for this would demonstrate a lack of confidence in them, and mutual confidence and trust is essential

for the patient's sense of security. The experienced *krou* are equally aware of their possibilities and their limitations. They do not hesitate to ask for our opinion when they feel there is a risk involved in the case they are treating. Sometimes they themselves decide that the patient should be sent to hospital. Occasionally a case is discussed. It may well happen that we then decide to try out a traditional form of treatment, under supervision.

Decisions are always taken together with the patient's traditional doctor. This does not present any problems. The *krou* know that we trust them and want to prove that this trust is merited. They do not take any risks on their own, and they do not make their patients take any either. Thus the patient's safety and sense of security depends on the acknowledgement and acceptance of shared responsibility. It is interesting to note that ethically and by tradition the *krou* feel morally obliged to care for anyone who consults them. Yet in the camps they do occasionally refuse to treat a patient, and have sometimes even succeeded in persuading such patients to accept modern therapy. This link between the two medical systems can also act in reverse, for the hospital admissions service often sends patients to the *krou*. The *krou* themselves are sometimes called in for consultation at the hospital when a patient shows signs of psychological disturbance, or when he refuses to enter hospital or receive modern treatment.

This collaboration between traditional and Western medicine is a new and original experience, both for the ICRC and its medical teams and for the traditional healers. There are now nearly 200 of them, including their assistants, working in the four ICRC centres. It did not go without saying from the beginning that they would agree to participate, particularly since we were extremely demanding with regard to the quality of the co-operation itself. For that matter the high standards set applied equally to the Khmers and to the members of the ICRC working in the centres.

The traditional medicine centres are very dynamic. Our co-operation is motivated by psychological, sociological and ethnological considerations. We shall try to define some of these considerations.

From the very start we tried to understand and respect the spirit of traditional medicine as far as possible. We had to allow for the Khmer mentality, for their way of life and rhythm of work. An ethnocentric approach would have been pointless, for these centres could not possibly be organized on Western lines. On the other hand we were not working as ethnologists, for our duties were not confined to observing and studying traditional Khmer medicine. The purpose we had set ourselves was to build up genuine co-operation. For this certain prerequisite conditions

had to be recognized and accepted, namely that the two medical systems are complementary and not competitive. Any attempt to prove that one is superior to the other would be vain and not without danger for the patients. The culture, training, knowledge and techniques of the Western practitioners and the traditional practitioners are different, but all have the same purpose, namely to alleviate human suffering. To achieve this aim it is enough to choose by common agreement the best means of doing so. It would be a denial of these basic conditions for co-operation to have the *krou* constantly supervised by Western doctors.

A *krou* is traditionally respected in his own country. He is respected by the refugees as well. It goes without saying that genuine co-operation serving a real purpose could only be based on a relationship of mutual esteem, trust, respect and understanding. A relationship of this kind is natural and spontaneous when there is more than a purely intellectual acceptance of the prerequisite conditions and attitudes described above.

The traditional healers were uneasy in the beginning and hesitant to join in the project. They realized that there were certain risks involved in practising their medicine in broad daylight among the many Western doctors and nurses present in the camps. We told them that we were convinced of the value of their medicine, that Westerners in general were not familiar with it and would judge by what they saw. It was therefore important for all the *krou* to uphold the reputation of traditional Khmer medicine, their own reputation and that of the centres. They willingly accepted this idea. In the meantime their anxieties have been dispelled, but the idea of a mission to fulfil remains. It was thus easy to justify the limits we set without the *krou* feeling these limits as a lack of confidence in them. They saw that our concern was not only for the patients, but for them as well. These limits were readily acceptable, because they were reassuring for the *krou* themselves.

A genuine *krou* does not ask his patient for payment. The patient himself offers something in accordance with his means, as a token of confidence or gratitude. In the camps the majority of refugees have no means of following this tradition. So the ICRC does so on behalf of all the patients, making a weekly offering to all the Khmers working in the camps. The amount offered is intentionally very small, which largely helps to preserve the ideal inherent in the services of the *krou*. We felt that it was useful for the Khmers working in the camps to have an ideal, for refugees are people who are dependent, receiving aid, and are therefore in a humiliating and demoralising situation. In the centres they feel that they are working to help other refugees, to preserve part of their cultural heritage and safeguard the good reputation of their medicine.

Therein lies their commitment to co-operation with the ICRC. Experience has shown that they are very sensitive to this aspect, for it gives them a means of affirming their personal merits, which in turn helps them to endure their situation. An ideal can easily be lost. The personal qualities of the ICRC members present in the centres, their attitude and motivation play a very important part in sustaining this ideal, or restoring it when it is gradually fading.

Khmer therapy

Traditional Khmer medicine is very elaborate and complex, and we can only give an outline of it here. Some of the methods used by the *krou* may seem strange, but there was no reason to reject them outright. We had to judge whether they were acceptable in a refugee camp and in co-operation with a humanitarian organization. The *krou* tell us about each new therapy they consider using, and provide us with all the information we desire. We then evaluate the situation from two points of view before agreeing or refusing, namely the patients' safety and medical ethics. We may then set certain limitations, but always take care to justify them. After a period of observation these limitations can often be relaxed, but some always remain, because certain patients are more inclined to accept Western medicine. We have to avoid identifying ourselves too fully with traditional healers, so that we can keep the distance needed to preserve our own capacity of judgement.

We can distinguish between five forms of treatment: medication, therapeutical burning, rubefaction, massage and treatment by magic.

The traditional stock of drugs consists of a wide variety of products, mostly of vegetable origin. The medicinal properties are found in certain specific parts of trees or plants, such as the roots, bulbs, rhizomes, the bark, leaves, flowers, fruit, branches or trunk. Some constituents are of animal origin, such as bones from elephants or horses. Minerals such as sulphur or alum are also used.

The centres obtain their supplies from four sources. The *krou* can gather the plants they need in the forests around the camps; some species are cultivated in nearby gardens; certain fresh components are bought at local markets; the remainder is provided from the traditional pharmaceutical stocks of the ICRC, which can have products brought from further away if necessary.

Treatment consists of a variable number of elements. Decoctions are prepared by boiling a substance in water until the liquid is reduced by two thirds. Each patient drinks three to four litres per day of these infusions throughout the whole course of treatment. Certain medicines

are presented in dry form. Powders are taken stirred into a glass of 30° rice alcohol or water. Pills or tablets can be obtained by blending powders with honey or palm sugar. The *doh thmâ* technique is very special: the solid constituents of the medicine are rubbed against a moist stone, producing a very fine blend when a small amount of liquid is added. The *thnam sdâh* is another medicine with a very special form of application. The *krou* chews one or two vegetable substances such as betel leaf or arek nut and sprays the juice on the lesion requiring treatment, for example in the case of some skin diseases. The other medicines for external use are in the form of liquid blends, ointments or pastes. To treat infections of the nose and throat, the traditional healers prescribe "dry inhalations" in certain cases: the substances smouldering slowly in a long bamboo pipe give off smoke which is breathed in by the patient. "Moist inhalations" are also used: the patient then breathes in the vapour from a mixture previously brought to the boil.

There is not sufficient space here to examine the diagnostic methods of the *krou*, their ideas concerning the causes of illness, the affections they identify, the theoretical basis for their medical concepts, etc. Traditional Khmer medicine is coherently elaborated. In some cases its logic is immediately perceptible for a modern doctor. For example, the *krou* distinguish between three kinds of haemorrhoids, namely an internal haemorrhoid combined or not with a small external haemorrhoid; an external haemorrhoid localised on one varicose vein; and a haemorrhoid affecting several veins and producing varices of a greater or lesser extent. They treat them according to type by local applications of ointment (there are several kinds with different effects), by cauterization or by hip-baths. In every case a decoction is prescribed, to be taken once the haemorrhoid has disappeared.

Therapeutic burns are performed by using a small cigar of vegetable fibres or a small piece of glowing bark of a tree. Sometimes the burn is made by a small pellet lit on the skin. The *krou* do not apply any septic products upon these burns, which are superficial except in certain very specific cases where the burn is slightly deeper. In India and Nepal, in contrast, cases of tetanus have been observed following this therapy, due to the application of cattle dung on the burn. This the Khmers do not do. This therapeutic burning was very widely practised in the camps at the patient's home, before the traditional medicine centres were established. It was better to accept it openly and be able to keep it under supervision, rather than reject it and have it practised in secret.

Insofar as this form of treatment as practised by the *krou* does not present any real danger, we have tried to make the Western doctors

understand that they should accept it. They might very well find it disputable, but they should not oppose it in the camps, for it is very deeply rooted in the Khmer customs and culture. The medical teams were often shocked and scandalized when they arrived in the camps and saw the resultant scars of this treatment. Yet their attitude was an even greater potential danger than the burn itself, for it gave the patient a sense of rejection and guilt. Mild colic attacks, for instance, are one of the symptoms for which this treatment is applied. But colic can have various causes and may, for example, indicate an abdominal syndrome calling for an operation. It would be dangerous for a patient or his family or friends to delay in consulting the Western doctors if his condition deteriorates, simply because he has first tried this traditional treatment and fears their reaction.

Rubefaction is another therapeutical method. A temporary congestion of the skin is caused by pinching or rubbing with a coin dipped in paraffin or camphorated ointment. A variation of this therapy consists of repeatedly pinching the skin at the same places, concentrating on the thorax, the back, the neck and the front of the arms. It is indicated when the patient complains of feeling generally unwell, with a dull ache all over, difficulty in breathing, raised temperature, in other words all the symptoms of influenza. It can be compared with the cupping glasses still used in some European countries, though not as widely as in the past.

Traditional Khmer massage is centred on the veins and not the muscles, because the Cambodians regard the veins as the source of the pain. The massage is very strong, following the course of the superficial and deeper veins in the arms and legs, between the ribs and in the abdomen. For headaches the massage is concentrated on the temporal and frontal veins. This has a very clear effect in an incipient migraine attack and stops the pain. Treatment by massage is habitually combined with stretching or manipulating the joints.

Magic also has therapeutic effects for the Khmers. For them the world is populated with myriad spirits. Not all of them are systematically hostile—so the Cambodian do not have to live in a permanent persecution climate—but they can cause suffering if they are offended.

When a child is born with a prolapsed cord—with the umbilical cord encircling the body or the neck, its *krou kâmneut* is offended. A special offering must be made to this spirit, which inhabits the child even before its birth. The child will suffer from headaches or be *chkuot*, which means deranged, if this precaution is not taken. Several children have been taken to traditional medicine centres by parents sometimes on the verge of abandoning them because of the gravity of their behavioural disturbances.

They were unstable and aggressive, or morose and depressive. When this condition can be attributed to the offended *krou kâmneut*, the traditional healer makes a *sla thor*. He uses the upper stem of a young banana tree, candles and incense sticks, and then wraps several loops of white thread around it all. This offering is an evident symbol of the child's body and the umbilical cord, and always has a lasting and spectacular effect upon the child. It is easy to understand how it works. The family, influenced by a very strong sense of cultural determinism, expected the child to be deranged because the appropriate offering was not made, whatever the reason for this omission. Such cases have occurred frequently in Cambodia in recent years, due to the authorities' attitude towards religious and magic rites. A child tends to behave as the family expects it to behave. So such children acted as though they were deranged, although they were not in fact suffering from any serious psychotic disturbance. After the *sla thor* was made, the cultural determinism had the reverse effect—the children were expected to recover normal health, they were no longer compelled to play a part, and could be themselves.

A Western doctor might be inclined to ascribe the child's problems to cerebral damage caused by foetal anoxia. It may be tempting to believe that the brain was harmed by a lack of oxygen during delivery because of the umbilical cord constricting the infant's neck, particularly if resuscitation was necessary after birth. Such an organological approach would result in several sedatives being prescribed, but would not really come to grips with the problem.

A forbidden desire can give rise to a conflict situation with all its associated psychological suffering. Some Khmer attribute the origin of such a desire to black magic. Magical treatment enables people thus afflicted to speak about the conflict within them, for it is generally accepted that the spirit inhabiting them speaks through their mouth. The patient himself feels that the desire is wrong, but the belief in magic reduces or prevents the development of a guilt complex, for since the patient has been magically induced by someone unknown to experience this desire, he is not responsible himself, but is on the contrary the victim of outside force. Some Western doctors have made psychiatric diagnoses such as hysterical neurosis or psychosis after observing the behaviour and speech of people thus possessed. Yet this belief in possession serves to express and solve certain situations of psychological conflict for people whom the Khmer do not regard as *chkuot*. The Khmer themselves can easily distinguish between people who are possessed and those who really are deranged.

* * *

To sum up, the traditional medicine centres established by the ICRC in the Khmer refugee camps have satisfied a definite need, clearly confirmed by the number of patients who consult them each day. In addition, the experiment has given food for thought to many doctors and nurses, who have thus acquired a greater understanding of the part played by certain cultural phenomena in pathological symptomatology. The ICRC's official recognition of the value of co-operation with the *krou* has furthermore shown the importance accorded to respect of the culture, customs and traditional heritage of those in need of humanitarian aid.

Dr J. P. Hiegel

*Psychiatrist, psychoanalyst
Co-ordinator of traditional Khmer
medicine for ICRC in Thailand*

Red Cross assistance and protection ¹

by Jacques Moreillon

1. Introduction

Assistance is the essence of all Red Cross actions; protection and assistance are the essence of all ICRC actions.

To approach the subject of this paper “Red Cross assistance and protection”, one should recall a few basic rules and concepts as guidelines in this study.

Firstly it should be clear that we shall not deal here with situations of natural disasters, which normally require Red Cross assistance only. Nor shall we deal with situations of internal disturbances or tensions, which involve mainly the ICRC and its activities in favour of persons detained for political or security reasons.

We shall therefore address ourselves only to situations of armed conflicts—whether international or not—and of their direct results, including refugees.

Secondly we should determine the categories of persons who, in these situations, call for Red Cross assistance and protection: to use one word for all of them, one could say that they are “the helpless”. Indeed, whether prisoners of war, civilian internees or refugees, whether wounded, women, children or aged, their common denominator is helplessness. Helpless in the hands of the enemy or helpless in the face of sudden adversity and on foreign soil, they need the assistance and the protection of the Red Cross, whether to survive or simply to keep their human dignity.

¹ Introductory speech read at the Second Asian Regional Conference of the Red Cross, Djakarta, 4-11 February 1981.

2. The relation between protection and assistance in armed conflicts

It seems proper that notions of both protection and assistance should be discussed simultaneously, as they are linked in a number of ways, especially in armed conflicts and similar situations. In such situations, assistance activities often assume the character of protection operations and *vice versa*, to such an extent that they become inseparable. That is one reason why the International Red Cross, in article 6 of its Statutes, entrusted the ICRC with the final responsibility for carrying out the humanitarian work of the Red Cross in the event of armed conflicts.

The idea of entrusting both functions to a single body has its source and justification in past experience; to protect an adversary in captivity or in occupied territory is not the same as to bring relief to needy inhabitants in their own country. Admittedly, a humanitarian body will not refuse to distribute relief supplies even if it is not allowed to protect the helpless but, in the event of armed conflicts, the co-operation of the authorities will vary in matters both of assistance and of protection; under such circumstances it is necessary, if unity in humanitarian action is to be maintained, that a single body should have an overall view, and have final responsibility for the conduct of these operations by the Red Cross movement.

Thus, basically, protection and assistance cannot be separated in situations of conflict, even though it may be possible, in the interest of clarity, to consider them separately, as we shall do in this paper.

3. Protection

Definition

Neither the Geneva Conventions nor the International Red Cross Statutes contain a definition of “protection”, undoubtedly because it is a concept that is easily understood. Yet if a definition were required one might say that, in Red Cross action, “to protect” implies preserving the helpless victims of conflicts who are either in the hands of an adverse authority or, as refugees, totally dependent on the will of a host country, not party to the conflict, from the dangers, sufferings and abuses of power to which they may be exposed; it also implies defending them and giving them support. In a broader sense, one can say that “protection” also includes developing, publicising and ensuring application of and respect for international humanitarian law.

Basically, the action of protection is linked with the ICRC’s role as a neutral intermediary entrusted to it by the Geneva Conventions, the

Statutes of the International Red Cross and the resolutions of International Red Cross Conferences; in practice it has frequently been exercised in situations beyond the scope of the Conventions.

Neutrality is a fundamental principle which is binding on all Red Cross components, not only on the ICRC. However, the multinational structure of the League and the fact that the National Societies are auxiliaries to the public authorities make it more difficult for any of them to act as a neutral intermediary than it is for the ICRC, which is uni-national and whose members are co-opted. This view is supported in the Geneva Conventions which refer nearly forty times to assistance and protection activities to be entrusted to the ICRC (whether named specifically or not), in its capacity as an impartial humanitarian body.

Impartiality, like neutrality, is not the prerogative of the ICRC; it is an obligation both for National Societies and for the League. However, the States, in the Geneva Conventions, chose to assign to the ICRC the task of protecting and assisting, without discrimination and in proportion to their needs, the helpless victims of armed conflicts.

Participation of National Societies in the function of protection

National Societies are in fact associated by the ICRC in the function of protection wherever circumstances permit.

In cases of armed conflicts and similar situations, National Societies are of course generally engaged in assistance tasks, but they can also play a useful part in protection. They can do so all the more effectively if the manner in which they exercise their responsibilities is clearly defined with their respective governments and in harmony with the role of the ICRC.

The National Society of a country stricken by armed conflict or some similar situation can play its part in various ways, namely by:

- (a) having its government ensure that the Geneva Conventions are fully respected and implemented;
- (b) making its government aware of the paramount importance of protection by the ICRC;
- (c) organizing assistance operations;
- (d) making occasional visits to detainees pending ICRC visits and in close liaison with the ICRC.

The National Societies of countries not involved in a conflict may:

- (a) participate in assistance action;

(b) undertake protection tasks when asked to do so by the ICRC or by all parties to a conflict.

All National Societies can and should co-operate in preparations for protection, especially through the dissemination of knowledge of humanitarian law, and the ICRC should arouse their interest in such activity and co-ordinate their operations.

Role of the League of Red Cross Societies

The League should obviously take an active part in protection in the wide sense which we mentioned before. Article 5, para 1 (j) of the League's new Constitution says that one of its functions is "to assist the ICRC in the promotion and development of international humanitarian law, and collaborate with it in the dissemination of this law and of the Fundamental Principles of the Red Cross among the National Societies."

This article indubitably constitutes a further step forward in ICRC-League co-operation, a co-operation which has been intense in the past years.

Moreover, article 5, para 1 (i), of the League's new Constitution enjoins the League "to bring help to victims of armed conflicts within the framework of the agreed functions of the League as a member of the International Red Cross and in accordance with the agreements concluded with the ICRC."

This article confirms article 2 (Red Cross action in the event of conflict) of section I (Relief actions of National Societies for the civilian population) of the ICRC-League Agreement of 25 April 1969, while leaving the door open for other similar future agreements.

The mention of this agreement brings us to the question of assistance strictly speaking, especially for refugees.

4. Assistance

In case of an armed conflict

The 1969 ICRC-League Agreement provides that where the civilian population stricken by an international conflict is in its own national territory, and particularly where displaced persons are involved, the ICRC assumes general leadership of international action on behalf of the Red Cross as a whole.

As we have seen above, this is necessary because of the close links between protection and assistance in the event of a conflict and in order

to reach all victims, including those who would otherwise be left without help. This also holds good where action is to be for the benefit of the civilian victims of a domestic conflict. In both cases it is necessary to protect certain categories of the population from discrimination.

The League of course maintains full relations with National Societies of countries involved in a conflict. It might even, at times, intensify its contact with them consistent with articles 4 and 5 of the 1969 Agreement.

In favour of refugees

To ensure protection in countries at war, the ICRC may have to co-ordinate all operations, including those relating to civilians who have taken refuge in a third country, sometimes even when the intervention of a neutral intermediary is theoretically not or no longer necessary. Sometimes, as in cases where frontiers are easily crossed or where neighbouring countries may exert considerable influence, an overall approach by a single institution on both sides of the border is indispensable if the unity of Red Cross action is to be maintained. This has, for instance, been the case on the border between Thailand and Kampuchea.

However, there are many situations where this comprehensive aspect of the situation does not have to be taken into account or is non-existent and where it is quite naturally the League which co-ordinates the action of National Societies for the benefit of refugees. Such has been the case, for instance, with refugees in Malaysia.

There can be no hard and fast rule settling beforehand whether it is the League or the ICRC which co-ordinates Red Cross efforts for refugees. This can only be established on a case by case basis, through dialogue between the Geneva institutions. The co-ordinating body provided for in the ICRC-League Agreement is precisely there to make these discussions easier, and what matters is much more the human quality of that dialogue than the legal quality of written agreements.

Protection in a broad sense

As we have indicated before, protection in a broad sense includes the development of international humanitarian law and the dissemination of knowledge of that law.

There are two points regarding protection in its broad sense that are of particular concern to the ICRC and to the Red Cross movement at the moment, namely promoting ratification by the governments of the 1977 Protocols and defining the ICRC attitude towards allegations of violations of international humanitarian law. Because of lack of space,

these two important matters are simply mentioned here, but the reader will no doubt grasp the paramount significance of having the 1977 Protocols, which are the latest development in international humanitarian law, ratified by as many States as the Geneva Conventions; on the second point, the attitude the ICRC should adopt in case of alleged violations of international humanitarian law, an article was published in the *International Review of the Red Cross* (March-April 1981), to which the reader may refer.

Jacques Moreillon

*Director of the Department
of Principles and Law in the ICRC*

INTERNATIONAL COMMITTEE OF THE RED CROSS

Declaration of succession of Saint Lucia to the Geneva Conventions

On 18 September 1981, the Swiss Government received from Saint Lucia the instrument containing its declaration of succession to the four Geneva Conventions of 12 August 1949 for the protection of war victims, pursuant to the previous ratification of those Conventions by the United Kingdom of Great Britain and Northern Ireland.

The declaration of succession entered into force retroactively to 22 February 1979 the date when Saint Lucia became independent.

Saint Lucia is the 150th State to become a party to the Geneva Conventions.

Declaration of succession of the Commonwealth of Dominica to the Geneva Conventions

On 28 September 1981, the Swiss Government received from the Commonwealth of Dominica the instrument containing its declaration of succession to the four Geneva Conventions of 12 August 1949 for the protection of war victims, pursuant to the previous ratification of those Conventions by the United Kingdom of Great Britain and Northern Ireland.

The declaration of succession entered into force retroactively on 3 November 1978, when the Commonwealth of Dominica became independent. It is the 151st State to become a party to the Geneva Conventions.

Austrian President visits ICRC

While in Switzerland, the President of the Republic of Austria, Mr. Rudolf Kirchschläger, visited the headquarters of the International Committee of the Red Cross in Geneva on 9 September 1981. As guest of the Swiss Federal Council during his State visit, Mr. Kirchschläger, was accompanied by Mr. Kurt Furgler, President of the Swiss Confederation and Mr. Georges-André Chevallaz, Federal Councillor, as well as the Austrian Minister of Foreign Affairs and the Minister of External Commerce.

On their arrival at ICRC headquarters, Mr. Kirchschläger and his entourage were welcomed by ICRC President, Mr. Alexandre Hay, who introduced to them members of the Committee and of the ICRC directorate and representatives of the League of Red Cross Societies, the Swiss Red Cross and its Geneva branch, and the Henry Dunant Institute.



ICRC President visits the United States

The President of the ICRC, Mr. Alexandre Hay, visited Washington from September 13 to 17 for talks with senior representatives of the United States administration. It was his first official visit to the United States. Mr. Hay was accompanied by Mr. J.-P. Hocké, director of the department of Operations in ICRC, Mr. A. Modoux, head of the division Press and Information, Mr. M. Veuthey, head of the division for International Organisations.

Mr. Hay met the American Vice-President, Mr. George Bush, Mr. Alexander Haig, Secretary of State, and the US ambassador to the United Nations, Mrs. Jeane Kirkpatrick, as well as government officials, members of the Senate and of the House of Representatives.

While in Washington Mr. Hay also met senior members of the American Red Cross, including its President, Mr. G. M. Elsey, and its Chairman, Dr. J.H. Holland.

The ICRC President's discussions centred on three main points: the need for increased and sustained financial support for ICRC activities in the world, the spread of violence which constitutes a problem of growing concern, and the ICRC's wish for the United States to ratify the 1977 Protocols.

Inauguration of the International Red Cross Audio-Visual Centre

The International Red Cross Audio-Visual Centre in Geneva was officially inaugurated on 30 September.

A joint creation of the International Committee of the Red Cross and of the League of Red Cross Societies, the Centre produces and distributes a full range of audio-visual material on the history and activities of the Red Cross. Its services are available to all National Red Cross and Red Crescent Societies, the media and the general public.

The opening of the Centre, located in the building of the League of Red Cross Societies, is an important step in the co-operation between the two international organizations which for the first time undertake the joint administration of a permanent service.

Twenty-eighth award of the Florence Nightingale Medal

GENEVA, 12 MAY 1981

Circular No. 517

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

LADIES AND GENTLEMEN,

In its Circular No. 516 of 25 August 1980, the International Committee of the Red Cross had the honour to invite the Central Committees of National Societies to send in the names of nurses and voluntary aids whom they judged qualified to receive the Florence Nightingale Medal. This invitation, which quoted Article 1 of the Regulations, was accompanied by application forms to be completed by National Societies.

The chief object of this Medal is to honour nurses and voluntary aids who have distinguished themselves exceptionally by their devotion to sick or wounded in the difficult and perilous situations which often prevail in times of war or public disaster. The Regulations also provide

that not more than thirty-six medals shall be awarded every two years and that the candidates' names must reach the International Committee of the Red Cross *before 1 March* of the year in which the award is to take place.

In accordance with these Regulations, the International Committee, after a careful study of the forty-nine candidatures submitted by twenty-five National Societies, has the pleasure of announcing that for the twenty-eighth 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.

AUSTRALIA

1. *Sister Bridget Agatha Johnson*, Graduate Nurse and Voluntary Aid. Honorary Nursing and First Aid Adviser to the Australian Red Cross Society. Director of Training, Tasmanian Division. Executive Member of the Divisional Council, Tasmania.

CANADA

2. *Dr. Helen Kathleen Mussallem*, Graduate Nurse. Executive Director, Canadian Nurses Association. Retired.
3. *Miss Ethel L. M. Thorpe*, Graduate Nurse. Registered Nurse, St. Norbert Nursing Home, Fort Garry (Manitoba).

CHILE

4. *Sra. Beatriz F. L. de Fernández*, enfermera voluntaria de la Cruz Roja Chilena. Consejera del Comité Central de la Cruz Roja Chilena, de la Junta Ejecutiva e Inspector General de la Cruz Roja Chilena.

KOREA (REPUBLIC OF)

5. *Mrs. Sung-ok Lee*, Graduate Nurse. Director, Nursing Service of the Korea Hospital, Seoul.

CUBA

6. *Enfermera Idolidia Torres Jauma*, enfermera graduada. Jefa de enfermeras de la provincia de La Habana.

7. *Enfermera Elba Marro Cabrera*, enfermera diplomada. Graduada como enfermera general el año 1964. Certificado de auxiliar voluntaria de la Cruz Roja desde el año 1963. Asesora del Departamento de Enfermería en la provincia de Camagüey.
8. *Enfermera Gladys M. Roig Jiménez*, enfermera diplomada. Diploma de auxiliar de enfermería en 1961. Diploma de enfermera general en 1969. Certificado de sanitaria, auxiliar voluntaria de la Cruz Roja en 1960. Jefa de enfermería de un Policlínico Integral en la ciudad de Manzanillo, provincia de Granma.
9. *Sanitaria María Álvarez Napolez*, auxiliar voluntaria. Certificado de auxiliar voluntaria (sanitaria) en 1961. Jefa del Departamento de Medicamentos en la Cruz Roja de La Habana.

U.S.A.

10. *Dr. Ruth B. Freeman*, Registered Nurse. Doctorate of Education. Enrolled American Red Cross Nurse for Voluntary Aid. Consultant.

FINLAND

11. *Mrs. Inkeri Kallela*, Registered Nurse. Diploma in Basic Nursing Education. Specialization in Public Health Nursing. Master of Public Health of Harvard University. Executive Director for the Finnish Foundation of Nursing Education.

FRANCE

12. *M^{lle} Juliette Lasvignes*, Diplôme Infirmière Croix-Rouge française en 1928. Directrice de l'Ecole d'assistantes de service social en 1940. De 1944 à 1972 Directrice des deux Ecoles d'infirmières et d'assistantes de service social. Retraitée.
13. *M^{lle} Suzanne Martin-Laval*, Infirmière diplômée. Directrice de l'Ecole d'infirmières du Camas (Hôpital de la Croix-Rouge française). Retraitée.
14. *M^{me} Claude de Peyerimhoff*, Auxiliaire volontaire. Conductrice ambulancière de la Croix-Rouge française. Directrice du Service automobile sanitaire de la Croix-Rouge française. Conseillère du Service automobile sanitaire de la Croix-Rouge française.

15. *M^{lle} Marie Louise Saint Oyant*, Infirmière diplômée. Directrice de l'Ecole d'infirmières et d'assistantes de service social.

GREECE

16. *M^{me} Efi Anastassiadou*, Infirmière volontaire. Certificat d'auxiliaire volontaire en 1940. Inspectrice du Corps des infirmières volontaires.

HUNGARY

17. *M^{me} D' Gizella Buda*, Auxiliaire volontaire. Diplôme d'infirmière volontaire en 1942. Diplôme de soins au foyer en 1943. Retraitée.
18. *M^{me} Rozalia Dolezar*, Auxiliaire volontaire. Diplôme d'infirmière volontaire de la Croix-Rouge hongroise en 1942. Retraitée.
19. *M^{me} Magdolna Takacs*, Auxiliaire volontaire. Diplôme de soins au foyer en 1942. Retraitée.
20. *M^{lle} Katalin Toth*, Auxiliaire volontaire. Diplôme d'infirmière volontaire de la Croix-Rouge hongroise en 1914. Retraitée.

JAPAN

21. *Mrs. Toshi Matsumori*, Graduate Nurse. Red Cross Diploma for professional nurses in 1919. Retired.
22. *Miss Katsuko Umemoto*, Graduate Nurse. Red Cross Diploma for professional nurses in 1929. Lecturer at the Nursing Department of the Matsuyama Practical College of Nursing of the Matsuyama City Medical Association.
23. *Miss Misue Tsusue*, Graduate Nurse. Red Cross Diploma for professional nurses in 1928. From 1966 to 1968 Lecturer at the Practical Nurse Training School attached to Beppu University. From 1970 to 1971 Lecturer at the Aoba Nurse Training School attached to Beppu University.

MONGOLIA

24. *Mrs. J. Dolgorjav*, Graduate Nurse in 1930. Retired. Red Cross volunteer.

NEW ZEALAND

25. *Mrs. Megan Margaret Crisp*. Graduate Nurse. From 1972 to 1974, Director, Voluntary Aid Detachments, New Zealand Red Cross. From 1974 to 1978, Director, Health and Welfare, New Zealand Red Cross. From 1978 to 1981, Volunteer Lecturer and Examiner, First Aid and Nursing. Red Cross Volunteer.

PHILIPPINES

26. *Mrs. Guia Arboleda Rea*, Registered Nurse. Chapter Administrator of the Philippine National Red Cross.

GERMAN DEMOCRATIC REPUBLIC

27. *Sister Gertraud Ulbricht*, Graduate Nurse. From 1959 to 1978, Chairman of the examining board for practical nursing in the Leipzig country district and, from 1958 to 1979, Matron of the District Hospital at Zwenkau. Member of the Commission for Social and Sick-nursing Service of the Presidium of the German Red Cross of the German Democratic Republic and member of the Commission for Care for Old-age Pensioners.

ROMANIA

28. *M^{me} Aneta Neculau*, Auxiliaire volontaire. Diplôme de Sœur Croix-Rouge en 1957. Commandante de groupe sanitaire Croix-Rouge.

UNITED KINGDOM

29. *Miss Helen M. Cookson*, *ARRC.*, *SRN.*, Graduate Nurse. Senior Nursing Officer, Hong Kong Red Cross Medical Centre.

CZECHOSLOVAKIA

30. *Mrs. Zlatica Jesenska*, Voluntary worker of the Czechoslovak Red Cross. Member of the District Committee of the Czechoslovak Red Cross in Zvolen, Chairman of the basic organization of the Czechoslovak Red Cross in Zvolen.
31. *Mrs. Miroslava Pavelcová*, Graduate Nurse. Head Nurse at the Psychiatry Department of the Army Hospital in České Budějovice. Member of the basic organization of the Czechoslovak Red Cross.

U.S.S.R.

32. *Vozniouk Natalia Tikhonovna*, Infirmière diplômée. Infirmière en chef de la Croix-Rouge.
33. *Kountsevitch Sofia Adamovna*, Infirmière diplômée. Chef de la bibliothèque de l'Institut de Technologie C. M. Kirov de Biélorussie.
34. *Fedioukova Maria Andreevna*, Infirmière diplômée.

YUGOSLAVIA

35. *Infirmière Anka Meles*, Infirmière diplômée. Retraitée.

ZAMBIA

36. *Mrs. Jane Mulimba*, Graduate Nurse. Nursing Officer. University Teaching Hospital, Lusaka.

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 acknowledgments 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

EXTERNAL ACTIVITIES

Africa

ICRC assistance operations

During the first six months of 1981, the main ICRC assistance operations in Africa were in Angola (Planalto region), Uganda (West Nile Province), Chad and the Horn of Africa. It distributed more than 6,000 tonnes of relief, valued at almost 14 million Swiss francs.

Angola

The deterioration of the situation in Angola created serious problems for the delegation there. Its activities were suspended for several weeks, in May and June, in the Planalto region; they were resumed, on 26 June, in the provinces of Bailundo, Huambo and Bié, by means of two aircraft.

In Bailundo, the ICRC is trying to bring the existing hospital infrastructure back into operation. There were many wounded who were cared for by the ICRC medical team. Relief was distributed to the needy in the hospitals, the special feeding centre and the nearby camp.

In Katchungo, the special feeding centre continued working during the delegates' absence, thanks to its local staff, and a number of new cases of serious malnutrition were admitted for treatment.

In the Bié Province, two relief operations—the first in the area—were carried out: At the Cangala leprosarium in Kuito, clothes, soap and blankets were distributed to some 200 lepers; in Chivanda, about 2,200 displaced persons received clothing and soap. Food assistance was not considered necessary.

On 30 June, the ICRC store in Huambo was attacked and plundered. On 16 July, a mine exploded on the Bailundo airstrip, regularly used by ICRC aircraft, which compelled the delegates to suspend their activities

once again. Only the Katchiungo special feeding centre can still be regularly supplied.

The food stocks built up by the ICRC on the Planalto will be enough to cover needs until November, but after that logistic problems will arise, because the delegation will have to convey new supplies, stored in the port of Lobito, to the Planalto by rail or by road, if conditions are safe; otherwise, another airlift will have to be organized between Lobito and Huambo.

From 26 to 31 August, the ICRC Deputy Director of Operations, Mr. Michel Convers, and the ICRC chief medical officer, Dr. Rémi Russbach, were in Angola to assess the situation, which is still very unsafe. Despite the danger, however, some relief activities were resumed on the Planalto at the end of August.

South Africa and Namibia

The ICRC regional delegation in Pretoria continued its usual assistance to families of detainees, providing food to some 500 persons every month. A similar action was launched in Namibia in July by the ICRC office recently opened in Windhoek.

Ghana

On 7 July, the Government of the Republic of Ghana appealed to the ICRC to provide assistance following clashes between two tribes in the north of the country. The ICRC responded by sending a delegate to make a survey in the area. The delegate reported an urgent need for medicaments and medical equipment. A first consignment of relief, to a value of about 19,000 Swiss francs, was accordingly dispatched from Geneva.

Chad

Following the surveys carried out in March, May and June in several parts of the country, the ICRC delegation in Chad made one last visit, towards the end of July, to Abeche and its surroundings. It reached the same conclusions as those drawn during previous missions, namely that the population no longer needed emergency assistance from the ICRC, but long-term aid from other humanitarian organizations. The ICRC is gradually ceasing its activity in Chad.

It is expected that the ICRC will nevertheless participate in a rehabilitation programme for war disabled, as it has done in other countries.

A workshop will be opened and local staff trained by an ICRC physio-therapist to manufacture, fit and repair artificial limbs.

Up to the end of July, the ICRC continued, in co-operation with the welfare centres, distributing food to undernourished children and needy families in N'Djamena.

On 4 August, sixteen prisoners of war—the last, according to the authorities—were released and received material assistance from the ICRC.

Uganda

From 8 to 17 July, a member of the Executive Board of the ICRC, Mr R. Jäckli, accompanied by Mr D. Helg from the ICRC Operations Department, was in Uganda to discuss protection problems with the authorities. It was considered necessary that the ICRC should continue its protection activities and its medical and food assistance programmes in the West Nile area. On 6 August, four ICRC delegates, including the head of the delegation in Kampala, Mr J.-C. Rochat, returned to Arua to re-open the ICRC office temporarily closed after the incident on 24 June.

An ICRC physician and nurse regularly visit the dispensaries in the West Nile Province to help the local medical staff working there. From January to the end of July, 250,000 Swiss francs worth of medicaments and medical equipment were sent from Kampala to the West Nile.

The ICRC delegation in Uganda continued visiting prisons and distributing food, blankets, clothes and soap for the detainees. To improve its activities in favour of detainees, the delegation was increased by one physician, two nurses and a hygiene specialist.

On 27 March, the Ugandan Government announced an amnesty in favour of some 3,000 detainees. The first 1,425 persons were released on 25 July. The ICRC delegation helped them return to their families.

Gambia

In August, just after the events that occurred at the end of July in Gambia, two ICRC missions went to Gambia. First, a medical delegate and a relief specialist went to Banjul to make an initial survey; then at the end of August the regional delegate for Central and West Africa, Mrs. J. Egger, was in Gambia to transmit to the authorities the ICRC's offers of service, especially for protection, and to establish contacts with the national Red Cross Society.

A first consignment of medicaments and medical equipment for the hospitals, amounting to 15,000 Swiss francs, was dispatched by the ICRC from Geneva and Dakar.

Ethiopia

The Debré Zeit rehabilitation centre for the disabled, which is run under the supervision of the ICRC, continued working for military amputees. From January to the end of July 1981, the centre made 136 artificial limbs, 105 wheelchairs and 350 pairs of crutches.

Negotiations are under way to open similar rehabilitation workshops for civilian disabled, in Asmara and Harar.

From January to the end of June, the ICRC continued supplying the Ethiopian Red Cross with relief that was distributed to some 40,000 needy persons in the provinces.

Latin America

Delegate-general's mission

From 6 to 29 July, Mr A. Pasquier, ICRC delegate-general for Latin America, carried out a mission to five countries: Nicaragua, Costa Rica, El Salvador, Honduras and Guatemala.

In *Nicaragua*, the delegate-general's talks with the authorities resulted in authorization being granted to ICRC delegates to visit places of detention under the authority of the police. Until then, only prisons directed by the national penitentiary service had been visited by the ICRC. He also put forward some proposals designed to bring some improvements in the prisons' medical services.

Mr. Pasquier also met leaders of the Nicaragua Red Cross and attended a meeting of its National Council, to whom he spoke about ICRC activities.

In *Costa Rica*, the delegate-general discussed with officials of the National Red Cross Society its programme for the dissemination of knowledge of international humanitarian law and Red Cross principles. He also took part, in Costa Rica, in a working session of the League's regional bureau, during which the five-year development plan of the National Societies of Latin America and the Caribbean and the dissemination of international humanitarian law were discussed.

In *El Salvador*, the delegate-general conferred with the President of the Junta and Ministry of Defence officials. Among the questions discussed, particular attention was paid to those relating to the ICRC's protection work in the civilian and military places of detention.

Mr. Pasquier also raised the question of ICRC assistance activities to displaced persons. In the department of Morazan, there are at present 25,000 displaced persons to whom the ICRC distributes aid. The relief action has to overcome difficulties relating to logistics and dangerous conditions in the department of Chalatenango. The ICRC has confirmed on the spot that the needs of the displaced persons, the vast majority of whom are women, children and aged people, are acute.

Mr. Pasquier conferred with National Red Cross Society officials about the humanitarian activities in aid of the victims of recent events and how the ICRC and the Salvadoran Red Cross could collaborate in the joint programme to bring aid to displaced persons.

In *Honduras*, the delegate-general met representatives of the authorities and National Red Cross Society leaders.

In *Guatemala*, he conferred with the President of the National Red Cross.

El Salvador

The ICRC delegation in El Salvador continued its protection and assistance tasks in aid of persons affected by the events.

Early in July, the delegates visited a camp for displaced persons in Suchitoto where overcrowding had raised problems. From San Miguel, they continued to distribute various relief goods to the conflict areas in the department of Morazan; in June, weekly distributions were organized in 14 villages, containing about 25,000 displaced persons. Food aid amounting altogether to about 185 tonnes was distributed. The mobile medical team continued to provide medical care in Morazan. These relief operations are being continued.

Moreover, the ICRC delegation continued to provide assistance to detainees. In June and July, the delegates carried out 202 visits in 94 places of detention in various parts of the country and in the capital, San Salvador.

Bolivia

The Minister of the Interior renewed the authorization previously granted to the ICRC to visit places of detention, thus allowing Mr. A. Kobel, ICRC regional delegate for the Andean countries, to go

to two centres of detention of the Special Security Service, where he saw a dozen detainees. He also went to a hospital to visit a trade union leader who had been severely injured when arrested. When the Bolivian authorities informed Mr. Kobel that they were prepared to release this detainee on account of his injuries, the ICRC delegate made arrangements for the transfer of the injured detainee to a hospital in Boston (United States). He was taken on board a regular flight and was accompanied by Mr. Kobel and a doctor of the Bolivian Red Cross.

Colombia

In July, two ICRC delegates visited the prison of La Picota, where they saw 111 detainees. Their visits were carried out in accordance with standard ICRC procedure.

Cono Sur

At the beginning of July, Mr. E. Corthésy, ICRC regional delegate for the countries of the Cono Sur, went to Chile, then to Paraguay at the beginning of August, and later in August to Uruguay.

In each of those countries, the regional delegate conferred with the authorities and with National Red Cross Society officials.

Asia

Delegate-general's mission

From 28 June to 17 July, the ICRC delegate-general for Asia, Mr Jean de Courten, went to the People's Democratic Republic of Korea, the People's Republic of China, and Pakistan.

The delegate-general stayed in the People's Democratic Republic of Korea, at the invitation of the National Red Cross Society. He was received by members of the Government and of the National Society, and in particular by the Vice-Prime Minister, Mr. Kim Gyong Ryon, and the President of the Red Cross, Mr. Son Song Pil. He conveyed to them the ICRC's interest in the solution of the humanitarian problems, especially the separation of families, affecting the Korean population since 1947. He confirmed that the ICRC was prepared, if it was thought opportune, to fulfil its traditional role of a neutral intermediary to facilitate contacts between the two National Societies concerned and to try and speed up the solution of these problems.

In the People's Republic of China, the ICRC delegate-general had various interviews with representatives of the National Red Cross and of the Ministry for Foreign Affairs. They discussed, in particular, some matters connected with the border conflict with Viet Nam and the forthcoming International Red Cross Conference in Manila.

Mr. de Courten's visit to Pakistan will be referred to under the heading dealing with that country.

Thailand

In July and August, the ICRC delegation continued its activities in aid of refugees in the camps along the border between Thailand and Kampuchea, an area which is still the scene of occasional military operations.

Following armed clashes between opposing groups at the beginning of July, a large number of casualties were admitted to the camp hospitals and dispensaries. Later on the situation calmed down to a certain extent.

In July and August the ICRC maintained its medical staff in Thailand: there were two teams working in the camps south and north of Aranyaprathet, and in the camp at Khao-I-Dang there was a surgical team composed of 12 persons sent by the British, Danish, Finnish, Irish and Swedish Red Cross Societies. After the above-mentioned events in July, Khao-I-Dang hospital received 234 new patients, 62 of whom were wounded by mines or bullets.

The ICRC delegation also continued to supply medicaments and medical equipment to the teams of other humanitarian organizations assisting the refugees. In July 72,000 dollars worth, and in August 67,000 dollars worth of medical and paramedical equipment was distributed in the border area.

The three Khmer traditional medicine centres set up by the ICRC in the camps at Kamput, Sakaeo and Khao-I-Dang, which have been operating for several months, are currently treating about 1,000 patients a day. They were placed under the responsibility of the Order of Malta on 15 July.

The medical assistance given by the ICRC also includes transportation of a large number of sick and wounded refugees to hospital for better treatment.

In addition to providing medical aid and occasionally distributing relief, the ICRC is also carrying out protection activities. It visits some persons who are detained in refugee camps near the border and in other places of detention. The delegation concerns itself with the situation

of some Vietnamese and Khmer nationals in particularly dangerous surroundings. It also tries to reduce the tensions between refugees of various origins and between the refugees and the local population.

Protection activities include the still considerable task carried out by the Tracing Agency in registering refugees, tracing missing persons and transmitting family mail. From April to the end of July, for example, the delegation transported and distributed some 20,000 letters of refugees; this was done in close co-operation with the tracing and mail services of the Thai Red Cross Society.

The Agency office also drew up some 2,000 files on unaccompanied refugee Khmer children, about 800 of whom are in the camps in Thailand set up by the UN High Commissioner for Refugees. After steps being taken with the Kampuchean authorities and thanks to the co-operation of the Red Cross in Phnom Penh, the ICRC hopes to trace the families of the children when they are still alive and bring the children and their relatives together again.

The ICRC delegation and the Thai Red Cross also co-operated in providing medical assistance and distributing food to the Thai population living in the border area and affected by the events and the presence of refugees.

Kampuchea

The ICRC delegation in Phnom Penh continued its medical aid to hospitals in Kampuchea.

At the end of July, the ICRC completed its fourth distribution to hospitals in the 19 provinces of medicines and medical equipment in the form of 500 kits specially prepared to meet the requirements of 10,000 patients over a period of three months. Some of the hospitals (in Phnom Penh especially) received extra kits containing medical supplies to cover 6 months.

The Japanese Red Cross donated two ambulances, one of which was given to the provincial hospital of Kompong Speu and the other to Svong Hospital in the province of Kompong Cham.

The ICRC also continued regularly forwarding human blood concentrate to the hospitals. This will not be necessary much longer because a blood bank was inaugurated in Phnom Penh on 25 August.

The Swiss Red Cross signed an agreement with the authorities to send a medical team to the provincial hospital of Kompong Cham.

The Australian Red Cross donated 56 tons of protein biscuits, which were distributed to 39 orphanages throughout the country.

In July and August, the plane chartered by the ICRC made 24 flights between Bangkok and Phnom Penh and transported to Kampuchea over 50 tons of medical equipment and food, valued at over 270,000 dollars.

The Tracing Agency office in Bangkok drew up some 600 files on unaccompanied refugee Khmer children in Thailand and transmitted them to Kampuchea, in the hope that relatives could be traced there. The Red Cross in Phnom Penh and the ICRC delegation are actively co-operating in the tracing of the families.

Indonesia

Timor

The ICRC and the Indonesian Red Cross are continuing a reduced relief operation in East Timor, as mentioned previously. An ICRC delegate, Mr C. Neukomm, was there at the end of June and the beginning of July and visited seven villages still receiving assistance. The situation, according to him, was quite encouraging: the medical programme and the relief distributions conducted by the Indonesian Red Cross medical staff and voluntary workers were proceeding very satisfactorily.

Philippines

The ICRC regional delegate, Mr. J.-F. Olivier, and a medical delegate, Dr. Willi, carried out a four-day mission on the island of Pata (extreme south of the Philippines), where some 700 persons had been displaced as a result of disturbances last February. Dr. Willi examined 253 patients. Some medical relief was provided. This mission was successful. A survey mission had been made in the same area, at the end of March.

Vietnamese refugees in South-East Asia

In an attempt to stop piracy which is still causing so much suffering to refugees crossing the Gulf of Siam from Vietnam to a country of first asylum, contacts were established in August, in Geneva, between the UNHCR, UNICEF, the League and the ICRC, on the one hand, and the representatives of various Western countries, India, Australia, as well as Thailand and Malaysia, on the other. The ICRC and the HCR are continuing to urge these governments to take energetic action to discourage and repress acts of piracy in the territorial and international waters of the Gulf of Siam.

Pakistan

During his visit to Pakistan at the beginning of July, the ICRC delegate-general for Asia, Mr Jean de Courten, accompanied by the head of the ICRC delegation in Pakistan, Mr J.-M. Monod, had a number of interviews with the Pakistani authorities and the Red Crescent. It was agreed that ICRC activities should henceforth focus to a greater extent on war surgery and on the hospital for Afghan casualties opened in June in Peshawar. The hospital's capacity would be raised to care for the increased number of wounded, and a prosthesis workshop would be set up for the disabled. It was also agreed that vehicles, medical relief and personnel would be made available to the Pakistani Red Crescent to enable it to run, jointly with the ICRC, three first aid centres in the « Tribal Agencies », where the wounded receive emergency care before being transported to the ICRC hospital in Peshawar.

As part of the re-distribution of medical tasks, responsibility for public health matters has been taken over by the Pakistani Government and the UN High Commissioner for Refugees. The three mobile ICRC teams, which had previously worked in the "Tribal Agencies", were replaced in mid-July by HCR teams.

During his mission, the delegate-general also discussed protection problems, and especially the protection of prisoners, with the various parties concerned.

Middle East

Lebanon

In July there was a short and relative lull in the general situation, followed by a sudden deterioration in southern Lebanon and Beirut.

During the second half of July, the ICRC had to increase its medical assistance to hospitals and dispensaries in the south of the country, particularly in Nabatieh, Tyre and Sidon. The ICRC delegation organized three convoys to replenish the medical supplies of its sub-delegation in Tyre, which was completely cut off from the rest of the country. These convoys had to cross makeshift bridges and fords during a cease-fire negotiated with all the parties. In Beirut the ICRC increased its medical support to the Lebanese Red Cross and the "Palestinian Red Crescent".

The ICRC expressed to the parties involved in the conflict its grave concern about the escalation in violence during the recent events and reminded them of the respect due to the civilian population and property.

In addition to these activities made necessary by the events, the ICRC delegation in Lebanon is discharging other tasks throughout the country, such as making surveys, followed by distributions according to needs; visiting detainees; assisting persons displaced by occasional fighting; interventions and provision of relief to families whose houses are being destroyed.

To cover medical requirements in periods of tension, when transport is difficult or impossible, the ICRC built up stocks of medicaments and medical equipment in six different areas of the country.

The ICRC reactivated and is now supporting the blood banks of the Lebanese Red Cross and the Lebanese People's Relief, in Tyre and Sidon. It transported by air to Beirut a large quantity of fresh blood, offered by the Norwegian Red Cross to the Lebanese Red Cross.

In June, a poliomyelitis epidemic was feared in Zahle, which was then under siege. The ICRC supplied and conveyed, during a special cease-fire, 20,000 doses of vaccine.

An ambulance was offered to the Lebanese Red Cross by the Egyptian Red Crescent. Along with the other vehicles given previously by other National Societies, this gift contributed to reducing the shortage of ambulances in the country.

The ICRC delegation also afforded support to foreign nationals in Lebanon. It made special efforts to help some 200 foreign workers, mainly Indian and Sri Lankan nationals, who were stranded in Zahle without any means. It co-operated with the "Palestinian Red Crescent" to shelter and subsequently repatriate 220 Egyptian workers who had lost their jobs as a result of the events.

The Tracing Agency office attached to the ICRC delegation is dealing with a large number of family messages. During the second quarter of 1981 and as a consequence of disturbances, the quantity of family messages gathered, conveyed and distributed throughout Lebanon increased three-fold as compared to the first three months of the year.

Syria

During the first half of 1981 the ICRC delegation in Damascus continued its protection and assistance activities for persons affected by the Israel-Syrian conflict (i.e. Tracing Agency work and relief activities for civilian Arab internees in Israel and the territories occupied by Israel and for displaced persons from the Golan). It also continued, as a consequence of the situation in Lebanon, its efforts in aid of Syrians detained in Lebanon and Lebanese detained in Syria.

Iraq/Iran conflict*Prisoners of war*

In July and August, the ICRC delegations in Iraq and Iran continued their protection activities in aid of prisoners of war. They visited the camps, sometimes also the prisons and hospitals, where prisoners of war were held. During their visits, they generally distributed toiletries, clothes, books and cigarettes.

Second repatriation

The second repatriation of severely wounded prisoners of war and civilian internees between Iraq and Iran took place on 25 August 1981, under the auspices of the ICRC. At Larnaca airport (Cyprus) the ICRC handed over 45 Iraqis and 40 Iranians to the representatives of their own countries. It was the second repatriation organized by the ICRC since the beginning of the conflict, the first having taken place on 16 June.

An aircraft specially chartered for the operation by the ICRC had left Geneva on the evening of 24 August. Four tons of relief supplied by the Swiss Red Cross and the League of Red Cross Societies for the victims of the earthquake in Iran had been loaded on board and were afterwards handed over to the Iranian Red Crescent.

Occupied territories

The ICRC delegates continued visiting the Iranian territories occupied by the Iraqi armed forces. On 13 July, for instance, they visited the area of Qasr-I-Shirin, where there were only Iraqi soldiers.

Iran*Mission to Kurdistan*

From 17 to 25 August, four ICRC delegates, including one medical delegate, visited several places of detention in Kermanshah and Sanandaj, in Iranian Kurdistan, where they saw over 1,800 detainees. For the first time, they were allowed access to places of detention in two Pasdars' barracks in these towns.

During their mission, the ICRC delegates also visited a displaced persons' camp with some 3,200 Iranians who had been displaced from Khuzistan by the war.

The delegates had interviews with the Governor of Kermanshah, the Vice-Governor of Sanandaj and with officials of the revolutionary tribunals. They also met the heads of the local branches of the Iranian Red Crescent and talked with the local authorities in charge of assistance to displaced persons.

Israel and the occupied territories

During July and August, the ICRC delegation in Israel and the occupied territories made 477 visits to security detainees under interrogation, held by the army. The delegates also went to 9 prisons where they visited detainees awaiting trial or already sentenced, held by the prison service.

During those two months, the ICRC also organized the passage of two groups of students (53 persons in all), at Kuneitra, between the occupied territory of Golan and Syria. Four released security detainees were transferred under the auspices of the ICRC to Jordan across the Allenby bridge, two others at Kuneitra to Syria and one at Roshanikra to Lebanon.

**Joint Commission
of the Empress Shôken
Fund**

No. 72

Geneva, 11 April 1981.

SIXTIETH DISTRIBUTION OF INCOME

The Joint Commission entrusted with the distribution of the income of the Empress Shôken Fund met in Geneva on 26 March 1981. The Japanese Red Cross Society was represented by H. E. Ambassador Fumihiko Suzuki.

The Commission noted the statement of accounts and the situation of the Fund as at 31 December 1980 and confirmed that the balance available amounted to S. Fr. 176,845.56.

In examining the applications, the Joint Commission reviewed the experiences of the past few years. The Commission noted that the criteria (a.b.c.) it had established for allocation were still valid:

- a. to restrict the number of allocations and thereby increasing the allocations so as to permit the beneficiary National Societies to implement the plans envisaged;
- b. to uphold only those from developing National Societies unable to have their projects financed otherwise and, among such Societies, whenever feasible those which have hitherto benefited least from assistance from the Shôken Fund;

- c. to refrain from considering the requests from those National Societies which have not conformed to the requirements under article 5ter of the Regulations according to which the beneficiary National Societies are expected to report on the use of the allocations received.

The Joint Commission further decided that:

- i. allocations be transferred to the beneficiaries only upon presentation of either invoice or proof of purchase;
- ii. allocations remaining unclaimed or unused after six months of such allocations are to be withdrawn and added to the amount available for the next distribution.

Nine National Societies submitted requests for allocations from the 60th distribution of income and the Joint Commission decided to make the following grants based on the above mentioned criteria:

Bangladesh Red Cross Society: SFr. 30,000
for the purchase of a mobile blood collection unit for the Blood Transfusion Programme

Egyptian Red Crescent Society: SFr. 45,000
for the equipment of a Child Care Centre in Port-Saïd

Lao Red Cross: SFr. 50,000
for the purchase of a mobile blood collection unit for the Blood Transfusion activities

Mauritius Red Cross: SFr. 25,000
for the purchase of a vehicle for the Rodrigues Branch

Red Cross Society of Panama: SFr. 25,000
for the purchase of a vehicle for the Red Cross School Brigades

The Joint Commission also decided that the unused balance of S.Fr. 1,845.56 will be added to the income available for the 61st Distribution.

In accordance with article 5 ter of the Regulations, the beneficiary National Societies are required to report in due course to the Secretariat of the Joint Commission on the use which has been made of the allocations received. The Joint Commission would like this report, accompanied by photographs if possible, to reach it at the latest by the end of the year during which the allocation is used. It furthermore reminds beneficiaries of article 5 bis of the Regulations which prohibits them assigning the grant for purposes other than those specified, without the previous consent of the Commission.

In accordance with the Regulations, the 1981 income will be distributed in 1982. To facilitate National Societies to make applications in conformity with the Regulations, the Joint Commission has decided to send, as in the past year, model application forms to all National Societies.

The Joint Commission desires to remind National Societies that such requests must indicate the purposes for which the allocation will be used, in order for them to be considered; they must also, as far as possible, be accompanied by a plan of financing. Requests must be submitted to the Secretariat of the Joint Commission before 31 December 1981.

For the Joint Commission

League of Red Cross Societies

H. Beer
B. Petterson (Secretary)
B. Bergman

*International Committee
of the Red Cross*

M. Aubert (Chairman)
P. Gaillard
M. Martin

Empress Shōken Fund

BALANCE SHEET AS AT DECEMBER 31, 1980 (expressed in Swiss francs)

ASSETS	S.Fr.	LIABILITIES AND CAPITAL	S.Fr.	S.Fr.
Securities in portfolio		Capital as at 1.1.1980 . . .	2,829,510.73	
Bonds in Swiss francs . . . (market value: <i>SFr 1,926,900.—</i>)	1,865,970.10	<i>Plus</i> : Contributions from Japanese visitors	1,432.80	2,830,943.53
Bonds in foreign currencies (market value: <i>SFr 643,900.—</i>)	677,035.30	Funds available at 31.12.1980		176,845.56
	2,543,005.40	Provisions:		
Fixed deposits		Reserve against fluctuations		67,362.50
Banque Hypothécaire du Canton de Genève	29,311.03	for administrative expenses:		
Crédit Suisse, Luxembourg	300,000.—	Balance carried forward from the previous year	17,600.92	
Crédit Suisse, Zurich DM 300,000.—)	272,760.—	Transfer from the income statement as per the statutes	9,161.14	
	602,071.03		26,762.06	
Debtor		<i>Less</i> :		
Account receivable, withholding tax recoverable	14,375.80	Administrative expenses for the year 1980.	6,744.75	20,017.31
Cash at Bank		Commitments		
Messrs. Hentsch & Cie, Genève	15,028.60	Allocations to be with- drawn	68,013.15	
Crédit Suisse, Genève	19,999.50	League of Red Cross Societies	31,298.28	99,311.43
	35,028.10	Total of liabilities		3,194,480.33
Total of assets	3,194,480.33			

SITUATION OF INVESTMENTS AS AT 31 DECEMBER 1980

<i>Securities</i>		<i>Nominal Value</i>	<i>Purchase Price</i>	<i>Market Value</i>	
		<i>S.Fr.</i>	<i>S.Fr.</i>	<i>S.Fr.</i>	<i>%</i>
5 %	Crédit Suisse, Zurich, variable, 1980/92 . . .	50.000.—	50.000.—	50.250.—	100.50
4¾ %	Union Bank of Switzerland 1980/83 . . .	200.000.—	200.300.—	200.000.—	100
5½ %	Sumitomo Electric, convert. 1980/86 . . .	100.000.—	100.300.—	121.000.—	121
3¾ %	Fujitsu Ltd., convert. 1979/84	100.000.—	100.166.—	125.000.—	125
3½ %	Kitazawa Valve Co. Ltd., convert. 1978/83	100.000.—	101.675.—	105.000.—	105
5¾ %	Sharp Corp., Osaka, convert. 1980/85 . . .	100.000.—	100.300.—	124.250.—	124.25
4¾ %	Dainichi Seika Co. Ltd. 1977/82	100.000.—	100.000.—	95.500.—	95.50
7¼ %	Fujita Corp. Kogyo 1976/81	200.000.—	200.000.—	200.000.—	100
5¾ %	Best Denki, Japan 1980/85	150.000.—	150.450.—	145.500.—	97
6¾ %	Japan Development Bank 1970/85	400.000.—	402.480.—	412.000.—	103
6½ %	Worldbank, Washington 1971/86	160.000.—	160.000.—	164.800.—	103
4¾ %	Worldbank, Washington - May 1979/89 . .	200.000.—	200.300.—	182.000.—	91
			<u>1.865.971.—</u>	<u>1.925.300.—</u>	
5½ %	Tokio Rubber Industry Co. Ltd. 1978/83 DM	100.000.—	86.756.—	80.729.—	89.50
6½ %	Nippon Kokan K.K. 1979/84 DM	100.000.—	90.571.—	82.803.—	91.80
4 %	Kansai El. Power, convert. 1979/84 . . DM	200.000.—	161.182.—	164.795.—	91.35
8 %	The Netherlands 1977/87 DFL	200.000.—	165.339.—	155.145.—	93.80
10¼ %	Ennia Assur. Co., NL 1980/90 DFL	200.000.—	173.187.—	160.438.—	97
			<u>677.035.—</u>	<u>643.910.—</u>	
			<u>2.543.006.—</u>	<u>2.569.210.—</u>	
<i>Bank Deposits</i>					
Banque Hypothécaire du Canton de Genève			29.311.—		
Crédit Suisse, Luxembourg			300.000.—		
Crédit Suisse, Zurich		DM 300.000.— at 90,92	272.760.—		
		Total	<u>602.071.—</u>		

**STATEMENT OF INCOME AND EXPENDITURE
FOR THE YEAR ENDED DECEMBER 31, 1980**

	<i>S.Fr.</i>	<i>S.Fr.</i>
INCOME		
Interest income from bonds		136,566.05
Interest in bank deposits		46,656.69
		<u>183,222.74</u>
EXPENSES		
5% of total income above transferred to the Provision for administrative expenses (article 7 of the statutes of the Fund) . .		9,161.14
RESULT		
Excess of income over expenditure for 1980.		<u>174.061.60</u>
STATEMENT OF APPROPRIATION		
Balance carried forward from previous year		<u>212,783.96</u>
<i>Less:</i>		
Fifty-ninth distribution of income for the year 1979 to six National Societies	180,000.—	
Allocation to the reserve against fluctuations	30,000.—	210,000.—
<i>Unused balance</i>		2,783.96
Excess of income over expenditure for the year 1980		174,061.60
<i>Balance as at December 31, 1980 as per balance sheet</i> . . .		<u>176,845.56</u>

The account of the Empress Shōken Fund have been audited by Société Fiduciaire OFOR S.A. The financial report is obtainable from the League of Red Cross Societies.

First seminar on International Red Cross emergency medical actions

The first seminar on International Red Cross emergency medical actions, jointly organized by the ICRC and the League of Red Cross Societies, took place in Geneva from 13 to 16 February 1981. Eighty-five doctors, nurses, nutritionists and health technicians, all of them with practical experience gained in several emergency field missions for the International Red Cross, took part in the seminar. They represented 23 National Societies.

Specific character of Red Cross medical action

Beside some important subjects discussed, the seminar gave special emphasis to the difference between Red Cross medical action and that of other organizations. It was noted that the Red Cross acted on the basis of its own special principles, such as neutrality, impartiality, non-discrimination, etc. This special characteristic often stood in the way of integration of the Red Cross with actions by other organizations—governmental or non-governmental—which operated under different rules. In the event of conflict, for example, the ICRC came to the aid of victims on both sides of the front without distinction, whereas other organizations acted only in one particular region or for victims chosen on the basis of their own criteria.

Importance of criteria for action

In medical programmes, as in all of its actions, the Red Cross must observe certain rules: it must act only in the interest of the victims; it must not create the need for a kind of medical service not adapted to local conditions; it must make sure that there was a certain balance between

the aid given to victims and the conditions under which the general population lived, so as to avoid favouring the former in comparison to the latter. The Red Cross had also to take into consideration local resources in personnel and material in its planning, and use them first in its action. Red Cross teams had also to make certain that the largest possible number of patients benefited from their care, without giving privileges to some as compared to others.

It was also important to respect local traditions and the cultural heritage of the victims.

Finally, it had to be borne in mind that Red Cross medical programmes were limited to periods of emergency and that it was therefore advisable to use simple and rational techniques.

There was also reference in the discussions to external pressures which must be resisted. These were often expressions of public opinion and could lead to precipitate and uncontrolled action which could be injurious to the interests of the victims. The Red Cross had therefore to make sure it was not carried away by emotional currents when engaged in an emergency situation.

Strengthening of co-ordination role urged

A medical action, even in a time of emergency, had to be carefully planned and strictly co-ordinated. In that connection, all concerned were in favour of the strengthening of the ICRC role as a co-ordinator in conflicts and of the League in situations resulting from natural disasters. The Red Cross had to act in a controlled manner corresponding to the needs recognized and the priorities determined by its specialists. Any hasty shipment of medicaments, food, vaccines, equipment, field hospitals and medical teams must be absolutely ruled out in Red Cross activities, for these were often likely to serve political rather than humanitarian purposes, to the detriment of the victims and of the institution.

Well trained personnel

Emergency medical action, it was pointed out, could not be improvised, so that the personnel provided by National Societies must be well trained. In addition to their technical training, they must be well informed about the Red Cross movement and its principles and about the dangers to be faced. Experience in the field had proved that the members

of a Red Cross team had to be versatile and be well informed in fields which went beyond their own specialities. The frequently limited number of persons in a team made it impossible to call upon a great number of specialists, and it was therefore essential for a doctor to have some knowledge of epidemiology, hygiene, nutrition and sanitation, and for a surgeon to know the principles of wartime surgery and be able to operate under difficult conditions. In that connection, reference was made to the example of surgical teams on the Kampuchea-Thailand frontier which had to concern themselves with sanitation problems, such as the construction of latrines and the incineration of refuse in the camps. Such problems were unlikely to be encountered by a doctor in his native country.

Several other subjects were discussed during the seminar, for instance: the transfer of sick and wounded people to other countries, tuberculosis treatment, vaccinations, nutrition programmes, etc.

Final recommendations

In the final plenary session, the participants agreed unanimously on the following recommendations:

a) National Societies wishing to participate in emergency medical actions should develop the preparation of their personnel and material in accordance with the directives of the ICRC and the League.

b) The roles of the ICRC and the League as coordinators of emergency medical actions should be strengthened and the National Societies should not act independently of the established programmes.

c) Emergency medical actions should be planned and directed by experienced professionals. They should be carried out only in relation to the needs of the victims, both in qualitative and quantitative terms.

d) Every National Society should establish a group of experienced professionals responsible for health problems and whose role should not be only consultative but also executive, in the planning and implementation of emergency medical actions.

These recommendations will be discussed at the forthcoming international Red Cross Conference in Manila in November 1981.

A detailed report on the seminar will be published as soon as possible, in the form of a monograph which will serve as a guide to National Societies in training health and medical personnel for emergency actions.

AMERICAN RED CROSS CENTENNIAL

This year, the American Red Cross is celebrating its Centennial. It was founded by a fifty-nine year old woman named Clara Barton, who was born in North Oxford, Massachusetts, taught school for fifteen years, and was one of the first women to work for the United States government. During the American Civil War (1860-1865), she became known as the "Angel of the Battlefield" for her volunteer work among the wounded. After the Civil War, she went to Europe and learned firsthand about the Red Cross movement, participating in its relief effort during the Franco-Prussian War of 1870-1871. On her return home she worked with friends to found a Red Cross society. She first met with strong opposition from the government and it was only on 21 May 1881 that the American Association of the Red Cross was formed, with Miss Barton as president. In March 1882, President Chester A. Arthur signed, and the United States Senate ratified, the Geneva Convention of 1864, which led to the official recognition of the new society by the ICRC on 20 September 1882. The Constitution of the society contained a special feature. It did not limit the activities of the Association to relief in case of war but it included compliance with a wish expressed at the International Red Cross Conference in Berlin (1869), relief assistance in case of natural disasters.¹

The first challenge came in September 1881 after devastating forest fires in Michigan, but Miss Barton met it by collecting clothing and funds to send to the victims. In 1882 and 1884, similar demands on the fledgling organization were met during massive flooding by the Ohio and Mississippi Rivers with Miss Barton directing relief operations from chartered steamboats. Her efforts reached a peak in 1889 following disas-

¹ There is a very interesting résumé of the foundation of the American Red Cross and of the difficulties which preceded it in *Bulletin international des Sociétés de secours aux militaires blessés*, published by the ICRC, 1876, p 90, 1882, pp. 41, 92, 185.

trous flooding of Johnstown, Pennsylvania, when a dam break took a fearful toll of lives.

Clara Barton returned to the battlefield in 1898 during the Spanish-American War when she directed operations to provide food, nursing care and medical supplies to civilians and military forces in Cuba.

Two years later, in 1900, the Congress of the United States chartered the American Red Cross with responsibility for providing services to members of armed forces and relief to disaster victims. Following Miss Barton's retirement in 1904, internal administration and organization were improved under Mabel Boardman, a particularly talented leader. Under her direction, the congressional charter was revised in 1905 but contained the same obligations as the 1900 version. More than 75 years later, the American Red Cross continues to operate under this mandate.

In April 1906, the San Francisco earthquake provided another great challenge. President Theodore Roosevelt appointed the American Red Cross the nation's official relief agency to deal with the needs of the stricken city. The organization carried out the enormous task of mobilizing relief speedily and administering recovery efforts efficiently.

From 1909 through 1914, the American Red Cross continued to respond to the needs of the growing nation, developing programs in elementary hygiene and home care of the sick under pioneer nurse Jane Delano. Her Red Cross nurse enrollment became the official reserve for the Army and Navy in World War I. During the same years, the American Red Cross initiated first aid training in a variety of industries. The training handbook was translated into major foreign languages to meet the needs of immigrants then coming to America. Water safety training, meeting the needs of millions of Americans, took place during the same period, as swimming and lifesaving training were made available on an organized basis.

When Europe became a battlefield in 1914, the American Red Cross faced the emergency with only 107 chapters. The demands upon it, and the desire of Americans to assist in the relief effort, caused an explosive growth to 3,864 chapters by 1918, incorporating nearly one fifth of the American population in membership.

In 1916, one year before America's entry into World War I, the American Red Cross organized 50 hospital units that later were assigned to France. Some 20,000 nurses were recruited for wartime service. Four ambulance sections served in northern Italy. Today still, Red Cross-recruited nurses serve in major American disaster relief operations, meeting the needs of sick and injured victims. In 1917, with the United States deeply involved in World War I, the junior Red Cross was formed,

providing a channel for youth involvement in the relief effort. Today, Youth Services continue to provide a means for children to serve their communities and engage in international programs. Relief commissions were sent to France, Belgium, Russia and the Balkans to combat diseases and to aid civilians during and after the war.

After the war was over, the American Red Cross suggested to the French, British, Italian and Japanese Red Cross Societies that the vast resources which they had accumulated for intervention during the hostilities should be allotted to public health and to organizing relief in the event of natural disasters. In this way, the American Red Cross took a leading role in the foundation (5 May 1919) of the League of Red Cross Societies.

* * *

During the next twenty years, the American Red Cross improved its disaster techniques to cope with twentieth century demands and it started services to veterans returning from the First World War. Flooding of unprecedented severity occurred during 1927 and 1937 by the Ohio and Mississippi Rivers. Red Cross met the emergency through deployment of its increased volunteer strength. Disastrous drought and depression years during the thirties brought home the need for public health and nutrition. In hard-hit rural areas, the Red Cross was called upon by the government to assist in the distribution of food and clothing to families stunned by a national economic collapse of the highest magnitude.

During the same period, Red Cross took the first steps in blood donor recruitment which had become necessary to meet the demands of progressing medical technology. This modest beginning led to the formation of the present Red Cross Blood Services, today a major supplier of blood and blood products to the nation.

* * *

As the United States edged toward its involvement in a Second World War, the American Red Cross girded itself to support the demands to be placed on it. During the World War II period, the American Red Cross recruited more than 70,000 nurses for military duty, provided volunteers and staff in military hospitals, assigned staff to major military units in theaters of war around the globe, and supplied more than 13,000,000

units of blood plasma for American servicemen. The organization also operated clubs and mobile club units for servicemen in overseas rest and recreation areas. From 1941 to 1946, the American people contributed 784,000,000 dollars as well as millions of volunteer hours to meet the needs of servicemen and their families at home and abroad. During and following the conflict, the American Red Cross, along with other Red Cross Societies, the League of Red Cross Societies and the International Committee of the Red Cross, carried on extensive relief for civilian victims. American Red Cross assistance to Western Europe during the war years through 30 June 1946, amounted to about 152,000,000 dollars, of which about 67,000,000 dollars represented the value of supplies purchased with government funds.

On the restoration of peace, the American Red Cross helped Red Cross Societies in stricken nations reorganize and cooperated with them in tracing and reuniting family members separated by the war. Nearly 40 years later, this effort continues, marking the awesome magnitude of the problem.

* * *

In the three and a half decades following World War II, advancing technology, the rising tide of social expectancy of the citizens, and improvements in transportation and communications have altered modes of delivery of service to Americans. External events at home and abroad have played their part in shaping a spirit of flexibility within the society.

During the same period, the United States was buffeted by natural disasters requiring enormous and costly relief efforts. These included a succession of severe floods and devastating hurricanes. The Red Cross is involved in almost 40,000 disaster relief operations annually, ranging from killer hurricanes to one-family fires and including special incidents such as the Three Mile Island nuclear accident and the Mount St. Helens eruptions. The increased cost of living and inflation in recent years have led the Red Cross to make strenuous efforts to obtain all resources needed by the victims to resume normal living. In addition, the Red Cross continues to provide emergency disaster relief in the way of food, clothing, shelter, blood and blood products, medical and nursing care, occupational tools, and other assistance to meet urgent needs.

Many Red Cross courses in health and safety, and in other services, have been devised to help people avoid emergencies, to prepare for those

that cannot be avoided, and to cope with them when they do occur. Nursing and Health Services teach participants how to care for the ill and the elderly at home.

During the Korean conflict and the war in Indochina, Red Cross staff provided counseling, communications, and recreation support for members of the Armed Forces.

In the mid-1970's, when more than 150,000 refugees fled Indochina, and later, when another 130,000 persons left Cuba and Haiti, the Red Cross worked with other private agencies and the government in centers where the refugees were temporarily housed pending their sponsorship in communities throughout the country. The Red Cross Refugee Locator Unit in Washington, D. C., continues to operate, reuniting families and friends from Indochina.

The decade of the seventies was a time of considerable growth for the Red Cross Blood Services, which now collect, process, and distribute more than half of the nation's total volunteer blood supply. A computerized inventory system enables blood centers to balance their overages and shortages with each other every day, thus preventing wastage.

The Red Cross has used the new technologies of the late twentieth century in various ways to enable it to give better service to people. A communications satellite has been available to link disaster-ravaged areas with the outside world. Video-tape has provided more effective means of training and furnishing public information.

Nearly 1,500,000 persons give service to their community through the Red Cross, and nearly 4,200,000 individuals donate blood in Red Cross regional blood centers or are recruited for cooperating local blood banks. There are more than 4,000,000 students in more than 21,000 elementary and secondary schools involved in Red Cross activities. Many of these young people are being trained for leadership roles in the future.

* * *

American Red Cross President George M. Elsey, in his book *The American Red Cross: The First Century*, examines the Society's first hundred years and gives some of his views concerning the organization and its service in the coming century.

He wrote inter alia: "The question arises: What will the 1980's and later decades mean to the (American) Red Cross? I would rather phrase the question: What will (American) Red Cross mean to the nation in the '80s and beyond?"

“America need not fear the future, nor should its Red Cross. In its first century, the American Red Cross has evolved into a great national tradition of voluntary service. Millions of men, women and youth have educated people to help themselves and to help each other. Voluntary service will continue, but as the nation confronts future challenges, it will take new forms. Red Cross service rests on the bedrock philosophy that Americans can make the country a better place to live in by working together through voluntarism... We have the conviction that the lessons of its first hundred years will provide a secure foundation for the Red Cross to meet the challenges of the future through new services, new relationships and new talents.”

* * *

The International Review thanks the American Red Cross for contributing this article and at the same time extends its congratulations and warm wishes.

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BOOKS AND REVIEWS

H. MONTEALEGRE KLENNER: STATE SECURITY AND HUMAN RIGHTS ¹

The maintenance of the security of the State and the respect of human rights are today two subjects of major concern, especially in Latin American countries.

To satisfy both those imperatives, which at times may appear to be in conflict with each other, H. Montealegre offers a comprehensive and universal solution: the respect of municipal law and of international law. In his book, he endeavours to give a rigorously reasoned demonstration of the validity of this proposition.

The author points out that today there are numerous countries where regimes rule under emergency powers which they claim to be necessary to safeguard the gravely threatened security of the State. These circumstances have led to the proclamation of martial law, and to various persons or groups of citizens being branded as enemies of the State and brought to trial on charges of treason, which is equivalent to applying the concepts of traditional law of war to situations which they were not intended to cover. On the other hand, modern international law, which was specifically designed to deal with such problems, has not been referred to in the majority of cases. These abnormal juridical situations reveal a profound uneasiness, arising from the determination to maintain the security of the State. The factors of State security and juridical mechanisms of its defence are systematically described in detail by H. Montealegre.

His analysis considers traditional law and traces its evolution in order to explain the problem in the light of contemporary juridical thought. While wars were formerly considered to be matters affecting exclusively the parties involved, and internal conflicts to be the affair

¹H. Montealegre Klenner: *La seguridad del Estado y los derechos humanos*. Academia de Humanismo cristiano. Santiago de Chile, 1979, 772 pp. (in Spanish only).

solely of the country in which they occurred, today that is no longer true. A conflict, whatever its nature, can represent a threat to international peace and security; the security of the State no longer appears to be a purely internal matter and begins to assume a universal character.

For a scientific approach to this vast and controversial problem, the author has taken as his starting-point an axiom of international law, namely that a State is made up of three constitutive elements: territory, government and population. According to Montealegre, the security of the State is ensured if a juridical system exists that will allow it to act efficaciously when one of those three elements is threatened, and if it is possible to secure the country's territorial integrity, the government's stability and the respect of the inhabitants' fundamental rights. Since none of those constitutive elements can alone represent the State, the defence of the State can only be obtained by the balance of all three elements in such a way that none of them is in a position of supremacy in relation to the other two. Should one of them be threatened or attacked, the State should be able to call upon the law in order to exercise a form of self-defence which should always be in due proportion.

The security of the State may be threatened from outside by a war which would endanger its territory; in such situations, the law of war and international humanitarian law are applicable and the author gives an account of their development and content. Internally, the security of the State may be menaced by an insurrection trying to overthrow the government; in this connection, the norms applicable in non-international armed conflicts are discussed in the second part of the book. But a threat to the security of the State may also come from the government itself, when the latter systematically violates the fundamental and inalienable rights of its citizens; this is therefore the subject-matter of the third part of the book, in which human rights are outlined.

The originality of Montealegre's book lies in his treatment of the violation of human rights as a factor undermining the security of the State. The author considers that the State has a twofold responsibility where the respect of human rights is concerned. First, if a State has ratified the Geneva Conventions, it is responsible towards the international community for the enforcement of the rights contained in the Conventions; and secondly, the constitutions of States impose a specific duty on the authorities to guarantee those rights to the inhabitants. The systematic violation of human rights by the State is a threat to its own security, because its action provokes both an external and an internal reaction. Every oppressive regime finishes up by generating an aggressive response. In contrast, the respect of human rights is an element of

international peace; that is why the defence of the dignity of the human person—defence which is often at the origin of oppressive or aggressive plans—constitutes a defence of peace. In this respect, the individual is to be considered as a valid element of the international juridical system.

In the author's view, the law of nations must take into account, over and above the States, the human person and beyond the universal community of nations there is the universal community of human beings, whose vital rights and mutual recognition constitute a fundamental mechanism of the security system.

Writings on international humanitarian law in Spanish are far from numerous. This particular book, which examines, in addition to that law, the classical law of war and human rights, is also a valuable work of reference, for in it may be found a consideration of the latest developments in international law in general, including the 1977 Protocols to the Geneva Conventions in particular.

The publication of this book is an event and its author deserves our thanks. It is primarily a scholarly and legal work, but it also holds a message of peace.

Sylvie Junod

The *International Review of the Red Cross* welcomes articles on subjects relating to international humanitarian law and the Red Cross.

Such articles must, however, comply with the following rule: they must avoid all reference to current political situations or events and sterile controversies on political, religious or racial topics.

■ Manuscripts may be submitted in French, English, Spanish or German. They should if possible be typewritten and must not exceed 12,000 words, with a minimum of footnotes.

Authors are requested to send their contributions to the editor of the *International Review* (address on page 3 of the Review), without failing to indicate their address.

EXTRACT FROM THE STATUTES OF
THE INTERNATIONAL COMMITTEE OF THE RED CROSS

ADOPTED 21 JUNE 1973

ART. 1. — *International Committee of the Red Cross*

1. The International Committee of the Red Cross (ICRC), founded in Geneva in 1863 and formally recognized in the Geneva Conventions and by International Conferences of the Red Cross, shall be an independent organization having its own Statutes.

2. It shall be a constituent part of the International Red Cross.¹

ART. 2. — *Legal Status*

As an association governed by Articles 60 and following of the Swiss Civil Code, the ICRC shall have legal personality.

ART. 3. — *Headquarters and Emblem*

The headquarters of the ICRC shall be in Geneva.

Its emblem shall be a red cross on a white ground. Its motto shall be *Inter arma caritas*.

ART. 4. — *Role*

1. The special role of the ICRC shall be:

- (a) to maintain the fundamental principles of the Red Cross as proclaimed by the XXth International Conference of the Red Cross;
- (b) to recognize any newly established or reconstituted National Red Cross Society which fulfils the conditions for recognition in force, and to notify other National Societies of such recognition;
- (c) to undertake the tasks incumbent on it under the Geneva Conventions, to work for the faithful application of these Conventions and to take cognizance of any complaints regarding alleged breaches of the humanitarian Conventions;
- (d) to take action in its capacity as a neutral institution, especially in case of war, civil war or internal strife; to endeavour to ensure at all times that the military and civilian victims of such conflicts and of their direct results receive protection and assistance, and to serve in humanitarian matters, as an intermediary between the parties;
- (e) to ensure the operation of the Central Information Agencies provided for in the Geneva Conventions;
- (f) to contribute, in view of such conflicts, to the preparation and development of medical personnel and medical equipment, in co-operation with the Red Cross organizations, the medical services of the armed forces, and other competent authorities;
- (g) to work for the continual improvement of humanitarian international law and for the better understanding and diffusion of the Geneva Conventions and to prepare for their possible extension;
- (h) to accept the mandates entrusted to it by the International Conferences of the Red Cross.

2. The ICRC may also take any humanitarian initiative which comes within its role as a specifically neutral and independent institution and consider any question requiring examination by such an institution.

ART. 6 (first paragraph). — *Membership of the ICRC*

The ICRC shall co-opt its members from among Swiss citizens. It shall comprise fifteen to twenty-five members.

¹ The International Red Cross comprises the National Red Cross Societies, the International Committee of the Red Cross and the League of Red Cross Societies. The term "National Red Cross Societies" includes the Red Crescent Societies and the Red Lion and Sun Society.

ADDRESSES OF NATIONAL SOCIETIES

- AFGHANISTAN (Democratic Republic) — Afghan Red Crescent, Puli Artan, *Kabul*.
- PEOPLE'S SOCIALIST REPUBLIC OF ALBANIA — 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, *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, *Dacca 2*.
- PEOPLE'S REPUBLIC OF BENIN — Red Cross of Benin, B.P. 1, *Porto Novo*.
- BELGIUM — Belgian Red Cross, 98 Chaussée de Vleurgat, 1050 *Brussels*.
- 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*.
- 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*.
- 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, Carrera 7a, 34-65, Apartado nacional 1110, *Bogotá D.E.*
- CONGO, PEOPLE'S REPUBLIC OF THE — Croix-Rouge Congolaise, place de la Paix, *Brazzaville*.
- COSTA RICA — Costa Rican Red Cross, Calle 14, Avenida 8, Apartado 1025, *San José*.
- CUBA — Cuban Red Cross, Calle 23 201 esq. N. Vedado, *Havana*.
- CZECHOSLOVAKIA — Czechoslovak Red Cross, Thunovska 18, 118 04 *Prague 1*.
- DENMARK — Danish Red Cross, Dag Hammarskjöldsgade 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, 3a Avenida Norte y 3a Calle Poniente, *San Salvador, C.A.*
- ETHIOPIA — Ethiopian Red Cross, Rass 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 (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, 3ª 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, 7a Calle, 1a y 2a Avenidas, *Comayagüela, D.M.*
- HUNGARY — Hungarian Red Cross, V. Arany János utca 31, *Budapest V. Mail Add.: 1367 Budapest 5, Pf. 249*.
- ICELAND — Icelandic Red Cross, Nóatúni 21, 105 *Reykjavik*.
- INDIA — Indian Red Cross, 1 Red Cross Road, *New Delhi 110001*.
- INDONESIA — Indonesian Red Cross, Jalan Abdul Muis 66, 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 10 001, *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, *Pyeongyang*.
- KOREA, REPUBLIC OF — The Republic of Korea National Red Cross, 32-3Ka Nam San-Dong, *Seoul*.
- KUWAIT — Kuwait Red Crescent Society, P.O. Box 1350, *Kuwait*.
- 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, JKR 2358, Jalan Tun Ismail, *Kuala Lumpur 11-02*.
- 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° 1032, *México 10 D.F.*
- 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 Aketa 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, 169, Sarwar Road, *Rawalpindi*.
- 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, Jirón Chancay 881, *Lima*.
- PHILIPPINES** — Philippine National Red Cross, 860 United Nations Avenue, P.O.B. 280, *Manila D 2803*.
- POLAND** — Polish Red Cross, Mokotowska 14, *Warsaw*.
- PORTUGAL** — Portuguese Red Cross, Jardim 9 Abril, 1 a 5, *Lisbon 3*.
- ROMANIA** — Red Cross of the Socialist Republic of Romania, Strada Biserica Amzei 29, *Bucarest*.
- 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, Fack, S-104 40 *Stockholm 14*.
- SWITZERLAND** — Swiss Red Cross, Rainmattstr. 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*.
- 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, Nabunya Road, P.O. Box 494, *Kampala*.
- UNITED KINGDOM** — British Red Cross, 9 Grosvenor Crescent, *London, SW1X 7EJ*.
- UPPER VOLTA** — Upper Volta Red Cross, P.O.B. 340, *Ouagadougou*.
- 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 No. 4, Apart. 3185, *Caracas*.
- VIET NAM, SOCIALIST REPUBLIC OF** — Red Cross of Viet Nam, 68 rue Bà-Triêu, *Hanoi*.
- YUGOSLAVIA** — Red Cross of Yugoslavia, Simina ulica broj 19, *Belgrade*.
- REPUBLIC OF ZAIRE** — Red Cross of the Republic of Zaire, 41 av. de la Justice, B.P. 1712, *Kinshasa*.
- ZAMBIA** — Zambia Red Cross, P.O. Box R.W.1, 2837 Brentwood Drive, *Lusaka*.