PROTECTION OF HEALTH CARE AND LAW ENFORCEMENT

CASE STUDIES AND PROPOSED GUIDELINES FOR THE IMPROVED INTERACTION BETWEEN LAW ENFORCEMENT AGENCIES AND HEALTH-CARE PROVIDERS IN ORDER TO PROTECT AND FACILITATE ACCESS TO HEALTH CARE IN EMERGENCIES OTHER THAN ARMED CONFLICTS

REFERENCE

ICRC

The International Committee of the Red Cross (ICRC) would like to thank all of the participants who took part in providing information for this report, as well as the panel of experts who reviewed the document and provided invaluable feedback which improved the final version.

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INTRODUCTION

Law enforcement agencies (LEAs) and health-care providers coexist in many of the contexts in which the ICRC operates. In emergency situations not related to armed conflict, including situations of violence, there are various moments at which this interaction can take place – moments that can be both challenging and collaborative.

The past two years have been most notably marked by the COVID-19 pandemic and the rise of social unrest, in part linked to the effects of pandemic control measures and the uncertainty generated by the disease.[1] This has come on top of protracted situations of collective violence, urban violence and other emergency scenarios where the health needs of populations grow exponentially, such as in cases of natural disasters or waves of displacement or migration. It is these emergency situations that do not reach the threshold of armed conflict[2] that this paper will focus on.

In each of these moments, multiple rights, responsibilities, duties and prerogatives interact. It is the role of law enforcement to ensure public safety, while it is the role of health-care workers to provide care according to medical ethics. Patients also have duties and are subject to the law. But regardless of their alleged crimes, they have the right to life and, more specifically, the right to health.

In many cases, law enforcement officials and health-care workers can exercise their prerogatives without incompatibility while prioritizing the right to life and health for all. For this to be successful, it requires a mutual understanding of the legitimate roles and responsibilities of different state functions. It also requires that law enforcement officials not act in opposition to human rights, which in many cases would bring the prerogatives of health-care workers to work in the best interests of their patients into tension with law enforcement.

However, even when both health-care workers and LEAs carry out their duties in accordance with legal standards and ethical duties, and with mutual understanding, there will remain moments of tension.

One of the clearest points of tension will be when the balance between individual rights is weighed against a collective interest like public health or public security. This can result in health-care workers being obligated to share certain information about a patient's condition. It can also result in restrictive measures being put in place to control a public health emergency or in access to health care being momentarily disrupted.

Another broad area of tension can exist when LEAs play an expanded role in health care, owing to the scale of a crisis and the need for LEAs' logistical capacity, to the specific risks faced by health-care workers or to the enforcement powers of LEAs. In playing this greater role, LEAs can blur some of the necessary distinctions between the two fields. The lack of distinction between these two sets of activities – health care and law enforcement – can erode trust in health-care providers, as well as affecting access to care for patients and the safety of health-care workers and facilities in some contexts.

A third broad area of tension exists when the political stance of impartial health-care workers and their involvement in, or affiliation with, individuals or groups of interest to LEAs is perceived by LEAs as health-care workers forfeiting their protections and the legitimacy of their actions. This often goes hand-in-hand with LEAs seeking to limit certain groups or individuals from accessing health care as a way to punish or deter them, for example, for their political position or participation in protests.

These are not conceptual challenges. Interaction between law enforcement and health-care workers is inevitable and it is important that this interaction takes place in a way that promotes mutual understanding

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1 Ortiz, I., Burke, S., Berrada, M. and Cortes, H. "*World Protests: A Study of Key Protest Issues in the 21st Century*" 2022. New York: Palgrave MacMillan, IPD Columbia University, Friedrich-Ebert-Stiftung. https://link.springer.com/book/10.1007/978-3-030-88513-7

2 ICRC, "How is the Term 'Armed Conflict' Defined in International Humanitarian Law?" ICRC Opinion Paper, March 2008. https://www.icrc.org/en/doc/assets/files/other/opinion-paper-armed-conflict.pdf

and respect for the impartiality of health-care workers, that preserves the community's trust in health-care providers and that reduces tensions through dialogue. This is essential for ensuring the safety of health care and for facilitating access to health care.

This report seeks to be as practical as possible by identifying some of the common points of tension and collaboration between health-care workers and LEAs, and then by examining some case studies where it has been possible to overcome or address some of the common points of tension. The focus of this report is to propose some broad recommendations, which have been developed from both case studies and open-source information and can serve as a starting point for adaptation to specific emergency contexts.

This report focuses on situations that do not meet the threshold of armed conflict. It therefore includes, for example, situations of urban violence, political unrest and pandemics. This report focuses exclusively on law enforcement officials,[3] i.e. state officers exercising police powers (this could include police, intelligence officials, state security forces, etc.).

3 Code of Conduct for Law Enforcement Officials, commentary on Art. 1, Commentary: (a) The term "law enforcement officials", includes all officers of the law, whether appointed or elected, who exercise police powers, especially the powers of arrest or detention. (b) In countries where police powers are exercised by military authorities, whether uniformed or not, or by State security forces, the definition of law enforcement officials shall be regarded as including officers of such services.

METHODOLOGY

This report is not intended to be an academic study but rather a practical guide. However, the development of the report did make use of a number of qualitative research methodologies.

OPEN-SOURCE INFORMATION REVIEW

This phase of the information collection process for this report entailed identifying open sources of information from academic journals and grey literature, including from the press. Keyword searches were centred around the different ways in which LEAs and health-care workers interact (first responders/first-aiders and LEAs, ambulances and LEAs, health-care facilities and LEAs, pandemics/COVID-19 and LEAs, etc.).

IN-DEPTH INTERVIEWS

This phase of the information collection process included interviewing ICRC delegates in the field, experts in Geneva and external experts outside of the ICRC. Semi-structured interviews took place with a total of 28 people. Of these interviewees, 23 were internal ICRC armed and security forces delegates and focal points working on the protection of health care in different delegations. The rest of the interviews were conducted with external subject matter experts.

CASE STUDY IDENTIFICATION

Through the in-depth interview process and literature review, it was possible to identify a number of case studies that demonstrated positive practice. These case studies were organized thematically and supplemented by information gathered in additional open-source reviews.

EXPERT PANEL REVIEW

The findings of the research have been presented to an expert review panel of ICRC staff and external experts for review and comment.

LIMITATIONS

The limitations of this report include the difficulty in obtaining detailed information of case studies due to: (i) staff turnover of the people involved, (ii) a lack of documentation for some of the case studies identified, and (iii) the need to avoid the inclusion of privileged or sensitive information. In addition to this, there is very little documentation available in the literature on the interaction between LEAs and health-care workers outside of Europe and North America. The experiences offered by the COVID-19 pandemic are also not yet fully documented.

THE GUIDING FRAMEWORKS: HUMAN RIGHTS, CODES OF CONDUCT AND MEDICAL ETHICS

While the interaction between LEAs and health-care providers is inevitable, especially during emergencies, there are legal frameworks, codes of conduct and ethical duties to guide this interaction. There are "laws that regulate police, laws that regulate medical personnel, and laws that protect patients, even when they are arrested or incarcerated".[4]

The International Covenant on Civil and Political Rights (ICCPR, 1966) protects the fundamental rights of everyone – regardless of the context – to life, to be free from cruel, degrading and inhuman treatment, and to be free from all forms of discrimination. The "right to health" first appeared in the Constitution of the World Health Organization (1946) and is enshrined in the ICCPR (1966).

Under Article 12 of the International Covenant on Economic, Social and Cultural Rights, states must take steps to ensure the right of everyone to the highest attainable standard of physical and mental health. General Comment No. 14 of the United Nations Economic and Social Council states that the right to health includes essential primary health care, access to minimum essential food, basic shelter, housing and sanitation, and an adequate supply of safe and potable water, as well as essential drugs. These core obligations are non-derogable and require states to respect, protect and fulfil the right to health. The right to medical care is also provided for under Article 25 of the Universal Declaration of Human Rights, an instrument accepted in whole or in part as international customary law.[5]

General Comment No. 6 on the right to life of the United Nations Human Rights Committee states that the right to life in the ICCPR also contains the obligation for states to take positive measures to protect life, including measures to ensure health care, especially in life-threatening circumstances.[6]

These obligations on states to ensure a right to health have consequences for the relationship between law enforcement and health-care workers. For example, arresting medical personnel for providing care may constitute a violation of the protection against arbitrary arrest and detention, even if this is done lawfully under domestic legislation. In addition to this:

> States have a non-derogable obligation to ensure access to health infrastructure. They must therefore respect medical units and transports. States may not target them or use them to launch law enforcement operations or to carry out other similar measures. States must also take measures to protect medical units and transports from attacks or misuse by third parties.[7]

While LEAs are obliged to uphold and protect a population's fundamental rights, their obligations in facilitating and protecting the right to health when exercising their law enforcement functions is additionally outlined in soft law. According to the *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials*, adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders (in Havana, Cuba, 27 August to 7 September 1990), law enforcement officials must, whenever the lawful use of force and firearms is unavoidable, "ensure that assistance and medical aid are rendered to any injured or affected persons at the earliest possible moment".[8]

4 Janeway, H; Samra, S; Song, J. "An Ethical, Legal, and Structural Framework for Law Enforcement in the Emergency Department" Annals of Emergency Medicine, Volume 78, Issue 6, 2021, Pages 749-751, https://www.sciencedirect.com/science/article/abs/pii/S0196064421007964

5 ICRC. Health Care in Danger Initiative. "Protecting Healthcare. Guidance for the Armed Forces". November 2020. https://healthcareindanger.org/wp-content/uploads/2021/03/4504_002-ebook.pdf

6 *Ibid*.

7 ICRC. "Respecting and Protecting Health Care in Armed Conflicts and in Situations Not Covered by International Humanitarian Law" 2012. https://www.icrc.org/en/doc/assets/files/2012/health-care-law-factsheet-icrc-eng.pdf

8 Principle 5 (c), UN Basic pr4inciples on the Use of Force and Firearms https://www.ohchr.org/en/professionalinterest/pages/useofforceandfirearms.aspx

Health-care providers also have duties that can facilitate and support a less conflictual relationship with LEAs. This includes the importance of impartiality outlined by the World Medical Association[9] as well as the unconditionality of relief and care. In addition to this, medical ethics are fundamental in guiding the work of health-care providers. The three pillars of health-care ethics are respect for the autonomy and dignity of the individual, maintaining confidentiality and ensuring genuine and valid consent for any procedure.[10]

Although emergency situations can create moments of exception, the right to health can only be limited "as long as the purpose of doing so is to assure the welfare of the general population".[11] Both limitations and derogations cannot violate other international law, must be necessary, proportionate and non-discriminatory and must be publicly declared and time-bound.

For a state to limit the right to health for security reasons or the preservation of public order, it would have to justify that "such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society".[12]

9 World Medical Association. "WMA Regulations in Times of Armed Conflict and Other Situations of Violence". Adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956, and edited by the 11th World Medical Assembly, Istanbul, Turkey, October 1957, revised by the 35th World Medical Assembly, Venice, Italy, October 1983, the 55th WMA General Assembly, Tokyo, Japan, October 2004, editorially revised by the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006, and revised by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012. https://www.wma.net/policies-post/wma-regulations-in-times-of-armed-conflict-and-other-situations-of-violence/

10 ICRC. "Health Care in Danger: The responsibilities of health-care personnel working in armed conflicts and other emergencies" August 2012. https://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4104-the-responsibilities-health-care-personnel.pdf

11 Ibid.

12 Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) Adopted at the Twenty-second Session of the CESCR, on 11 August 2000. https://www.refworld.org/pdfid/4538838d0.pdf. In addition, art. 4 of the International Covenant on Economic, Social and Cultural Rights states that "The States Parties to the present Covenant recognize that, in the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject such rights only to such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society."

POINTS OF INTERACTION

Through key informant interviews and open-source data collection, it was possible to identify a number of moments during which health-care workers, patients and LEAs interact. These interactions are more common during moments when a crime is suspected or has been committed, during situations of violence or in emergencies that increase the role of LEAs. The most common moments of interaction identified can be summarized as follows:

THE FIRST POINT OF INTERACTION CAN BE BETWEEN PATIENTS, FIRST RESPONDERS AND LEAS. In emergency situations, this often occurs during protests and situations of unrest, or during mass-casualty events. For example, protest action can result in direct injuries caused by the confrontation between protesters and LEAs, requiring pre-hospital care and first aid in the field or the transfer of the injured to hospitals.

THE SECOND POINT OF INTERACTION CAN BE BETWEEN PATIENTS IN TRANSIT, AMBULANCES AND LEAS. These moments of interaction can occur when a person needing medical attention is being transported, or during a public health emergency or security operation when law enforcement officials are enforcing movement restrictions as part of public health or security measures. For example, during road closures, health-care workers (including ambulance crews) need to dialogue with both protesters and LEAs to respect their impartiality and to allow the transfer of the injured and sick. Both parties often qualify first responders as collaborators of the other party.

THE THIRD POINT OF INTERACTION CAN BE BETWEEN PATIENTS, HEALTH-CARE WORKERS IN A HEALTH-CARE FACILITY AND LEAS. This third point of interaction can further be divided into health-care facilities that are mobile (mobile clinics), emergency rooms (ERs)/emergency departments (EDs) where trauma patients enter a secondary health-care facility and other departments of health-care facilities such as morgues. For example, this point of interaction can occur when the police bring a person under custody for treatment, when LEAs are seeking information, when a search and arrest operation takes place within a health-care facility or when health-care workers are required to report certain health information.

THE FOURTH POINT OF CONTACT CAN BE BETWEEN COMMUNITIES IN GENERAL AND LEAS IN THE CONTEXT OF A PUBLIC HEALTH EMERGENCY, where law enforcement officials may be enforcing certain publichealth measures. For example, LEAs can impose compliance with certain sanitary measures when implementing a government's response to a publichealth emergency.

During each of these moments of interaction, health-care workers may be providing treatment to **individuals who may be of interest to LEAs**, such as undocumented migrants or people in conflict with the law. In many emergency situations, these individuals – and other groups of people of interest to LEAs – may be more vulnerable because of socio-economic factors, or owing to their legal status, their political opinions or other considerations.

The vulnerability of patients is in contrast to the powers bestowed on LEAs. At each point of interaction, LEAs can be playing one or more of three different roles. They can be playing a regulatory role with regard to the provision of health care and access to such care for patients, they can be interacting with health-care workers while a patient is under care and they can be securing health-care provision.

TENSION

There are a number of tension points that can exist between LEAs and health-care providers during these various moments of interaction. These points of tension occur within each of the generic policing functions, such as the use of force, or arrest and detention, as well as in other policing functions that may occur during a public health emergency such as the enforcement of containment measures or border control, or in cases where there is a need for exceptional measures such as crowd or movement control. For health-care workers, these challenges are encountered during their functions as first responders, transporting patients and providing care in facilities. For communities, these tensions are experienced when trying to access health care during emergencies.

Based on ICRC field experiences and open-source information, some examples of tensions that can arise during the different points of interaction between health-care workers and law enforcement, with consequences for the protection of health-care workers and facilities, and for access to health, can include:[13]

PATIENTS, FIRST RESPONDERS AND LEAS

- LEAs failing to differentiate between impartial health-care workers and protesters when health-care workers make their political opinions clear or are in support of protesters
- Law enforcement personnel failing to provide medical assistance to people injured in law enforcement operations (LEOs)
- LEAs harassing or using force against first responders, health-care workers or ambulances in order to deter or punish health-care workers from providing assistance to certain groups or individuals

PATIENTS IN TRANSIT, AMBULANCES AND LEAS

- LEAs obstructing the movement of health-care workers, first responders or ambulances in emergency situations
- LEAs using medical equipment, uniforms, establishments or ambulances for LEOs, such as transferring LEA personnel or ammunition

PATIENTS, HEALTH-CARE WORKERS IN A HEALTH-CARE FACILITY AND LEAS

- LEAs using health-care centres as staging posts for LEOs (which could entail launching LEOs from within health-care facilities into the community)
- Civilians disrespecting the humanitarian work of health-care workers and taking advantage of the protective status of health-care facilities to seek refuge during different situations of violence, without being sick or injured
- LEAs interrogating or detaining a patient under care or using health-care centres to identify and detain political opponents, protesters and others before the necessary medical treatment has been completed
- LEAs threatening, coercing or systematically – or for no legitimate reasons – obliging health-care workers to hand over confidential patient records or to report certain individuals, thereby undermining community trust in health-care providers
- LEOs taking place in or around health-care facilities and impeding access to health care for communities in the vicinity
- Generalized LEA surveillance that undermines patient confidentiality
- LEA actions that arbitrarily undermine patient autonomy (such as handcuffing patients to beds unnecessarily)
- Gunshot wound (GSW) patients or patients injured in LEOs being detained/questioned before receiving medical attention or being forced to go through lengthy law enforcement proceedings before being allowed to access care
- Use of riot-control agents in close proximity to health-care facilities
- Patients being transferred out of health-care facilities to places of detention against medical advice or before completing their treatment

13 The specific contexts in which the below examples are drawn from have been anonymised. These examples are drawn from open-source information and from information provided during key informant interviews.

COMMUNITIES IN GENERAL AND LEAS IN THE CONTEXT OF A PUBLIC HEALTH EMERGENCY

- Lack of effective communication with the population during LEA enforcement of public health measures in a public health emergency
- The increasing role of LEAs in the state's responses to health crises can undermine community trust in health-care provision (using coercive action to enforce public health measures such as containment)
- Blanket movement restrictions imposed by LEAs during pandemic/epidemic lockdowns that prevent access to health care for patients
- LEAs arbitrarily applying lockdown restrictions on health-care workers during a pandemic
- Enforcement of lockdowns that result in violence toward health-care workers by LEAs (for example, detention or physical assault of health-care workers accused of breaking lockdown laws)

PEOPLE OF INTEREST TO LEAS, HEALTH-CARE WORKERS AND LEAS

- Policies that criminalize the provision of health care to certain individuals, especially on grounds of countering "terrorism"
- LEAs conducting security screening and arresting the injured before they have received treatment, or slowing down or delaying their access to health care
- LEAs preventing movement and restricting access to assistance and health care as a way to deter migrants, including refugees, from entering a specific country or region
- LEAs using health-care facilities to identify migrants deemed irregular by the authorities and to carry out arrest operations
- Domestic legislation used to punish health-care workers under false pretences (for example, for spreading false information or for working without the correct authorization)
- Expansive use of border-control measures during a public health emergency to restrict movement of refugees/people seeking asylum
- Administrative sanctions, including pay cuts, suspension, dismissal or even revocation of professional licences to crack down on medical professionals suspected of affiliation with, or having provided support to, government opponents or banned groups
- LEAs forcing medical professionals to perform acts that might be perceived as harmful to the patients (approving solitary confinement, or supervising "tough" interrogation sessions involving conduct that may amount to torture or other ill-treatment)
- Providing health-care activities as a cover for security activities, such as intelligence gathering

The reasons for these negative experiences are both "technical" and "political" problems. Technical problems are those that can be fixed by, for example, ensuring greater understanding of LEA obligations, better coordination and other practical measures that can be implemented by both LEAs and health-care workers. Political problems, on the other hand, entail cost-benefit calculations on behalf of LEAs that result in conscious restrictions being placed on certain groups in accessing health care, and deterrents or limitations on health-care providers in assisting those groups, including targeted acts of violence toward health-care workers and facilities. This can occur in situations where, for example, LEAs consider it in their interests to prevent protesters or political opponents from accessing health care as a way to deter them from engaging in activities deemed to be a threat to security. Often, these political decisions are justified on the grounds of public safety and security. However, the misuse of this exception generates mistrust in LEAs among the population and health-care workers.

A lack of knowledge about the obligations of LEAs or how to implement their obligations is a technical problem requiring important technical fixes. A lack of acknowledgement of the applicability of the right to health for people designated as "criminals", or a belief that not upholding some people's individual rights is more beneficial than upholding those rights, is a political decision requiring political engagement and dialogue in order to promote respect for the LEA's legal obligations. Finally, a belief that the suppression of the rights of an individual patient is in the interests of the population as a whole is a legitimate justification that may have been miscalculated or influenced by the preceding two factors, requiring both technical and political engagement.

The negative experience of interaction between law enforcement and health-care providers is just one part of the picture. There are also positive experiences that demonstrate the value of communities trusting law enforcement and health-care providers.

COLLABORATION

The positive experiences that can be pre-identified with regard to health-care worker and LEAs interaction include:

PATIENTS, FIRST RESPONDERS AND LEAS

- Health-care workers and LEAs effectively coordinating during political protests to ensure the ability of first responders to move and to facilitate safe access to health care for patients
- LEAs that foresee and adopt protocols for the care of the injured during violent situations
- LEAs providing first aid, search and rescue, transporting patients or providing health-care services immediately after a natural disaster

PATIENTS IN TRANSIT, AMBULANCES AND LEAS

- LEAs escorting ambulances or essential medical supplies during situations of unrest or insecurity
- LEAs ensuring that safe evacuation routes exist for the injured before launching an LEO

PATIENTS, HEALTH-CARE WORKERS IN A HEALTH-CARE FACILITY AND LEAS

- Domestic legislation reinforcing the confidentiality of patient information or reinforcing the right of certain patients to receive treatment
- LEAs protecting health-care workers from hostile patient families or communities
- LEAs setting up security perimeters, at a distance from hospitals, to increase protection while ensuring their neutrality is still preserved and limiting confusion between LEA and health-care facilities in places where health-care facilities are at particular risk
- LEAs facilitating health-care workers' access to health-care facilities during times of political unrest
- Domestic legislation punishing particular forms of violence against health-care workers and/or facilities
- Health-care workers, police and forensic experts effectively collaborating to deal with dead bodies in order to identify corpses
- LEAs preventing criminal groups from carrying out attacks within health-care facilities
- LEAs respecting "no gun" policies within health-care facilities in order to preserve the neutrality of health care

COMMUNITIES IN GENERAL AND LEAS IN THE CONTEXT OF A PUBLIC HEALTH EMERGENCY

- LEAs securing buildings that need to be disinfected during an outbreak or pandemic
- Logistics support from LEAs for vaccine distribution during a public health emergency
- Joint command posts being established between different actors at the highest level of government during a public health emergency to ensure smooth collaboration
- LEAs protecting vulnerable communities at risk of violence owing to stigmatization in a pandemic
- LEAs raising awareness among a community of public health measures during a pandemic
- LEAs combating online misinformation and disinformation during a pandemic
- LEAs positively enforcing public health measures during a pandemic (by, for example, providing information on the importance of mask wearing and social distancing in communities)

PEOPLE OF INTEREST TO LEAS, HEALTH-CARE WORKERS AND LEAS

- LEAs collaborating with health-care workers in the collection of evidence for criminal prosecution in the case of, for example, sexual and gender-based violence (SGBV). This is done in a way that respects a victim's/survivor's dignity, well-being and autonomy.
- LEAs ensuring that gunshot victims receive emergency medical treatment ahead of any legal proceedings
- Investigative and law enforcement procedures respecting patient confidentiality
- LEAs requesting collaboration from health-care workers through a legal representative of the health institutions and not directly from health-care workers in the health-care field
- LEAs respecting the principles of neutrality, impartiality, humanity and professional secrecy of health-care workers

Many of these positive experiences occur in contexts where there is community trust in the role of LEAs and health-care providers, and mutual trust between health-care workers and LEAs. Trust is not built during times of crisis. It is built in times of calm, and maintained during crisis situations by ensuring that certain measures are in place to preserve that trust. For example, COVID-19 has demonstrated the importance of a trustful relationship between LEAs and communities in order to manage public health emergencies. But other emergency situations have demonstrated how the actions of LEAs in relation to health care can undermine that trust. While community trust in LEAs and health-care workers is an ideal pre-requisite for effective collaboration, there is still a need for measures to be put in place to ensure the protection of health care and access to health in situations where that trust does not exist.

This report will focus on positive case studies and recommendations that can further elaborate on some of the important technical fixes. Where possible, it will also demonstrate why it is in the interests of law enforcement and health-care workers to preserve a population's access to, and trust in, health-care provision. The COVID-19 pandemic has illustrated that any short-term gains that may have existed for LEAs not to protect access to, and provision of, health care have long-term implications when dealing with a pandemic such as COVID-19, which requires community trust to manage.

POINTS OF INTERACTION BETWEEN HEALTH-CARE WORKERS, LEAS AND PATIENTS	EXAMPLES OF TENSIONS	EXAMPLES OF COLLABORATION
FIRST RESPONDERS	• LEAs failing to differentiate between impartial health-care workers and protestors during political unrest. • LEAs hampering first responders from addressing needs during an emergency. • Law enforcement personnel failing to provide medical assistance to people injured in LEOs.	• Health-care workers and LEAs effectively coordinating during political protests to ensure the ability of first responders to move and to facilitate safe access to health care for patients. • LEAs that foresee and adopt protocols for the care of the injured during violent situations.
MOVEMENT OF PATIENTS	• LEAs obstructing the movement of health-care workers, first responders or ambulances in emergency situations. • LEAs using medical equipment, uniforms, establishments or ambulances for LEOs, such as transferring LEA personnel or ammunition.	• LEAs escorting ambulances or essential medical supplies during situations of unrest or insecurity. • LEAs ensuring that safe evacuation routes exist for the injured before launching an LEO.
HEALTH-CARE FACILITIES	• LEAs interrogating or detaining a patient under care or using health-care centres to identify and detain people before the necessary medical treatment has been completed. • LEAs threatening, coercing or systematically – or for no legitimate reasons – obliging health-care workers to hand over confidential patient records. • LEOs taking place around or inside health-care facilities and impeding access to health care for communities in the vicinity. • Patients being transferred out of health-care facilities to places of detention against medical advice or before completing their treatment.	• Domestic legislation reinforcing the confidentiality of patient information or reinforcing the right of certain patients to receive treatment. • LEAs protecting health-care workers from hostile patient families or communities. • LEAs facilitating health-care workers' access to health-care facilities during times of political unrest. • LEAs preventing criminal groups from carrying out attacks within health-care facilities.
PUBLIC HEALTH EMERGENCIES	• The increasing role of LEAs in the state's responses to health crises can undermine community trust in health-care provision (using coercive action to enforce public health measures such as containment). • Blanket movement restrictions imposed by LEAs during pandemic/epidemic lockdowns that prevent access to health care for patients. • LEAs arbitrarily applying lockdown restrictions on health-care workers during a pandemic.	• Joint command posts being established between different actors at the highest level of government during an epidemic or pandemic to ensure smooth collaboration. • LEAs protecting vulnerable communities at risk of violence owing to stigmatization in a pandemic. • LEAs raising awareness among a community of public health measures during a pandemic.
PATIENTS OF INTEREST FOR LEAS	• Policies that criminalize the provision of health care to certain individuals, especially on grounds of countering "terrorism". • LEAs conducting security screening and arresting the injured before they have received treatment, or slowing down or delaying their access to health care. • LEAs using health-care facilities to identify migrants deemed irregular by the authorities and carry out arrest operations.	• LEAs collaborating with health-care workers in the collection of evidence for criminal prosecution in the case of, for example, SGBV. • LEAs ensuring that gunshot victims receive emergency medical treatment ahead of any legal proceedings. • Investigative and law enforcement procedures respecting patient confidentiality.

CASE STUDY 1

ACCESS TO HEALTH CARE FOR INJURED PROTESTERS IN SOUTH AFRICA AND VENEZUELA

SOUTH AFRICA

In late 2016, students at university campuses across South Africa organized widespread protests under the banner of #FeesMustFall. Students called for an end to university fees. At the University of the Witwatersrand in Johannesburg, the university administration requested the support of the police to manage the situation.

The deployment of police on the university campus had a number of direct and indirect consequences, which were documented by the Socio-Economic Rights Institute of South Africa (SERI) in a document entitled *A Double Harm: Police Misuse of Force and Barriers to Necessary Health Care Services: Responses to student protests at the University of the Witwatersrand, September to November 2016*.[14] The report alleges that a number of violations took place in the way in which the police dealt with the protesters.

In addition to these findings, the report refers to the "double harm" caused by the lack of preparedness on behalf of the authorities to deal with the injuries caused by the police's use of force. Those who were injured faced difficulties in accessing essential medical attention. This was in part addressed by student first-aid volunteers from the medical school and staff at the existing campus health-care facility.

The responsibility of the police to provide treatment to those injured during the use of force was something that had been reaffirmed by a Commission of Inquiry following the killing of 34 striking mineworkers in Marikana in 2015. The Commission of Inquiry had recommended, that in "an operation where there is a high likelihood of the use of force, the plan should include the provision of adequate and speedy first aid to those who are injured".[15] However, these recommendations had not been implemented in the case of the police's handling of the #FeesMustFall protests.

In response to these challenges, a group of stakeholders, including the police, civil society, the ICRC, Médecins Sans Frontières and student medical volunteers, came together to develop *Guidelines for the provision of health care services during higher education protest action*.[16] The drafting of the guidelines involved high-level engagement from the police. While tensions existed in the first interactions between the different stakeholders, a decision was taken to focus on a way forward with regard to access to health care. As a neutral actor, the ICRC played an important bridge-building role between the different stakeholders. The stated purpose of the document is as follows:

> This document serves as a guide for all parties, including but not limited to: the university management; university health professional staff; volunteer student first aiders; student protesters; staff protesters; South African Police Services (SAPS); private medical services as well as private security, on their roles, acceptable conduct and expectations, towards the realization of the safe delivery of health care, including but not restricted to emergency medical treatment. This document should be read as putting forward foundational principles that would support the development of specific plans by institutions of higher education, which should be contextualized to the distinctive circumstances of each institution.

14 Rayner, M; Baldwin-Ragaven, L and Naidoo, S. "A Double Harm: Police Misuse Of Force And Barriers To Necessary Health Care Services. Responses To Student Protests At The University Of The Witwatersrand, September To November 2016" SERI.

15 Marikana Commission of Inquiry: Report on Matters of Public, National and International Concern Arising out the Tragic Incidents at the Lonmin Mine in Marikana, in the North West Province (March 2015), p. 552 at para. F(1).

16 Nelson Mandela Foundation, *Guidelines for the provision of health care services during higher education protest action*, 2017: https://www.nelsonmandela.org/uploads/files/NECFGuidelinesStudentProtest.pdf.

The guidelines recall various obligations and duties on all parties, including the obligation of health-care workers to uphold medical ethics, the neutrality and sanctity of health-care services, the responsibility of LEAs to provide first aid, non-interference in the work of health-care providers, the ethical duty of health-care workers to maintain patient confidentiality, the obligation on the university to provide adequate access to medical and psychological services, the duty of law enforcement to ensure the safety and security of the public and to uphold the law, the right to assembly as a human right, the provisions of international human rights mechanisms and the codes of conduct governing police behaviour.

The guidelines proceed to outline ways in which access to health care can be facilitated, how health-care facilities and transport can be protected, how coordination and training can be improved and how the guidelines can be best implemented.

EXCERPT FROM GUIDELINES FOR THE PROVISION OF HEALTH CARE SERVICES DURING HIGHER EDUCATION PROTEST ACTION

The guidelines were tabled in a joint sitting of parliament and were presented by the police themselves. The experience showed the benefits of strategic partnerships and coordinated efforts to build mutual understanding between LEAs and health-care workers. Identifying common ground and focusing on that enabled stakeholders from a variety of backgrounds and with different perspectives to agree on practical guidelines to ensure safe access to health care.

1. FACILITATION OF ACCESS TO HEALTH CARE

1.1 Taking into account the various forms of protest action, all parties should, where practicable, formulate a university-specific plan to facilitate access to health-care services. This plan should enumerate detailed information for the provision of health-care services, including contact numbers, command chains, site maps indicating the location of health-care facilities and any other relevant matters, in order to ensure the principle of medical neutrality.

1.2 Any health care provided by volunteer first-aiders, university staff, the local population, non-governmental organizations or other third parties does not relieve the state of its obligations to provide health care.

1.3 Health-care personnel for so long as they are legitimately acting in their capacity as health-care workers during periods of protest action may not be attacked, harassed, harmed or punished by anyone at the time of service provision or later as a form of victimization. Health-care personnel, presenting themselves as such, shall not carry out activities outside the course and scope of practice while working or volunteering in their medical capacity.

1.4 Health-care personnel must prioritize assessment and treatment without discrimination, based only on the patient's medical condition. Health-care personnel decide, in accordance with triage norms, clinical reasoning and ethical principles of health care, which patient receives priority.

1.5 All health-care personnel, transport and facilities should be marked with objectively visible markings to indicate the nature of that object, person or location as designated for medical care. Upon adoption of the plan referred to in 1.1 or as soon as is practicable, all stakeholders must agree on distinctive signs, or emblems to be used to distinguish health-care services and individuals providing such services during the protest.

1.6 The provision of medical attention must be the first priority for a suspect who requires health care prior to his/her arrest and/or removal from a health-care facility. To this end, a dialogue between law enforcement officials and health-care personnel will take place before the transfer of the patient into the custody of law enforcement officials.

2. PROTECTION OF HEALTH-CARE FACILITIES AND TRANSPORT

2.1 All parties shall respect and protect health-care facilities, transport and equipment at all times and these shall not be the object of attack or violence.

2.2 In accordance with the neutral status of health-care facilities and in order to protect staff and patients, health-care facilities or first-aid posts should be weapon-free areas.

2.3 Recognizing that protest action may have the potential to hinder access to health-care facilities, such access to health-care facilities must be ensured at all times by all stakeholders/parties.

2.4 LEAs should respect health-care facilities and use the principle of precaution by carefully planning their operations to avoid the strict necessity to use force near such facilities and their being harmed. If the use of force is nevertheless unavoidable, the force used must respect the principles of necessity and be strictly proportionate to the threat posed by an individual or group of individuals. This use of force does not justify harm to health-care facilities in proximity to any such threat.

2.5 No health-care facility should be used for purposes other than for providing health care. Likewise, information about injured persons is privileged.

2.6 Medical vehicles or transport shall be respected by all stakeholders and shall not be subject to violence of any kind from any source. The access of medical vehicles to patients should be unhindered at all times and consideration of this taken into account in the planning or management of a protest. Designated routes for the transporting of the injured persons should be identified and with coordination among all parties to ensure appropriate medical assistance to injured people.

2.7 Commanders of LEAs should give suitable operational orders to all law enforcement officials deployed in order to ensure that priority and coordination is given to medical transports and those in need of emergency medical care.

3. COORDINATION AND TRAINING

3.1 All stakeholders must ensure adequate training and credentialing of all relevant personnel. Training should take into account emergency preparedness, risk assessment and management, negotiation, stress management, communication skills and capacity-building.

3.2 Where practicable, stakeholders should include social sensitization on the roles and responsibilities of all stakeholders involved in protest action, or the management of such situations including responses to incidents involving threats of or actual incidents of violence. Such training (sensitization) should make specific mention of the obligation of state law enforcement officers to provide first aid and ways to ensure minimal disruption for health-care facilities.

3.3 First aid providers must receive adequate training on their rights and responsibilities, in particular on their ethical obligations as well as specific training on the delivery of health-care services during protest action.

4. IMPLEMENTATION

4.1 Following the acceptance of these guidelines, all stakeholders should establish a university-specific plan, as outlined in 1.1 above, which indicates their adherence to the principle of medical neutrality and impartiality through policies and procedures to safeguard health care in situations of protest actions.

4.2 The plan referred to in 4.1 must take into account contingency planning for all possible and anticipated health-care needs, which should also conform to the spirit and intention of these guidelines.

4.3 The development and implementation of the university specific plan must be sufficiently resourced to ensure that health care is available and accessible in relation to protest action.

4.4 By endorsing these guidelines, all parties commit themselves to work for the promotion of the stipulated principles within these guidelines, including by appropriate dissemination and training among relevant officials and concerned parties.

4.5 The principles enumerated herein apply to all in-sourced and out-sourced services to the university and the compliance thereto should be a condition of the hiring of such services by university management or any other stakeholder.

4.6 A technical working group should be established to operationalize and govern each university-specific plan and must include representation from all stakeholders at each institution.

4.7 The technical working group that is responsible for the implementation and governance of the university-specific plan arising from these guidelines must include the establishment of appropriate, independent and impartial monitoring and evaluation mechanisms.

VENEZUELA

During protests in Venezuela in 2015, the government passed a resolution to govern the role of the armed forces in responding to the protests, titled the *Norms of Action of the Bolivarian National Armed Forces in Control of Public Order, Social Peace and Citizen Coexistence in Public Meetings and Demonstrations*, also referred to as Resolution 8610.

Although the resolution was controversial in some quarters, owing to use of armed forces for establishing public order,[17] it contained a number of positive provisions that reiterated the *Standards for Policing Protests* that were passed by the General Police Council in 2011. Resolution 8610 outlined what it considers to be the progressive and proportional use of force, prohibited the use of tear gas in residential areas, prohibited the use of force against protesters who are fleeing or injured and, most importantly for the purposes of this study, required officers to ensure that the injured receive immediate medical assistance.

In order to increase the trust of the injured in accessing health care, the ICRC and the Venezuelan Red Cross put in place a system whereby patient names were not recorded when they received assistance from first responders or in their transfer to health-care facilities:

> During the demonstrations, the Venezuelan Red Cross was able to assist 1,005 people by the end of July 2017. Its adherence to the principle of impartiality allowed the National Society to administer first aid to 19 members of the armed and security forces. In addition, the Venezuelan Red Cross transferred 51 patients to various health-care centres and donated emergency surgical supplies to 24 hospitals. It also provided drinking water to demonstrators and members of the security forces.[18]

OTHER EXAMPLES

In situations where there is a breakdown of trust between LEAs and health-care workers, a third party can play an important role in troubleshooting and in basic coordination during an emergency situation such as political unrest or protests. For example, in Jerusalem, the ICRC played the role of receiving information about access constraints facing Palestine Red Crescent Society ambulances during protests in Jerusalem. The ICRC was able to notify a pre-identified focal point in the police of any problems that were being encountered.

17 Smilde, D and Hernaiz, H. “Resolution Allowing Venezuela’s Armed Forces to Police Protest Creates Alarm”. 6 February 2015. Venezuela Politics and Human Rights. https://www.venezuelablog.org/resolution-allowing-venezuelas-armed-forces-to/

18 ICRC. “Activities of the ICRC in Venezuela and Venezuelan Red Cross” 5 October 2017. https://www.icrc.org/en/document/activities-icrc-venezuela-and-venezuelan-red-cross

CASE STUDY 2

REAFFIRMING OBLIGATIONS TO TREAT GSW VICTIMS IN NIGERIA AND PAKISTAN

NIGERIA

In order to curb the growing problem of firearm use in Nigeria, the government passed the Armed Robbery and Firearms Decree (Act) in 1984 and then amended the act in 1986 to become the Robbery and Firearms (Special Provisions) Act 1986. The act stated that "it is the duty of any person, hospital or clinic that admits, treats or administers any drug to any person suspected of having bullet wounds to immediately report the matter to the police". The act went on to criminalize the sheltering or treatment of GSW victims without reporting the case to the police. According to the act, "it shall be an offence punishable under this Act for any person to knowingly house, shelter, or give quarters to any person who has committed an offence under section 1 (2) of this act".

The implementation of this law resulted in health-care workers often delaying treatment for people with GSWs until after the case had been reported to the police and clearance received from the police to treat the patient. This resulted in patients with GSWs facing significant delays in receiving care:

> These constraints posed a major challenge for hospitals and clinics. Health workers were reluctant to provide life-saving care and found themselves in a difficult legal position. In many cases, doctors were questioned and even arrested for doing their duty and treating gunshot victims. To shield themselves from interference by law enforcement officials, health-care workers felt compelled to request police clearance before providing any treatment. At the same time, by reporting gunshot cases to the police, health-care workers could be exposed to retaliation from patients and their relatives for denunciation.[19]

The National Health Act of 2014 went some way to addressing the inaccurate implementation of the previous acts. The National Health Act stated that "a health-care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason". However, this did not resolve the problem of health-care workers waiting for police clearance before treating GSW patients.

In 2017, the National Assembly of Nigeria passed the Compulsory Treatment and Care for Victims of Gunshots Act 2017.[20]

The act is explicit in its purpose, stating that it is "an act to provide for the compulsory treatment and care for victims of gunshots". The act states that "every hospital in Nigeria whether public or private shall accept or receive, for immediate and adequate treatment with or without police clearance, any person with a gunshot wound".

It is also explicit on the duty of "every person, including security agents" to provide assistance to GSW victims. The act states that patients should be treated "with or without initial monetary deposit" and that patients should not be subjected to "inhuman and degrading treatment or torture by any person or authority including the police or other security agencies".

The act does, however, emphasize the obligation for GSW victims to be notified to the police within two hours of commencement of treatment. Although this enables the police to immediately begin their investigation, the police are explicitly not permitted to transfer the patient from the hospital "unless the Chief

19 ICRC Nigeria in collaboration with the Association of Public Health Physicians of Nigeria. "Health Care In Danger: Training module for medical students, healthcare workers and teachers". June 2021. https://reliefweb.int/sites/reliefweb.int/files/resources/hcid_training_module_2021.pdf

20 National Assembly of the Federal Republic of Nigeria. "Compulsory Treatment and Care for Victims of Gunshots Act". 2017. https://laws.lawnigeria.com/2018/04/20/lfn-compulsory-treatment-and-care-for-victims-of-gunshots-act-2017/

Medical Director of the hospital certifies him fit and no longer in dire need of medicare".

The compulsory treatment act was disseminated through a directive from the Inspector General and demonstrates the way in which the regulatory role of the police can be used to increase access to health care.

PAKISTAN

In August 2018, a 10-year-old girl – Amal Umer – was shot and killed in crossfire between police and suspected criminals in Karachi.

During a Supreme Court hearing on the case – which ruled in favour of the family – the Chief Justice of Pakistan said that the "policemen did not know where to shoot and where not to shoot". He went on to state that "some suitable standard operating procedures, system of intelligence gathering and proper weapons training should be in place, since the lives of the people cannot be put in risk unduly".[21]

After Amal was shot, her parents took her to a hospital where she was denied treatment and referred to another facility without an ambulance being organized despite her having a head wound.

In general, it has been noted that difficulties in access to health care for GSW patients existed because of medico-legal obligations in place:

> It was impracticable for a gunshot wound patient to obtain medical treatment in private hospitals notwithstanding a critical health condition; in case of emergency, instead of providing medical treatment, the injured person would be referred to a public hospital for health-care medical treatment. The private hospital's reasons for refusing patients and referring them to a public hospital were twofold. The first was a requirement of law, as only at a public hospital could one find a notified medico-legal (medical) officer to provide medical treatment to gunshot wound patients and only such medico-legal (medical) officers at a public hospital were competent and authorized by the government to issue Medico-Legal Certificates. Moreover, the practice of medical professionals at public hospitals appears to have been that, based on the nature of the injury, the medical professionals either called a police official because of the duty of disclosure or demanded a Memorandum of Police from the patient or the person accompanying him or her in order to avoid potential liability for failure to comply with the duty of disclosure, which would have required forwarding information to the police.[22]

In the aftermath of Amal's death, the Sindh cabinet approved the Sindh Injured Persons Compulsory Medical Treatment (Amal Umer) Act 2019:[23] "Both the police and medical professionals are under the administrative control of the provincial government of each province. Legislation pertaining to their respective duties, therefore, is generally adopted and regulated at the provincial level through provincial legislation and regulations."[24]

21 Bhatti, H and Iqbal, N. "SC orders Sindh govt to pay Rs1 million as compensation for Amal Umer's death" 11 February 2020. Dawn. https://www.dawn.com/news/1533809

22 De Dycker, S et al. "Legal opinion on the obligation of healthcare professionals to report gunshot wounds. Australia, China, Colombia, Egypt, El Salvador, France, Lebanon, Mexico, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Philippines, Russia, South Africa, South Sudan, Spain, Tunisia, Ukraine, United Kingdom" 30 June 2019. Swiss Institute of Comparative Law. https://www.isdc.ch/media/1834/17-120-final-nov19.pdf

23 Provincial Assembly of Sindh. NO.PAS/LEGIS-B-02/2019 - The Sindh Injured Persons Compulsory Medical Treatment (Amal Umer) Bill. 19 March 2019. http://shcc.org.pk/public-docs/Amal_Act.pdf

24 De Dycker, S et al. "Legal opinion on the obligation of healthcare professionals to report gunshot wounds. Australia, China, Colombia, Egypt, El Salvador, France, Lebanon, Mexico, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Philippines, Russia, South Africa, South Sudan, Spain, Tunisia, Ukraine, United Kingdom" 30 June 2019. Swiss Institute of Comparative Law. https://www.isdc.ch/media/1834/17-120-final-nov19.pdf

The act states that "it is compulsory to provide medical aid and treatment without any fear, to any injured person, to save his or her life and protect his or her health during an emergency and for matters connected thereto". The act lays out the responsibility of every citizen to "assist an injured person in a time of peril and emergency". The act goes on to state that "where an injured person is brought to a hospital, such injured person shall be provided with compulsory medical treatment without any delay, on a priority basis, without complying with medico-legal formalities or demanding payment prior to the administering of compulsory medical treatment".

The act highlights the responsibility of hospitals to have at least two ambulances at the hospital premises. However, the act forbids the transfer of patients unless the medical treatment cannot be provided at the hospital.

The act states that no LEA is permitted to interrupt or interfere with the provision of treatment and that patients cannot be interrogated while receiving compulsory medical treatment.[25] In addition to this, a patient is not allowed to be taken to a police station or for any "medico-legal procedure" to be conducted before the necessary compulsory medical treatment "has been fully provided".

The act also offers protections to hospital staff and those bringing the patient to the hospital: "Any person who brings an injured person to a hospital and/or the hospital staff who treat the injured person shall not be harassed by any person including a police officer or officer of a law enforcement agency".

25 "Provided that such interrogation shall not take place until the condition of the injured person as determined by the treating Doctor is out of danger or without the permission of the concerned hospital where the injured person is being treated".

CASE STUDY 3

MANAGING LEA PRESENCE IN THE EMERGENCY DEPARTMENT IN THE UNITED STATES AND BEYOND

UNITED STATES OF AMERICA

In the United States, a toolkit entitled Police in the Emergency Department: A medical provider toolkit for protecting patient privacy[26] was developed by a group of physicians, lawyers, clinical social workers and both law and medical students in order to support hospitals in developing policies to ensure patient rights are respected in interactions with law enforcement. The development of the toolkit was supported by the Georgetown University Health Justice Alliance, an academic medical-legal partnership. The toolkit has the "limited goal of providing practical guidance that can be immediately implemented by health-care workers given the laws and resources that currently exist".

The toolkit grounds its recommendations in medical ethics and sets a high standard for the divulging of patient information: "Respect for patient autonomy is one of the core principles of medical ethics. The principle should extend to patient interactions with law enforcement, such as questioning or surrendering of property in the absence of a valid court order or warrant."

Steps that the toolkit proposes every ED provider take to ensure patients' rights are protected

In interactions with law enforcement, ED providers should:
- approach and identify officers who are present in patient care areas
- refuse to consent to police questioning of patients, information disclosures access, and searches and seizures without patient authorization or legal authority such as judicial warrants, court orders and specified probable cause
- use formal processes to refer warrants, court orders, or other requests regarding patient access or protected health information to authorized parties such as an administrative supervisor, legal department, or medical records department.

Source: Working Group on Policing and Patient Rights, *Police in the Emergency Department: A medical provider toolkit for protecting patient privacy.*

The toolkit advises health-care facilities to develop policies "to help ensure protection of patient rights":

> Areas to target include: (1) visitor access, (2) sharing of information with police, (3) securing, storing, searching, and sharing of patient property, including contraband and weapons, (4) police requests for the performance of tests or procedures, (5) family visitation when law enforcement is present, and (6) use of handcuffs, forensic restraints, and shackles. Hospitals that lack policies in these areas or that have policies that do not safeguard patient rights make it easier for law enforcement to abuse their power and more difficult for medical staff who do not have legal expertise to protect their patients.

The toolkit sets a standard of patient privacy protection that will often not be possible to achieve in many of the contexts in which health-care workers and law enforcement officials interact, primarily owing to varying local legislation that, in some cases, enables law enforcement officials to gather patient information without a court order. However, the toolkit offers a useful list of practices to consider when designing written guidelines for the interaction between health-care workers and law enforcement in an ER setting.

26 Working Group on Policing and Patient Rights. "Police in the Emergency Department: A medical provider toolkit for protecting patient privacy." 2021. https://www.law.georgetown.edu/health-justice-alliance/wp-content/uploads/sites/16/2021/05/Police-in-the-ED-Medical-Provider-Toolkit.pdf

OTHER EXAMPLES

In one hospital in which the ICRC supports the ED, the facility is used by the community in a large district, as well as by LEAs to conduct mandatory medical check-ups for witnesses or arrested suspects. Under domestic law, it is obligatory to conduct this examination before a person can appear before the court. As a result, LEAs were entering the hospital with their weapons, as is permitted under local law, in order to ensure the protection and safety of the suspect undergoing a medical examination.

Several incidents were witnessed where the entry or presence of LEAs in the ER temporarily obstructed the workflow, as well as the access of other patients to the ER and to other parts of the hospital.

The ICRC, together with the hospital management, considered it necessary to find a viable alternative to address the issue. A meeting was organized by the ICRC with the presence of LEA representatives and the hospital management.

After a visit to the ER and a discussion between participants at the round table, it was agreed to use an alternative pathway for mandatory medical check-ups for persons in the custody of LEAs. This included the use of the decontamination room in the ER for the mandatory check-up of suspects brought in by LEAs. The advantage of this approach is that the room has a separate entry. LEAs can close the door of the room and guard it, while the main entry/exit to the ER remains open and accessible for all. Normal triage can be conducted, and the guarded patient will be seen by the medical staff without revealing his/her presence or identity to others. This ensures that other patients have access to health care, that staff can perform their job and that LEAs are still able to secure their patient.

Another step that was decided upon was to build a gate and parking area in front of the decontamination room to facilitate the entry of LEAs and the suspects into the area without any obstruction of the main entrance of the ER. A focal point was appointed at the hospital, whom LEAs can call in order to announce their arrival.

CASE STUDY 4

ENSURING EMERGENCY MEDICAL SUPPLY DELIVERIES DURING PROTEST ACTION IN COLOMBIA, BOLIVIA AND BEYOND

COLOMBIA

In April 2021, protests erupted in Colombia in response to a plan announced by the government, which included an increase in taxes and reforms to the health-care system. The largest protest movements were concentrated on the main roads that connect the cities of the south-west and centre of the country, blocking all land-based economic activity, even towards Ecuador. The epicentres of the protest were in the capital Bogotá and Cali, among other cities. Violence broke out between protesters, security forces and armed civilians. Road blockages resulted in reported ruptures in the supply of medical equipment, including oxygen, to health-care facilities and the restriction of ambulance movements.

In response to the escalating violence and the difficulties in accessing the wounded and transporting medical supplies, the Colombian Red Cross established a project that engaged with all interested parties in order to ensure the safe passage of ambulances and vehicles with medical supplies. This was often in the form of aid "caravans" into the most-affected areas of the protests and roadblocks. A humanitarian caravan is the configuration of several vehicles that move materials, equipment or people related to health care. These supply caravans – which included COVID-19 medical supplies and oxygen – were accompanied by Colombian Red Cross vehicles in order to facilitate their humanitarian protection during the transfer of the supplies from one place to another and between cities.

In order to ensure the safe movement of these supplies and ambulances, the Colombian Red Cross would coordinate with all concerned parties, including unified government command posts, LEAs, medical supply transport companies and the protesters themselves.

In support of these activities, a team of Red Cross volunteers conducted an 18-day operational communication activity by touring the roads and cities most affected in the country.[27] The purpose of the activity was to develop a dialogue to strengthen awareness of the action of the Red Cross and the use of the red cross emblem, in order to promote respect for vehicles related to health-care actions, such as ambulances and trucks supplying oxygen and medicines during protests. The mission included engagement with community leaders, teachers, village leaders, young people, health-care personnel, relief organizations, the general population, the police, the army, the media, migrants, health-care personnel and indigenous communities.

Early on in the activities, the team was able to engage with the National Police. While engaging with community members at roadblocks, the team provided first aid and was able to explain the correct use of the emblem. Concerns were raised by protesters on the excessive use of the "medical mission" emblem to bypass the roadblocks.

Through engagement with protesters at roadblocks, it was possible for the Red Cross to identify contacts to be informed on the movement of aid "caravans".

By engaging with a broad range of stakeholders, the team was able to build acceptance for the Red Cross and improve the passage of humanitarian caravans and the exercise of the medical mission.

Through the various concerns gathered on the misuse of the emblem, the Colombian Red Cross was able to formulate recommendations to the local authorities on the better control and good use of the emblem.

27 Comunicación operacional en bloqueos y movilizaciones sociales en sur del pais.

One of the lessons learnt from this activity was the need for the Colombian Red Cross to explain that it does not hand over patients to the security forces. This highlighted the need to establish, preserve and communicate the work of the Red Cross in order to build and maintain trust among communities. Another lesson learnt was that situations of violence can generate acute effects on health-care providers and tension with LEAs. This tension can be addressed through transparent dialogue.

BOLIVIA

In 2020, protests swept through Bolivia. Anti-government protesters blocked streets, demanded that the elections should proceed after months of delay and called for greater rights for indigenous communities in particular. At the end of August, workers went on strike and the crisis escalated. According to the *New York Times*, the protesters "set up 70 roadblocks, marooning about six million residents of three highland regions, including Bolivia's most important metropolis, La Paz".[28] The *New York Times* went on to report as follows:

> Protest organizers said they were allowing medical workers, medical suppliers and fuel to pass through the blockades. But government health officials said the blockades have reduced the supply of oxygen and other materials for coronavirus treatment, causing deaths. Although there are no official figures, doctors from local hospitals said at least eight patients have died in the cities of Oruro and El Alto, outside La Paz, because of oxygen shortages this week.[29]

The ICRC and the Bolivian Red Cross were asked to support the delivery of oxygen to health-care facilities that were no longer able to be supplied through their regular mechanisms. It was decided that the oxygen delivery vehicles would be emblematized and escorted by the Bolivian Red Cross. The ICRC made use of its interactions with LEAs to support the Bolivian Red Cross' activities.

The Bolivian Red Cross had to demonstrate to protesters that their mission was entirely humanitarian in order to be able to pass roadblocks, and coordination was necessary with Bolivian LEAs to ensure that the supplies could move unhindered.

The delivery of the oxygen supplies from Santa Cruz required extensive coordination between different branches of the Red Cross, with different government bodies and LEAs and with the protesters themselves.

In one of the deliveries that was organized by the Bolivian Red Cross, there were "more than 28 people, including volunteers and staff, who accompanied the caravan, throughout the six days since it left the city of Santa Cruz until it reached La Paz. The caravan transported 66 tons of oxygen, which supplied hospitals in different parts of the country".[30]

The Colombia and Bolivia cases demonstrated the way in which actors that are respected as impartial can play a critical role in coordinating between law enforcement and health-care facilities to address critical health-care needs that require cooperation from LEAs and other actors, such as protesters during emergency situations.

28 Trigo, M and Kurmanaev, A. "Bolivia Under Blockade as Protesters Choke Access to Cities" 7 August 2020. New York Times. https://www.nytimes.com/2020/08/07/world/americas/bolivia-roadblock-blockade.html

29 *Ibid.*

30 IFRC. "Bolivia: crossing the country to save lives" 31 August 2020. https://reliefweb.int/report/bolivia-plurinational-state/bolivia-crossing-country-save-lives

CASE STUDY 5

VICTIMS/SURVIVORS OF SEXUAL AND GENDER-BASED VIOLENCE AND LAW ENFORCEMENT IN SOUTH AFRICA

LEAs have a specific role to play in cases of violence that require medical-legal proceedings for the advancement of criminal charges. This is specifically the case in SGBV-related cases.

To ensure a survivor-friendly environment for receiving medical treatment and reporting cases of SGBV to law enforcement in South Africa, Thuthuzela centres were established as a "one-stop shop" for victims/survivors. "The centres are facilitated by a top level inter-departmental management team comprised of the departments of Justice, Health, Education, Treasury, Correctional Services, Police, Social Development and designated civil society organizations."

Thuthuzela's integrated approach to rape care seeks to ensure that children, women and men who are survivors/victims of sexual violence are treated with respect and dignity and ensured justice:

> When reporting, the victim is removed from crowds and intimidating environments, such as at the police station, to a more victim-friendly environment before being transported by police or an ambulance to the Thuthuzela Care Centre at the hospital. En route, the victim receives comfort and crisis counselling from a trained ambulance volunteer or police officer. Once at the Thuthuzela Care Centre, the victim is ushered to a quiet, private space, and welcomed by the site-coordinator. A doctor is immediately summoned to conduct a medical examination. The victim is then given information on the procedures to be performed. The victim (patient) signs a consent form for medical examination and blood specimens. If the medical examination happens within 72 hours of the rape, DNA and PEP is conducted, after which the victim is offered the opportunity to take a bath or shower and to change into clean clothes. After that, the investigating officer on call at the centre takes the victim's statement. Thereafter, the victim receives appropriate medication and is given a follow-up date for further medical treatment, before being transported home.[31]

Although there have been challenges to the roll-out of the Thuthuzela model, where it has been implemented, it is considered a positive example of the necessary cooperation between health-care workers and LEAs in ensuring safe and dignified access to health care and legal recourse.

31 Thuthuzela Care Centre Brochure. August 2009. https://www.npa.gov.za/sites/default/files/resources/public_awareness/TCC_brochure_august_2009.pdf

CASE STUDY 6

ENSURING SAFER ACCESS TO HEALTH CARE IN BRAZIL

Health-care facilities are often in danger in contexts with a high prevalence of violence. The Brazilian city of Fortaleza has seen some of the biggest increases in gang-related violence in the country. Gangs from São Paulo, Rio de Janeiro and the Amazonas have been struggling over control of the city with the closest large port to Europe and Africa.[32]

The Fortaleza city government signed a technical support agreement with the ICRC in April 2018 to initiate the Safer Access Framework (SAF) in order to support essential public services in managing the impact of violence on essential services. The SAF is a methodology designed to prevent, reduce, mitigate and respond to the risks associated with a community's exposure to situations of armed violence.

In an effort to encourage the promotion and integration of international human rights standards into law enforcement, technical cooperation agreements were signed with the Department of Public Security and with the Municipal Department of Citizen Security and the Fortaleza Municipal Guard.[33]

To ensure better protection of municipal health-care facilities, a standard operating procedure (SOP) was developed for unarmed municipal guards stationed at health posts. This SOP guides the municipal guards on how to behave when stationed at health posts, and how to respond to incidents in these locations. All of the recommendations developed in the SOP aim to professionalize the municipal guard in protecting municipal services, while guaranteeing fundamental human rights are respected in their conduct.

This experience demonstrated the way in which the risks faced by health-care facilities can be addressed through engagement with LEAs and health-care workers. The case study demonstrates the value in developing specific SOPs to address the priority issues identified in specific contexts as a way to ensure the professionalization of the interaction between LEAs and health-care workers in managing risks.

32 Kaiser, A. "It's complete chaos': Brazilian state overwhelmed by rash of gang violence" 9 January 2019. The Guardian. https://www.theguardian.com/world/2019/jan/09/brazil-ceara-violence-fortaleza-gangs-bolsonaro

33 ICRC. "The ICRC in Fortaleza – Leaflet". 25 March 2021. https://www.icrc.org/en/document/icrc-fortaleza-leaflet

RECOMMENDATIONS

These recommendations are organized according to the various points of interaction between health-care workers and law enforcement. While many of the recommendations are drawn from the experiences outlined in the case studies, some have been identified more generally from literature, open sources, academic literature and key-informant interviews. It is for this reason that each recommendation section is accompanied by a commentary that provides further insights into the recommendations.

1. FIRST RESPONDERS, HEALTH-CARE WORKERS AND LAW ENFORCEMENT: DUTIES TO TREAT, THE NEED FOR COORDINATION AND THE SAFETY OF FIRST-AID PROVIDERS

RECOMMENDATION 1.1: COORDINATION

LEAs and health-care first responders should pre-identify a systematic information-exchange system and an inclusive coordination mechanism when needed for situations of unrest/protest or mass-casualty events that should include:

- protocols for the movement of first responders into areas where LEOs are taking place
- a focal point within law enforcement who can be contacted by a focal point from civil defence or other first responders to troubleshoot any issues that may arise
- agreements on the needed identification of first responders in order to facilitate quick access and to prevent blockages at possible checkpoints or security perimeters
- procedures to determine what kind of protection would be appropriate in different situations (in some circumstances, no protection will be safer than police protection) and the way in which that protection can be requested if needed
- agreement on the obligation of first responders to treat all patients based on medical needs alone prior to possible arrest or detention procedures by law enforcement (unless the patient poses a risk to first responders)
- where possible, an agreement that the names of the injured will not be documented by first responders and shared with LEAs in order to ensure trust in first responders as providers of medical assistance only and not as part of LEOs.

RECOMMENDATION 1.2: SAFE AREAS

First responders and LEAs should identify a "safe area" close to protest sites in situations of political protests or unrest, which can provide first responders with a safe space to work from, close enough to where injuries may occur.

RECOMMENDATION 1.3: JOINT EXERCISES

Joint exercises should be carried out between LEAs and first responders, including others involved in providing emergency response, in order to ensure that each actor's role and responsibility is clearly understood. Roles and responsibilities should be laid down in domestic legislation in order to provide legal certainty beforehand (so they are not only clearly understood but also clearly defined).

RECOMMENDATION 1.4: LEGAL OBLIGATION TO ASSIST

In many contexts, there is a legal obligation on all individuals to rescue, or to provide assistance to, people in need of urgent medical care. In cases where this is not legislated, agreements should be reached between first responders and law enforcement on the need to facilitate the work of all first responders providing impartial medical assistance, including those that may be considered as being affiliated with a protest movement or political opponents (as long as they are carrying out their work impartially). LEAs should not prevent the work of impartial health-care providers or first responders even if they are affiliated with protest movements.

RECOMMENDATION 1.5: FIRST AID AFTER THE USE OF FORCE

LEAs are obliged to provide first aid to the injured following the legitimate use of force, or they should enable the work of others (in safety) following an operation. In order to enable LEAs to fulfil this responsibility, training on first aid should be conducted and LEAs should be equipped with the appropriate medical material needed to fulfil this duty. LEAs should also receive training on the use of force in order to avoid the unnecessary infliction of injuries during their operations.

RECOMMENDATION 1.6: CONTINGENCY PLANNING

Contingency plans must be formulated by LEAs according to the identified risks and adverse effects associated with the use of force. These plans must calculate the potential impact of the use of force and prepare the necessary resources to respond to the possible needs generated. Developing simulation exercises at the strategic government, tactical or coordination levels and at the community level can be useful. For example, the planning of LEOs might point to scenarios in which the use of force would need to be applied. In such cases, those operations and the LEAs engaged in them should ensure that first responders are on standby and that routes for medical evacuation are foreseen and cleared. In case of a planned operation that must be confidential for operational reasons, LEAs should warn the first responder as soon as possible or provide first aid with their own internal care services.

COMMENTARY

Difficulties in the interaction between LEAs and first responders can exist owing to a lack of pre-established coordination mechanisms that can help to facilitate the access of first responders to areas where LEOs are taking place. Other difficulties can exist because of a lack of awareness or understanding of the role of first responders, for example in providing assistance impartially. In addition to this, LEAs often lack the capacity or training to carry out first aid in fulfilment of their responsibilities.

A number of steps can be taken to address these challenges. Firstly, it has been found to be useful for there to be a legislated responsibility on all individuals to provide assistance to people in need of urgent medical care. This does not necessarily include medical assistance but could include things like keeping a person safe until help arrives.

“A duty of rescue can be defined as the obligation for one person to assist another who is in danger. Under this concept, a first-aider who has failed to assist a victim may be criminally liable. However, the existence of such a duty and its applicability criteria vary widely across jurisdictions.”[34] Legislation on the duty to respond lays down the responsibilities on all individuals to assist those in need of emergency care and the role of LEAs in facilitating this. “It is therefore important to ensure that there is an adequate framework so that first aid providers will not suffer any legal or financial consequences when choosing to provide assistance. In addition to the legal protection for first aid providers, some national legislations have gone further by imposing a duty to rescue (or duty to act) and punish the failure to provide first aid to a person in need.”[35]

However, in some situations, such as during political protests or other situations of violence, LEAs fail to differentiate between health-care workers and protesters or other groups in tension with LEAs. LEAs and military forces may interpret the political commitments of health-care workers as removing protections they would otherwise enjoy.[36] Although this is often an acute problem during times of protest, it is important to reiterate that the political involvement of health-care workers does not remove their protection or undermine the legitimacy of their impartial delivery of health care.

34 Global First Aid Reference Centre. “First Aider Liability: Surveying the Legislations Regarding Liability of First Aid Providers around the World” December 2020.

35 Global First Aid Reference Centre. “First Aider Liability: Surveying the Legislations Regarding Liability of First Aid Providers around the World” December 2020.

36 Rubenstein, L. “Perilous Medicine: The Struggle to Protect Health Care from the Violence of War”. 2021. Columbia University Press.

In addition to this, it is essential to reiterate the obligations on LEAs to provide first aid, without discrimination, to casualties that may result from the use of force. [37] These obligations should be included in their SOPs. In the case of South Africa, a Panel of Experts report on Policing and Crowd Management, established by the Minister of Police, made the following recommendation:

> The SAPS [South African Police Services] should introduce an internal directive to establish the principle that SAPS members who have first aid training are required to provide first aid 'within the limits of their training' in situations where they encounter people requiring medical attention. A specific directive should be developed on this issue as it is a general principle based on the duty of care and it will not be adequate to address it in directives on crime scene management or on arrested persons. The directive should make allowance for the fact that members who have been involved in a violent confrontation may not immediately be in a suitable frame of mind for providing first aid.[38]

The panel went on to recommend that "in crowd management operations and other large operations or operations where the use of lethal force is likely, police should provide their own first aid teams of trained SAPS members".[39] In addition to this, "first aid teams that are deployed in crowd management operations should be trained and equipped to deal with potentially fatal consequences of the use of less-lethal weapons (such as risk of asphyxiation from teargas, especially to young children) as well as other types of injuries likely to arise in these situations".[40]

With these obligations and responsibilities reaffirmed, it becomes clear that various organizations and actors can complement each other's efforts to ensure the safe delivery of health care in emergencies. This collaboration can be improved by forward planning. There are a number of steps that can be taken in advance of a situation requiring coordination between law enforcement and first responders, "such as establishing plans, coordination mechanisms, joint exercises, training programmes or simulations with governments, health-care personnel, members of the local community and others involved in providing emergency response".[41] Forward planning and adequate coordination will also facilitate accountability and after-action reviews whenever needed.

During situations of protest, there are a number of best practices and recommendations that can be learned from in addition to the case studies of Colombia, South Africa and Venezuela explored in this paper. For example, following the Black Lives Matter protests in Orlando, a clear recommendation was made to "create a safe zone very near to the protest area where medical personnel have safe access to attend to any injured person, whether acting officially or as volunteers, along with a safe way to transfer patients from the protest area to the safe medical area".[42]

37 ICRC. Health Care in Danger Initiative. "Protecting Healthcare. Guidance for the Armed Forces". November 2020. https://healthcareindanger.org/wp-content/uploads/2021/03/4504_002-ebook.pdf

38 "Panel of Experts Report on Policing and Crowd Management". Established by the Minister of Police in terms of the recommendations of the Marikana Commission of Inquiry. 27 May 2018. https://www.saps.gov.za/resource_centre/publications/pannel_of_experts_2021.pdf

39 *Ibid*.

40 *Ibid*.

41 ICRC. "Ambulance and Pre-Hospital Services In Risk Situations". November 2013. https://www.icrc.org/en/doc/assets/files/publications/icrc-002-4173.pdf

42 Hampton, K. et al. "Now they seem to just want to hurt us": Dangerous Use of Crowd-control Weapons against Protestors and Medics in Portland, Oregon". 8 October 2020. Physicians for Human Rights. https://phr.org/our-work/resources/now-they-just-seem-to-want-to-hurt-us-portland-oregon/

2. AMBULANCES AND LAW ENFORCEMENT: FREEDOM OF MOVEMENT AND ACCESS

RECOMMENDATION 2.1: FREEDOM OF MOVEMENT

LEAs should allow patients and their families unrestricted and timely travel to medical facilities for treatment. Movement of ambulances should therefore be facilitated at all times. Patients being transported by private means should also have their access to health-care facilities supported by LEAs. Pre-agreements should be reached between ambulances and law enforcement officials on the conditions under which movement can be restricted into an area of LEO or during the implementation of public health measures. These exceptions should be kept to a strict minimum and should only be implemented in a way that is time-bound, proportionate and non-discriminatory.

RECOMMENDATION 2.2: TIMELY CIRCULATION

When a checkpoint is established by LEAs, such as during security operations or during the implementation of public health measures such as lockdowns, effort should be made to create a "fast lane" for the use of emergency vehicles. If this is not feasible, all checkpoint personnel should be informed that emergency vehicles can go to the front of a queue at a checkpoint. When possible, checkpoints should be notified of an ambulance's movement to facilitate rapid transfer through checkpoints. Any searches conducted by LEAs on ambulances should be done in a way that is minimally disruptive to legitimate health-care activities.

RECOMMENDATION 2.3: EXCEPTIONS DURING CURFEWS, LOCKDOWNS OR OTHER MOVEMENT RESTRICTIONS

In the event of a curfew or movement restrictions imposed as part of an LEO, or as part of public health measures such as lockdown enforcement, exceptions on the freedom of movement of supplies, ambulances and medical staff (including to and from work) should be pre-agreed. This should include:

- an agreement on the necessary identification needed by health-care workers and ambulances to facilitate their passage through checkpoints. Such identification should ideally be pre-existing identification of, e.g. professional medical bodies, rather than additional authorization being needed in individual cases.
- a notification system for the movement of vehicles, patients or staff to ensure their safe passage.
- a focal point from the LEA that can be contacted by a focal point in the health-care community to resolve any challenges encountered in the movement of staff, vehicles and supplies.

RECOMMENDATION 2.4: PRE-PLANNING

LEAs should identify routes for the evacuation of injured persons prior to an operation. Evacuation routes for the wounded should be secured and ambulances should have unhindered access to areas where the injured can be picked up and transported from.

COMMENTARY

Without adequate coordination, the movement of patients, medical staff and supplies during emergency situations such as unrest, urban violence or in times of pandemic can be complicated, resulting in unnecessary delays and leading to poor outcomes for patients needing emergency care. "A lack of proper coordination is often one of the main reasons for undue impediments to the swift and rapid passage of ambulances and other medical transports through checkpoints."[43]

Throughout the research for this report, participants noted the difficulties in ensuring the safe movement of health-care workers during COVID-19 lockdown measures. LEAs were often unsure of how to implement lockdown measures and health-care workers were often not well-identified. Mechanisms were often not in place to ensure that health-care workers could move freely.

43 ICRC. "Protecting healthcare from violence. Legislative checklist." April 2021. https://healthcareindanger.org/wp-content/uploads/2021/05/legislative_checklis_on_protecting-health-care-from_-violence_web-1.pdf

In protest situations, there were reported cases of security measures being implemented that disproportionately disrupted the free movement of health-care workers and ambulances.

Some of these challenges, during times of public health emergencies and security operations, could be overcome by pre-agreeing on measures to coordinate the movement of ambulances and the identification required to facilitate such movement. Clear guidelines on the situations under which LEAs could limit the movement of ambulances can also help to reduce tension and confusion during emergencies.[44] For example, the guidance for armed forces in protecting health care produced by the Health Care in Danger Initiative clearly recommends the setting of rules in SOPs, operational orders and/or other relevant documentation "on the level of authority by which, and the exceptional circumstances in which, movement of medical personnel and vehicles in an area of operations may be restricted".[45]

Many of the challenges faced in ambulance movement can be foreseen prior to an emergency situation and can benefit from adequate pre-planning and coordination.

44 ICRC. Health Care in Danger Initiative. "Protecting Healthcare. Guidance for the Armed Forces". November 2020. https://healthcareindanger.org/wp-content/uploads/2021/03/4504_002-ebook.pdf

45 *Ibid*.

3. HEALTH-CARE FACILITIES AND LAW ENFORCEMENT: PATIENT CONFIDENTIALITY, DIGNITY AND AUTONOMY

RECOMMENDATION 3.1: PRESERVING THE RIGHT TO HEALTH

LEAs should take all available measures to ensure that LEOs do not disrupt patient care and do not hinder health-care workers from carrying out their duties. This should include avoiding LEOs in the vicinity of health-care structures that could hamper access to care for a population, and avoiding carrying out operations inside a health-care facility that would disproportionately disrupt care being provided in the facility or that would put health-care workers or patients at risk.

RECOMMENDATION 3.2: GUIDELINES TO FACILITATE INTERACTION

Context-specific guidelines should be created for the interaction between LEAs and health-care workers in health-care facilities, particularly during moments where law enforcement prerogatives need to be balanced with health-care workers' responsibilities and obligations to their patients. SOPs can be developed to identify the way in which certain LEOs can take place in health-care facilities in order to minimize disruption, and to protect health-care workers and patients. Specific types of law enforcement activities should be considered in these SOPs, including:

- conducting search operations in health-care facilities
- conducting arrests within health-care facilities
- conducting investigations where information is required from a health-care worker
- questioning patients
- restricting the autonomy of patients (for example with handcuffs)
- responding to emergency calls from health-care workers in danger.

These SOPs need to be context-specific and should take into account international human rights law and standards, domestic legislation and medical ethics. These SOPs should be designed with the objective of preserving the quality of care for patients, ensuring access to health care, upholding medical ethics, ensuring the maintenance of trust in health-care facilities and in the relationship between health-care workers and patients and providing a workable framework for legitimate law enforcement activities in health-care facilities.

RECOMMENDATION 3.3: THE TRANSFER OF PATIENTS OUT OF HEALTH-CARE FACILITIES

No patient should be discharged or handed over to the custody of LEAs against medical advice or before the completion of emergency treatment.

RECOMMENDATION 3.4: MEDICAL CONFIDENTIALITY

Medical confidentiality should be respected at all times. Health-care workers and LEAs need to have clear agreements during periods of relative calm on the expectations of each party with regard to the exceptional circumstances under which the sharing of patient information is permitted. It is unethical for medical personnel to disclose confidential information without the patient's consent, unless there is a real or imminent threat of harm to the patient or to others. Exceptions to medical confidentiality should be clearly defined and easily understood, ideally in domestic legislation. Any pre-defined exceptions should be consistent with medical ethics. This would include cases when it is in the best interest of the patient, during public health emergencies or when divulging personal information will prevent the commission of serious crimes. These exceptions should be in line with domestic legislation and should be sufficiently clear so that first responders and health-care workers can easily identify when the sharing of personal information with LEAs is compulsory, as opposed to when it is simply permitted.

RECOMMENDATION 3.5: PROCEDURES FOR DEALING WITH LEA REQUESTS

Health-care facilities should establish an internal procedure for dealing with law enforcement requests. This should include a designated focal point to receive requests from law enforcement. This focal point and the procedures that will be followed within a health-care facility should be included in the context-specific guidelines. Individual health-care workers should be shielded as much as possible from having to take case-by-case decisions, in order to allow them to focus on patient care. Where possible, these decisions should be delegated to a designated official within a health-care facility's administration.

RECOMMENDATION 3.6: REGULATING ENTRY TO HEALTH-CARE FACILITIES

LEAs should limit their presence in health-care facilities to critical or exceptional circumstances only. As the ER is a common point of entry into health-care facilities, these facilities should ensure that access to an ED is regulated in order to avoid the excessive presence of LEAs, which may inadvertently result in the loss of patient confidentiality.

RECOMMENDATION 3.7: REPORTING OF GSWS

If the reporting of GSWs is legally obligatory, as it is in some countries, SOPs for all health-care facilities should be developed that ensure that it is clear to all parties that the first duty is to provide care to the patient. Additionally, it should be clarified as to who is responsible for reporting the GSW and, what level of information it is necessary to provide, and within what timeframe. In order to preserve trust in health-care providers and to ensure that people needing treatment feel safe to access health-care facilities, information should ideally not include the patient's name, and the person reporting the GSW should be from the administration of the hospital rather than the attending health-care worker. When under a legal duty to disclose patient information protected under medical confidentiality, health-care personnel should take all necessary precautions in order to protect patients' other personal and health-care related information and only disclose the information strictly required.

RECOMMENDATION 3.8: LINES OF COMMUNICATION

Direct lines of communication must be pre-identified between health-care facilities and with LEAs in order to be able to request assistance and protection when health-care workers, patients or facilities are at risk, or to alert LEAs of disruptive behaviour by an individual official.

RECOMMENDATION 3.9: PRESENCE OF LEAS IN A HEALTH-CARE FACILITY

In cases where LEAs need to be present in a health-care facility – for example when taking a detained patient for treatment – care should be taken to ensure that health-care workers are able to carry out their duties safely and without undue hindrance, and that minimal disruption of health-care services occurs. Practical measures such as using a separate entrance to the health-care facility (pre-agreed with the health-care facility) can help to reduce disruption.

COMMENTARY

In the previously explored points of interaction between LEAs and health-care providers, many challenges can be overcome through prior coordination and engagement. Similarly, within health-care facilities, such prior dialogue has been identified as an essential step for reducing possible points of friction. However, within the health-care facility context, there are moments when the responsibilities and duties of health-care professionals may clash with the efforts and responsibilities of LEAs, requiring dialogue and a balancing of interests that ensure that a patient's rights are upheld.

Law enforcement personnel and health-care workers have two distinct and legitimate roles and responsibilities. LEAs are working to fulfil criminal justice aims, while health-care workers are working to provide medical treatment.[46] It is often in an ER where these two sets of responsibilities can come into interaction with each other.

46 Harada, M. *et al*. "Policed Patients: How the Presence of Law Enforcement in the Emergency Department Impacts Medical Care". 28 July 2021. The Practice of Emergency Medicine/Original Research. Volume: 78. Issue: 6. Page:738-748. https://www.annemergmed.com/article/S0196-0644(21)00380-2/fulltext

Law enforcement officers may be present in an ER, which is the entry point to many health-care facilities, for multiple reasons, including "ensuring public safety, preventing the escape of patients in custody, collecting evidence, documenting injuries, and, in some cases, patrolling ED waiting rooms".[47] While carrying out these functions, LEAs interact with health-care workers, whose aims are primarily medical and whose sole concern should be the well-being of their patient in accordance with medical ethics. Therefore, "interactions between law enforcement officers and medical personnel in the ED are complicated by the need to balance health interests of individuals against criminal justice interests of the state".[48]

The need to balance these two interests requires prior discussions between LEAs and health-care facilities to define procedures for managing what could become competing priorities. This is particularly of importance in a number of situations that can be pre-identified as having the potential for competing interests, including the sharing of patient information, the arrest and transfer of patients under care, the reporting of GSWs and the conduct of specific LEOs (such as search operations) within health-care facilities.

International human rights law does provide important guidance in such contexts. The guidance developed by General Comment No. 14 of the CESCR contains the notion of "acceptability" (paragraph 12), which is described as follows: "All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned". Paragraph 35 states that "obligations to protect include to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct".[49]

The General Comment by the United Nations Human Rights Committee to the Covenant creates an important framework for evaluating breaches of confidentiality. General Comment 16 states as follows: "Effective measures have to be taken by States to ensure that information concerning a person's private life does not reach the hands of persons who are not authorized by law to receive, process and use it, and is never used for purposes incompatible with the Covenant".[50]

The reporting of GSW patients is where this principle is often put to the test. A legal opinion produced for the ICRC on the duty to report GSWs to the police states as follows:

> Only four countries impose no duty to disclose GSWs: France, Niger, Papua New Guinea and South Sudan. It would therefore appear that in these countries, a medical doctor, in principle, would only be required to disclose confidential information relating to a patient suffering from GSWs if ordered by a Court to do so. However, even where there is no obligation for health-care professionals to disclose GSWs, there are indications that, in practice, health-care professionals in some of these countries actually do disclose gunshot wounds to governmental authorities.[51]

47 *Ibid*

48 *Ibid*.

49 See also Breitegger, A. "The legal framework applicable to insecurity and violence affecting the delivery of health care in armed conflicts and other emergencies" International Review of the Red Cross (2013), 95 (889), 83–127. pp. 121–122.

50 Physicians for Human Rights and School of Public Health and Primary Health Care, University of Cape Town, Health Sciences Faculty. "Dual Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms". 2002. https://phr.org/wp-content/uploads/2003/03/dualloyalties-2002-report.pdf

51 De Dycker, S et al. "Legal opinion on the obligation of healthcare professionals to report gunshot wounds. Australia, China, Colombia, Egypt, El Salvador, France, Lebanon, Mexico, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Philippines, Russia, South Africa, South Sudan, Spain, Tunisia, Ukraine, United Kingdom" 30 June 2019. Swiss Institute of Comparative Law. https://www.isdc.ch/media/1834/17-120-final-nov19.pdf

The opinion goes on to note that "in most countries, the presence of a gunshot wound is not expressly mentioned as a normative ground for an obligation to report confidential information".[52] In some countries, the obligation to report a GSW is based on whether the health-care worker suspects a criminal offence has taken place. However, "the health-care professionals in question are forced into a situation where they are required to assess the gravity of the criminal offence that they suspect has occurred, even though they may have no legal or criminal experience or knowledge".[53]

The ICRC summary of the report notes that "the existence of an obligation of doctor-patient confidentiality is essentially universal, while other than that there is little uniformity concerning the duty to report and its interplay with the duty of confidentiality among the countries covered and that no country provides for a specific procedure to resolve these conflicts".[54]

The lack of procedures to resolve these conflicts once again points to the need for discussions and agreements to be reached prior to emergency situations between law enforcement and health-care facilities. The ICRC points out that "exceptions should not be subject to discretion to the extent where there would be the potential to render the principle of medical confidentiality essentially meaningless".[55]

According to Janeway, Samra and Song, "the failure to demarcate appropriate boundaries between law enforcement's security, emergency response, and policing functions results in confidential patient information disclosures that go well beyond statutory mandates and permissions."[56] They go on to say that "clinicians have an individual responsibility to protect their patients from unlawful and overbroad police conduct. But it is ultimately the hospital's responsibility to protect patients' privacy, dignity, and autonomy."[57] The authors recommend that "hospitals must develop clear policies and protocols regarding police presence and law enforcement requests for patient Information".[58] They argue that "hospitals should be gatekeepers of privacy. Instead, hospitals have made patient care spaces public, and courts have deferred to hospitals' delineations".[59]

There are precedents that have been set for the highest standards of respect for patient confidentiality. In Belgium, the Code of Medical Ethics (Section 55) requires doctors to ensure professional secrecy regardless of the circumstances. Section 458 of the Belgian Penal Code condemns any violation of professional secrecy, unless the provider is called upon to testify in a court or before a parliamentary commission of inquiry, or is required by law to disclose confidential information that has been entrusted to it.[60]

The need to preserve patient confidentiality is a well-documented foundation of patient trust in health-care provision. As early as 1927, an editorial in the *Journal of the American Medical Association* noted that the duty "to report gunshot wounds and other injuries due to firearms will tend to lead persons so injured to postpone or even to avoid medical treatment, in order to prevent the entry of the case on the public records. … Legislation that tends to produce these results can hardly be regarded as desirable."[61] A study by Schwartz found that poor delineation between health-care workers and LEAs increased mistrust towards health-care providers and health-care institutions as a whole. Another study by Hacker *et al.* found that,

52 *Ibid*.
53 *bid*.
54 ICRC. "Study provides insight on health staff practices revolving reporting gunshot wounds". 9 December 2019. https://www.icrc.org/en/document/report-gunshot-wounds-study-gives-fresh-insights-obligation-health-staff
55 ICRC. Health Care in Danger Initiative. "Domestic Normative Frameworks For The Protection Of Health Care." May 2015. https://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4215-domestic-normative-frameworks-for-the-protection-heath-care.pdf
56 Janeway, H; Samra, S; Song, J. "An Ethical, Legal, and Structural Framework for Law Enforcement in the Emergency Department" Annals of Emergency Medicine, Volume 78, Issue 6, 2021, Pages 749-751, https://www.sciencedirect.com/science/article/abs/pii/S0196064421007964
57 *Ibid.*
58 *Ibid*.
59 *bid*.
60 ICRC. Health Care in Danger Initiative. "Domestic Normative Frameworks For The Protection Of Health Care." May 2015. https://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4215-domestic-normative-frameworks-for-the-protection-heath-care.pdf.
61 JAMA. "Compulsory reporting of gunshot wounds" 1927;88:404. https://jamanetwork.com/journals/jama/article-abstract/245134

among immigrant patient populations, the fear of collaboration between law enforcement and health-care providers led to decreased health-care service utilization.

The grounds for the recommendations outlined in this report are to establish procedures that would enable legitimate law enforcement activities while still preserving patient confidentiality and enabling health-care workers to respect their medical ethics, therefore ensuring the maintenance of trust in health-care providers. On the part of health-care workers, this entails ensuring that police presence and requests are evaluated and dealt with according to policies that are established and transparently available. On the part of LEAs, this requires ensuring that they follow the highest standards of procedural due diligence when accessing patients in health-care facilities, in order to preserve the privileged patient–health-care worker relationship.

Developing SOPs between LEAs and health-care facilities can help to overcome many of the uncertainties and points of tension that can exist within a health-care facility. In order to develop a policy for the interaction between LEAs, patients and health-care workers, it is necessary to take into account a number of ethical and legal considerations, including patient confidentiality, autonomy and dignity, the impact of LEA presence on the delivery of care, domestic legislation regarding the mandatory reporting of certain cases (such as GSWs) and custodial chains of evidence.[62]

The medical ethics that can guide the development of these guidelines or SOPs should include:

Medical ethics considerations for LEA presence in health-care facilities

The principle of autonomy refers to the patient's right to make decisions regarding their own medical care without being influenced or coerced by outside parties. Is the patient actually under arrest or in police custody, or are the police simply accompanying the patient with the intent to question them? What are the local laws with regard to these patients?

Benevolence refers to the physician's responsibility to prevent "deliberate, unnecessary or avoidable harm to patients". Does the police presence impede the patient's care or violate their trust or privacy?

The principle of beneficence requires that the physician have a positive impact on the patient's health. Is the presence of law enforcement benefiting the patient in some way?

Under the principle of justice, all patients should be treated equally regardless of their personal or financial situation. Is the patient receiving the same care and being treated with the same respect that any other person arriving in the trauma bay would expect to receive?

Source: "To protect and serve: The ethical dilemma of allowing police access to trauma patients"[63]

62 Tahouni, Morsal & Liscord, Emory & Mowafi, Hani. "Managing Law Enforcement Presence in the Emergency Department: Highlighting the Need for New Policy Recommendations". 2015. The Journal of emergency medicine. 49. https://www.researchgate.net/publication/279067936_Managing_Law_Enforcement_Presence_in_the_Emergency_Department_Highlighting_the_Need_for_New_Policy_Recommendations)

63 Ott, Katherine C, Douglas Brown, Ira J Kodner, Kathryn Bernabe, and Jennifer Yu. "To protect and Serve: The Ethical Dilemma of Allowing Police Access to Trauma Patients." American College of Surgeons, 4 October 2017. https://bulletin.facs.org/2017/10/to-protect-and-serve-the-ethical-dilemma-of-allowing-police-access-to-trauma-patients/

4. COMMUNITIES AND LAW ENFORCEMENT DURING A PUBLIC HEALTH EMERGENCY: NECESSITY AND PROPORTIONALITY

RECOMMENDATION 4.1: TRAINING ON NEW LEGISLATION

LEAs should receive adequate training on any new legislation that is passed during public health and other type of emergencies. Specific attention should be given to ensuring that the enforcement of public health control measures does not adversely impact the delivery of health care (such as the overly strict application of lockdown measures that may hamper the movement of health-care workers and patients).

RECOMMENDATION 4.2: PROTECTIVE EQUIPMENT

LEAs should be equipped with the necessary protective equipment, considering their level of exposure while carrying out law enforcement during a pandemic. This would also contribute to ensuring that their presence in health-care facilities does not pose additional risks to health-care workers and patients.

RECOMMENDATION 4.3: GUIDELINES ON THE ROLE OF LEAS IN PANDEMIC RESPONSE

Clear guidelines/SOPs should be established on the role of LEAs in the roll-out of public health measures that occur alongside health-care workers. Consideration should be given to the need for health-care workers to maintain trust among populations that may distrust law enforcement. This may require increased effort at maintaining the distinction between health-care workers and law enforcement. Other factors that should be taken into account include the role of law enforcement in crowd control, for example at a vaccination site or quarantine site, and the role of law enforcement in protecting health-care workers when they are at risk.

RECOMMENDATION 4.4: ROLE OF LEA IN COMBATING RISING SGBV CASES DURING A PANDEMIC

LEAs should put in place measures to ensure that those who are at risk of, or are victims/survivors of, SGBV have the increased levels of assistance they need from law enforcement during pandemics, which result in increased vulnerability. This should include considerations about victims/survivors of SGBV being able to move during curfew or lockdown times, codes or safewords that can be used by people in danger at designated locations such as pharmacies to trigger the intervention of law enforcement in order to facilitate access to health care or safety, and safe areas where survivors of SGBV or at-risk individuals can be accommodated. It should be noted that the compulsory reporting of SGBV cases to LEAs by health-care workers is not considered good practice in any circumstance as it can reduce access to health care for victims/survivors.

RECOMMENDATION 4.5: PROTECTING STIGMATIZED GROUPS

LEAs should identify people and groups who may be at risk of stigmatization and violence because of a pandemic and ensure that mechanisms are in place to ensure their safety.

RECOMMENDATION 4.6: COMMUNICATION

Considering that LEAs are often the face of imposing lockdown measures during a pandemic, extra attention should be given to regularly communicating about lockdown measures, their purposes and the ways in which exceptions can be obtained, particularly in relation to facilitating safe access to health care.

COMMENTARY

LEAs are often at the forefront of enforcing public health measures in response to public health emergencies including pandemics.[64] The role of LEAs in the COVID-19 response generally included the enforcement of public health directives to reduce risks in certain public locations (for example, enforcing wearing of masks)

64 Jennings, W.G., Perez, N.M. The Immediate Impact of COVID-19 on Law Enforcement in the United States. Am J Crim Just 45, 690–701 (2020). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7275851/

as well as the more specific roles of enforcing quarantine orders for individuals and securing health-care facilities and testing centres.[65] This role, however, varied drastically between contexts depending on the restrictions put in place by different governments, and even by different regions within the same country. "If a jurisdiction responded aggressively, then the police might be asked to enforce such public health directives as wearing masks, closing businesses with indoor or significant in-person contact, or prohibiting events and large gatherings. At the other end of the spectrum, if the public health response in their jurisdiction was limited or weak, police might not be involved in managing public health risk at all."[66] While public health departments mostly lead the actual response to the pandemic, LEAs are expected to enforce mandatory elements of the response. As with other moments in which health-care workers and law enforcement interact, this requires joint planning.

The issues that emerged through the interviews for this report can broadly be characterized along the following lines:

- the impact of COVID-19 on LEAs themselves and the lack of adequate training and measures to address these risks
- the inappropriate application of public health measures that would inadvertently hamper the work of health-care professionals
- the difficulties faced by LEAs in keeping up with, and adapting to, fast-changing regulations
- the rise in social unrest associated with lockdown measures, economic strain and the way in which the pandemic response measures became politicized in many contexts.

The National League of Cities in the United States developed guidelines on the role of law enforcement during COVID-19, which recommended as follows:

> State and local government's policies related to COVID-19 should be clearly communicated to all local law enforcement officers. Local law enforcement leaders should clearly establish how officers are to interact with the community and enforce the rules. Officers should be prepared to answer questions about testing kit availability, travel restrictions, quarantine and isolation, and personal safety measures (including who the public should call for such information). The role of law enforcement should be focused on informing the public about the current restrictions and encouraging individuals to comply with the state and local emergency health declarations.[67]

What the pandemic has demonstrated is that community trust in both health-care workers and law enforcement is essential to ensuring compliance with the public health measures put in place to manage the pandemic. "To promote voluntary compliance with these public health measures, positive police-community relationships and public trust are imperative."[68] In order to preserve trust and the legitimacy of governments during pandemics, the United Nations Assistant Secretary-General for Rule of Law and Security Institutions in the Department of Peace Operations argued that "it is therefore in the interest of governments to ensure that emergency restrictions on rights are necessary, proportionate, legal and time bound".[69]

65 Jackson, et al. "Promising Practices from Law Enforcement's COVID-19 Response" Rand Corporation. 2021. https://www.rand.org/pubs/research_briefs/RBA108-1.html

66 Ibid.

67 Ors, Y. "Role of Law Enforcement During COVID-19 Pandemic". 25 March 2020. National League of Cities. https://www.nlc.org/article/2020/03/25/role-of-law-enforcement-during-covid-19-pandemic/

68 Jennings, W.G., Perez, N.M. The Immediate Impact of COVID-19 on Law Enforcement in the United States. Am J Crim Just 45, 690–701 (2020). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7275851/

69 Zouev, A. "COVID and the Rule of Law: A dangerous Balancing Act" United Nations. 2020. https://www.un.org/en/coronavirus/covid-and-rule-law-dangerous-balancing-act

In many countries, the pandemic resulted in an increase in the reported cases of gender-based violence and femicide. This is demonstrated by the following example:

> An estimated 7 out of 10 femicides in Latin America occur in a victim's home, and coronavirus lockdowns have marooned women under the same roof as their abusers. The impact was rapid and dramatic. Several countries saw substantial increases in calls to emergency hotlines following stay-at-home measures. Argentina, for example, has reported a 39 per cent spike since March, while Colombia saw a staggering 90 per cent rise. Emergency calls to Mexico's shelters increased by 60 per cent. Calls to the military police 190 hotline in São Paulo state increased 45 per cent.[70]

The lockdown not only resulted in victims of domestic abuse being confined to their homes, but also limited their ability to move around and seek help. It was reported that LEAs were often unaware of the need or their duty to facilitate the movement of victims of domestic abuse who might be seeking help in violation of lock-down measures. In some countries, women were specifically allowed by law to leave their homes to seek help.

One set of guidelines, produced for the police in India on respecting human rights while enforcing the lock-down, recommended as follows:

> Take special measures and formulate plans to address the specific needs and vulnerabilities of women, children, the sick, senior citizens, disabled persons; or any other group, which will be particularly hampered by the restrictions on movement and social interaction, including:
> a. Assisting in delivering rations or medicines to their residences
> b. Escorting anyone in need to a hospital, bank, ration shop or provisions store, or any other essential service
> c. Facilitating the continuity of medical or support services for the sick, senior citizens, and disabled persons especially or anyone in need
> d. Where possible, making regular phone calls to check in on anyone in need[71]

The guidelines went on to make the following recommendation to police:

> Recognize the distinct hardship and safety concerns faced by vulnerable groups including the homeless, migrant workers, sex workers, trans persons, members of minority groups, women and children in unsafe houses, and communities ... susceptible to hate crimes. As a start, this can be done by:
> a. Devising specific support services or strategies for anyone in need
> b. Consulting civil society organizations and other relevant stakeholders to build a repository of effective referrals for anyone in need
> c. Assuring anyone in need of police presence and response[72]

These guidelines suggest an overall need for LEA to take into consideration heightened vulnerability and political tension caused by the pandemic. "In this atmosphere, a 'soft policing' approach that prioritizes community engagement, empathy and compassion, rather than the traditional 'militarized' approach typically adopted by police departments, is needed."[73]

70 Prusa, A. et al. Pandemic of Violence: Protecting Women during COVID-19. 27 May 2020. New Security Beat. https://www.newsecuritybeat.org/2020/05/pandemic-violence-protecting-women-covid-19/

71 Commonwealth Human Rights Initiative. "Respecting Human Rights while Enforcing the Lockdown: Guidelines for Police". March 2020. https://www.theiacp.org/sites/default/files/CHRI%20Guidelines%20to%20the%20Police__Lockdown__31%20March%202020.pdf

72 Ibid.

73 Wasseem, Z. "Coronavirus Pandemic Puts Police in the Spotlight in Pakistan: Health crisis reveals challenges and offers an opportunity for police reform". 16 June 2020. United States Institute of Peace. https://www.usip.org/publications/2020/06/coronavirus-pandemic-puts-police-spotlight-pakistan

5. BORDER CONTROL, IMMIGRATION AND ACCESS TO HEALTH CARE

RECOMMENDATION 5.1: LEGAL STATUS AND ACCESS TO HEALTH

All migrants in need should have access to health care, irrespective of status, without fear of arrest, detention or deportation. LEAs should not require health-care workers to carry out migration-related law enforcement activities and should respect the duty of health-care workers to preserve medical confidentiality except in specified circumstances. Therefore, LEAs should not require health-care workers to report patients based on their legal status in a country, or to share any individual information collected from migrants in the exercise of their medical mission with a view to using such information for law enforcement or surveillance-related purposes.

RECOMMENDATION 5.2: IRREGULAR BORDER CROSSINGS AND ACCESS TO HEALTH CARE

LEAs involved in border control activities should develop protocols for ensuring access to health care for migrants at irregular border crossing points, who may be particularly vulnerable as a result of their journey or because of conditions at the irregular border crossing point. A lack of access to health care should not be considered as a measure to deter people from crossing borders irregularly.

RECOMMENDATION 5.3: PRE-PLANNING

State authorities must treat migrants with humanity in all circumstances and refrain from excessive use of force in border management operations. Force may only be used as a last resort, when other means remain ineffective or without any promise of achieving the intended result. In line with international human rights law standards, any use of force must be consistent with the principles and requirements of legality, necessity, proportionality, precaution and accountability. In all circumstances, mediation and de-escalation should be encouraged. LEAs involved in border control should ensure that there is access to health care before launching any LEO that may result in the use of force. Considerations on the need to ensure access to health care should be coordinated between different country border guards, first responders, ambulances and hospitals that may receive patients. If necessary, access into "no-man's land" should be coordinated with ambulances and first responders, and safe passage for patients to the nearest health-care facility should be assured before any law enforcement activities are carried out. Patients should not be transported from health-care facilities to immigration detention or pre-removal facilities until medical assistance has been completed.

COMMENTARY

LEAs have a specific role to play in immigration and border control. It is in the conduct of these duties that LEAs and health-care workers may interact. Migrants, including refugees, are often more vulnerable owing to language barriers, socio-economic factors and exposure to violence or hostile environments, and may require or seek health care at different points in their journey or in the country of destination.

In the United States, the agency that oversees border patrol said its agents averaged "69 trips to the hospital each day across the country. In the first half of the year, the federal government said Border Patrol agents had spent about 153,000 hours monitoring detained people at hospitals, as more families and children were crossing the border from Mexico. That's the equivalent of about 20,000 8-hour shifts spent at hospitals." This number clearly demonstrates the large span of interaction between LEAs and health-care workers in the context of migration.[74]

Many of the recommendations developed for LEAs in general in a health-care facility would equally apply in the context of migration, as the right to health extends to migrants, regardless of their legal status.

74 Licon, A. "Border Patrol's growing presence at hospitals creates fear" Associated Press. 17 October 2017. https://apnews.com/article/immigration-miami-us-news-ap-top-news-border-patrols-52a38ce1d4b84e289b8073b47674514e

However, there are some specific considerations to take into account. The first consideration is the fear of arrest or deportation that many irregular migrants may have when accessing government health-care facilities. This often results in an informal barrier preventing migrants' access to health care and other basic services. This fear is due to the possibility of health-care workers reporting irregular migrants to LEAs/ immigration authorities, to the general presence of LEAs inside hospitals, or to the active border control operations that may take place inside some health-care facilities.[75]

There are approaches that can be taken by a state and respected by both LEAs and health-care workers with regard to ensuring that migrants, including refugees and asylum seekers, have access to health care without discrimination. The prerogative of a state to regulate and control migration to and within its territory rests with immigration and law enforcement authorities. However, it is not part of the health-care professional's function to participate in law enforcement activities. Health-care workers should not be asked to, or agree to, disclose individual information where a breach of confidentiality amounts to a violation of human rights and the humanitarian imperative of "do no harm" and could result, for instance, in detention, prosecution and/or deportation of the person concerned. When it comes to migrants, including refugees, provided there exists no likelihood of harm to a third party in the absence of disclosure, "the principle of confidentiality and of making health services available to people in need should take precedence over the state's interest in using health professionals to assist in enforcement of immigration laws. Health professionals must therefore decline to report [irregular migrants] to state authorities. It may be particularly difficult for health professionals working in state institutions or on a government payroll to resist pressures to report. Strong institutional mechanisms must be in place to support them."[76]

75 Ibid
76 Physicians for Human Rights and School of Public Health and Primary Health Care, University of Cape Town, Health Sciences Faculty. "Dual Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms". 2002. https://phr.org/wp-content/uploads/2003/03/dualloyalties-2002-report.pdf

CONCLUSION

The recommendations outlined in this document cover multiple different approaches to ensuring improved interaction between health-care workers and law enforcement.

The first layer of recommendations can be considered as operational or technical. These recommendations cover the concrete steps and measures that are needed to improve the safety of health-care workers and facilities, as well as to better facilitate access to health care. These measures range from the informal coordination needed, for example, to ensure the safe movement of patients by ambulances, to the more formal need to reach agreements – such as through SOPs or guidelines – that reinforce mutual understanding and clarify the ways of functioning between health-care workers and LEAs in emergencies. What is common to all of these operational recommendations is the need to improve dialogue before emergency situations in order to reduce the potential for misunderstandings and, more generally, to better ensure improved patient outcomes.

The second layer of recommendations includes the policy work needed to improve the regulatory landscape that governs the various moments of interaction between health-care workers and law enforcement. This policy-level work requires a willingness to ensure that the regulatory environment of law enforcement's interaction with health-care workers is first and foremost in the interests of patients. This is necessary in order to preserve trust in health care, which global pandemics such as COVID-19 have demonstrated to be essential in ensuring effective response and control.

Technical solutions are needed to reduce unnecessary misunderstandings and conflictual interactions that do not promote the protection of health-care facilities and access to health care. However, many of the conflictual interactions between health-care workers and LEAs are a result of political decisions that enable or empower LEAs to make use of expansive powers in the advancement of security interests. In these situations, the technical fixes identified in this report will only go so far in protecting health-care providers and patients. However, this document does demonstrate what could be considered best practices grounded in laws, codes of conduct and ethics that should not be superseded by political interests. However, the implementation of these recommendations will often require both a technical discussion to improve interactions and reduce unnecessary misunderstandings, and political dialogue to demonstrate that ensuring the preservation of trust in health care is in the interests of all. If COVID-19 has shown health-care workers and LEAs one thing, it is that trust in health care is difficult to build, easy to undermine and essential when collectively confronting a challenge as immense as a global pandemic.

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4567/002 11.2022