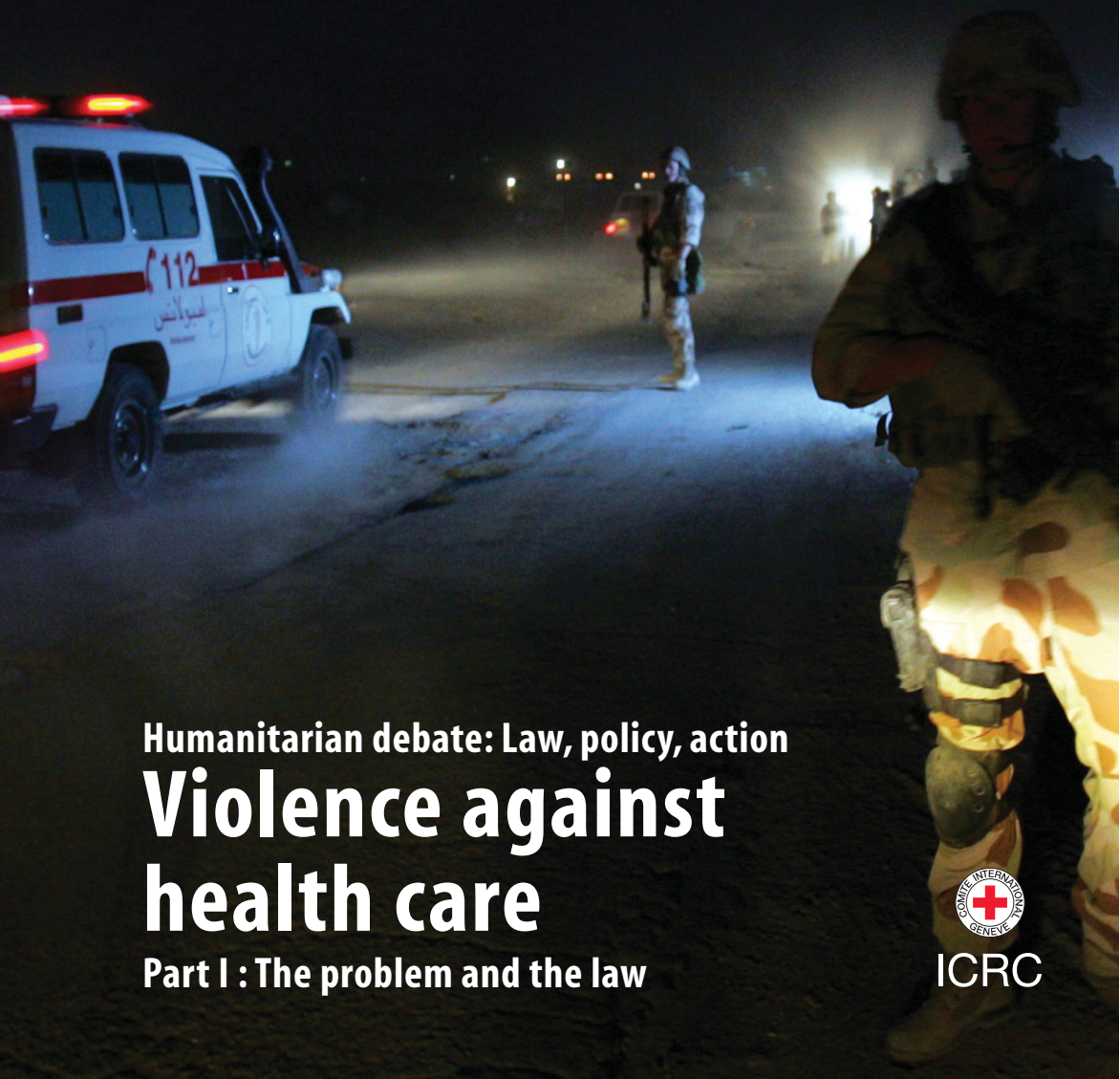


Volume 95 Number 889 Spring 2013

# INTERNATIONAL REVIEW of the Red Cross



Humanitarian debate: Law, policy, action

## Violence against health care

Part I : The problem and the law



ICRC

### Aim and scope

Established in 1869, the *International Review of the Red Cross* is a periodical published by the ICRC and Cambridge University Press. Its aim is to promote reflection on humanitarian law, policy and action in armed conflict and other situations of collective armed violence. A specialized journal in humanitarian law, it endeavours to promote knowledge, critical analysis and development of the law, and contribute to the prevention of violations of rules protecting fundamental rights and values. The *Review* offers a forum for discussion on contemporary humanitarian action as well as analysis of the causes and characteristics of conflicts so as to give a clearer insight into the humanitarian problems they generate. Finally, the *Review* informs its readership on questions pertaining to the International Red Cross and Red Crescent Movement and in particular on the activities and policies of the ICRC.

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**REVIEW**  
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**Violence against  
health care**

Part I: The problem and the law

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## EDITORIAL: VIOLENCE AGAINST HEALTH CARE: GIVING IN IS NOT AN OPTION

An improvised explosive device is detonated as a military convoy passes by. While crowds of people and relief workers rush to the scene to assist the wounded, a second bomb explodes, timed so as to inflict the greatest possible damage on the emergency services.

Vehicles are being held up at an army checkpoint on a major highway: everyone – including an ambulance on its way to the hospital – is forced to queue for hours. It takes too long and the patient dies from lack of treatment.

A doctor is put in prison for having treated wounded demonstrators following violent clashes between an opposition movement and the police.

An armed group seizes a health-care centre, loots it, and kills the wounded members of the enemy group as well as the medical personnel. The local inhabitants have no access to health care and many of them have no choice but to flee the area.

These incidents could have taken place anywhere today, from the Central African Republic to Syria.<sup>1</sup> They are a part of the contemporary reality of warfare – so much so, in fact, that they barely stand out in the constant stream of news headlines. They are just a few examples of the types of threats, attacks, and obstructions that health services experience in armed conflicts and other emergency situations. Not only are medical personnel deliberately targeted, but wounded people, be they civilians or military, are not spared either.

The accumulation of such incidents creates insecurity – real or perceived – and their consequences go beyond their immediate impact. The lack of security creates ‘medical deserts’, depriving entire communities of access to health care and causing severe and lasting disruption to public health across geographical areas. The indirect consequences of violence against health care are thus diffuse, insidious, and silent, but may assume disastrous proportions.

Nonetheless, the protection of the wounded and of medical personnel is part of the common heritage of the world’s cultures and religions.<sup>2</sup> The respect traditionally shown for the work of those providing medical care has always been matched by the respect for medical ethics shown by medical personnel themselves. Medical ethics derive from the civilisation of ancient Greece, with the famous Hippocratic Oath; in Arabic medicine, the earliest surviving text on medical ethics is Ishāq ibn ‘Alī al-Ruhāwī’s tenth-century book *Practical Ethics of the Physician*.

Moreover, modern humanitarian work and international humanitarian law (IHL) were born out of indignation over the fate of the war-wounded abandoned on the battlefield. The creation of the Permanent International Committee for the Relief of Wounded Soldiers in 1863 – today known as the International Committee of the Red Cross (ICRC) – and the adoption of the original Geneva Convention of 22 August 1864 ‘for the Amelioration of the Condition of the Wounded in Armies in the Field’ were the direct outcomes of a general realisation that a modicum of humanity needed to be maintained even in wartime.

The most important principles in the 1864 Geneva Convention,<sup>3</sup> which were retained in the text of the subsequent Conventions, include the obligation to care for the wounded without distinction on the basis of nationality; the neutrality and inviolability of medical personnel and establishments; and the adoption of an emblem to distinguish and protect the latter.

The protection of the wounded and medical personnel and the organisation of relief operations were thus the primary concerns of those who pioneered modern humanitarian action. It took every ounce of their energy to mobilise civil society and the community of states at the time in order to establish national protection structures and international protection instruments.

Yet, exactly 150 years later, attacks on the wounded and on medical personnel, the obstruction of access to health care, and the deliberate destruction of medical facilities in armed conflicts and other emergency situations continue. Are we witnessing an increase in this type of violence, coupled with a decline in respect for IHL? Is the current extent of the phenomenon attributable to the nature of contemporary armed conflicts? Because no long-term statistics are available, we have no answer to those questions, but we can at least consider that violence against health care can be: (1) a persistent phenomenon; (2) a potential exacerbation of an old phenomenon; or even (3) the resurgence of this aspect of warfare. It is time for the international community to reaffirm that there are limits to inhumanity and to take a close look at the current causes of violence against health care, one of the major humanitarian challenges of the present era.

1 See Romaric Bekourou, ‘Central African Republic: thousands forced to flee, health facilities looted’, available at: [www.youtube.com/watch?v=-cck2zYeZII](http://www.youtube.com/watch?v=-cck2zYeZII); International Committee of the Red Cross (ICRC), ‘Somalia: Lifeline Mogadishu’, available at: [www.icrc.org/eng/resources/documents/audiographics/video/2013/05-27-somalia-health-care-in-danger.htm](http://www.icrc.org/eng/resources/documents/audiographics/video/2013/05-27-somalia-health-care-in-danger.htm); British Red Cross, ‘Call for an end to attacks on aid workers in Syria as International Red Cross and Red Crescent Movement marks 150th anniversary’, 29 October 2013, available at: [www.redcross.org.uk/About-us/News/2013/October/Solidarity-call](http://www.redcross.org.uk/About-us/News/2013/October/Solidarity-call).

2 In India, for example, the ancestral laws of Manu require the victor to spare the wounded. In Burkina Faso, custom prohibits the killing of people who do not take part in the fighting and requires that the wounded of both parties be cared for. For a brief summary of the different traditions, see, for example, Véronique Harouel-Bureloup, ‘Droit international humanitaire: la coutume’, in *Grotius International*, 7 March 2013, available in French at: [www.grotius.fr/droit-international-humanitaire-la-coutume/](http://www.grotius.fr/droit-international-humanitaire-la-coutume/).

3 Geneva Convention of 22 August 1864 for the Amelioration of the Condition of the Wounded in Armies in the Field, 75 UNTS 31, entered into force on 21 October 1950.



## What is the actual problem?

‘One of the first victims of war is the health-care system itself.’<sup>4</sup> The International Red Cross and Red Crescent Movement, which is a witness and sometimes a direct victim of repeated incidents of this kind, has taken note of the seriousness of the phenomenon, which has been highlighted by the work of experts such as Leonard Rubenstein and Robin Coupland.<sup>5</sup> Between 2008 and 2010, the ICRC carried out a study of a 655 violent incidents affecting health care in sixteen different countries.<sup>6</sup> The study drew attention to the different forms of violence that hinder the provision of medical care: direct attacks on patients, medical personnel, and medical facilities – particularly pillaging and kidnapping – or cases of arrest and refusal to grant access to medical care.

In 2013, new data collected by the ICRC<sup>7</sup> showed that the vast majority of violent incidents against health services that took place during 2012 – more than 80 per cent of the 900 or so incidents recorded in twenty-two countries – affected local health-care professionals. A quarter of the people affected by these incidents were killed or wounded, while the remainder of the incidents consisted of beatings, threats, arrests, kidnapping, and other violent occurrences. The data collected do not allow a single class of perpetrator to be identified as predominant but, conversely, indicate that those responsible include not only state armed forces and security forces but also non-state armed actors. In this issue of the *Review*, Fiona Terry analyses violence against health-care providers and facilities across three contexts in which access to health care is particularly difficult: Afghanistan, the Democratic Republic of the Congo, and Somalia. Similarly, based on six contemporary case studies, Enrico Pavignani, Markus Michael, Maurizio Murru, Mark Beesley, and Peter Hill analyse the consequences of state failure on health-care provision.

Abuse of the medical mission by criminal groups or parties to the conflict for trafficking purposes or as a cover for military operations contributes to the rapid erosion of the protection afforded to medical services as a whole. Indeed, when some ambulances are misused, the entire health-care system looks suspicious to combatants and suffers the consequences, which can range from ambulances having to wait a long time at checkpoints to doctors and facilities being directly targeted.

The effects of violence against health care extend far beyond the moment of the attack and its immediate consequences. Attacks on medical services affect not only the personnel directly targeted but also the entire population who depend on them for health care. On the one hand, for each health-care professional attacked, there are hundreds, sometimes thousands of patients who will not be able to receive

4 Marco Baldan, ICRC chief war surgeon, in *Health Care in Danger: Making the Case*, ICRC, Geneva, 2011, p. 7, available at: [www.icrc.org/eng/assets/files/publications/icrc-002-4072.pdf](http://www.icrc.org/eng/assets/files/publications/icrc-002-4072.pdf).

5 See their articles in this issue of the *Review*.

6 ICRC, *Health Care in Danger: A Sixteen-Country Study*, July 2011, available at: [www.icrc.org/spa/assets/files/reports/report-hcid-16-country-study-2011-08-10.pdf](http://www.icrc.org/spa/assets/files/reports/report-hcid-16-country-study-2011-08-10.pdf).

7 ICRC, *Violent Incidents Affecting Health Care – January to December 2012*, 15 May 2013, available at: [www.icrc.org/eng/resources/documents/report/2013-05-15-health-care-in-danger-incident-report.htm](http://www.icrc.org/eng/resources/documents/report/2013-05-15-health-care-in-danger-incident-report.htm).

treatment, be it preventive (such as vaccination campaigns) or curative (such as surgery or rehabilitation). On the other hand, repeated acts of violence against health care may result in doctors leaving the area because they – justifiably – fear for their safety. Deprived of access to health care, communities are thus left to suffer the consequences over the long term.<sup>8</sup>

The evident erosion of the protection of medical personnel is of concern not only in conflict areas and emergency situations. For several years, serious problems of violence against medical personnel, particularly in the emergency services, have also been observed in peaceful countries. Health-care services may sometimes be the target of criminal activities, but it is often the patients and their families who are the cause of the problems and security incidents. If lack of security at hospitals tends to be trivialised in peacetime, what will happen in a time of crisis? This concern reinforces the need to adopt a preventive approach, also in countries that are not currently affected by armed conflict or other emergency situations.

While health-care professionals have rights that protect them, they also have obligations and responsibilities, which are tied to the rights of the wounded and sick in their care. They are thus bound by IHL and human rights law as well as by medical ethics. Respect for those ethics by medical personnel is another aspect of the problem of health care in times of conflict and in emergency situations. National medical bodies have an important role to play, particularly in order to avoid any state interference and to ensure that respect is shown for the code of ethics by the profession itself. In South Africa, for example, Dr. Wouter Basson, former head of the apartheid regime's bacteriological and chemical programme, was accused of developing chemical weapons designed to put anti-apartheid militants out of action. The ultimate aim of that research was to find a chemical means of stemming the rise in demographic power of the black population. In 2013 the Health Professions Council of South Africa found him guilty of violating medical ethics.<sup>9</sup>

## An increasing mobilisation

It is essential to tackle violence against health care as one single complex issue rather than as the simple sum of independent incidents. Mandated by the International Conference of the Red Cross and Red Crescent in 2011,<sup>10</sup> the ICRC launched a four-year project entitled Health Care in Danger with a view to encouraging the various parties concerned to take measures to remedy the state of affairs in the field, and to consulting a wide range of experts tasked with identifying solutions to the problem.

8 See the interview with the Liberian minister of health, Dr. Walter Gwenigale, in this issue of the *Review*.

9 See 'South Africa's "Dr Death" Basson found guilty of misconduct', in *BBC News Africa*, 18 December 2013, available at: [www.bbc.com/news/world-africa-25432367](http://www.bbc.com/news/world-africa-25432367).

10 See Resolution 5, 'Health care in danger: respecting and protecting health care', adopted at the 31st International Conference of the Red Cross and Red Crescent, 1 December 2011, available at: [www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm](http://www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm).

The *Review* asked Pierre Gentile, who is in charge of coordinating the project at the ICRC, to report on its progress in this issue.

Similarly, several non-governmental organisations (NGOs) have developed their own campaigns in this area. For example, Médecins sans Frontières (Doctors without Borders, MSF) has launched the project Medical Care Under Fire, which regularly provides information on security incidents affecting health care.<sup>11</sup> In this issue of the *Review*, Caroline Abu Sa'Da, Françoise Duroch, and Bertrand Taithe present a study of the way in which MSF tackles the issue of violence and attacks on it or on patients in its care. They advocate for the development of critical reflections on insecurity phenomena in the context of humanitarian action.

Another relevant group is the Safeguarding Health in Conflict Coalition, which is composed of NGOs, associations of health-care professionals, and an academic centre.<sup>12</sup> Its aim is to promote respect for IHL and human rights relating to the safety and security of health-care facilities, health workers, ambulances, and patients in armed conflicts and other situations of violence.

Attacks on health care must be considered first and foremost as a *humanitarian* problem and not merely as a problem encountered by *humanitarian workers*. After years of efforts, it is extremely encouraging to see that this subject has now been taken up outside the International Red Cross and Red Crescent Movement and NGOs: many other influential actors and states are tackling the problem. For instance, the International Council of Nurses<sup>13</sup> and the World Medical Association<sup>14</sup> are now partners in the ICRC's Health Care in Danger project, and the topic was recently discussed at the World Health Assembly.<sup>15</sup> In his report on the protection of civilians submitted to the United Nations Security Council in May 2012,<sup>16</sup> the Secretary-General also made numerous references to attacks on medical services and asked the Security Council to be more proactive in that area. Several states, such as Norway, Australia, and South Africa, are actively supporting the Health Care in Danger project at the global level.

In addition, efforts have been made at the national level, in partnership with the ICRC and the National Red Cross and Red Crescent Societies. We also have a lot to learn from some states which, faced directly with the problem, have already

11 See the Medical Care Under Fire' website, available at: [www.msf.org/topics/medical-care-under-fire](http://www.msf.org/topics/medical-care-under-fire).

12 See the Safeguarding Health in Conflict Coalition website, available at: [www.safeguardinghealth.org](http://www.safeguardinghealth.org).

13 See [www.icn.ch/news/whats-new-archives/safeguarding-health-in-conflict-coalition-1506.html](http://www.icn.ch/news/whats-new-archives/safeguarding-health-in-conflict-coalition-1506.html).

14 The World Medical Association (WMA) states: 'Medical ethics constitute a major area of cooperation between the ICRC and the WMA. This was formalised by a Memorandum of Understanding signed on the 26th of June 2013. With this agreement, the WMA aims to contribute to the development of the project, especially by addressing the responsibility of health-care personnel in armed conflicts and other emergencies.' See World Medical Association, 'Health Care in Danger Project', available at: [www.wma.net/en/20activities/60campaigns/11HealthDanger/index.html](http://www.wma.net/en/20activities/60campaigns/11HealthDanger/index.html).

15 International Federation of Health and Human Rights Organisations, 'World Health Assembly adopts resolution on WHO's role in documenting attacks on health workers and facilities', 30 May 2012, available at: [www.ifhro.org/news-a-events/360-world-health-assembly-adopts-resolution-on-whos-role-in-documenting-attacks-on-health-workers-and-facilities](http://www.ifhro.org/news-a-events/360-world-health-assembly-adopts-resolution-on-whos-role-in-documenting-attacks-on-health-workers-and-facilities).

16 Report of the Secretary-General on the protection of civilians in armed conflict, UN Doc. S/2012/376, 22 May 2012, paras. 33–34. See also the Report of the Secretary-General on the protection of civilians in armed conflict, UN Doc. S/2013/689, 22 November 2013, para. 23.

started to introduce solutions to reduce violence against health workers. For instance, in this issue the *Review* has made space for the views of the National Permanent Roundtable for the Respect of the Medical Mission in Colombia, whose experience is making it possible for practical recommendations to be worked out for the future.

## Seeking solutions

While there is clearly much work that remains to be done, there is a body of legal and ethical rules protecting health care in peacetime and in wartime.

Under IHL, the parties to an armed conflict are required to protect, collect, and care for the wounded and sick, as well as to protect medical personnel, medical units, and medical means of transport against attack, to show respect for them, and not to impede the provision of treatment. In order to guarantee that protection, IHL precisely defines the use of distinctive emblems protected by the Geneva Conventions and their Additional Protocols. It also requires respect to be shown for the principles of medical ethics, by banning, for example, the use of coercion to compel health-care professionals to provide treatment that contravenes those ethics.

In situations below the threshold of an armed conflict, access to health care is protected by human rights law and national law, in particular through the right to health. At all times and in all circumstances, states are under an obligation to guarantee their populations an effective system of health care.

In this issue, Vivienne Nathanson analyses the ethical challenges faced by medical practitioners in times of conflict by comparing them with peacetime situations. The legal aspects of health-care protection are presented and discussed in several articles in this edition of the *Review*. Alexandre Breitegger presents an overview of the legal framework applicable to health care in times of conflict and other emergency situations; Amrei Müller analyses the complementarities between the rules of IHL and the right to health, specifically in situations of non-international armed conflict; and Katherine Footer and Leonard Rubenstein affirm the importance of human rights for the protection of health care in situations to which IHL does not apply, or as a complement to it. The question of criminal justice is addressed in an account by Judge Miroslav Alimptic, a Serbian investigative judge at the Novi Sad district court in the case of the massacre at Vukovar Hospital during the war in the former Yugoslavia. Lastly, Marisela Silva Chau and Ekaterina Ortiz Linares analyse Colombian case law relating to the prohibition of punishment for carrying out medical activities that are in keeping with medical ethics.

Even in wartime or during violent uprisings, it must be possible to ensure that the wounded and sick have rapid access to health care, and practical measures may be taken by the various actors concerned (doctors, political leaders, academics, military staff, representatives of civil society, and so on). The ICRC has conducted a series of workshops with these actors in different parts of the world, with a view to

proposing future solutions.<sup>17</sup> The measures taken by these actors, depending on the context and if implemented, could save thousands of lives throughout the world. A non-exhaustive list of such measures is presented in the following box:

- Establish a full and consistent legal framework in each country so as to protect the provision of health care in all circumstances.
- Take measures in the fields of education, training, and dissemination of the relevant rules so as to contribute to preventing incidents.
- Include a combination of criminal, administrative, and disciplinary sanctions in the suppression of attacks against health care.
- Establish control mechanisms for the use of the protective emblems by the medical mission at the national level.
- Institute a system for following up data concerning threats and attacks against medical personnel, patients, facilities, and means of transport at the national and/or international level.
- Take prioritisation measures at checkpoints, such as the identification and the clear and consistent designation of medical transport.
- Identify standardised procedures among security forces, suppliers of health care, and authorities in order to provide a framework for operations carried out by security forces in health-care facilities (such as searches and tracking down suspects).
- Improve the planning and conduct of attacks on military objectives located in the immediate vicinity of health-care establishments (or on such establishments that have lost their protection against attacks because they have been used for military purposes) in order to minimise the impact on health care.
- Exempt health-care professionals from the legal obligation to divulge certain information obtained in the course of their work, and define precisely exceptions to medical confidentiality in national legislation.
- Have National Societies play an important role, including in efforts to protect the emblem and to prevent its abuse, in the areas of sensitisation, monitoring of abuses, and the implementation of national legislation.
- Ensure that volunteers from emergency services, including those from the Red Cross or Red Crescent, benefit from a health insurance plan.

17 The ICRC has also established an interactive web-based network of organisations and people working to provide safe access to health care in armed conflict and other emergency situations. The network gives its members access to a resource centre devoted to the publication of documents and tools and enables them to contribute to it. Members may also exchange their practical experiences, share a community calendar and follow the recommendations drawn up at workshops on health care in danger. For more information, see: [www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-expert-consultations.htm](http://www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-expert-consultations.htm).

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Each individual can contribute to improving the protection of health care by sharing information and proposing solutions. The *Review* has chosen to take part in this project by inviting people who have witnessed violence against health care, academics, humanitarian workers, members of the judiciary, government representatives, and medical experts to contribute to this thematic issue. The journal thus brings together operational, legal, and ethical perspectives. The articles in this issue make it possible to (1) illustrate the humanitarian problem by presenting the results of several case studies from the field; (2) review the relevant legal and ethical frameworks; and (3) outline different solutions at the legal, operational, and policy levels. Opening this issue, Dr. Walter Gwenigale, director of a hospital that was attacked during the conflict in Liberia and current minister of health and social protection, recounts his experience. He analyses the dangers faced by health-care professionals in times of conflict, the long-term consequences of such violence, and the measures that can be taken to prevent it.

Violence against health care: there are few subjects that draw attention so vividly and radically to the worst and the best of our humanity. The worst is the abuse of force against those who need treatment or those who are there to give it. The best is the commitment of volunteers and medical personnel who brave widespread insecurity, oppression, and direct violence to provide treatment out of respect for their ethics. To facilitate awareness of the problem is just a first step towards identifying solutions that can be disseminated and implemented. All the risks to which these men and women are consciously exposed cannot simply be put down to 'fate'.

*Vincent Bernard*  
*Editor-in-Chief*



## Interview with Walter T. Gwenigale

Minister of Health and Social Welfare of the Republic of Liberia.\*

*To open this issue on ‘Violence against Health Care’, the Review sought the perspective of a health-care professional who has worked in the context of an armed conflict.*

*Dr Walter T. Gwenigale is the Minister of Health and Social Welfare of the Republic of Liberia. A practising surgeon for more than 30 years, including during the civil war, he has served as Bong County health officer, director of Phebe Hospital and president of the Christian Health Association of Liberia. He has also served on the World Health Organization’s executive board and as a board member of the Roll Back Malaria campaign.*

*In this interview, Minister Gwenigale explains how the armed conflict in Liberia impacted on the work of remotely-located Phebe hospital, on the needs of its patients and on the ability of the hospital staff to provide them with adequate medical care. He describes the main security challenges and the way in which the hospital staff attempted to address them. He also recalls instances in which the hospital staff and facilities were the direct target of this violence, sometimes leading to tragic consequences. In addition to the short-term impact of the armed conflict he witnessed as a doctor, Minister Gwenigale also reflects on the long-term effect of this conflict on the health system in Liberia today.*

⋮⋮⋮⋮⋮⋮

\* This interview was conducted on 4 December 2012 in Monrovia, Liberia, by Pedram Yazdi, Communication delegate, and Varney Bawn, communication assistant, International Committee of the Red Cross (ICRC) delegation in Liberia.

***Minister, how would you describe your experience as a doctor working in a hospital during the war?***

As many people in Liberia are aware, I worked as a doctor in Phebe Hospital<sup>1</sup> during the whole war and during that time, I came up against two real problems: how to treat people coming from areas directly affected by the conflict and what to do about the families of staff members. When the war came, my wife and three children were with me in Liberia and I was worried about what might happen to them. I decided to stay with my patients but I sent my family abroad. The fact that I decided to stay with my patients encouraged other employees to stay too, but they sent their families back to their villages. The people who stayed with me were really putting their lives at risk.

At the time though, we thought the war would be very short. Many of the patients at the hospital who were well enough to leave, did so. Those who had come for elective surgery decided to leave and return once the war was over.

In times of armed conflict, a doctor's first responsibility is to patients already admitted to the hospital, as well as to the people taking care of them, and then to wounded people who arrive as the conflict continues and the fighting moves closer to the hospital.

During the conflict, security became a real challenge for us as four or five different armed groups took over the hospital; one group would come and force out another, before in turn being forced out themselves. It was a serious problem, especially for some of our bed-ridden patients who had fought against these armed groups and whose lives were now in danger.

For example, we had wounded fighters from the Doe Army<sup>2</sup> in the hospital. As the fighting came closer, the most seriously injured patients were transferred to Monrovia. When Prince Johnson's<sup>3</sup> people took over, we were seriously concerned about the security of those patients that had previously been fighting Prince Johnson's supporters. We had to try to protect them so that they would not be killed. So we had to manage all these concerns and threats at the same time in what was a very volatile environment.

***How did you keep patients safe when armed groups came into the hospital?***

It was difficult, but we tried to distinguish between those patients with an obvious war wound and those without – for example, patients with typhoid or cholera from drinking dirty water. We had a place next to the hospital called Waterside Village where we could hide war-wounded people.

1 Editor's note: Phebe Hospital in Gbarnga (about 300 kilometres from Monrovia in central Liberia's largely rural Bong County) opened in 1921 and never stopped working throughout the conflict (1989–2003). See the hospital's website: <http://phebehospital.com/>

2 Editor's note: Samuel Kanyon Doe (1951–1990) was the head of state of Liberia from 1980 to 1990.

3 Editor's note: Prince Johnson was a senior commander of Charles Taylor's National Patriotic Front of Liberia (NPFL). In 1990, he left the NPFL to form the Independent National Patriotic Front of Liberia (INPFL), which captured a part of Monrovia in September 1990.



We had other ways to hide people and keep them safe. I remember very clearly that at one point the supporters of Charles Taylor<sup>4</sup> were killing members of the Mandingo ethnic group, so one of my staff kept a Mandingo man in his house for months. No one would have guessed that a Mandingo man was hidden there.

When a new armed group came into the hospital, the first thing I tried to do was identify the commander, who would usually introduce himself. Then we would explain to them why we were there, that is that we were there to help them and treat them if they got wounded. Sometimes we would bring them into the hospital to visit their wounded friends. When they saw their comrades lying in bed and being treated, they came to understand that the hospital was there to help them.

Finally, we used to insist that no one could enter the hospital armed, and this was generally obeyed. When fighters came, they would leave their weapons outside with their friends before they came in. Then when they left, they would get their weapons back. It was generally very useful to establish this rule.

### ***What was the situation of the civilian population around the hospital area?***

Because of security concerns, we could not provide health outreach services. We could only take care of emergencies in the hospital and were prevented from carrying out vaccination campaigns in the area. We could not leave the hospital because there were fighters in all of the surrounding villages.

However, a consequence of staying instead of leaving is that you gain people's confidence and they come to you seeking refuge. So, in addition to taking care of patients, we looked after internally displaced people who came to us because they thought the hospital compound would be safe.

This did not stop us doing our work, of course; there were different people taking care of the displaced people. The ICRC, for instance, brought food from their office in Man, Ivory Coast, to us in Phebe. Then the chaplain, the pastor, and other people in the compound, working with humanitarian workers, handed out the food and other supplies brought by NGOs and the ICRC. The hospital staff themselves were busy taking care of wounded and sick people and malnourished children coming from areas affected by the fighting.

### ***What kind of violence did your patients face during the war? What about your staff and the hospital?***

I think the most frequent form of violence I came across was rape, not only of women, but also of men. In some cases, fighters were raping people as a way to dominate them in war. Another pattern was people having their limbs severed. Personally, I spent many, many hours in the operating room trying either to remove

4 Editor's note: Charles Taylor headed the NPFL from 1989, until he was elected as Liberia's president in 1997.

pieces of shrapnel from patients or trying to treat people who were shot in the stomach and bleeding. Sometimes we had to go as far as amputating limbs that had been shattered by bullets. We saw different types of wounds, including bullet wounds, knife wounds, wounds with cutlasses, and so on.

Another problem we had to face was looting of the facilities themselves. Some were looted, others were burnt down. I was in charge of C.B. Dunbar Hospital in Gbarnga, the capital of Bong County, but it was burnt down. Almost all the clinics were looted; if there were things there that the fighters wanted, they would just take them as their due. The hospital materials were, of course, of value to the warring factions because they needed them to treat their wounded members. Sometimes they would take some of our drugs back to their base to treat their people. In addition, they stole not only hospital supplies, but also the hospital staff's belongings.

### ***What happened during the Phebe Hospital massacre<sup>5</sup> in September 1994?***

At the beginning of the war, many of the health-care facilities in remote areas were abandoned. Only a few remained open. The only places that were protected – and only if the fighters knew that they were there to help them and to treat their wounded – were those located on main roads. One of the biggest challenges was that the areas where hospitals were located came under the control of different groups, depending on the evolution of the conflict. So the armed group that took control of a certain area was always suspicious of hospital staff – they would suspect them of having collaborated with the armed group that had previously controlled the area.

I was not in Phebe when the massacre happened. From the account I was given, soldiers from the United Liberation Movement of Liberia for Democracy (ULIMO) took Phebe from the National Patriotic Front of Liberia (NPFL), and stayed there for several days. When the NPFL got stronger it pushed the ULIMO out again. ULIMO soldiers warned the staff in Phebe that the NPFL would think that they had helped them and would certainly kill them as punishment. The ULIMO advised staff and patients to leave, but the staff refused because they had their patients to take care of. On 23 September 1994, armed men took several members of our staff outside and shot them dead. The hospital chaplain was also killed, as well as two of the nurses. I understand that many of the people who had taken refuge in Phebe were shot as well.

My own mother was in the hospital. When everything was over, someone went and saw my mother in her bed; she was already dead. I was not there, and I could not bury my mother until February the following year as I was not able to come back before.

When I came back, the staff told me that they had taken the remaining patients to Totota. Phebe Hospital was moved three times; twice to Totota, and the

5 Editor's note: in September 1994, the hospital was attacked and looted. It was reported that at least 100 people were killed, namely hospital staff, patients and civilians who had sought refuge in the hospital. See inter alia Republic of Liberia Truth and Reconciliation Commission, *Final report - Volume II: Consolidated Final Report*, 2009, at pp. 174, 181 and 182.

third time to a place called Salala. The hospital never closed, but they kept moving the patients away from the fighting. They were helped by humanitarian organizations such as the ICRC and Médecins Sans Frontières (MSF) Belgium. However, many things were looted from Phebe Hospital – in particular, medical equipment – as well as property from the surrounding houses.

***Do you think the massacre could have been prevented? Does there need to be greater awareness of the rights and duties of medical staff in times of armed conflict?***

Certainly, those who were working in the hospital could not have prevented it. As medical workers, we take care of wounded people. The people who went to talk to those armed young men – like the chaplain – were not given the opportunity for dialogue, and were shot. The hospital staff were not fighters: they did not have weapons, and so they could not have prevented any armed group from coming in. They were the victims of the violence; they were helpless and caught between different armed factions. All we were ever trying to do was to stay and take care of patients and displaced people. But what can an unarmed civilian do to stop people from massacring others?

In Phebe, we knew we were taking a risk by staying. Many people did not feel comfortable leaving because they felt they had a job to do. Sadly, what we were trying to prevent happened anyway: we thought that if we left the hospital, it was going to be destroyed and that we would not have anything left at the end of the war. So that is why we stayed. In the end, neither staff nor patients nor equipment were spared. When we came back from Salala, where we had evacuated to, everything had been looted.

We can teach medical staff about their rights and obligations – for instance, telling them to treat their patients without discrimination, not to abandon them – but it will not have much impact if the people with weapons are not themselves aware of their obligations. If they do not know that they are supposed to respect people who are doing humanitarian work, we have a problem. That was our main challenge: people who were fighting each other, not knowing that they had a responsibility to respect and protect us so that we could do our work.

Training medical personnel on their rights and duties would be valuable, but it is even more important to teach the fighters about their obligations. You always have to take into account who you are talking to. Talking about the rules of the Geneva Conventions to people who have never heard of them, or even the ICRC, and explaining rights and obligations is not an easy task. The war in Liberia started at the end of 1989 and ended only fourteen years later. Some fighters were very young when they became involved in the war: if you are recruited at the age of ten for example, when the war ended you were already 24, and you still did not know how to read and write. You would also probably not know anything about the rights of medical workers.

So even if medical workers knew their rights, one would still have to make sure that those carrying weapons also knew the rights of medical workers. In this

context, the only reason that might make fighters hesitate before resorting to violence is the awareness that if they themselves became wounded, they would need medical personnel to treat them.

During the war, our staff at Phebe became accustomed to dealing with different warring factions, and tried to confront them; we stood up and explained to them why we were there. But once again, people who carry weapons must be educated enough to know that hospital staff are not the enemy. However, we also talked to some of our staff to explain to them how to behave in certain circumstances. We told them they had to make sure that every patient knew why they were there and that we would take care of them – even child soldiers who were heavily drugged or under the influence of alcohol.

***As the Minister of Health, how would you describe the health-care situation in Liberia today? What are your main challenges?***

Health care in Liberia today has suffered the effects of the war. When I became minister, there were three important issues and all of them had to do with the consequences of the war. The first big issue was the tremendous shortage of trained medical workers. When the war began, they left the country and went to work in Europe, America, Guinea, Ghana, or the Ivory Coast. We have subsequently had to address this shortage, and we are still dealing with the problem today.

The second issue was the destruction of health-care infrastructure – clinics, hospitals, and equipment had all been wrecked. Even if we had had enough medical workers, we did not have adequate facilities for them.

The third issue, affecting not only the health system but also the entire country, was the lack of money. Before the war, a surgeon like myself in Liberia would earn 3,000 Liberian dollars a month;<sup>6</sup> after the war, salaries were as low as 50 US dollars a month. Such salaries could not attract professionals to return to Liberia to work. There was no money to buy medicine either, so we had to depend on hand-outs from international NGOs. In essence, you could say that the Ministry of Health was actually run by international NGOs right after the war, because they were the ones that had the drugs and the supplies and were running the hospitals.

***What has been the impact of the war on your work as Minister of Health in post-conflict Liberia?***

The three big challenges that I mentioned – lack of adequate human resources, lack of infrastructure and lack of money – still remain. I have to deal with them in parallel. There are also serious problems with the delivery of care itself, due to the war and people running away.

As doctors, the types of patients we receive are also different because of what happened to them during the war. Vaginal fistula is a big problem among

6 Editor's note: as of the 1 December 2013, 1 Liberian dollar (LRD) was worth 0.01 US dollar.

women, for example. The condition is commonly caused by prolonged labour in childbirth; the head of the baby presses on the bladder, against the bones, and the bladder gets damaged. Women can end up passing urine – and in some cases faeces – on themselves continually. This condition can also be caused by sexual violence, as occurred during the war in Liberia. Some of the violence certain women faced during the war therefore may still have consequences on their health today.

Another example was injuries or illnesses that we thought were under control, such as tuberculosis (TB). Because of the war, patients either ran out of money to buy the necessary drugs or ran away from the area where there was a clinic distributing them, and that has caused an increase in tuberculosis. If a patient suffers from leprosy, without medicine, the disease starts coming back again. So the armed conflict has clearly had an impact on people's health.

Finally, one health issue in post-conflict Liberia that is not addressed enough is mental health. There are so many young people who spent the war killing other people, and there were even reports of cannibalism. With the war over, these people face serious emotional problems. As the Minister of Health, I have to ensure that they are provided with adequate care.

There are so many other people who were affected by the conflict. Take, for example, an old man who had a very fine place to live – a place where he wanted to retire. But his house was burnt down during the conflict, and he suddenly has nowhere to go. As the minister, I ask myself: How can we try to rehabilitate people like this old man? How can we help children whose parents were killed in the war?

### ***What is the Liberian government doing to improve facilities and services?***

I previously identified three major challenges for health care in post-conflict Liberia. The first one was human resources. To address it, we have put quite a bit of money into the medical college so that we can improve the quality of training for doctors. We have renovated the medical college with funding from the World Bank; we also provide students with monthly stipends. One of our greatest needs was for midwives, so we have increased the number of students in the midwifery school and are opening additional midwifery schools.

With respect to infrastructure, we have renovated a lot of clinics, and are building many new ones and fitting them out with the right equipment. With the help of Chinese investors, we have built a very big hospital here in Sanniquellie, Nimba County, called Tappita, which has a computerized-tomography (CT) scanner and other up-to-date equipment. Other clinics have been renovated and re-opened. We are making considerable efforts to improve our infrastructure.

### ***How much do you work with other ministries? Are steps being taken to gather data or reports on incidents of violence against health care?***

All the ministries have to work together; we all rely on each other. In the Ministry of Health, for instance, I could not do my job well without the Ministry of Education

because education is crucial to understanding how to keep people healthy; I could not work well without the Ministry of Public Works because we have to have functioning roads for ambulances to get patients to hospitals; the Minister of Agriculture is important for the nutrition of patients, and so on. During the events for National AIDS Day, for example, one of the biggest groups that took part was the army. The army was there in force because they have a doctor assigned to them to make sure they have proper medical information.

In terms of data collection on incidents of violence, the medical workers themselves are reporting what is happening to them, but besides that, there are other ministries who are fighting against other types of violence against our people. The Ministry of Gender, for example, receives reports on gender-based violence, including rape, so we are getting information, but, thank God, it is not like it was during the war.

***What recommendations would you make to other countries or health ministers concerning violence against health care?***

To me, this is not an issue that affects medical workers only. No one, be they a doctor, a farmer or a public servant should be subject to violence. We depend on each other. News reports have stated that Liberia is hoping to become a middle-income country. You cannot achieve that by destroying the country's fabric through conflict; you can only do that if you maintain peace. So we should all be working together towards strengthening the country so that in the end, when you have built something up, you do not see it destroyed.

In Liberia, the war was mostly carried out by people who were not educated. If fighters are educated, if they are taught about the Geneva Conventions and why they should follow them, they will respect the rules. If they have never heard of the Geneva Conventions, they will not.

The best protection I can think of to avoid another conflict, however, is reconciliation and long-lasting peace, so that you do not have to worry about the issue of violence against health care. If you do not have people fighting and killing each other in the first place, then you do not have to worry about protecting patients and health-care personnel in hospitals from armed violence. So all of us should work hard towards reconciliation and peace. We are lucky that we have now gone more than ten years without war; many countries have suffered from repeated wars and long-lasting conflicts.

***Today, from Mali to Syria, we hear reports of violence against health care on an almost daily basis. What is your message to the midwives, doctors and surgeons working in such situations?***

I think that as medical professionals, we are trained to help people and to make sure that they get the help that they need. I have been listening to what is happening in Syria, where people are even performing surgery in mosques because that is all

they have. We cannot abandon people just to protect ourselves. If we are to protect them, we must be able to do our job. And I pray that the people who know this will help us. To bomb a clinic where you know medical workers are doing their job is a terrible thing, but we know it is happening. How can we deal with the people that are doing that? How can we help them understand that they are not helping their people, but are actually killing their own people? That is a formidable challenge. But my advice to my fellow medical workers is that we are trained to help, to save lives, and we cannot abandon that duty.





# Violence against health care: insights from Afghanistan, Somalia, and the Democratic Republic of the Congo

## **Fiona Terry**

Fiona Terry is an independent researcher who has been conducting studies for the Health Care in Danger project of the International Committee of the Red Cross. She holds a doctorate in international relations from the Australian National University, is the author of *Condemned to Repeat? The Paradox of Humanitarian Action*,\* and is a member of the Editorial Board of the *International Review of the Red Cross*.

## **Abstract**

*This article explores the methodology and main findings of field studies conducted for the ICRC's Health Care in Danger project in Afghanistan, Somalia, and the Democratic Republic of the Congo between 2010 and 2013. It discusses some of the actions that the ICRC takes in its health programmes to facilitate access to health care, and its approach to promoting better respect for the laws protecting it. It then suggests what more needs to be done to curb the violence.*

**Keywords:** ICRC Health Care in Danger project, Afghanistan, Somalia, Democratic Republic of the Congo, DRC, access to health care, violence against health care, protected status of health care and patients, documenting violence.



\* Cornell University Press, Ithaca and London, 2002.

There are few violent incidents that shock the conscience more than a deliberate attack on a hospital, the murder of health workers carrying out a vaccination campaign, or the detonation of an explosive-packed ambulance at the scene of an accident to amplify the shock and carnage caused. Such events make world news amid expressions of outrage at these grave violations of international law. What is less recognised is that these dramatic events represent just a fraction of the violence carried out against health-care providers and facilities every day: it is a common occurrence that takes many more insidious forms than those reported in the media. This violence prevents millions of victims of armed conflict and other emergencies from reaching health care when they need it most.

In order to better understand the frequency and types of violence against the health system, the International Committee of the Red Cross (ICRC) launched the Health Care in Danger project in 2011 after a preliminary study in sixteen countries suggested that the problem was under-reported and under-analysed. ICRC delegations in twenty countries beset by armed conflict or other situations of violence were asked to gather information on such incidents. To complement this, the ICRC commissioned three in-depth studies to explore the issues in Afghanistan (2010), Somalia (2012), and the Democratic Republic of the Congo (DRC, 2013).<sup>1</sup>

This article discusses some of the main findings from these three internal studies. Some of the violence documented was intentional, aimed at preventing, disrupting, or refusing to facilitate medical assistance for those perceived to be the enemy and their supporters. But the vast majority of incidents concerned a lack of respect for the protected status of health care and patients. In other words, health structures and transport were damaged, looted, or closed not because they provided health services per se but because they were not spared or exempted from such aggression.

The first part of the article discusses what types of incidents were included in the scope of the Health Care in Danger studies, before looking into the findings. It then discusses how the ICRC is responding to the lack of respect for the sanctity of health care around the world and suggests what more could be done.

## Documenting violence against health care

As custodian of international humanitarian law (IHL), part of the ICRC's regular responsibilities include monitoring respect for the rules protecting health care. As described in more detail in other articles in this volume,<sup>2</sup> in times of armed conflict, IHL obliges all parties to an armed conflict to do the following:

- respect and protect medical personnel, units, and transport that are used exclusively for medical purposes;

1 Fiona Terry, 'Protecting health-care in Afghanistan: IHL violations and the ICRC's response, April 2009–April 2010', ICRC internal document, June 2010; Fiona Terry, 'ICRC Health-Care in Danger project: Somalia case-study', ICRC internal document, July 2012; Fiona Terry, 'ICRC Health-Care in Danger project: Democratic Republic of Congo case-study', ICRC internal document, March 2013.

2 See *inter alia* Alexandre Breitegger's article in this issue.

- provide medical care and attention without any adverse distinction based on grounds other than medical ones;
- respect the wounded and sick, protect them from attack or ill-treatment and ensure they receive adequate medical care;
- take all possible measures to search for, collect, and evacuate the wounded and sick without discrimination.

Human rights law also provides obligations for states to protect the wounded and sick from attacks, as well as to respect, protect, and fulfil the right to health.<sup>3</sup>

There are, however, many actions that impede or obstruct access to health care that do not constitute a violation of IHL, so the field studies enlarged the scope of inquiry to include both breaches of the law and lesser offences against health care. Incidents were grouped into the following categories:<sup>4</sup>

1. Violence against health facilities:

This included attacks on, or interference with, medical facilities such as clinics, hospitals, medical stores, laboratories, and pharmacies, including bombing, shelling, forced entry, shooting into buildings, destroying materials, and looting. It also included the cordoning off of an area containing a health structure that prevented access to it by health staff and patients.

2. Violence against health staff:

This included attacks on medical, paramedical (including first-aid volunteers), and support staff assigned to medical functions, including killing, kidnapping, harassment, threats, intimidation, robbery, and arrests and detention for performing medical tasks.

3. Violence against the wounded and sick:

This category comprised assaults on patients or those trying to access medical care, including killing and injury, harassment and intimidation, blocking or interfering with timely access to care, denial of medical assistance and discrimination, and interruption of medical care through arrest and/or detention of wounded fighters by forces who could not or would not assure a continuity of medical care.

4. Violence against medical transport:

This included attacks on ambulances, medical ships, planes, or evacuation helicopters, whether civilian or military, and interference with the transport

3 For more information, see *inter alia* the articles by Alexandre Breitegger, Amrei Müller, and Len Rubenstein and Katherine Footer in this issue.

4 These categories were also used in the ICRC publication *Health Care in Danger: Making the Case*, ICRC, Geneva, 2011, available at: [www.icrc.org/eng/resources/documents/publication/p4072.htm](http://www.icrc.org/eng/resources/documents/publication/p4072.htm) (all internet references were last accessed in June 2013).

of medical equipment and supplies. It also included the armed hold-up of medical aid organisations while travelling in marked vehicles.

5. Misuse of health facilities or protective emblems:

The final category covered incidents involving the improper use of the Red Cross or Red Crescent emblems and other signs designating medical facilities, transport, or personnel (including perfidy), and acts that compromised the neutral character of civilian health facilities. Carrying arms in a health structure, while not a violation of IHL per se, can compromise perceptions of the structure's neutrality.

Most incidents recorded in Afghanistan, Somalia, and the DRC affected more than one of the categories above. Breaking down each incident into these categories and entering them on a table provided an effective way in each context to visualise the trends in violence against health care. The patterns that emerged sometimes ran contrary to perceptions held in the ICRC delegations, which might have been coloured by one or two shocking events that were not necessarily representative of the larger problem. A deeper analysis of the trends permitted field teams to better tailor their subjects of discussion with belligerent parties in order to address the most pressing problems identified.

The documentation and field studies also helped to recalibrate the images associated with a specific context within the broader organisation. An enduring image of Somalia from the early 1990s, for instance, is of a pickup with mounted machine gun parked outside the operating theatre of Mogadishu's Medina hospital in order to prevent fighters from ordering surgeons at gunpoint to give their wounded comrade priority treatment. Twenty years of continuous conflict since then, and an absence of law and order, has given rise to the assumption that health care around the country must be under constant siege – yet this is not the case. There are grossly inadequate health services in many parts of the country, but not the violence associated with the past. Today visitors to Medina hospital agree to hand in their weapons at the entrance in exchange for a numbered chit. Moreover, health professionals interviewed in the capital said that medical structures were respected by fighters and the general population second only to mosques. Even issues of clan-based discrimination and retaliation against medical staff who failed to save a patient were much less prevalent than first assumed. Thus the project has not only shed light on failures to respect health-care but also raised interesting questions on why respect for it is better in certain contexts or among certain belligerent parties than others.

## Challenges to obtaining accurate data

Efforts to gain an accurate insight into the types and frequency of violence against health care have met with several important challenges. First and foremost among these challenges in Afghanistan, Somalia, and the DRC was simply that of obtaining information on incidents from the myriad of actors in the health field, particularly

in Somalia and Afghanistan, where whole swathes of territory are inaccessible to ministry of health staff and international aid organisations. It was only through talking to patients in Mirwais hospital in Kandahar, for instance, that the ICRC was able to have some idea of the state of health services in opposition-controlled regions of the south, and the problems patients faced trying to reach the hospital. Accessing health care outside major towns is difficult in all three countries at the best of times, involving long journeys on foot, by donkey, or by motorcycle. It is impossible to know how many sick and wounded never make it to a health centre.

Persuading other actors in the health field to share information on incidents has also proved surprisingly difficult. This can be partly explained by the sensitive nature of negotiations with warring parties or criminal gangs over security incidents, particularly ones involving kidnapping and demands for ransom payments. But it also reflects a certain competitiveness among aid organisations, which prefer to downplay problems they encounter in favour of retaining the image of success that is so essential to their fundraising efforts at home and towards their institutional donors. A proportion of all security incidents can be traced to the actions or image of a specific aid agency, whether revenge extracted for the dismissal of a national employee in Somalia, the repercussions of a bad deal with a local militia in Afghanistan, or community anger at broken promises by a non-governmental organisation whose ambitions outstripped its capacities in the DRC. There are few aid organisations willing to publicise such incidents in any detail. National health providers – both public and private – are an even more elusive source and yet, by their sheer number, are doubtless exposed to more incidents than international actors. Thus the sources of information on incidents remain quite limited, which presents an important bias in the data.

Second, the variety of incidents encountered in each context raised questions over the criteria for inclusion in the data set and generated much discussion among the ICRC teams. One view was that only cases of violence in which there was a motive linked to the medical function should be included. According to this view, the shooting dead of a doctor during an armed robbery at his house would not be included, nor would the kidnapping of a nurse if there was a demand for ransom, nor would the armed hold-up of an ICRC vehicle unless it was carrying medical staff or supplies. But the problem with narrowing the criteria in this way is twofold: first, the motive is rarely clear, and even purely criminal acts can have political overtones given that criminal gangs are unlikely to be able to operate in parts of Afghanistan, Somalia, or the DRC without the tacit or active agreement of the armed group controlling the territory. Second, and more importantly, the consequences of an incident such as the killing or kidnapping of a health professional can be just as detrimental for the population whether or not the motive was linked to the victim's medical function. This is particularly true for Somalia, which has only one doctor for every 25,000 people.<sup>5</sup> Hence the three case studies

5 World Health Organization, *World Health Statistics 2012*, Chapter 6, available at: [www.who.int/gho/publications/world\\_health\\_statistics/2012/en/index.html](http://www.who.int/gho/publications/world_health_statistics/2012/en/index.html).

looked at the consequences as well as the motives involved when determining whether to include an incident or not.

## The studies' main findings

In the decades of armed conflict in Afghanistan, Somalia, and the DRC, fighters have committed some very serious violations of the laws protecting health-care facilities, personnel, and transport. The First Congo War (1996–1997) that destroyed the Rwandan refugee camps in the eastern DRC, for example, began with soldiers entering the Lemara hospital in South Kivu on October 6 and slaying over 30 patients and hospital staff. In Somalia, the looting and expulsion of many large aid agencies in 2011 dramatically reduced health services at a time of food shortages throughout the south and central regions, triggering a rise in the number of vaccine-preventable diseases that compounded the ravaging effects of malnutrition. And in Afghanistan, perfidy has been committed on several occasions, including in April 2011, when an ambulance was used in a suicide attack on a police training academy on the outskirts of Kandahar.<sup>6</sup>

In the periods under review in each case study (Afghanistan from April 2009 to April 2010, Somalia from 2006 to 2012, and the DRC in 2012), such grave incidents were relatively rare, although the consequences of the ban on many health-oriented aid agencies in parts of Somalia continues to be felt to the present. But unlike the two other incidents mentioned above, health care in the Somalia case does not appear to have been misused, attacked, or withheld as part of a military strategy to harm the opposing side: aid organisations were not expelled in order to deprive the population of health care.<sup>7</sup> In fact, none of the countries studied experienced the scale of attacks on medical facilities and staff, with the alleged aim of deliberately depriving the opposition of medical care, that can be seen in Syria today.<sup>8</sup> Nevertheless, some such incidents did occur, and they are discussed in the following section; the article then turns to the most common forms of violence encountered, which stem more from a lack of respect for the protected status of health care rather than an overt desire to misuse it or attack it.

## Strategic use of violence against health care

Intentional violence or threats of violence against health-care structures and staff for military purposes occurred more in Afghanistan than in Somalia or the DRC. This is no doubt linked to the asymmetrical nature of the conflict waged there

6 ICRC, 'Afghanistan: ambulance used in attack on Police Training Compound', ICRC News Release 11/85, 7 April 2011, available at: [www.icrc.org/eng/resources/documents/news-release/2011/afghanistan-news-2011-04-07.htm](http://www.icrc.org/eng/resources/documents/news-release/2011/afghanistan-news-2011-04-07.htm).

7 The ban itself did have some military rationale, however, with the militant Islamist group Al Shabaab concerned that the personnel of some aid agencies were spies and would report on the location of leaders, who would then be the target of drone attacks.

8 See Jonathan Whittall, 'My enemy's doctor is my enemy', in *The Huffington Post*, 10 April 2013, available at: [www.huffingtonpost.co.uk/jonathan-whittall/syria-medicins-sans-frontieres\\_b\\_2829593.html](http://www.huffingtonpost.co.uk/jonathan-whittall/syria-medicins-sans-frontieres_b_2829593.html).

between a heavily armed, well-equipped, and well-trained international force and their Afghan allies on one side, and a fragmented but shrewd collection of groups on the other. Although the Taliban acknowledged that the use of an ambulance in the April 2011 attack near Kandahar was wrong and ‘would not happen again’,<sup>9</sup> it was not the first time a vehicle painted as an ambulance had been used in an attack,<sup>10</sup> and perfidy is actually encouraged in the Taliban’s *Layha* or Code of Conduct. The rules which allow for a suicide bomber to feign civilian status and fighters to adapt their physical appearance in order to blend in with the local population remained unchanged from the 2009 to 2010 versions of the Code, whereas other clauses were altered and many added which seemed to reflect a desire to be better perceived by the Afghan population (such as the removal from the 2010 version of the article which condoned attacks on aid organisations).<sup>11</sup> Health structures and personnel often bear the brunt of the frustrations evident in fighting such an elusive enemy. First-aid posts and clinics have been raided by international and government forces looking for wounded opposition fighters, and staff have been threatened with reprisals if they refuse to report on the presence of such fighters in the future. In some instances, one violation provoked another: when staff at a hospital in Baghlan Province in the north were ordered not to treat opposition fighters or their families, the latter kidnapped a doctor to treat their wounded.

The overt Coalition’s policy of using ‘humanitarian’ assistance to win the hearts and minds of Afghan civilians and of extending the legitimacy of Hamid Karzai’s government around the country compromised the neutrality of medical and other assistance and became a target of the opposition. Several incidents in the 2009–2010 period in which health staff were threatened, pharmacies and clinics were ordered shut, or warnings were issued to the population not to use a certain health structure seemed to be directly aimed at undermining the Coalition’s claims that stability had been brought to an area. Moreover, Afghans seen to be collaborating with foreign troops or the government were threatened or ‘punished’. Even after a ‘successful’ military campaign to clear insurgents from Marjah in Helmand Province in February 2010, safety for health staff was far from assured. Local doctors refused to assist US Marines in restoring health care to the area, saying it involved too much risk. ‘To get here I was stopped three times by the Taliban who asked me where I was going, if I was working for the Americans. It’s too dangerous’, one doctor said.<sup>12</sup> By mid-2010, however, a change of tactics by the armed opposition could be observed; rather than interfering with or closing health facilities

9 ‘Afghanistan: Taliban rue ambulance attack’, in *IRIN*, 12 April 2011, available at: [www.irinnews.org/PrintReport.aspx?ReportID=92446](http://www.irinnews.org/PrintReport.aspx?ReportID=92446).

10 On 18 January 2010, for instance, an attack against a government building in Kabul was carried out in this way.

11 See Thomas H. Johnson and Matthew C. DuPe, ‘Analysing the new Taliban Code of Conduct (*Layeha*): an assessment of changing perspectives and strategies of the Afghan Taliban’, in *Central Asian Survey*, Vol. 31, No. 1, March 2012, pp. 77–91; and Muhammad Munir, ‘The *Layha* for the Mujahideen: an analysis of the code of conduct for the Taliban fighters under Islamic law’, in *International Review of the Red Cross*, Vol. 93, No. 881, March 2011, pp. 81–120.

12 Karim Talbi, ‘Uphill task for US Marines on Afghan healthcare’, in *AFP*, 24 March 2010, available at: [www.afghanistannewscenter.com/news/2010/march/mar252010.html#23](http://www.afghanistannewscenter.com/news/2010/march/mar252010.html#23).

in regions they had taken, they allowed such facilities to continue in order to gain the allegiance and support of the local population.

The DRC also saw some instances of violence against health care that seemed to form part of a larger strategy aimed at either punishing a population for its perceived allegiance to an armed group, or creating an uninhabitable ‘no-man’s land’ on disputed territory. The latter is particularly evident in the Masisi region of North Kivu, where whole villages have been emptied of their inhabitants and set on fire, including health facilities, in violence between the Hunde and Hutu communities. A strong political agenda was presumably also behind the attempt to assassinate world-renowned gynaecologist Dr Denis Mukwege at his home in Bukavu in October 2012. His legitimacy as a doctor working with victims of severe sexual violence lends considerable weight to his criticisms of the impunity reigning in the DRC for such crimes, and he and members of his staff have received threats as a direct result of the work they undertake. There were also a few incidents in the DRC of health staff being kidnapped in order to gain treatment for rebel fighters.

Although not falling within the period of time analysed by the field study, just a few years earlier the DRC was the site of one of the worst manipulations of health services for military ends ever encountered. On one day in October 2009, government forces attacked seven vaccination sites in the Masisi region where the families of rebels fighters from the *Forces démocratiques de libération du Rwanda* (Democratic Forces for the Liberation of Rwanda) were lined up for measles inoculations. Members of the *Médecins sans Frontières* (Doctors without Borders, MSF) team who had organised the campaign, and had obtained security ‘guarantees’ from all sides, felt as if they had been used as bait.<sup>13</sup> The immediate consequences were devastating enough, but MSF also wondered what longer-term impact this betrayal of trust would have on the organisation’s ability to conduct vital vaccination campaigns and other health programmes in the future.

Evidence of the deliberate misuse or destruction of health-care facilities for military gain in Somalia was much harder to find than elsewhere. Human Rights Watch (HRW) alleged that damage caused to three hospitals in Mogadishu during the Ethiopian occupation of the city in 2007 was intentional, and suggested that this was because the Ethiopians suspecting the facilities of treating insurgents.<sup>14</sup> All three hospitals were badly damaged and looted, and one of them, Al Arafat, stayed closed for years. But interviews with former hospital staff who were present at the time suggest that the rationale for the Ethiopians’ behaviour was not as clear as HRW suggests.<sup>15</sup> They claim that Ethiopian officers wanted to use at least one of the hospitals as a vantage point and treated the staff well, and that it was lower-ranked soldiers who looted the hospital. The staff denied having heard accusations that the hospitals were aligned to Al-Qaeda or that there was graffiti to this effect painted

13 ‘DR Congo: MSF vaccination used as bait in unacceptable attack on civilians’, MSF press release, 6 November 2009, available at: [www.doctorswithoutborders.org/press/release.cfm?id=4055&cat=press-release](http://www.doctorswithoutborders.org/press/release.cfm?id=4055&cat=press-release).

14 See Human Rights Watch (HRW), *Shell-Shocked: Civilians under Siege in Mogadishu*, HRW, New York, August 2007, pp. 51–57.

15 Interviews with staff of the hospitals took place in Mogadishu in June 2012.



on the walls as HRW claimed. Nevertheless, the Ethiopian troops were responsible for not respecting these health facilities as they were obliged to do under IHL, nor protecting them from looting by others.

## Non-respect for the protected status of health care and patients

The most frequent problem witnessed in the health field in all three case studies was the inability of the wounded and sick to obtain health care when they needed it. There were different types of obstructions identified in each case study, discussed below, but one common to all was the general failure of combatants to assist wounded civilians to obtain medical assistance in the wake of a military confrontation. In all contexts there seemed to be efforts made to evacuate wounded fighters from the scene, give them first aid, and organise onward transportation to a medical facility, often by a member of the Red Cross and Red Crescent Movement. But it was rare to see military personnel making similar efforts to ensure that civilians received care. This is undoubtedly the most overlooked obligation under international law of all fighting forces in these three contexts.

### *Impediments to patients reaching health care*

Heavy fighting in the Somali capital, Mogadishu, in 2007, 2009, and 2010 caused some of the worst impediments to reaching health care seen in any of the case studies. The shelling and street battles were so intense in March 2007 that people dared not venture from their houses and the injured and dead lay where they fell. Bodies rotted in the streets. Again in August 2010, heavy fighting in various parts of the city prevented people from leaving their homes for an eight-day stretch. Until late 2008, there was no ambulance service in Mogadishu and most wounded arrived at hospital by wheelbarrow, by donkey-cart, or on foot. Since 2009, a couple of ambulance companies have been active and have helped save many lives. However, most are ill equipped, and the drivers and ‘medics’ lack any kind of medical training.<sup>16</sup> Furthermore, transporting the wounded and sick at night is dangerous: there are few vehicles on the roads after dark due to the climate of fear and suspicion of insurgent attacks. In light of all this, being able to reach a health facility when needed, even in the relatively vibrant capital, remains a major challenge.

In the southern and central regions of Somalia, it is the limited number of health facilities and constraints to supplying them with drugs and equipment that present the main obstacles to the wounded and sick receiving timely assistance. Medical supplies and equipment were stolen from several UN compounds in 2009 and again in 2011 when all UN agencies were expelled from Al Shabaab-controlled territory. The 2009 targets included UNICEF’s central store in Jowhar, which held supplies for over 100 clinics run by local aid agencies and communities. The theft of cold-chain equipment destroyed thousands of vaccines, and expensive nutritional

<sup>16</sup> ‘Life and death on the streets of Somalia’, in *Forgotten Diaries*, 28 August 2010, available at: <http://forgottendiaries-ethiopia.blogspot.ch/2010/08/life-and-death-on-streets-of-somalia.html>.

supplies destined for 40,000 malnourished children in 200 therapeutic and 80 supplementary feeding centres also disappeared.<sup>17</sup> Nobody has a clear picture of how many people in southern and central Somalia are without access to health care today or what the consequences are in terms of mortality and morbidity. Several cases of wild polio were recently detected in Somalia,<sup>18</sup> raising fears of the virus spreading among this pool of unvaccinated children and reversing the gains made towards eradicating the disease worldwide.

Looting of health facilities and resupply vehicles is also a major cause of insufficient health services in the eastern DRC. More than half of all lootings were allegedly committed by government soldiers of the *Forces armées de la République démocratique du Congo* (Armed Forces of the Democratic Republic of the Congo, FARDC), and the rest by non-state armed actors, whether linked to an armed group or bandits. This looting – which does not just target health centres but extends to shops, churches, and private houses – is symptomatic of broader structural problems in the DRC linked to the weakness of the state. Members of the armed forces do not receive a regular salary and hence support themselves through other means such as illegal mining and trade in endangered wildlife and other contraband. They, and members of non-state armed groups, prey on the local population, forcibly taking what they want. Health centres, with their medicines, equipment, and cash, are easy targets, and the loot is taken as ‘spoils of war’. Incidents of looting tend to increase in times of heightened tension, when troops are on the move from one region to another. There was an upsurge of incidents from May 2012 after the M23 rebel group began attacking government positions in North Kivu and FARDC reinforcements moved up from the south. As they did so, other armed groups moved into the vacated territory, sometimes looting along the way. The FARDC’s retreat from Goma was also accompanied by serious incidents of pillage and rape, especially in the lakeside town of Minova,<sup>19</sup> although the MSF-supported hospital in the town was fortunately spared.

The main obstacles to reaching health-care facilities in Afghanistan were directly related to insecurity, in several different ways. First, a lack of reliable security guarantees in peripheral regions prevents government health staff and many local and international aid agencies from providing health services there. The wounded and sick are obliged to travel long distances to reach the care that they need. Second, the planting of improvised explosive devices along roads impedes the safe circulation of patients and health staff,<sup>20</sup> even in areas where adequate

17 ‘Hostilities against aid work in Jowhar put lives of Somali children and women at risk’, UNICEF press release, Nairobi, 17 June 2009, available at: [www.unicef.org/media/media\\_50020.html](http://www.unicef.org/media/media_50020.html).

18 ‘Polio outbreak spreads in Somalia’, Polio Global Eradication Initiative, 30 May 2013, available at: [www.polioeradication.org/tabid/488/iid/305/Default.aspx](http://www.polioeradication.org/tabid/488/iid/305/Default.aspx).

19 See Pete Jones, ‘Congo’s army accused of rape and looting as M23 rebels win image war’, in *The Guardian*, 26 November 2012, available at: [www.guardian.co.uk/world/2012/nov/26/drc-army-accused-rape-murder-congo](http://www.guardian.co.uk/world/2012/nov/26/drc-army-accused-rape-murder-congo).

20 ‘Afghanistan: mines prevent resumption of normal life in Marjah’, ICRC News Release 10/34, 5 March 2010, available at: [www.icrc.org/eng/resources/documents/news-release/2010/afghanistan-news-050310.htm](http://www.icrc.org/eng/resources/documents/news-release/2010/afghanistan-news-050310.htm).

health services exist. And third, checkpoint procedures and road closures constitute a major barrier to the wounded and sick obtaining rapid medical assistance. Lengthy searches of vehicles at checkpoints create long queues and often a wait of several hours to pass through. In the 2009–2010 period there was no system for fast-tracking medical emergencies, and bypassing the queue was perilous: in 2009, several civilians were shot dead when trying to overtake the clogged traffic. Road closures during security sweeps also prevent the wounded getting to health care on time. A girl injured by an explosion in the Chahar Dara district of Kunduz died soon after arriving at the hospital on 3 February 2010, having been carried on foot for an hour because the road was cordoned off.

A final area of concern noted in Afghanistan and the DRC was the arrest of wounded and sick patients (suspected or actual ex-combatants) and their removal from health facilities against the advice of medical staff. While being *hors de combat* does not provide immunity from arrest and prosecution, the detaining authority is obliged by law to ensure the continuity of health care for those it detains, something that was not always respected. In the DRC, there were several incidents of the wounded being taken away from a medical structure, one of whom was still on intravenous antibiotics following an operation. Follow-up of his case suggested that he did not receive the treatment he required. In Afghanistan, the security forces face a delicate balance between ensuring the security of towns at which wounded men arrive and respecting their right to rapid health care. The opposition's penchant for disguise exacerbates the wariness of security forces, and the wounded sometimes face long interrogation before receiving any medical treatment.

### *Violence against health-care personnel*

All three contexts saw incidents in which health personnel were threatened or attacked for having performed their functions of treating all wounded and sick fighters in need of assistance without discrimination as to the side on which they fought. In the DRC and Afghanistan, some health staff were also kidnapped by opposition fighters in order to treat their wounded. But the vast majority of violent incidents affecting health personnel were related more to their proximity to fighting or their exposure to banditry by virtue of having a job, rather than being targeted for the functions they perform per se. The most exposed to crossfire and suspicion are the Red Cross and Red Crescent volunteers in each context, who often find themselves having to be near the site of fighting in order to evacuate the wounded, administer first aid, or identify and bury the dead. In the DRC and Afghanistan, such volunteers often faced threats stemming from suspicion of what they are doing, despite wearing vests clearly identifying their affiliation with the Red Cross and Red Crescent Movement. Although less involved in administering first aid in Somalia than in other contexts, Somali Red Crescent personnel are also wary of the risks associated with their job. In some areas, the clinics they run limit the extent to which they offer pre-hospital care and medical transfers to critically ill or injured

patients because of fear of the potential repercussions for staff of failing to save the patient's life.

The killing and kidnapping of aid agency personnel, including health workers, has caused major repercussions on the health sector in Afghanistan and Somalia, and to a lesser extent the DRC. National health staff in Afghanistan and Somalia have faced being killed because of their work with 'foreign infidels' and kidnapped to extract ransom from their families or organisation. Many quit their posts following violent incidents against themselves or their colleagues, leaving health posts understaffed. Some incidents, such as the bombing of the Benadir University graduation ceremony in Mogadishu in December 2009, have long-lasting and far-reaching consequences. The founder of the medical faculty, Dr Shahid, as well as several of the teaching staff perished in the blast at the Shomo Hotel, and six of the graduating doctors left to work abroad following the incident, three of them after receiving intensive treatment for their injuries.<sup>21</sup> These doctors and students were not the target of the attack – it was aimed at the four government ministers present at the prestigious graduation ceremony, which was only the second to have occurred over the past twenty years. All four ministers died in the attack. But the repercussions of the bomb extended far beyond the range of the blast, as Somalia still struggles to train and retain health-care professionals. In 2011, more than forty Somali doctors were working in Nairobi, concerned for their safety and that of their families if they were to return to Somalia.<sup>22</sup>

The kidnapping and killing of expatriate health workers also has far-reaching secondary effects as international aid organisations scale down their assistance or close their programmes altogether in the wake of a violent incident. The killing of three MSF staff in the coastal Somali town of Kismayo in January 2008, for instance, provoked the withdrawal of MSF's eighty-seven international staff from fourteen projects across the country. Similarly, the murder of two MSF staff in Mogadishu in December 2011 prompted the closure of all health projects run by the Belgium section of MSF. And the kidnapping of two Spanish MSF workers from the Dadaab refugee camp in Kenya in October 2011 and their transfer to Somalia has put a halt to all MSF's non-emergency medical programmes throughout the country until the women are released. The consequences of these 'knock-on' effects of violence against health-care are impossible to quantify but undoubtedly deprive tens of thousands of Somalis of quality medical assistance.

A final common problem encountered in the studies, particularly in the DRC and Afghanistan, was the presence of armed and/or uniformed men inside medical facilities. This not only compromises the neutral image of health facilities but also poses a threat to health personnel and other patients. A common complaint heard in the DRC was that the presence of uniformed soldiers in hospitals, performing the function of care-taker (*garde-malade*) for sick or wounded

21 Interview with Mohammed Nur, Vice-Rector of Benadir University, Mogadishu, 12 June 2012.

22 M. Arte, 'Exodus of medical professionals from Somalia', in *Somalia Report*, 5 November 2011, available at: [www.somaliareport.com/index.php/post/715/Exodus\\_of\\_Medical\\_Professionals\\_from\\_Somalia](http://www.somaliareport.com/index.php/post/715/Exodus_of_Medical_Professionals_from_Somalia).

colleagues, causes additional psychological trauma and stress to hospitalised rape victims, given that so many of the rapists were men wearing uniforms.

## **The ICRC's activities to safeguard health care**

The field studies found that the ICRC, through its medical and protection work, is already addressing some of the main concerns highlighted by the research: the difficulties faced by the wounded and sick when trying to access health care, and violence against health facilities and personnel. The ICRC integrates actions aimed at protecting health-care personnel, facilities, transport, and patients into its health projects. These range from physical protection such as fixing film to hospital windows to prevent a bomb blast from turning glass into deadly projectiles and constructing safe areas in health centres for staff and patients, through to negotiating the safe passage of ambulances through checkpoints or discussing attacks on health centres with leaders of the armed group responsible. Strict adherence to the humanitarian principles of neutrality and impartiality is vital to the ICRC's ability to cross front lines to rescue wounded fighters and civilians, and to the ICRC's credibility when raising violations of IHL with all parties to a conflict in the hope of curbing abuses.

The benefits of this integrated approach are clearly evident in the ICRC's work in the Kivu region of the DRC. In 2012, the ICRC evacuated 370 seriously wounded fighters and civilians from conflict areas and transferred them to the referral hospitals in Goma and Bukavu that the ICRC supports financially and with expertise and training from surgical teams. The evacuations were carried out by plane, by helicopter, and by road, but also on foot from remote regions with the help of Congolese Red Cross volunteers. One such evacuation took thirty-five volunteers several days to complete, carrying the wounded on stretchers across very rough terrain. Despite the ferocity of the fighting in the eastern DRC and frequent violations of IHL, only one of these evacuations encountered a security problem. A convoy of ICRC trucks carrying thirty-four wounded fighters was stopped and threatened while travelling through territory controlled by an opposing side. But having notified all armed groups of its movements and gained assurances that the convoy would be respected, the 'misunderstanding' was soon diffused once a more senior soldier appeared. Respect for the neutrality of the ICRC-supported hospital in Goma is also clearly on show when touring the wards: young men with their legs in traction recovering from gunshot wounds lie quietly in beds adjacent to their mortal enemies. The fighters understand that group allegiances are left at the door and that patients are to remain *hors de combat* until discharged.

Security constraints in Afghanistan and Somalia do not permit the ICRC or the Red Crescent Societies to conduct evacuations from battle zones as in the DRC. Hence in Afghanistan the ICRC requests taxi drivers who are able to travel in relative safety in these regions to do so, and reimburses their costs according to strict criteria. In Somalia, the ICRC has deployed surgical teams to various hospitals around the country when they were overwhelmed by an influx of wounded,

operating on all regardless of the side on which they fought. The ICRC-supported Keyseway Hospital in Mogadishu that is run by the Somali Red Crescent has seen its neighbourhood change hands many times over the past 20 years but apart from some damage caused by stray bullets and mortars, it has been spared the destruction inflicted on so much of the city. The staff are adamant that the hospital has been protected because everyone knows they might need it one day and will be able to receive treatment no matter which clan they belong to. Consistently applying this principle of impartiality has been essential to the hospital's survival.

Giving training in first aid to combatants is another way in which the ICRC seeks to reduce casualties of conflict, and this programme – offered to all sides – also provides an excellent platform from which to discuss the importance of health care and the need to respect and protect it. In Afghanistan, such training is given to Taliban and other opposition fighters as well as government security agencies and police. The ICRC is able to tailor its messages to address the specific problems witnessed by different groups. Hence government forces were encouraged to respect medical ethics that ensure the confidentiality of patients and to prioritise medical care over interrogation of wounded suspects, while the opposition fighters were encouraged to respect the protective Red Cross emblem, health structures, and staff. This contact with average fighters, to speak to them about the law and to hear their views, complements more formal interventions aimed at the upper echelons of armed groups and military forces which occur in the wake of violent incidents against health care. Such verbal and written reports on incidents have had considerable success in Afghanistan, influencing, for instance, changes to the US forces' rules of engagement in health facilities.

Thus the ICRC's broad palette of activities in the health field, combined with its protection work, provides an ideal basis from which to investigate further avenues for reducing violence against health care. The systematic data collection introduced through the Health Care in Danger project is helping delegations to better understand the types and frequency of violent acts against health care and to adapt their operational programs and the content of discussions with belligerent parties accordingly. Furthermore, the involvement of all Red Cross and Red Crescent partners in the process has facilitated the sharing of issues and best practice across dozens of different contexts.

## **Conclusion and way forward**

The scope and number of violent incidents perpetrated against health care in the three field studies is clearly a cause for concern. At best, there has been widespread disregard for the right to health care and the protected status of health facilities, personnel, and transport. At worst, health care has been manipulated, attacked, or prohibited in order to harm a perceived enemy. And every violent attack on health-care facilities, personnel, or transport has wider repercussions than on those directly involved: the suspension or closure of health services because of security concerns has undoubtedly affected millions of lives.

Because data on violence against health care have never been compiled by any international organisation in the past,<sup>23</sup> it is impossible to judge whether the situation is worse now than in previous decades. Past conflicts have seen their share of horrific assaults on health-care facilities, personnel, and patients: over 200 bodies were found in a mass grave after the hospital in the Croatian town of Vukovar was emptied in 1991;<sup>24</sup> wounded Tutsis were hauled from the backs of ambulances and executed at checkpoints during the Rwandan genocide of 1994;<sup>25</sup> the only functioning hospital in the north of Sri Lanka during the conflict was shelled in February 2009,<sup>26</sup> killing and wounding many of the 500 people seeking treatment there; and just one month earlier, emergency workers were prevented from helping the wounded and dying in destroyed houses in Gaza city.<sup>27</sup>

But what is certain is that the instrumentalisation of aid in the ‘war on terror’ has cast suspicion on the motives and agendas of aid organisations in Afghanistan and further afield, including Somalia. This suspicion was exacerbated for health-care providers by the role that a doctor played in locating Al Qaeda leader Osama bin Laden in his hideout in Abbottabad in Pakistan in 2011 through the collection of DNA samples during a fake vaccination campaign. The number of attacks on vaccination teams has certainly increased, notably in Pakistan, since then. And to make matters worse, US officials who supported the misuse of medical services in this way show no remorse for their actions. One interviewed by *The Guardian* said:

The vaccination campaign was part of the hunt for the world’s top terrorist, and nothing else. If the United States hadn’t shown this kind of creativity, people would be scratching their heads asking why it hadn’t used all tools at its disposal to find Bin Laden.<sup>28</sup>

It is this kind of mentality that is going to pose the greatest challenge to improving the safety of health care in conflicts around the world. Once the act of providing health care loses its neutrality like this, or its impartiality through discrimination as to who is accepted for treatment and who is not, its protected status is compromised and it is vulnerable to attack.

23 See Leonard Rubenstein and Melanie Bittle, ‘Responsibility for protection of medical workers and facilities in armed conflict’, in *The Lancet*, Vol. 375, January 2010, pp. 329–340.

24 See International Criminal Tribunal for the former Yugoslavia, *Mrkšić et al.*, (‘Vukovar Hospital’ case), IT-95-13/1; and the *Ovčara* cases before the War Crimes Chamber of the Belgrade District Court.

25 ‘Rwanda 1994: la vraie vie est absente’, talk given by Philippe Gaillard, Head of ICRC delegation in Rwanda during the genocide, at the Red Cross and Red Crescent Museum, Geneva, 18 October 1994, available at: [www.icrc.org/eng/resources/documents/misc/5xkca5.htm](http://www.icrc.org/eng/resources/documents/misc/5xkca5.htm).

26 ‘Patients killed in cluster bomb attack on Sri Lanka hospital’, in *The Guardian*, 4 February 2009, available at: [www.guardian.co.uk/weather/2009/feb/04/srilanka-terrorism](http://www.guardian.co.uk/weather/2009/feb/04/srilanka-terrorism).

27 ‘Gaza: ICRC demands urgent access to wounded as Israeli army fails to assist wounded Palestinians’, ICRC News Release 09/04, 8 January 2009, available at: [www.icrc.org/eng/resources/documents/news-release/palestine-news-080109.htm](http://www.icrc.org/eng/resources/documents/news-release/palestine-news-080109.htm).

28 Saeed Shah, ‘CIA’s fake vaccination programme criticised by Médecins Sans Frontières’, in *The Guardian*, 14 July 2011, available at: [www.guardian.co.uk/world/2011/jul/14/cia-fake-vaccination-medecins-frontieres](http://www.guardian.co.uk/world/2011/jul/14/cia-fake-vaccination-medecins-frontieres).



The recurring incidents of violence faced around the world indicate that much more needs to be done to enhance respect for the laws protecting health care and patients. First, there needs to be much greater awareness among health agencies, ministry of health staff, and private health providers of the protection accorded to health care under international law and the corresponding responsibilities of health staff to uphold medical ethics. Health staff and agencies need to come together in a concerted way to address the violence and to put more mechanisms in place to prevent it. It was striking to see how few health centres and hospitals in the DRC, for instance, had established rules to prevent the entry of weapons into the facility. When suggested, the idea was immediately well received by the health personnel. Such procedures need to become the norm in health facilities and transport around the country so that they raise fewer objections over time.

Second, the health community needs to get behind communication initiatives aimed at educating the population on the consequences of perpetrating violent acts against health care. One dissuasive message could be clearly stating that such acts may amount to war crimes and can incur severe punishments on the perpetrators. Perhaps this message needs to be dissociated from aid organisations operating in the field, though, to avoid creating suspicions that evidence of such acts will be forwarded to the International Criminal Court – a fear that has already led to threats against health staff in the DRC and expulsions of aid agencies from Sudan. This message could be complemented by a second message in a more persuasive vein that appeals to reciprocity: that if you respect the health care of your enemies, they will be more likely to respect yours. Radio soap operas and other popular vectors could be used to carry messages aimed at allowing local health providers to do their job of helping the wounded and sick without impediments.

Third, one international agency should undertake the responsibility for monitoring violence against health care in a more systematic way than is done at present. Health organisations, both national and international, should be strongly encouraged to report on such incidents so that the problems can be better understood and addressed. More clarity is needed on the type of incidents to be reported so that subjectivity in this area can be minimised.

Fourth, aid organisations need to consider ways in which their actions and statements might impact upon perceptions of their neutrality in conflict settings. A recent statement by a senior official of the World Health Organization, for instance, linked vaccination to the defeat of Al Shabaab forces by African Union troops, stating publicly that ‘when al-Shabab is forced out, health agencies rush in and vaccinate children’.<sup>29</sup> This type of comment is unlikely to assist in efforts to scale up polio vaccinations in Al Shabaab-held regions in the wake of the recent polio outbreak. Many other aid agencies pay only lip service to the humanitarian postures that they need to adopt in order to safely operate in conflict zones,

29 ‘Somalia launching new five-in-one child vaccines’, in *AP*, 25 April 2013. This article was picked up by newspapers the world over, including Somali ones like *Hiiraan Online*: ‘New push against polio and new vaccines in Somalia’, in *Hiiraan Online*, 26 April 2013, available at: [www.hiiraan.com/news4/2013/Apr/29046/new\\_push\\_againt\\_polio\\_and\\_new\\_vaccines\\_in\\_somalia.aspx](http://www.hiiraan.com/news4/2013/Apr/29046/new_push_againt_polio_and_new_vaccines_in_somalia.aspx).



and many incidents occur due to miscommunication and insufficient acceptance by the local population. Given the broad repercussions that can result from one violent incident against an aid agency, all have a responsibility to improve their acceptability in the contexts in which they work.

Last but certainly not least, humanitarian organisations need to come together and object in bilateral discussions and publicly to any and all political initiatives that undermine the neutrality of health care. Just as the use of an ambulance in a suicide attack causes mistrust of all ambulances thereafter, to the detriment of those requiring a rapid transfer to hospital, so the engagement of a doctor in an act of espionage generates mistrust of health professionals, to the detriment of all. The more health care is misused, the more violence it will attract. It is in the interests of the whole health and broader humanitarian community to come together and fight for respect of medical ethics and the laws protecting health care.



# Making sense of apparent chaos: health-care provision in six country case studies

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## Abstract

*This research examines the impact on health-care provision of advanced state failure and of the violence frequently associated with it, drawing from six country case studies. In all contexts, the coverage and scope of health services change when the state fails. Human resources expand due to unplanned increased production. Injury, threat, death, displacement, migration, insufficient salaries, and degraded skills all impact on performance. Dwindling public domestic funding for health causes increasing household out-of-pocket expenditure. The supply, quality control, distribution, and utilisation of medicines are severely affected. Health information becomes incomplete and unreliable. Leadership and planning are compromised as international agencies pursue their own agendas, frequently disconnected from local dynamics. Yet beyond the state these arenas are crowded with autonomous health actors, who respond to state withdrawal and structural violence in assorted ways, from the harmful to the beneficial. Integrating these existing resources into a cohesive health system calls for a deeper understanding of this pluralism, initiative, adaptation and innovation, and a long-term reorientation of development assistance in order to engage them effectively.*

**Keywords:** health sector, state failure, conflict, health-care provision, statelessness, privatisation, commoditisation, structural violence.

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The impact of conflict on health professionals, health services, and ultimately people's health is at last being openly examined. Yet conflict also impacts on health systems; the distortions that it causes last well beyond the cessation of the violence, and become structured into the systems themselves.<sup>1</sup> In many settings violence may be seen as a consequence of state failure, which in turn is aggravated by it in a self-strengthening loop that is refractory to correction. The degeneration of health systems may predate the conflict, may arise directly or indirectly from it, or may be compounded by local or international responses to the societal disarray affecting these environments. In many cases, these health systems are already vulnerable, the descriptors of the states themselves reflecting differing international judgements of the aetiology of this vulnerability: fragile and conflict-affected states,<sup>2</sup> failed states.<sup>3</sup> The problems they face are often exacerbated as a result of the challenges to their health systems, but are rarely new. Yet even for those vulnerable systems, the crisis

- 1 Johan Galtung, 'Violence, peace, and peace research', in *Journal of Peace Research*, Vol. 6, No. 3, 1969, pp. 179–183.
- 2 Department for International Development, *Results in Fragile and Conflict-Affected States and Situations*, 28 February 2012, available at: <http://www.dfid.gov.uk/documents/Publications1/managing-results-conflict-affected-fragile-states.pdf> (last visited 16 August 2012); see also World Bank, *Fragility, Conflict and Violence*, available at: <http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/STRATEGIES/EXTLICUS/0,,menuPK:511784~pagePK:64171540~piPK:64171528~theSitePK:511778,00.html> (last visited 16 August 2012).
- 3 Fund for Peace, 'Failed States Index 2011–12', interactive grid available at: [www.fundforpeace.org/global/?q=fsi-grid2012](http://www.fundforpeace.org/global/?q=fsi-grid2012) (last visited 16 August 2012).

may provide opportunities for positive change, and in fact is an imperative for change.

This paper is based on an analysis of six country research case studies – Afghanistan, the Central African Republic (CAR), the Democratic Republic of the Congo (DRC), Haiti, Palestine, and Somalia – examining health service provision in severely disrupted environments, hosted by the University of Queensland and undertaken in 2010–2012, funded by the Danish Ministry of Foreign Affairs.<sup>4</sup> The research recognises that for many fragile and conflict-affected states, disruption is chronic and extensive, not merely part of a transient trajectory towards recovery, and that successive attempts at state-building often defy the rhetoric that underpins them. It acknowledges the reluctance of development actors to critically analyse emergent actors and governance at the periphery of fragile and conflict-affected states, and their implications for development.<sup>5</sup> This research seeks not just to examine more comprehensively the health provision mapped out within state frameworks and under their governance, but to reach beyond that. It seeks to provide insight into what provision of health services exists beyond the reach of the state and to examine the implications of these often unrecognised resources in rethinking potential health systems development.

The selection of the six case studies has been purposive. Five of these countries rank among the ten worst performers in the Fund for Peace Failed States Index,<sup>6</sup> but the key to their selection has been the diversity of these countries and of their crises: Afghanistan, with its centuries of resistance to state-building initiatives, its progress towards statehood, a ‘transition without end’;<sup>7</sup> the CAR, conspicuous by the paucity of analysis in the academic and political literature, and aptly characterised by the International Crisis Group, which struggled with the ‘Anatomy of a Phantom State’;<sup>8</sup> the DRC, whose colonially inherited borders have left it with a fissiparous geography of ‘populated peripheries

4 The project was hosted by the University of Queensland, which administered funding for the research and provided research ethics approval for the proposal. The research was undertaken by a core team of four public health researchers, two of whom have appointments at the University of Queensland. All researchers have extensive experience in post-conflict health systems. Additional expertise was contracted to provide specific experience where necessary. The use of independent public health consultants with extensive post-conflict health systems experience to undertake the bulk of the research was both advantageous and necessary, enabling access to more volatile areas where travel would not be approved under University travel guidelines.

5 Mark Duffield, ‘The symphony of the damned: racial discourse, complex political emergencies and humanitarian aid’, in *Disasters*, Vol. 20, No. 3, 1996, pp. 187–191.

6 Palestine is not recognised as a state by the international system based on UN membership, and therefore is not listed in the Fund for Peace Failed States Index.

7 Antonio Giustozzi, ‘Afghanistan: transition without end. An analytical narrative on state-making’, Working Paper No. 40: Development as State-Making, Crisis States Research Centre, November 2008, available at: [www2.lse.ac.uk/internationalDevelopment/research/crisisStates/download/wp/wpSeries2/wp402.pdf](http://www2.lse.ac.uk/internationalDevelopment/research/crisisStates/download/wp/wpSeries2/wp402.pdf) (last visited 16 August 2012).

8 International Crisis Group, *Central African Republic: Anatomy of a Phantom State*, Africa Report No. 136, 13 December 2007, available at: [www.crisisgroup.org/~media/Files/africa/central-africa/central-african-republic/Central%20African%20Republic%20Anatomy%20of%20a%20Phantom%20State.pdf](http://www.crisisgroup.org/~media/Files/africa/central-africa/central-african-republic/Central%20African%20Republic%20Anatomy%20of%20a%20Phantom%20State.pdf) (last visited 20 April 2012).

with no core';<sup>9</sup> Haiti, where natural disasters and disease outbreaks, compounded by social divisions, state disarray, and political instability, constitute a succession of 'routinized ruptures';<sup>10</sup> Palestine, with its legacy of expropriation, occupation, forced displacement, and dependency, eternally frustrated in its quest for full statehood;<sup>11</sup> and Somalia, the quintessential stateless nation, characterised by Peter Little as an 'economy without state'.<sup>12</sup>

Studying such extreme contexts offers distinct advantages. Far from being unfortunate aberrations affecting only a handful of beleaguered countries, the entrenched state withdrawal from health-care provision appears as a frequent phenomenon in the global South. Given the depth of these crises, each of the contexts we have studied may also foreshadow future developments in other peripheral countries: the extent of distortion and compensation is less transparent and open to examination in less disrupted environments, where even limited state mechanisms can deflect attention from what is still an active and pluralistic informal sector.

Each case study was informed by comprehensive documentary analysis of the available peer-reviewed and grey literature – government, bilateral, and multilateral agency reports, unpublished research, project reports and evaluations. Particular attention was given to the broader historical, geographical, political, economic, and social context in which health care is provided, in the belief that the latter is heavily influenced by the former. This effort to consider health care as part and parcel of a broader picture sheds light on health issues that would otherwise have been inexplicable. Despite their diversity, recurrent themes were evident in analyses of each of the six investigated health-care arenas. This article highlights these key themes, which offer insights that are also applicable in other distressed contexts.

Field visits enabled direct observation of the current context, both in the capital and in provincial centres. In-depth interviews were undertaken with key local informants from ministries of health, non-governmental organisations (NGOs), and bilateral and multilateral development agencies, using a common question guide, with the findings corroborated between members of the research team and local public health experts. Further triangulation was enabled through the circulation of draft reports internationally to public health practitioners with experience in each of these locations, and presentations at a series of international seminars.<sup>13</sup>

9 Jeffrey Herbst and Greg Mills, 'There is no Congo', in *ForeignPolicy.com*, 29 March 2009, available at: [www.foreignpolicy.com/story/cms.php?story\\_id=4763](http://www.foreignpolicy.com/story/cms.php?story_id=4763) (last visited 20 April 2012).

10 Erica Caple James, 'Ruptures, rights and repair: the political economy of trauma in Haiti', in *Social Science and Medicine*, Vol. 70, No. 1, 2010, p. 107.

11 International Crisis Group, 'The occupied territories have the dubious distinction of having become a failed state before even becoming a state', in *After Mecca: Engaging Hamas*, ICG Middle East Report No. 62, 2007, p. 9.

12 Peter D. Little, *Somalia: Economy without State*, Indiana University Press, Bloomington and Indianapolis, 2003, pp. 161–174.

13 An earlier version of this paper was presented as 'Health care in disrupted environments' at the Health Care in Danger Symposium, co-hosted by the International Committee of the Red Cross and the British Medical Association, London, 23 April 2012.

## Health service provision in severely disrupted environments: six country case studies

The impact of state degeneration and violence on health systems is diffuse, its penetration pervasive throughout the system. As with the experience of distress for each country, the destructive implications for health services are unique: each system is ‘unhappy in its own way’.<sup>14</sup> For Afghanistan, the CAR, the DRC, and Somalia, armed violence is overt and endemic. For Palestine, the strictures on movement and development are punctuated by episodic outbreaks of conflict. The violence that shadows Haiti is the structural, embodied echo of occupation, brutal dictatorship, political volatility, rural–urban inequity, and gendered abuse.<sup>15</sup> None among the studied states presents a past of good performance in any significant aspect, be it the maintenance of law and order, sovereignty over its territory, social services, economic progress, or respect of human rights.

The health sectors of each case study share commonalities in the impact of violence on their health status – life expectancy, neonatal and infant mortality, maternal mortality, and related indicators are poor relative to their regional neighbours – but the determinants of these outcomes are frequently particular to the context. The exception among these case studies is of course Palestine, a middle-income country with parameters that are comparable to other Middle Eastern countries, other than Israel.

The World Health Organization (WHO) framework of six ‘building blocks’ for strengthening health systems<sup>16</sup> – health services; human resources; financing; drugs, vaccines, and technology; health information; and leadership and governance – provides a structure for the analysis of these mechanisms, but given the complex nature of health systems and the societies within which they operate, the impact on each ‘building block’ produces effects that extend beyond any single system element, often profoundly distorting the whole.

What has become clear from the research is that national health systems, defined inclusively by WHO as ‘all the activities whose primary purpose is to promote, restore or maintain health’,<sup>17</sup> are themselves networks of complex adaptive systems, constantly changing and profoundly affected by local factors. Protracted disruption leads to enormous geographical and functional diversification, the constituents of which evolve over time in response to stress. The national

14 Wim Van Damme of the Institute of Tropical Medicine, Antwerp, aptly describes this phenomenon in disrupted health systems as the ‘Anna Karenina effect’, based on Tolstoy’s reflection that: ‘All happy families resemble one another, each unhappy family is unhappy in its own way’. Leo Tolstoy, *Anna Karenina*, Oxford University Press, Oxford, 1980 (1918), p. 1.

15 Elena Lucchi, ‘Between war and peace: humanitarian assistance in violent urban settings’, in *Disasters*, Vol. 34, No. 4, October 2010, pp. 973–995; Paul Farmer, ‘Political violence and public health in Haiti’, in *New England Journal of Medicine*, Vol. 350, No. 15, 2004, pp. 1483–1486; Paul Farmer, ‘On suffering and structural violence: a view from below’, in *Race, Ethnicity, Multidisciplinary Global Contexts*, Vol. 3, No. 1, 2009, pp. 305–325.

16 World Health Organization (WHO), *Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes. WHO’s Framework for Action*, Geneva, 2007.

17 WHO, *World Health Report 2000 – Health Systems: Improving Performance*, Geneva, 2000, p. 5.

boundaries of the health sector become irrelevant: conspicuous trans-border flows of health-care users, health professionals, diseases, medicines, organisations, and service models make the traditional concept of a 'national' health system too narrow to reflect such a fluid and varied landscape. It is not possible to discuss Palestine's health system without considering the interfaces with Israel, Lebanon, Jordan, and Syria; the health system in Haiti cannot be considered without recognising the flows of patients into the Dominican Republic, or Florida in the United States; patients from Somalia may seek recourse to treatment in Kenya, but may draw on web-based health care from Toronto or London. On the other hand, internal barriers, be they geographical, political, cultural, financial, or military, tend to fragment national health sectors into fairly autonomous local health-care provision systems that differ from each other in many aspects: health services in the CAR capital Bangui, for example, contrast dramatically with those in the rural provinces of the country, with the differing profile of services in each province again reflecting the province's own political histories and economic diversity. The collapsing of such diversity into national averages, as is usually done in health information system reports, conceals the actual patterns, papers over the dire circumstances of the most marginal regions, and obfuscates the analysis.

## Health services and the disrupted state

The issue of health-care coverage is significant in every context where the state is unable – or in some cases unwilling – to provide health services. While the pre-existing coverage of health services is often poor, services contract further away from active conflict, as in Afghanistan, concentrating development resources in the limited number of secure provinces and inevitably privileging their development and capacity over the long term. While this trend is broadly true of Afghanistan and the CAR, there have been opposite outcomes in the DRC, where conflict-affected eastern provinces have attracted humanitarian assistance and subsequently have fared better in terms of health services and the resultant improvements in health status than the uncontested – and neglected – Bandundu, Bas Congo, and East and West Kasai provinces.<sup>18</sup> The mal-distribution of staff exacerbates existing disparities in service provision, with those who have portable skills often taking advantage of these opportunities to migrate. The distortions are quickly institutionalised. Haiti, with its history of enduring *ensekirite*,<sup>19</sup> has largely reoriented its medical education towards emigration and personal opportunity,

18 Sarah Bailey, 'Humanitarian action, early recovery and stabilisation in the Democratic Republic of the Congo', Working Paper, Humanitarian Policy Group, Overseas Development Institute, London, July 2011.

19 Caple James, in her paper, defines *ensekirite* (the Creole term for insecurity) as describing 'the state of episodic emergency and instability that is sparked by political and criminal violence'. See E. Caple James, above note 10, p. 107.



and of the minority that stays, the best find employment with international organisations or NGOs.<sup>20</sup>

The mal-distribution of services, in the context of constrained health ministry resources and consequent administrative ‘reach’, is compounded when donors drive initiatives blueprinted on models proclaimed as successful elsewhere. Haiti’s ambitious 1998 devolution reforms based around an integrated health district – the *Unité Communautaire de Services* – remains functional in two districts, generously supported by international NGOs.<sup>21</sup> Yet the *Ministère de la Santé Publique et de la Population*, with a budget a fraction of that of its international donor ‘collaborators’ and direct control of less than 20 per cent of health facilities, while recognising the potential of the structures that the reforms introduced, is not in a position to expand them.<sup>22</sup> The ‘operational’ district model of health service delivery, which uses demographic, geographic, and socio-cultural parameters to locate a district referral hospital and its network of health clinics within an optimal catchment population,<sup>23</sup> was pioneered in the DRC (then Zaire) and had qualified success in Cambodia, but the limited resources devolved to the *Départements* in Haiti have meant that the potential of decentralisation has not been realised, except where there is external support. Donor-driven strategies such as contracting out have been promoted by the World Bank in Cambodia, Afghanistan, and subsequently Timor Leste.<sup>24</sup> The early evangelism for the model is now being questioned for its limited coverage in insecure districts,<sup>25</sup> its increasing dependence on NGOs at the expense of the state, and the implicit privatisation that it may introduce.<sup>26</sup> In Afghanistan, with donors eager to translate the Cambodian ‘success’ in a parallel post-conflict scenario, competitive contracting out to non-government health-care providers has resulted in a rapid geographic expansion of primary health-care services,<sup>27</sup> but with low levels of utilisation and persisting high out-of-pocket expenses for health, absorbed by a thriving private health sector. While the logic of the reforms may be compelling, for severely and chronically disrupted health sectors such as those of Haiti and Afghanistan, the capacity and infrastructure to sustain the massive devolution implicit in ambitious short-term donor-driven plans for achieving national health coverage is not available.

20 Fitzhugh Mullan, ‘The metrics of the physician brain drain’, in *New England Journal of Medicine*, Vol. 353, October 2005, pp. 1810–1818.

21 Laura Zanotti, ‘Cacophonies of aid, failed state building and NGOs in Haiti: setting the stage for disaster, envisioning the future’, in *Third World Quarterly*, Vol. 31, No. 5, 2010, pp. 762–766.

22 Interviews with senior *Ministère de la Santé Publique et de la Population* personnel estimated that between 15 and 20 per cent of health facilities were under their direct control.

23 Jean-Pierre Unger and Bart Criel, ‘Principles of health infrastructure planning in less developed countries’, in *International Journal of Health Planning and Management*, Vol. 10, 1995, pp. 113–128.

24 Benjamin Loevinsohn and April Harding, ‘Buying results? Contracting for health service delivery in developing countries’, in *The Lancet*, Vol. 366, No. 9486, 20 August 2005, pp. 676–681.

25 Stephanie Simmonds and Feroz Ferozuddin, *Support to the Health Sector in Helmand Province, Afghanistan*, Department for International Development Health Resource Centre, London, 30 December 2008, pp. 24–27.

26 Ronald Waldman, Lesley Strong, and Abdul Wali, *Afghanistan’s Health System Since 2001: Condition Improved, Prognosis Cautiously Optimistic*, Briefing Paper Series, Afghanistan Research and Evaluation Unit, Kabul, December 2006.

27 B. Loevinsohn and A. Harding, above note 24.

In contrast, the Palestinian conflict has resulted in the opposite distortion of health-care provision, encouraged by donor generosity: opportunistic development and duplication of health services, with multiple providers motivated by political, charitable, and business agendas. The resultant redundant structure features varied delivery models, dispersed decision-making centres, informal power structures, multiple funding sources, diversified supporting bodies, and traditional as well as institutional safety nets. While this may be undesirable in a more peaceful context, it appears appropriate to the current unpredictability affecting every aspect of life in Palestine, including health-care provision. The perseverance of community-based midwives despite the official policy preference for hospital deliveries is a pertinent example: with frequent conflict outbursts and daily movement limitations caused by the occupation, these midwives offer a precious spare option for care in an extremely constrained and erratic environment.<sup>28</sup>

Similarly, many of the flaws that have been identified in other health-care arenas have emerged as responses to a series of stressors. Multiple providers, often with different sponsors or mandates, compete with each other to produce a range of models, often with redundant service delivery. Institutional provision for the most marginal may coexist or overlap with traditional local community 'safety nets'. Governance for these facilities is often dispersed: decision-making may be made in provincial or national capitals, removed from the facilities themselves, or in some cases, in the international centres that are the source of funding. Local coordination is often problematic, reflecting informal power structures, multiple funding sources, and diversified supporting bodies. If the environment remains unfavourable, such flaws might constitute actual strengths: duplication of services means ready access when communities are divided by conflict, as experienced episodically in Palestine; multiple sponsors from the diaspora or international community have provided continuing financial support in Haiti when local economies fail; services based on ethnic or religious identity in Somalia provide help to those marginalised in their societies. In unstable situations, the features that would be undesirable in more socially cohesive situations now enable the delivery of health services in the least conducive conditions. These adaptive responses to stressors and neglect have, surprisingly, generated a range of services – though of questionable quality – in forbidding contexts such as Somalia or the CAR, where many observers would expect no services at all.

What is clear is that the health service gaps left by the absence or withdrawal of the state do not necessarily remain a vacuum. They are filled by health workers with limited, incomplete, or expedited training, retired staff, traditional practitioners, volunteers, and quacks. The actual services available to the customers will depend on which staff remain, the expenses incurred, the availability of drugs, access to supply lines, and adaptability to the dynamics of conflict. New priorities may emerge: trauma surgery in active conflict areas, or heavily mined agricultural

28 Rita Giacaman, Laura Wick, Hanan Abdul-Rahim, and Livia Wick, 'The politics of childbirth in the context of conflict: policies or de facto practices?', in *Health Policy*, Vol. 72, No. 2, May 2005, pp. 129–139.

fields; malaria where the population has to retreat to infested forested areas; malnutrition as a consequence of food insecurity and disrupted agricultural cycles; abortion as a consequence of failed family planning programmes, or more sinisterly, the product of rape.

While curative services may be offered within this emergent private sector, preventive programmes become more difficult to sustain: immunisation and child health services may be curtailed due to the risks of congregating, or threats to staff during outreach activities. Tuberculosis services such as DOTS (directly observed therapy, short course),<sup>29</sup> which need regular ongoing contact and predictable drug supplies, are frequently compromised. Public health programmes, however, are not always neglected, as demonstrated in the field of HIV/AIDS control: though Haiti is characterised as a low-prevalence country for HIV, generous funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria has been complemented by substantial funding from other development partners there. Support for HIV/AIDS continues to dominate development aid in health, despite the paucity of epidemiological data and the limited capacity to track outcomes related to this investment.<sup>30</sup>

The health-care network has been deeply affected by protracted decay in every studied setting. Thanks to investments shouldered by charities, NGOs, local entrepreneurs, and politicians, and diaspora-financed initiatives, in most contexts it has expanded in an unplanned and often undocumented way, with a burgeoning of atypical health facilities. Ubiquitous drug-selling outlets come to represent the most accessible contact points for the majority of the population. Over time, some of them acquire a micro-laboratory and a few beds. Small, lightly equipped facilities may come to dominate the landscape, as seen in the DRC. In comparatively privileged areas, donor investment in specific health programmes may lead to clusters of health-care facilities in the same district, with duplication of some services, whereas inaccessible, insecure, or destitute districts may lack even the most rudimentary services. Including atypical health facilities that specialise in specific health services or disease control when mapping health service coverage may not accurately represent access to basic services: one rural community in Haiti boasted a comprehensively equipped orthodontic clinic, courtesy of a successful former resident, but no other health-care facility.

Referrals between primary care facilities and more specialised services may be disrupted by political and military barriers (as in Palestine), by geographical, financial, and transportation obstacles (as in the CAR), by perverse incentives, by violence, sectarian, or ethnic mistrust, and by partisan partition. For women with complications of pregnancy, transfers to emergency obstetric care may not be

29 The DOTS programme, developed by WHO, has effectively transformed the management of tuberculosis, offsetting the higher cost of short-course therapy with the possibility of directly supervised daily treatment as an outpatient close to the patient's place of residence. Interruption to therapy, however, risks the development of resistant forms of tuberculosis, with significant implications for the patient and the community.

30 Emanuele Capobianco and Veni Naidu, *A Decade of Aid to the Health Sector in Somalia (2000–2009)*, World Bank, Washington, DC, 2010, pp. 25, 34.

undertaken because of the low predictability of appropriate services being available, their cost, and the risks of travel. In the end, referral flows depend more on customer preferences and opportunities than on provider decisions. The rational referral 'pyramid' – with broadly accessible primary care providing access to more specialised referral care – is not recognisable in most distressed settings, where health care is consumed locally. Where local provision is inadequate, access to care may be dependent on the mobility of health users.

## Human resources

While the overt distortion of health services is often the result of the threat of violence to populations and the health workers that serve them, the health sector itself is increasingly a direct focus for violence, for a variety of complex reasons. In conflicts where social services are promoted by the government, any challenge to it may target such services. The participation of women in nursing and midwifery provided a focus for Taliban threats to health facilities in Afghanistan. Following the use of polio immunisation as a pretext for the identification of Osama bin Laden in Abbottabad, the Taliban have blocked polio vaccination in tribal North Waziristan, though this does not appear to have extended to Taliban-dominated areas of Afghanistan.<sup>31</sup> The loss of human resources through death and injury, relocation, and migration contributes to the distortion of the health workforce, exacerbating already problematic rural–urban mal-distribution.

In Palestine, health care has gained an overtly political connotation as a field in which activists can engage, with the development of locally owned or managed health facilities that provide a politically preferable alternative to dependence on Israeli services forming a focus for contention. In the other case studies, the violence against health facilities and workers is predatory rather than political in nature. In the DRC, the widespread practice of detaining patients (or corpses) within the hospital until their bills have been settled is a bleak example of this direct, personal, and institutionalised violence.<sup>32</sup>

Relocation to avoid danger is only part of the general redeployment that takes place in distressed health-care arenas: with local agriculture and employment disrupted, the need to scrape together a basic livelihood appears to be the most influential factor in most settings. Health workers themselves are mobile, both within formal health sector structures and beyond them, concentrating in areas with better earning potential. Where a concentration of practitioners may produce economic competition, health-care demand may be stimulated to meet the

31 Declan Walsh, 'Taliban block vaccinations in Pakistan', in *The New York Times*, 18 June 2012, available at: [www.nytimes.com/2012/06/19/world/asia/taliban-block-vaccinations-in-pakistan.html](http://www.nytimes.com/2012/06/19/world/asia/taliban-block-vaccinations-in-pakistan.html) (last visited 23 August 2012).

32 Johan Von Schreeb and Markus Michael, *Joint Assessment of Health Status and Health System among Crisis Affected populations in the Democratic Republic of Congo (DRC) and the Humanitarian Health Sector Strategy for DRC*, WHO, Geneva, 2004, p. 24.

practitioners' financial imperatives, rather than servicing objective local needs. Arguable practices – poly-pharmacy, unnecessary investigations, non-rational use of antibiotics, injections where oral medication should suffice – contribute to soaring household expenses, but also drug-resistant disease and iatrogenic illness.

The recognition of the economic opportunities provided in health service provision has prompted the reorientation of some state-run training facilities and the emergence of private educational institutions in even the most disrupted environments. As business-oriented training institutions produce an excess of categories with higher status and earning perspectives, such as doctors and pharmacists, the imbalance between professions increases. With medical graduates from Haiti having established a solid regional reputation in previous decades, the largely hospital-based medical curriculum prepares undergraduates for an international role: educators indicated that 80 per cent of doctors emigrate on graduation. In the DRC, the spontaneous proliferation of medical schools and training institutions has led to an explosion of holders of substandard health-care qualifications, expecting employment in an already saturated market. In Somalia, new health professionals are trained in institutions created by local entrepreneurs and financed by fees and external support. In Palestine, the health-care training industry has expanded dramatically, beyond actual service necessities, in response to the scarcity of alternative job opportunities in other economic sectors. In Afghanistan, three doctors have been trained for every two nurses, with urban medical unemployment a consequence due to reluctance to serve in rural areas. Anecdotal evidence from the interviews suggests that the inflated salaries offered in non-health security-linked sectors have resulted in reports of doctors working as drivers in Kandahar province. Salaries for health workers in NGOs are at least 50 per cent higher than government salaries, eroding management and leadership capacity in key programmes.<sup>33</sup>

Gender issues exacerbate the limited access to health care available to women and girls. The existing educational disadvantage for girls in Afghanistan limits the pool available for training in midwifery or nursing, and the targeting of both female education and female health workers in that country by the Taliban compounds the shortage of women doctors and even trained birth attendants in rural communities, with already disturbing levels of maternal mortality. But misconceived concurrent attempts to professionalise nursing and midwifery are producing predictably negative consequences. The decision to require completed secondary education for access to midwifery training has resulted in rural women being increasingly excluded as a consequence of their educational disadvantage. Trained urban midwives are unwilling to fill rural vacancies, preferring unemployment to undesirable rural appointments.<sup>34</sup>

33 Human Resource Development Cluster, *National Priority Programs – Program Number 5: Human Resources for Health*, paper for Kabul Conference, Ministry of Public Health, Kabul, July 2010, p. 115.

34 Farooq Mansoor, Peter S. Hill, and Peter Barss, 'Midwifery training in post-conflict Afghanistan: tensions between educational standards and rural community needs', in *Health Policy and Planning*, Vol. 27, No. 1, January 2012, pp. 60–68.

Training in post-conflict situations is often patchy and of poor quality, resulting in qualifications whose standards are difficult to confirm or certify. With multiple parties to a conflict, duplication of training of health professionals occurs, with multiple categories emerging. The skill base of workers will reflect the priorities of the promoting bodies, with military medics, for example, frequently experienced in the acute management of trauma but unprepared to provide emergency obstetric care. In countries bordering our case studies, post-conflict integration of health workers, including former military health personnel, has further inflated a regional workforce that is often already bloated and inadequately supplied and remunerated. Reform attempts to upgrade the skills of the workforce and to downsize it are often constrained by political or clientelist imperatives to increase opportunities for employment within the public service. Yet the inability of government to pay salaries that provide an adequate standard of living results in informal fees demanded of patients for services that are nominally 'free', and an unregulated private sector of 'moonlighting' public sector staff feeding parasitically off the failures of the state system.

## Financing

Domestic public financing for health is frequently reduced during situations of conflict, as a result of shrinking revenues and increasing security-related expenditures. Military health services may be the one potential exception to this. State funding frequently contracts to (irregularly) cover salaries diminished by inflation, with limited allocations for drugs and outreach activities, and procurement, logistics, and distribution frequently disrupted. In the DRC and CAR, even diminutive salaries have failed for years to reach the employees of an absent state. The gap left by a contracting or absent public purse is filled by households, often supported by family remittances from abroad, charities, and official external assistance. Once all these financial contributions are added together, total health expenditure may attain considerable levels, with the highest proportion usually coming from out-of-pocket expenditure, despite the level of poverty of the involved population.

Private payments become integral to health service provision in all disrupted health-care arenas: health services offered by the *Départements* in Haiti are heavily dependent on user fees, and in Afghanistan, despite an ambitious effort to provide a basic package of health services through contracted-out NGOs, patients prefer to spend their money in the private for-profit sector, where services are perceived to offer better quality, easier accessibility, and a wider service profile. In Somalia, Islamic charities back investments in new facilities, which then charge (initially at discounted prices) for the provided services.<sup>35</sup> Analogously, mission

35 Andre Le Sage, 'Islamic charities in Somalia', in Jon B. Alterman and Karin von Hippel (eds), *Understanding Islamic Charities*, Center for Strategic and International Studies, Washington, D.C., 2007, p. 152.

health facilities have a long tradition of charging for services. With state financing for health in the DRC among the lowest in the world,<sup>36</sup> health administrations neglected by the state budget sustain themselves through the institution of '*la pompe aspirante*',<sup>37</sup> siphoning off a percentage of user fees paid to health facilities, with a cut sent on up the ladder.<sup>38</sup>

In acute interventions, international humanitarian funding for health may rise exponentially but not sustainably, with the mandates of humanitarian agencies reaching their defined end, the initial public support waning, and no development perspectives in sight. In the post-conflict phase, donor financing makes significant contributions to reforms across the sector, drawing on processes that have been trialled in other contexts: the Health Coverage Plan, trialled in Cambodia and subsequently applied with the contracting of NGOs in East Timor and then Afghanistan, is one example. Financing is inevitably framed by donor agendas, particularly where the local state is weak, and local planning frameworks are either inadequate or developed with extensive technical assistance.<sup>39</sup> Donor funding linked to donor priorities and diplomatic interests creates donor 'darlings' but also results in donor 'orphans' – those countries unwilling or unable to follow the script assigned to them by the aid industry, or lacking strategic significance. Limited local absorptive capacity and poor local infrastructure often constrain the resources able to be channelled through government funding mechanisms, leading to preference for implementation being given to international organisations or NGOs and to alternative systems that are difficult to reconcile with crippled government mechanisms. In the countries studied (with the notable exception of Palestine), the disarray of state management structures is so advanced that the recurrent donor initiatives intended to resuscitate them are regularly frustrated.

Ironically, military aid allocations – the 'hearts and minds' component of the military budget, significant in Afghanistan<sup>40</sup> – may in places exceed other aid for health, but lack the health systems and development experience required to make it effective in alignment with local practices. Furthermore, local capacity may exist to some extent but remain incompatible with donor requirements due to its high degree of informalisation. The poor grasp of the local context demonstrated by international actors leads to frequent embarrassments, as when evidence of having unintentionally or at times intentionally provided support to factions in the conflict emerges. Changes in local and geo-politics can feed into this: support for

36 World Bank, *Democratic Republic of Congo: Public Expenditure Review*, Report No. 42167-ZR, New York, March 2008, E44, p. 9.

37 This bleakly humorous metaphor, translated as 'the suction pump', draws attention to the way in which services parasitise their clients to sustain their own continuing existence, inverting the conventional duty of care relationship between the care provider and the population 'served'.

38 Health Systems 20/20 Project, *Comptes Nationaux de la Santé 2008–2009*, Abt Associates, Bethesda, MD, May 2011.

39 Ann Canavan, Petra Vergeer, and Olga Bornemisza, *Post-Conflict Health Sectors: The Myth and Reality of Transitional Funding Gaps*, Health and Fragile States Network and Royal Tropical Institute, Amsterdam, 2008.

40 Antonio Donini, 'Between a rock and a hard place: integration or independence of humanitarian action?', in *International Review of the Red Cross*, Vol. 93, No. 881, March 2011, p. 150.



Hamas-related charities has gained increased legitimacy as a consequence of the organisation's electoral success.

## Drugs, vaccines, and technology

Severe disruption is characterised by a conspicuous commoditisation of health, with pharmaceuticals providing an economic rationale for sustaining private provision of selected services in the absence of the state. In fact, pharmaceutical markets appear equally buoyant in all the studied countries. Business people, petty traders, health professionals, international agencies, and vertical programmes are all active in this crowded field, alighting big commercial interests. Despite the high visibility of such a mixed market, its study is often neglected. The informality of such pharmaceutical markets combines with their illicitness (in the eyes of international regulators and law enforcers) to challenge researchers. Besides being difficult, collecting reliable data may also be risky, particularly for in-country researchers vulnerable to political, factional, or criminal pressures. In this research, institutional travel advice constrained travel to provincial centres; researchers found the political complexities in Palestine problematic to navigate, and in Haiti they were warned of the dangers implicit in exploring pharmaceutical markets.

The porous borders of Somalia have allowed the increased importation of medicines from a range of sources, with a burgeoning network (including informal and at times murky elements) of financing and procurement put in place by local entrepreneurs; this network serves not only Somali territories, but well into the neighbouring regions.<sup>41</sup> The same international dimension of the pharmaceutical trade is recognisable in Afghanistan and the DRC. The absent regulation means that poor-quality or fraudulent medicines, many with European brand names, have facilitated access.<sup>42</sup> In extremely commoditised contexts such as the DRC, substandard medicines may be preferred to quality ones by customers and prescribers alike due to their lower price. Observation from the case studies suggests that self-treatment, in the absence of prescribing controls, frequently results in inadequate therapy, with implications for the development of antibiotic resistance, and the lack of Western medicines in insecure or neglected locations means that traditional healing practices are frequently substituted.<sup>43</sup>

Logistics and delivery operations for centralised medical supply systems are very sensitive to state disarray, and rank among the first public functions to degenerate. As a result, local opportunistic or compensatory (depending on the point of view) supply lines emerge. Vaccination programmes are vulnerable as

41 Caitlin Mazzilli, Rehana Ahmed, and Austen Davis, *The Private Sector and Health: A Survey of Somaliland Private Pharmacies*, UNICEF and the European Union, 2009, p. 49.

42 Harry Jeene, *The Health System in Karkaar Region, Puntland, Somalia*, Save the Children UK, London, 2010, p. 25.

43 Jillian C. Kohler, Enrico Pavignani, Markus Michael, Natalia Ovtcharenko, Maurizio Murru, and Peter S. Hill, 'An examination of pharmaceutical systems in severely disrupted healthcare systems', in *BMC International Health and Human Rights*, Vol. 12, No. 34, December 2012.



access and demand are compromised because of security concerns and the cold chain is disrupted. Ironically, successful interventions may create problems, with international organisations establishing short-term, parallel supply schemes that may displace or asphyxiate existing but frail state systems. In post-disaster Haiti, the free-care policies of some NGOs, such as *Médecins sans Frontières* (Doctors without Borders, MSF), place them in tension with local public providers, who charge fees for services and prescribed medicines that are often perceived as being of inferior quality. While these exogenous services are valued in the short term, this temporary competition may disrupt the delicate supply equilibrium, displacing small-scale local operators and creating difficulties in re-establishing supply links once international actors depart. As NGOs reach the end of their mission, the distribution of their residual supplies – particularly where they are committed to distributing these supplies free of charge and are unable to on-sell to local providers – floods local markets, disrupting the precarious balance of supply and demand.<sup>44</sup> Donations of expired, unneeded, unusable pharmaceuticals are a recurrent concern, particularly in crisis contexts attracting international attention. The Gaza Strip has been flooded with inappropriate supplies of medicines at several points in time, causing serious management and disposal difficulties.

State intervention, in the form of proper regulatory provisions, is constantly invoked to remedy the unruliness of these pharmaceutical markets. However, a poorly conceived and under-resourced regulation may be counterproductive, by offering opportunities to officials for extortive practices voided of benefits, and stifling informal initiatives that provide valuable alternatives to absent, erratic, or unreachable formally supplied medicines. Palestine offers the bizarre counterfactual of a pharmaceutical market highly regulated by Israel, which results in good-quality medicines sold at very high prices, out of proportion with the purchasing power of the average household.

## Health information

The health information system is one of the most vulnerable components of any health-care management system. As the health sector ceases to be administered as a comprehensive system, the demand for reliable information vanishes too. Data collection is further compromised through loss or relocation of the staff responsible for recording, reporting, or analysing the data. The aggregate data now available in the CAR and DRC, while of dubious accuracy, further distorts the realities. Figures from sites that are more geographically or politically accessible – and therefore privileged – may be extrapolated to the whole of the country, and incorrect assumptions made for inaccessible areas. In the CAR, ‘in practice, the SNIS [*Système*

44 Seth G. Jones, Lee H. Hilborne, C. Ross Anthony, Lois M. Davis, Federico Giroi, Cheryl Benard, Rachel M. Swanger, Anita Datar Garten, and Anga Timilsina, *Securing Health: Lessons from Nation Building – Chapter 5: Haiti*, Rand Corporation, Center for Domestic and International Health Security, Santa Monica, CA, 2006, p. 117.

*National d'Information Sanitaire*] is not used: not for planning, not for evaluation and not for management'.<sup>45</sup> Routine information systems are similarly not used in the other studied countries. Survey-originated information, largely propped up by the aid industry, was found to be much stronger in Palestine, Somalia, and Afghanistan. Its weakness resides in its piecemeal nature: alongside valuable insights about selected aspects, black spots persist. The latter may be more important than the former, as the under-study of private provision demonstrates across all health-care arenas. Comprehensive information is regularly scarce in health-care non-systems, an inadequately recognised aspect. In the absence of reliable government statistics, international organisations provide competing – and at times confusing – information. In their estimate of maternal mortality ratios for the CAR, the World Bank and United Nations agencies endorsed a figure of 850 per 100,000 live births in 2008, but included a range from 490 to 1,400 based on the 2003 Census and other estimates around the same period.<sup>46</sup>

Health information is a political commodity, used with often laudable intentions. While, in the absence of accurate vital registration systems, death and cause-of-death data are so poor as to become meaningless, estimates of these statistics rapidly become 'data', and attempts to rationally re-examine these estimates are vigorously contested. Health data may be crucial in establishing international support for disasters, as the current Horn of Africa famine projections show, but the politics of health information make it contentious: challenges to the estimates of deaths – particularly civilian deaths – in recent conflicts have pitted claim against counter-claim, methodology against methodology.

## Leadership and governance

In dysfunctional states, legitimate authority may have never existed; in conflict situations, where it is often contested or lost, the local ownership of health systems becomes a dubious concept, more likely to reside in informal social structures than in official formal ones. Even where the state is recognised by international bodies, it may look illegitimate to its citizens; moreover, its 'reach' may be truncated by its limited capacity. In all the case studies, health services are compromised by the limitations of the state: Afghanistan's fragile control of contracted health services – even with substantial international support – provides coverage for a very low proportion in some provinces;<sup>47</sup> in the CAR, 'the State stops at PK12' – that is, at the margin of the capital Bangui;<sup>48</sup> and the crippling absence of state funding for the DRC's health services results in parasitic state agents that are dependent on user fees

45 Olivier Barthes, *Analyse du Système d'Information Sanitaire: Rapport de Mission à Court Terme, Project Amélioration des Soins de Santé de Base dans les Régions Sanitaires 1 et 6 en République Centrafricaine*, Ministère de l'Economie et du Plan, Bangui, 2009, p. 9.

46 WHO, UNICEF, UNFPA, and World Bank, *Trends in Maternal Mortality 1990 to 2008: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank*, WHO, Geneva, 2010, p. 23.

47 S. Simmonds and F. Ferrozudin, above note 25, pp. 24–27.

48 Thomas Bierschenk and Jean-Pierre Olivier de Sardan, 'Local powers and a distant state in rural Central African Republic', in *Journal of Modern African Studies*, Vol. 35, No. 3, September 1997, pp. 441–442.

to feed themselves.<sup>49</sup> But the response to the massive measles epidemic affecting Maniema and South Kivu (in the DRC) in 2010–2011, delayed by health authorities because of their perceptions that related incentives were bypassing them in favour of more responsive NGOs, is revealing of the true motivations of such bodies.<sup>50</sup>

## Implications for health-care provision beyond the reach of the state

Any state unable to affirm itself over the territory supposed to be governed by it is an unlikely service provider. External support on a grand scale, such as what was provided for a decade to the Afghan state, may fail to make the state legitimate in the eyes of its population, whatever social services are provided in its name. Rather than waiting for state-provided health care, the disillusioned inhabitants of such countries have opted for alternative services, mostly privately supplied: privatisation is more visible where the state is crippled, but its reach in these disrupted environments is extensive. The expectation that a challenged state apparatus, even with generous international support, will be able to reverse such privatisation is unrealistic, and more pragmatic accommodations need to be made until sufficient governance capacity can be established.

These conclusions, then, are largely directed towards the international development community, and focus on those health service areas beyond the current reach of the state. They do not preclude state-building as a necessary component of development assistance, but they recognise that in chronically disrupted environments, complementary activities that build on the available local resources will be necessary in the medium- to long-term interim. Turbulent health-care arenas need to be managed with the long term in view. The rise of non-government and informal providers in these compromised environments exposes the limitations of an exclusive focus on public provision, and on the state capacity needed to materialise it.

Afghanistan has decided to add a ninth 'Millennium Development Goal' to the existing eight: that peace is a prerequisite for development.<sup>51</sup> But peace cannot be attained by administrative fiat or diplomatic gestures. Functioning states are needed to negotiate peace within their borders and ensure it takes root. Otherwise, low-intensity governance of the sort adopted in northern Somalia may represent the most viable trade-off. Accepting a minimalist role for the recovering state, negotiated with and accepted by non-state actors, may be a precondition for the slow regeneration of health-care provision. The perspectives needed for that development are system-wide, initiated in anticipation of those changes, and

49 J. Von Schreeb and M. Michael, above note 32.

50 Maurizio Murru and Enrico Pavignani, *Democratic Republic of Congo: The Chronically-Ill Heart of Africa*, University of Queensland, Brisbane, 2011, p. 37. See also Australian Centre for International and Tropical Health, *Health Services in Severely Disrupted Environments*, available at: [www.sph.uq.edu.au/acith](http://www.sph.uq.edu.au/acith) (last visited 23 August 2012).

51 Peter S. Hill, Farooq Mansoor and Fernanda Claudio, 'Conflict in least developed countries: challenging the MDGs', in *Bulletin of the World Health Organization*, Vol. 88, No. 8, August 2010, p. 562.

committed to the long term, and recognise all potential contributors to health in what are often complex and chaotic environments.

The implications of this research are far-reaching, if taken fully on board by development actors and donors. The research calls for changes in the framing of analysis of these contexts; an acknowledgement that the state is only one of many actors in health; a recognition that current time-frames, and the current expectations that shape them, are unrealistic; and a preparedness to rethink development engagement in ways that will allow effective harnessing of the diverse actors that currently provide services.

To reach beyond the reductionist official portraits of these complex, adaptive, and diverse health-care arenas will necessarily require new and substantially different analytical approaches. Aid portfolios need to be restructured to reflect the trans-border flows that are characteristic of many crisis complexes. Development actors need to take regional perspectives: with porous borders, and mobile ethnic groupings straddling post-colonial borders, the nation may no longer be the appropriate unit of analysis and planning. Only by shifting focus from territories and recognised boundaries to populations, both settled or on the move, can the constantly neglected trans-border constituent of health-care provision be adequately captured by the analysis. At the country level, to interpret current ongoing health scenarios and to anticipate future developments, adequate attention must be paid to the broader social and political environment. Conventional evaluation tools, particularly those that have been structured to examine specific sub-sectors such as disease control, are prone to miss, hide, or deform most of the key characteristics of these distressed contexts. The uncritical acceptance of government accounts of services in these disrupted environments provides a distorted understanding of the realities involved: those areas where the state still manages to influence events need to be mapped carefully, distinguishing them from areas beyond the state's reach.

For donors, this will require a reorientation in terms of both processes and partners. These informal health-care providers, who frequently account for the bulk of the market, will need to be brought into centre stage, in the analysis as well as in the policy discussion. An understanding of their activities and business models,<sup>52</sup> and of the intersections that they share with formal structures, is crucial to any health strategy. Collaboration with non-state, mostly informal actors implies difficult trade-offs, with huge implications for programming and accounting procedures. Introducing positive incentives in a pluralistic, largely informalised health-care arena, where actors play multiple, fluid roles, poses distinctive difficulties that are often not recognised. Recent assessments of performance-based financing in the DRC confirm this point.<sup>53</sup> Well-meant interventions may have

52 Gerald Bloom, Hilary Standing, Henry Lucas, Abbas Bhuiya, Oladimeji Oladepo, and David H. Peters, 'Making health markets work better for poor people: the case of informal providers', in *Health Policy and Planning*, February 2011, pp. 45–52.

53 Sarah Fox, Sophie Witter, Emily Wylde, Eric Mafuta, and Tomas Lievens, 'Paying health workers for performance in a fragmented, fragile state: reflections from Katanga Province, Democratic Republic of Congo', in *Health Policy and Planning*, 2013, pp. 1–10 (e-pub ahead of print; doi:10.1093/heapol/czs138).

unexpected harmful effects, or may generate the desired effects alongside heavy drawbacks. Appropriate financing instruments that take informal funding into account and enable informal health-care providers to be financed will need to be developed, and options can only be explored at the local level. With long-standing disruption, these spontaneous, adaptive but often stable local health systems, financed by a mix of private out-of-pocket expenditure and external support (comprising remittances and official and unofficial aid), are unlikely to transition readily into imposed top-down blueprints for services, but will have to be strengthened by adapted interventions, responding to local contexts and complementing and reorienting health services currently delivered on the ground.

New, agile funding mechanisms will be needed to support such an open exploratory approach, with some flexibility built into formal controls over operations. The detailed programming and reporting frameworks, such as logical framework analysis,<sup>54</sup> which have constrained the vigilant management opportunism that can take advantage of these fluid and unpredictable environments need to be revisited iteratively, responding to the observations of field implementers rather than distant desk personnel. Donor funding decisions should be based on mid- and long-term results, assessed by well-designed, realistic evaluations, rather than on programmatic adherence to structured projects that are likely to become obsolete long before they expire.

In light of the deep disarray that has persisted over decades in conflict-affected areas, the present distorted health systems environment should be accepted as enduring. The high degree of informalisation presented by these health-care arenas is not amenable to quick correction, even should the violence subside. Instead of planning for an elusive recovery, interventions should be designed to take root and thrive within the existing constraints and exploit the opportunities offered by the absent or impotent state. External actors need to ensure long-term commitments, designing coherent, uninterrupted interventions: any exit strategy in the short term will effectively abandon distressed populations to their fate. An instructive example of this is MSF, a high-profile humanitarian agency recognised for its short-term, resource-intensive programming but currently establishing a long-term comprehensive health-care programme in the CAR, responding to the need to rethink intervention modalities in circumstances with no immediate end in sight.<sup>55</sup>

In dealing with health services beyond the reach of the state, the international community has to accept its expanded responsibility: support for the development of state functions will need to continue, but in these environments, governance will need to be sought through both local and international partnerships. In the absence of functioning state governance for health, this comes to encompass policy-making as well as health-care provision. In many distressed

54 Logical framework analysis is a methodology for structuring the main elements in a project, facilitating its monitoring and evaluation. For more information, see, for example, *Logical Framework Approach: Handbook for Objectives-Oriented Planning*, Norad, 1999.

55 MSF, *Central African Republic: A State of Silent Crisis*, Amsterdam, 2011, pp. 13–15, available at: [www.msf.org.au/static/central-african-republic/a-state-of-silent-crisis.html](http://www.msf.org.au/static/central-african-republic/a-state-of-silent-crisis.html) (last visited 1 February 2013).

contexts, such as in Afghanistan, donor agencies are already dominating the health policy discussion without being willing to overtly acknowledge their dominance. In other situations, such as in Haiti, external assistance shapes the health field without encouraging a productive policy process in which facts on the ground precede intentions. Accepting their expanded role, and taking full responsibility for their failures, implies a thorough redesign of the way donor agencies intervene in under-governed environments. In the international development community's relationship with the state, a more honest dialogue will be necessary: political conditionality that links the funding of health service delivery to political milestones does little to persuade political actors,<sup>56</sup> and it certainly undermines health service delivery. Health-care provision should be supported because of its intrinsic merits, rather than as a constituent of ambitious state-building projects with shaky foundations and uncertain outcomes.<sup>57</sup>

56 Paul Collier, *The Bottom Billion: Why the Poorest Countries are Failing and What can Be Done about It*, Oxford University Press, Oxford, 2011, pp. 109–111.

57 Stuart Gordon, 'Health, conflict, stability and statebuilding: a house built on sand?', in *Journal of Intervention and Statebuilding*, Vol. 7, No. 1, 2013, pp. 29–44.

# The role of health-related data in promoting the security of health care in armed conflict and other emergencies

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## **Abstract**

*Health-related data provide the basis of policy in many domains. By using a methodology specifically designed to gather data about any form of violence and its impact, violence affecting health-care personnel, health-care facilities, and the wounded and sick in these facilities can be quantified on an objective basis. The impact of this form of violence and its accompanying insecurity goes beyond those directly affected to the many who are ultimately denied health care. Reliable data about both the violence affecting health-care personnel and facilities and the 'knock-on' effects of this violence on the health of many others have a critical role to play in influencing the policies of all stakeholders, including governments, in favour of greater security of effective and impartial health care in armed conflict and other emergencies. The International Committee of the Red Cross has undertaken a study*

\* This article was written in a personal capacity and does not necessarily reflect the views of the ICRC.

*that attempts to understand on a global basis the nature and impact of the many different kinds of violence affecting health care.*

**Keywords:** health-care data, Health Care in Danger, violence against health care, denial of access to health care, Sixteen-Country Study, insecurity of health care.



Whatever the circumstances, there are two absolute preconditions for delivering health care to sick or wounded people. The first is the availability of infrastructure and materials; the second is the ethical application by the health-care worker of professional knowledge and expertise within a relationship of trust with the person or persons concerned. Recognising these preconditions facilitates understanding of how health care is vulnerable in armed conflicts and other emergencies because a variety of constraints may result in one or both of these preconditions being unmet. Among the important constraints are lack of access for the wounded and sick to health-care facilities, inadequate or destroyed buildings, lack of materials or suitably qualified people, and the stretching of existing capacity beyond its limits. However, the one overriding constraint that can weigh heavily on both preconditions is lack of security.<sup>1</sup>

Armed conflicts or other emergencies involving widespread violence can disrupt health care in a variety of ways: fighting prevents personnel from reaching their place of work; health-care facilities and vehicles are inadvertently damaged; soldiers or police forcibly enter health facilities looking for enemies or ‘criminals’; and gaining control of a hospital is sometimes an objective for fighters. In the most serious cases, health-care facilities are directly targeted, the wounded and sick are attacked, and personnel are threatened, kidnapped, injured, or killed. In many parts of the world, thousands of wounded and sick people do not get the health care to which they have a right because of the many and varied forms of insecurity that affect health-care facilities or personnel. It is remarkable that these issues have only recently been recognised within the academic medical literature.<sup>2</sup>

The International Committee of the Red Cross (ICRC) has referred to the many forms of insecurity of health care as constituting one of the most serious and widespread humanitarian issues today.<sup>3</sup> However complex the interface of security, insecurity, health, and health care may be, it is clear that security of health-care personnel and facilities is a prerequisite for the delivery of health care; at the

1 Robin Coupland, ‘Security, insecurity and health’, in *Bulletin of the World Health Organization*, Vol. 85, No. 3, March 2007, pp. 181–183.

2 Leonard Rubenstein and Melanie D. Bittle, ‘Responsibility for protection of medical workers and facilities in armed conflict’, in *The Lancet*, Vol. 375, 2010, pp. 329–340. See also ICRC, ‘Health Care in Danger: first steps at London Symposium’, 25 April 2012, available at: [www.icrc.org/eng/resources/documents/feature/2012/health-care-in-danger-feature-2012-04-25.htm](http://www.icrc.org/eng/resources/documents/feature/2012/health-care-in-danger-feature-2012-04-25.htm). All internet references were last accessed in February 2013.

3 ICRC, *Health Care in Danger: Making the Case*, ICRC, Geneva, August 2011, available at: [www.icrc.org/eng/resources/documents/publication/p4072.htm](http://www.icrc.org/eng/resources/documents/publication/p4072.htm).



same time, lack of the prerequisite security is the most difficult constraint on health care to address.

There is yet another consideration. Armed conflicts and other emergencies involving widespread violence generate immediate and additional health-care requirements for wounded and sick people that exceed peacetime needs.<sup>4</sup> Hospitals can fill rapidly with the wounded, whether military or civilian. These additional health-care requirements arise at precisely the time when the accompanying insecurity makes it most difficult to address them.

Health-related data drive policy in many domains such as food hygiene, accident prevention, and ensuring environments free from pollution. This paper argues that health-related data can likewise play a critical role in improving the security of effective and impartial health care in armed conflicts and other emergencies. There are four central tenets to this argument. First, violent incidents and insecurity in armed conflicts and other emergencies can, because of their impact on people's lives and well-being, be viewed ultimately as health issues; it follows that these phenomena can be researched using an appropriate public health methodology.<sup>5</sup> Second, there are potentially ample data available in the form of reports of acts of violence affecting health care for such a methodology to be useful. The definition of violence adopted by the World Health Organisation (WHO) is key in this regard as it includes both threats and violent acts that results in deprivation.<sup>6</sup> Third, the data – both available and potential – pertain to two populations: on the one hand, those suffering the insecurity directly – that is, the wounded and sick and the health-care personnel who are subject to violence or threats of violence; and on the other, the hundreds of thousands, if not millions of people who are denied health care as a result of such violence and insecurity. Fourth, presentation of reliable health-related data in appropriate fora are essential for creating a burden of responsibility on the people who are in a position to assure the security of health care, in particular governments, their military bodies, and international organisations.

A further consideration is that health-care personnel may, through their normal clinical responsibilities, find themselves in possession of data about the nature and extent of violence in a given context, including violence perpetrated against other health-care personnel, health-care facilities, or the wounded and sick in those facilities. The process of collecting, analysing, and reporting such data is not without risk, especially if the data pertain to documentation of possible violations of international humanitarian law or human rights law. This can present health-care professionals with acute and unexpected dilemmas.

4 Pierre Perrin, *War and Public Health*, ICRC, Geneva, 1996, pp. 6–8.

5 See Insecurity Insight's description of the 'Taback-Coupland model', available at: [www.insecurityinsight.org/practice.html](http://www.insecurityinsight.org/practice.html).

6 The definition of violence adopted by the WHO is 'the intentional use of physical force or power – threatened or actual – against oneself, another person, or against a group or community that results in or has the likelihood to result in injury or death, psychological harm, maldevelopment or deprivation'. See Violence Prevention Alliance, 'Definition and typology of violence', available at: [www.who.int/violenceprevention/approach/definition/en/index.html](http://www.who.int/violenceprevention/approach/definition/en/index.html).

## Where are the primary data and what form do they take?

The ICRC's Sixteen-Country Study<sup>7</sup> was the first study dedicated to comprehending the nature of violence affecting health care on a global basis.<sup>8</sup> The study relied on a methodology that converts reports of individual incidents of violence (qualitative data) into quantitative data.<sup>9</sup> The sources of the 655 reports analysed in the study included media reports, the websites of, for example, the WHO and health-orientated non-governmental organisations (NGOs), and both public and confidential reports of humanitarian agencies and other health-care providers, including the ICRC. The ICRC field offices in the sixteen countries concerned were asked to forward any pertinent reports to the study team in Geneva (in keeping with the ICRC's confidential approach and for operational – including security – considerations, the sixteen countries were not identified in the study). Principal among the limitations recognised by the authors of the study was that the varied sources were likely to provide an incomplete dataset potentially containing some inaccuracies. Nevertheless, important conclusions could be drawn about the nature of the violence affecting health care. Importantly, it was *not* possible to comment on the extent of this violence; the 655 incidents captured by the methodology over a thirty-two-month period were certainly only a fraction of the real number of incidents. Furthermore, there would have been a bias towards the more serious incidents because they are more likely to be reported.

However, the real importance of the ICRC publishing this study is that it poses a question that has not been addressed elsewhere: how many people, communities, or even nations are denied health care as a result of violence directed at or obstructing health-care personnel or facilities, and what is the impact of this denial on their health? The 'knock-on' effects of such violence can only be massive. Their magnitude was demonstrated by the prediction that violence and insecurity due to conflict will be the main reasons for failure to achieve certain Millennium Development Goals, including the health-related ones.<sup>10</sup>

7 ICRC, *Health Care in Danger: A Sixteen-Country Study*, ICRC, Geneva, August 2011, available at: [www.icrc.org/eng/resources/documents/report/hcid-report-2011-08-10.htm](http://www.icrc.org/eng/resources/documents/report/hcid-report-2011-08-10.htm).

8 Editor's note: this article mainly focuses on the methodology used during the Sixteen-Country Study. Since then, the methodology has evolved and the ICRC, in the context of its monitoring activities, continues to collect data on incidents affecting the delivery of health care, through various sources of information.

9 See Taback-Coupland model, above note 5.

10 See 'Keeping the promise: a forward-looking review to promote an agreed action agenda to achieve the Millennium Development Goals by 2015', Report of the Secretary-General to the United Nations General Assembly, UN Doc. A/64/665, 12 February 2010, pp. 3 and 11. See also 'What will it take to achieve the Millennium Development Goals? An international assessment', United Nations Development Programme, June 2010, pp. 19–20, available at: [http://content.undp.org/go/cms-service/stream/asset/?jsessionid=aMgXw9lbMbH4?asset\\_id=2620072](http://content.undp.org/go/cms-service/stream/asset/?jsessionid=aMgXw9lbMbH4?asset_id=2620072); 'Beyond the midpoint: achieving the Millennium Development Goals', United Nations Development Programme, January 2010, pp. 60–75, available at: [http://content.undp.org/go/cms-service/stream/asset/?asset\\_id=2223855](http://content.undp.org/go/cms-service/stream/asset/?asset_id=2223855); Chapter 5, 'Deadly connections: wartime violence and indirect deaths', and Chapter 7, 'The death toll in the Democratic Republic of Congo', in *Human Security Report 2009–2010 – The Causes of Peace and the Shrinking Costs of War*, Human Security Report Project, Simon Fraser University – Canada, Oxford University Press, New York, Oxford, 2011.

Potentially available data pertain to two domains: first, the direct impact of violence on the wounded and sick, health-care personnel, and health-care facilities, and second, those suffering the knock-on effects (those denied health care as a result of the violence.) The authors of the ICRC study also emphasised how little data at present can be brought to bear on the full extent of the knock-on effects. Whilst both domains can be studied using public health methodologies, the sources of the data, and therefore the data-gathering methodologies, differ. The first requires observation and recording of violent events; reports of these events are written and made available for reasons other than studying violence and threats of violence. For example, a reliable media report of an attack on a hospital is written for the purposes of telling the news. The journalist – the ‘primary observer’ – is not knowingly writing his or her report as a contribution to a study using a public health methodology. This explains the pertinence of the methodology used in the ICRC’s study and goes some way to explaining how, inevitably, the data captured by the methodology are likely to be incomplete and, to a degree, inaccurate. However, as shown by the study, the value of collecting and analysing all available data should outweigh concerns about these limitations. Importantly, the paucity of data relating to violence affecting health care has only recently made its way onto the global health agenda at the World Health Assembly, which has given a mandate to the WHO ‘to provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies’.<sup>11</sup> Nevertheless, the WHO will have to identify and validate appropriate sources of information about violence affecting health care.

To begin to even understand the magnitude of the knock-on effects of violence affecting health care, the second domain of data can and must be generated by the full spectrum of public health methodologies. For example, demonstrating the knock-on effect of attacks on health-care workers attempting to bring health care to a population forcibly displaced over a border could involve recording increased mortality rates from infectious diseases within that population. One of the few contexts studied to measure the impact of violence and insecurity due to conflict on the health of a whole nation was the Democratic Republic of the Congo.<sup>12</sup>

The distinction between the two potential domains of data is important when considering a future research agenda, as discussed below.

New technologies bring new possibilities. Social media websites such as Twitter and Facebook allow real-time ‘citizen journalist’ reporting. Openly accessible web-based mapping technologies such as Open Street Map<sup>13</sup> permit anyone to contribute to, for example, mapping the location and even capacities of hospitals in a crisis. The generation and use of such ‘volunteer-generated information’ has

11 WHO, ‘WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies’, 65th World Health Assembly, 21 January 2012, Doc. EB130/SR/12, para. 2(8), available at: [http://apps.who.int/gb/ebwha/pdf\\_files/EB130/B130\\_R14-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_R14-en.pdf).

12 Benjamin Coghlan *et al.*, ‘Mortality in the Democratic Republic of Congo: a nationwide survey’, in *The Lancet*, Vol. 367, 2006, pp. 44–51.

13 See Open Street Map website, available at: [www.openstreetmap.org](http://www.openstreetmap.org).

been pioneered largely by Ushahidi<sup>14</sup> and the Crisis Mappers network.<sup>15</sup> These web-based organisations permit huge numbers of people, including people directly implicated in the context in question, to contribute to crisis-specific, immediate data-gathering exercises. The full potential of such technologies to contribute to the security of health care has yet to be realised. However, as with more conventional data gathering, there are complex political and security issues to be taken into account. Some countries may view a mapping exercise as impinging on their sovereignty or even their national security. Furthermore, it may not be possible to hide the identity of those mentioned in a report (that is, the victims) or those sending a report.

### How do the primary data impact on security of health care?

The means to address the many and varied forms of insecurity of health care do not lie within the health community; they lie first and foremost in the domain of law and politics, in humanitarian dialogue, and in the adoption of appropriate procedures by state armed forces, law enforcement officials, and other weapon-bearers. Guidelines to help health-care professionals to work effectively and impartially in insecure environments may help those professionals and the people being cared for but do not directly address the security issues.<sup>16</sup>

Whatever data are gathered about insecurity of health care, they have to be analysed and presented in a compelling manner. It is often said that, 'What gets counted gets done!' This fits with the belief of this author that reaching the people who can make a difference to any security issue involves four elements: being credible, making use of telling images (usually photographs), making the issue a public concern, and of course, having data that cannot reasonably be questioned. The publication of the ICRC's Sixteen-Country Study was the centrepiece of the launch of the public advocacy component of the ICRC's Health Care in Danger project in August 2011.<sup>17</sup> The coverage of the launch by the BBC stated in its opening paragraph: 'The ICRC report, Health Care in Danger, lists 600 attacks worldwide on doctors, nurses, ambulances and hospitals from mid-2008 to the end of 2010.'<sup>18</sup> This sentence, stated as headline news by a major global news organisation, represents the coming together of these four elements and, one hopes, generates both concern and an imperative to read further. The significance of the study was also not missed by mainstream medical media.<sup>19</sup> In other words, whilst

14 See Ushahidi website, available at: [www.ushahidi.com](http://www.ushahidi.com).

15 See Crisis Mappers – The Humanitarian Technology Network website, available at: <http://crisismappers.net/>.

16 ICRC, *Health Care in Danger: The Responsibilities of Health Care Personnel Working in Armed Conflict or Other Emergencies*, ICRC, Geneva, September 2012, Chapter 11, available at: [www.icrc.org/eng/resources/documents/publication/p4104.htm](http://www.icrc.org/eng/resources/documents/publication/p4104.htm).

17 See ICRC, above note 3.

18 Imogen Foulkes, 'Red Cross: rise in violence against medics in war zones', in *BBC News*, 10 August 2011, available at: [www.bbc.co.uk/news/world-europe-14464405](http://www.bbc.co.uk/news/world-europe-14464405).

19 Vivienne Nathanson, 'Delivering healthcare in situations of conflict or violence', in *British Medical Journal*, Vol. 343, d4671, 10 August 2011, available at: <http://dx.doi.org/10.1136/bmj.d4671>.

the data are important, the manner of their publication is equally important if one wishes to reach stakeholders outside the health community. Journalists and policymakers are well aware of the power of such data if it is credible and well presented. The primary objective of the data-gathering exercise was to generate greater awareness of the issue.

The author of this paper was a co-author of the Sixteen-Country Study; it is worth reporting some observations of how the study drove the ‘data-to-policy process’ in relation to security of health care. Importantly, the study had an impact *before* the data were collected. As part of ongoing discussions about how the ICRC’s health-related activities might be improved upon or expanded in many of the world’s trouble spots, it was remarked that whatever activities might be desired, the ultimate determinant of whether those activities happen is the security environment. The Sixteen-Country Study was commissioned to gain a better understanding of this environment. The scope of the study was expanded to include violence affecting the health activities not only of the ICRC and other components of the International Red Cross and Red Crescent Movement, but also of all health-care providers in armed conflicts or other emergencies. The field offices of the sixteen countries were requested to send any reports of incidents of violence affecting health care. These were combined with – and sometimes duplicated by – publicly available reports in the general media. However, policy began to change at a field level before the data gathering was complete *as a result of the request to assist in the data-gathering exercise*. In other words, being asked to collect reports of incidents of violence affecting health care changed the view of the personnel in ICRC field offices of both the issue and what could be done about it.

Externally, the ICRC has used the study to raise awareness of the issue and to indicate preventive measures. The study represented the *raison d’être* of the London symposium on ‘Health Care in Danger’ in April 2012. This was the event at which the ICRC, in close collaboration with the British Red Cross Society, the British Medical Association, and the World Medical Association, presented the issue formally to the health community and other important stakeholders, assuming, correctly, that this audience would not only be concerned but would also come up with pertinent recommendations to ameliorate the situation.<sup>20</sup> In a similar vein, a summary of the study was presented by the ICRC to the UN Security Council on 25 June 2012.<sup>21</sup>

Data about violence and its impact such as those presented in the Sixteen-Country Study can be used to do much more than raise awareness of the issues involved. Whilst the study does not show the extent of violence affecting health care, it goes some way to revealing the nature of that violence. This is an important distinction. Discussing the extent of a problem related to any form of violence may provide reasons for looking for preventive measures; establishing the nature of

20 See ICRC, above note 2.

21 United Nations Security Council, Department of Public Information, ‘Secretary-General describes appalling catalogue of violence inflicted on civilians in conflict, says “we must do more to save innocent lives” in Security Council’, Security Council Press Release No. SC/10683, 25 June 2012, available at: [www.un.org/News/Press/docs/2012/sc10683.doc.htm](http://www.un.org/News/Press/docs/2012/sc10683.doc.htm).

violence indicates the threats to and vulnerabilities of the victims, and it is only by understanding these threats and vulnerabilities that appropriate preventive policies can be generated. Any and all preventive policies relate in some way to these threats and vulnerabilities. With respect to the study in question, it showed an unexpected array of issues, dominant among which was the distinction between the nature of violence affecting health care perpetrated by non-state armed actors and that perpetrated by state actors. The results generated a search for appropriate preventive strategies that the ICRC can in the future present to all relevant stakeholders, whether non-state armed groups or governments. Examples of such preventive strategies include: taking all means to ensure the physical security of health facilities and protecting them against explosive force and armed entry; a framework for military forces to help them elaborate standard procedures with respect to organising fast transit of ambulances at checkpoints and search operations in health facilities; and elaborating recommendations for the better application of pertinent international law and development of appropriate domestic law. Such matters are the subject of the ICRC's current process of consultation mandated by the 31st International Conference of the Red Cross and Red Crescent.<sup>22</sup>

Lastly, such data may provide the means to report objectively and consistently on serious attacks on health care that might constitute violations of international humanitarian law or international human rights law. Such data could even constitute evidence in holding accountable those individuals responsible for such violations. There are obviously very serious political and security issues linked to the gathering and making available of such data, and this was not the purpose of the Sixteen-Country Study. This is the reason why the sixteen countries were not named and remain confidential.

## Parallel developments

Whilst the publication of the Sixteen-Country Study was the prime mover of the ICRC's Health Care in Danger project, other important initiatives have been running in parallel and mutually reinforce that project. Diplomatic moves that have at their origin a 2010 article in the *Lancet* (which pointed out the paucity of data on this issue)<sup>23</sup> eventually brought about the World Health Assembly resolution of May 2012 mentioned above.<sup>24</sup> Largely influenced by this paucity of data, a coalition of NGOs called Safeguarding Health Care in Conflict arose in 2012. This welcome initiative adds fuel to advocacy efforts and the search for practical solutions.<sup>25</sup> The most prominent medical NGO, *Médecins sans Frontières* (Doctors without Borders,

22 ICRC, *Healthcare in Danger: Respecting and Protecting Healthcare in Armed Conflict and Other Situations of Violence*, Resolution adopted at the 31st International Conference of the Red Cross and Red Crescent, Geneva, 28 November–1 December 2011, available at: [www.rccconference.org/docs\\_upl/en/R5\\_HCID\\_EN.pdf](http://www.rccconference.org/docs_upl/en/R5_HCID_EN.pdf).

23 See L. Rubenstein and M. Bittle, above note 2.

24 See above note 11.

25 See the Safeguarding Health in Conflict Coalition website, available at: [www.safeguardinghealth.org](http://www.safeguardinghealth.org).

MSF), took note of the ICRC's study and at the London Symposium voiced its determination to work on promoting security of health care.<sup>26</sup> The organisation has launched its own campaign to promote security of health care.<sup>27</sup>

An important development in terms of understanding the real issues relating to insecurity of health care has emerged. As a result of being requested to gather reports of incidents of violence affecting health care for the Sixteen-Country Study, ICRC staff in those countries began to ask local health-care providers what their most pressing security concerns were. In some contexts, the response made no mention of explosions, attacks by 'insurgents', or harassment by security forces; the main concern was violence and threats of violence from relatives or patients themselves who insist on faster, cheaper, or better treatment. This phenomenon was barely picked up in the Sixteen-Country Study, probably because it is grossly underreported, but reports are now emerging indicating the magnitude and urgency of the problem.<sup>28</sup>

## A research agenda?

This article represents a plea for more and better data gathering about violence affecting health care; such data should ultimately result in policies that assure the security and delivery of effective and impartial health care in armed conflicts and other emergencies. This of course begs the question: what sort of data will be most helpful in achieving this objective? In other words, what is the research agenda?

With respect to data pertaining to attacks on and obstruction of health care, there are promising developments, especially in relation to the World Health Assembly resolution of May 2012.<sup>29</sup> There is still no formal mechanism proposed that will collect, analyse, and report such data on a global basis, but this should not stop other organisations or independent researchers taking up this issue. One such initiative is the Security in Numbers Database run by Insecurity Insight.<sup>30</sup> The focus of this exercise is to build an accessible database of violent incidents affecting humanitarian aid workers, but the scope of the project includes violent incidents affecting health-care personnel and facilities.

More work needs to be done, and urgently, to gain insights into the violence perpetrated against health-care staff by patients or their relatives. As indicated above, the great challenge will be to gain an accurate picture of the nature and extent of the knock-on effects. A global picture is far from completion. In the

26 Talk by Dr. Unni Karunakara, President of MSF International, at the London Symposium, 23 April 2012, available at: [www.youtube.com/watch?v=hBeOgAdxXs0](http://www.youtube.com/watch?v=hBeOgAdxXs0).

27 See MSF, 'Medical care under fire', available at: [www.msf.org/topics/medical-care-under-fire](http://www.msf.org/topics/medical-care-under-fire).

28 Cam McGrath, 'Egyptian hospitals under attack as patients lose patience', in *Relief Web*, 4 September 2012, available at: <http://reliefweb.int/report/egypt/egyptian-hospitals-under-attack-patients-lose-patience>. See also Therese Hesketh *et al.*, 'Violence against doctors in China', in *British Medical Journal*, Vol. 345, e5730, 2012, available at: [www.bmj.com/content/345/bmj.e5730](http://www.bmj.com/content/345/bmj.e5730).

29 See above note 11.

30 See Insecurity Insight, 'Aid work in danger – security in numbers', available at: [www.insecurityinsight.org/projectshumanitarian.html](http://www.insecurityinsight.org/projectshumanitarian.html).



opinion of this author, researchers should, in the near term, resist the temptation to obtain a global picture of the total impact of insecurity of health care on people's health, even though this impact is clearly massive. The role of researchers working or intending to work in this domain should be to use established public health methodologies to create 'snapshots' that demonstrate the problem in a particular region or health-care facility, or with respect to a particular group of affected people. These snapshots could paint accurate local pictures that when pulled together into a more comprehensive picture could be very effective in bringing about policy changes at a global level.

Apart from public health studies, there is a role for the social sciences and security studies. For example, it would be important to find reliable proxy indicators of insecurity of health care. These might include factors such as the total number of violent incidents (of whatever outcome) in a given area, governance, development indices, a nation's military expenditure in relation to spending on health, and ethnic divides among a given population. In addition, what needs to be established in many parts of the world is whether health-care personnel leave or refuse to work in an insecure region because of insecurity, lack of financial opportunity, or both.<sup>31</sup>

In-country studies need to be done to show what measures are currently taken by and what measures are feasible for hospitals near conflict zones to improve the physical security of the wounded and sick, health-care personnel, and health-care facilities such as buildings and vehicles.

Other questions indicate useful avenues for this kind of research. How widespread, if at all, is the notion that health care is neutral and should be respected? Where does this notion come from? In demonstrations and uprisings, how important is the understanding of crowd behaviour when it comes to ensuring the security of, for example, ambulance staff?

## **The security implications of gathering health-related data from contexts of armed conflict and other emergencies**

Health-care providers can, simply because they are carrying out their duties in a particular context, become witness to the impact on people of violations of international humanitarian law or human rights law. Being witness to people's wounds and being in possession of routine hospital documentation or data gathered specifically about these wounded people, including how they sustained their wounds, can present health-care staff with an acute dilemma. Do they use this powerful, data-oriented testimony to reveal the nature and extent of violent events, and so possibly risk their security or that of their colleagues or the people they are trying to help? Or do they stay quiet, minimising the risk to themselves and others whilst at the same time being able to continue to treat people? The dilemma, as

31 John Zaracostas, 'Exodus of medical staff strains Iraq's health facilities', in *British Medical Journal*, Vol. 334, 28 April 2007, p. 865. See also Oxfam International, 'Rising to the humanitarian challenge in Iraq', briefing paper, July 2007, p. 11.



formulated here, does not represent a hypothetical situation; it is a day-to-day reality for many health-care professionals all over the world. The ICRC has recently published guidance on how this dilemma might be addressed.<sup>32</sup>

The ‘citizen journalist’ reporting on an attack involving health-care personnel or facilities together with those involved in capturing such information must be aware of the many potentially serious security issues. A message sent via Twitter, a post on Facebook, or a collation of ‘volunteer-generated information’ into, for example, real-time crisis maps can put in danger the victims, the person communicating, and their families and colleagues.<sup>33</sup> Furthermore, creating a map of a country in crisis might be viewed by the authorities concerned as an issue of sovereignty. The reaction of hostile authorities can be rapid and severe.

## Conclusion

The exercise of gathering, analysing, and presenting health-related data is critical to assuring the security of effective and impartial health care in armed conflicts and other emergencies. The ICRC’s Health Care in Danger project shows how pertinent data drive the ‘data-to-policy process’ and are more likely to bring about policy changes when presented credibly, with strong images and with a view to generating public concern.

A research agenda for the future would include generating data in relation to the direct impact of violence affecting health care and the ultimate knock-on effects on people’s health of this violence. Given that the ICRC has labelled attacks on and obstruction of health care as one of the most serious and widespread humanitarian issues today, it could be argued that investment in such research is overdue and could result in policies that improve the health of millions. However, the difficulties of undertaking any data-gathering exercise in this domain must not be underestimated.

<sup>32</sup> See above note 16.

<sup>33</sup> See Patrick Meier, ‘New information technologies and their impact on the humanitarian sector’, in *International Review of the Red Cross*, Vol. 93, No. 884, 2011, pp. 1239–1263.



## In conversation with the members of the National Permanent Roundtable for the Respect of the Medical Mission in Colombia

*The Colombian National Permanent Roundtable for the Respect of the Medical Mission (hereinafter ‘the Roundtable’) is a platform launched in 2008 on the initiative of the Ministry of Health and Social Protection and the Emergency Control Centre of the Ministry of Health of Cundinamarca with the support of the International Committee of the Red Cross (ICRC) and the Colombian Red Cross. It provides a space for discussion on topics related to the protection and safeguarding of health services, in the context of the non-international armed conflict taking place in Colombia. The permanent members of the Roundtable include a representative of the Ministry of Health and Social Protection, a representative of the Presidential Programme for Human Rights and International Humanitarian Law, the Colombian Red Cross and the ICRC. In this interview, the members of the Roundtable give their perspectives on the motives that inspire its work and the main challenges that it faces for the protection of the medical mission in Colombia.<sup>1</sup>*

⋮⋮⋮⋮⋮⋮

***What were the motives that inspired the establishment of the Roundtable, their founders and the beginning of their work?***

*Dr Julio Castellanos, San Ignacio's Hospital, Bogotá*

In Colombia, the work on the medical mission started in 1998. The aim was to register the impact of the non-international armed conflict on health services and, in particular, the difficulties the medical staff was facing in fulfilling its commitment of assisting the wounded and sick, under the rules of international humanitarian law (IHL). Although at that time the ICRC in Colombia had launched a campaign seeking to promote respect for and protection of health facilities and health personnel in the country, Colombia did not have a domestic institutional structure responsible for ensuring the respect and protection of the medical mission, nor for disseminating international standards on that topic.

Given this scenario, the ICRC and the Colombian Red Cross began to organise a series of meetings to which they invited external entities such as the Ministry of Health and Social Protection and the Emergency Control Centre of the Ministry of Health of Cundinamarca. Later on, the Presidential Programme for Human Rights and International Humanitarian Law also joined in. As part of these meetings a process of reflection began, which can be summarised by the following questions: should the campaign be directed at merely disseminating IHL related to the protection of the medical mission in general? Or should this campaign ultimately aim at reducing the number of victims through the prevention of specific violations of the respect due to the medical mission by disseminating IHL in conflict-affected areas of Colombia?

Recognising that the state has the primary responsibility for guaranteeing compliance with international standards on the necessary respect for and protection of the medical mission, other entities such as the Prosecutor-General of the Nation, the Prosecutor's Delegate, the Attorney General's Office and academic circles were subsequently incorporated into this space, which is now called National Permanent Roundtable for the Respect of the Medical Mission.

Since its inception, the Roundtable has had several objectives. Among them is to create preventive mechanisms such as informing all concerned actors of what the protection of the medical mission involves, including, among other things, drawing attention to the victims of the Colombian non-international armed conflict. It is also intended to provide a space to elaborate standards and guidelines addressed to the personnel of the medical mission to orient its behaviour towards preventing situations of risk for themselves (being correctly identified with the emblem, following security standards, etc.), as well as to facilitate the provision of effective health care and assistance to the victims.

1 This interview was conducted by Marisela Silva Chau, coordinator of the Legal Department at the ICRC Delegation in Colombia, and Ekaterina Ortiz Linares, former legal adviser at the ICRC Delegation in Colombia and current ICRC field delegate.

*Dr Francisco Moreno, Colombian Red Cross*

The work of the Roundtable reacts to certain internal needs and realities that impose the necessity to strengthen the respect for, and protection of, the medical mission in the country. It also reflects the commitment of the Colombian state towards the 31<sup>st</sup> International Conference of the Red Cross,<sup>2</sup> the Colombian Red Cross, and the ICRC itself, with regard to sensitisation to the necessary respect, protection and access to health services of victims of the armed conflict. This commitment has been honoured through the concrete actions of the Roundtable.

***In the Colombian context, what factors or motives led to the realisation of the need to strengthen respect for and protection of the medical mission? Have these factors changed over time?***

*Dr Julio Castellanos*

Among the various manifestations of the armed conflict in Colombia, it is clear that there are direct and indirect effects on access to health care by individual victims and by entire communities, in terms both of frequency and of adequate quality to ensure appropriate medical attention. We have observed the occurrence of direct attacks against the different elements that make part of the medical mission, such as threats to the integrity of health personnel, attacks on their facilities and even threats against the medical actions necessary for the welfare of the population. We have also witnessed attacks against the lives and integrity of the sick and wounded that require immediate attention, and the conflict in general affects the access of civilians to the provision of health services.

This situation has motivated the Roundtable to take action over the years and has allowed us to bring about the building blocks for the construction of a public policy to address the issue. Likewise, it has directed the Roundtable's activities to emphasise the obligation to respect and protect the medical mission and to disseminate information related to the work of health personnel in Colombia as well as to promote their duties and rights amongst all of the actors concerned.

Initially we prioritised the work of the Roundtable at the national level, since several violations to the health services occurred transversely and in different forms throughout the entire country, as a result of the armed conflict. However, as time passed, we realised the need to have presence not only at the national level but also at the regional level, particularly in those departments where major attacks on the medical mission were identified.

According to the records we keep on situations of non-respect of the medical mission (retention of ambulances, requests to doctors for confidential

2 31<sup>st</sup> International Conference of the Red Cross and Red Crescent, November 2011, Geneva, Switzerland.

information on certain patients, etc.) in different – mainly rural – regions of the country, we have identified that, unfortunately, between 2011 and 2012, the aforementioned events have increased, affecting even more the victims' access to health services.

***Since the creation of the Roundtable, which have been its main activities directed towards strengthening respect for and protection of the medical personnel and objects, and concretely, the provision of health services for protected persons under IHL?***

*Dr Luis Fernando Correa, representative of the Ministry of Health and Social Protection*

The Roundtable has developed different activities throughout the country. Among these, it is relevant to emphasise not only workshops of dissemination but also the elaboration of regulations for the promotion of respect for the medical mission. An example of the latter is the current Colombian *Manual of the Medical Mission* – approved by Resolution 4481 of 28 December 2012 of the Ministry of Health and Social Protection – that provides guidelines for the protection of health personnel, their material and facilities.<sup>3</sup> It is noteworthy that this manual defines as ‘infractions’ to the medical mission any ‘conduct that by action or omission affects the components and activities of the Medical Mission or its direct beneficiaries (patients or communities) and that is related to situations of public order, in disregard of one or several duties and rights’ of the medical mission; and as ‘incidents’ affecting the medical mission ‘any action or omission, direct or indirect, which prevents, delays or limits access to its services and that is not considered a violation of IHL’.<sup>4</sup>

Furthermore, since 2009, the Roundtable has encouraged and developed activities such as national seminars on issues related to the respect for the medical mission. From these experiences, it was deemed necessary to replicate such activities at the local level. So, in 2011, the Roundtable organised regional roundtables in the departments of Antioquia, Arauca, Nariño, Cauca, Norte de Santander, Bolivar, Huila and Chocó.

The Roundtable has also been involved in the training of health personnel in the country, through an agreement signed with the Colombian Red Cross.

Finally, with the support of the ICRC, the Roundtable has worked on the question of the use of the medical mission's emblem in the country by the people and institutions that are part of it.

3 *Manual de Misión Médica*, Ministry of Health and Social Protection, Bogotá, February 2013, available (in Spanish) at: [www.minsalud.gov.co/Documentos%20y%20Publicaciones/Manual%20de%20Misi%C3%B3n%20M%C3%A9dica.pdf](http://www.minsalud.gov.co/Documentos%20y%20Publicaciones/Manual%20de%20Misi%C3%B3n%20M%C3%A9dica.pdf) (last visited January 2014).

4 *Ibid.*, pp. 13 and 18.

***In general, what are the main challenges faced by the protection of the medical mission in Colombia? What challenges has the Roundtable faced in the development of its mission?***

*Dr Jorge Cubides, advisor of the Presidential Programme for Human Rights and International Humanitarian Law*

The Roundtable has faced several challenges since it started its work. Firstly, the reality and dynamism of the armed conflict present particular difficulties due to the presence of different armed actors, each one with specific attitudes towards the activities of the medical mission in different parts of the country. In this sense, the Roundtable has always been conscious of the importance of raising awareness among these actors on the need to respect medical structures, personnel and health activities in general. In this respect, the protection work that the ICRC carries out, given its access to the parties to the conflict, is necessary and complementary to the work of the Roundtable. In general, the Roundtable's activities seek to guarantee the civilian population's access to health services.

Secondly, the vulnerability of health personnel in remote and isolated areas of the country and the difficulty for the population to have access to them also represent challenges in terms of guaranteeing the protection of the medical mission. For this reason, the Roundtable has facilitated activities to engage state authorities in charge of promoting the protection of health-care personnel, in order to clarify the framework of responsibilities in case any dangerous situation occurs or violations are perpetrated against the components of the medical mission. The Roundtable has also promoted self-protection mechanisms for health personnel, whose only and exclusive mission is to provide quality medical services to the population.

Thirdly, the involvement of state agencies related to the protection of the medical mission (such as the police, the army, mayors, governors and health personnel), and, of course, of non-state armed actors, has always been (and remains) a challenge for the Roundtable. However, despite the change of political administration every four years, to date the Roundtable has received continuous support from the institutional authorities.

Fourthly, the Roundtable has had an additional challenge, which is to prevent and punish the misuse of the emblem by unauthorised personnel.

***What was the concrete added value of the Roundtable regarding the protection of the medical mission in Colombia?***

*Dr Tatiana Flórez, ICRC*

One of the most significant contributions of the Roundtable has been to achieve a generalised understanding and acceptance of the fact that the protection of the medical mission goes beyond the context of health services and personnel, and does

not only involve the authorities strictly related to this field. Today, it is understood that its protection involves political authorities like the government, the ombudsman and the Attorney General's Office, among other state entities.

Another important contribution of the Roundtable has been its replication at the regional level. Indeed, it has been shown that the work that it performs at the regional level allows the local authorities to feel supported by the central state institutions, which in turn have the support of the Colombian Red Cross and the ICRC. This has led to the empowerment of local authorities and, especially, the possibility of coordinating their responses in relation to events that affect the medical mission's activities.

***Given that the Colombian legislation incorporates the regulation of the use and protection of the emblem of the Red Cross, which serves the purpose of identifying the medical mission (both military and civilian), why did national authorities decide to create, in 2002, a different emblem for exclusive use of civilian medical personnel?***

*Dr Julio Castellanos*

This is a fundamental question. There were several reasons for creating the emblem of the medical mission for the exclusive use of civilian health personnel in Colombia. One should clarify that the decision to do this relied mostly on a rational and practical analysis, rather than a legal analysis, of the dynamics of the armed conflict in Colombia during 2000 and 2002.

The first reason relates to the issue of 'identity'. In the context of the Colombian armed conflict, the use of the red cross on a white background is allowed for both civilian and military health personnel. However, in view of the high vulnerability of military personnel (including their health-care workers) at that time – considering possible attacks against them by non-state armed groups – it was deemed necessary to provide civilian medical personnel with their own emblem for their exclusive use during the deployment of their activities within the context of armed conflicts, natural disasters or emergencies.

The second reason was the conviction that this emblem would allow civilian personnel to have the necessary protection beyond potential political decisions of whether there is an armed conflict or not, thus overcoming the possible implications of the non-application of IHL norms related to the protection of the medical mission.

The third reason relates to the issue of 'visibility'. At the time of the eruption of the volcano at Armero in 1985, it was observed that rescue and support organisations that participated in the relief effort, apart from the Civil Defence and the Colombian Red Cross, had neither uniforms nor distinctive signs to facilitate their identification. While the Civil Defence and Colombian Red Cross responded to the emergency quickly and effectively, other rescue and support organisations, identified with different colours and signs, were slower in their response to this





Figure 1: Emblem of the Colombian Medical Mission, created by Resolution 1020 (of 5 August 2002) and confirmed by Resolution 4481 (of 28 December 2012).

disaster because of a perception that they were not part of organised relief efforts. For this reason, the Roundtable thought of facilitating the visual identification of such personnel, carrying out a technical study that enabled the development of an emblem that would rely on symmetry and propitious colours for their identification in the field. This emblem is also used on their ID cards and the respective permission to carry them.

Finally, the fourth reason relates to the issue of 'protection'. We could make an analogy saying that when an antibiotic is used for everything, it eventually becomes ineffective. It is clear that the emblem of the red cross on a white background was used for the identification of personnel of the Colombian Red Cross, of the ICRC, and also of the health-care personnel of the state armed forces. Creating an emblem that would only identify the different civilian elements of the medical mission allowed for better access by civilian medical personnel to victims of armed conflict, natural disasters or any other catastrophes, and also for their protection on the ground, preventing confusions, resistances and erroneous perceptions of their mission, which are unfortunately a reality in non-international armed conflicts.

***We understand that the Roundtable has had a national and regional impact. What has been the process for the implementation of regional roundtables on the protection of the medical mission? Which entities are part of them and what type of topics do they address?***

*Dr Francisco Moreno*

While the National Roundtable discusses general issues of interest throughout the whole national territory, such as the legal framework for the protection of the medical mission, as its work advanced we saw the need to empower the authorities at a regional level. Thus, we took the decision of identifying the regions that faced

most difficulties in terms of protection of and respect for the medical mission and proposed to them the creation of institutional spaces in which the governors of the different regions would express their commitment on the issue. Nowadays, the regional roundtables are set up by administrative acts of constitution and their composition is similar to that of the National Roundtable, but structured in accordance with the needs of each department.

*Dr Luis Fernando Correa*

To date we have put in place four regional roundtables, in the departments of Norte de Santander, Arauca, Cauca and Nariño.

For the entities that participate in these roundtables, it was considered essential to promote not only the participation of authorities linked to the health sector, but also that of authorities with decision-making capacity that could give legitimacy to the issues addressed. In this way, the constitutive acts of these bodies asked for the participation of health and government secretaries (responsible for guaranteeing, respectively, health and security services in the regions) as well as the ombudsman and the Attorney General's Office. The process also involved the inclusion of departmental representatives of local civil society, such as universities, local medical personnel, non-governmental organisations, local representatives of the Colombian Red Cross, or officials of the World Health Organisation. Sometimes, members of the judiciary have joined for the purpose of monitoring possible offences against the medical mission.

The National Police and the armed forces have also been invited to participate in these roundtables. Their presence has not only brought experience and knowledge regarding the practical relevance of IHL to the discussions, but has also made them more willing to provide their support to facilitate access to health-care services in times of emergencies or to prevent its obstruction in isolated areas of the country.

The topics covered at the regional roundtables are those that respond to local issues. For example, they discuss themes such as the use of the emblem by health institutions, the institutional response to offences against the medical mission as a result of the armed conflict or other situations of violence, the analysis of requests for the authorisation to use the emblem of the medical mission, and training activities for medical personnel.

*Dr Jorge Cubides*

Additionally, through the creation of these regional roundtables, the Colombian state executes its obligation to implement its public policy in terms of protection of the medical mission at the decentralised level. Thus, from the regional roundtables, created on the basis of administrative acts with binding force, regional authorities can take concrete measures in response to offences against the medical mission.

***What factors have contributed to the successful creation and development of the regional roundtables? Could you share a concrete example?***

*Dr Luis Fernando Correa*

Initially, some of the factors included the identification of the neediest departments in terms of the protection of the medical mission, identifying best practices and replicating those best practices in other regions of the country.

Subsequently, the element that definitively contributed to the development of the regional roundtables was the commitment of the governors, which in turn stimulated other public officials to participate in the roundtables. The participation of hospital managers in remote regions, who experience first-hand the difficulties of providing health services, has been fundamental because they are the ones that understand best the local needs and bring to the discussions ‘a notion of reality’. The ICRC and the Colombian Red Cross have helped sensitise local officials in isolated areas in the wake of the conflict of the existence of these roundtables and the importance of their active participation in them.

A good example of implementation of a regional roundtable is the Norte de Santander roundtable. The elements that have led it to being a model one are, among others: the leadership and commitment of the local authorities, including those responsible for the health institutions; the collaboration between the members of the roundtable and the local police department; and the coordination of different institutions for the transfer of patients on safe and uncluttered roads.

The work carried out in other areas of the country should not be forgotten. The fact that the regional authorities have been willing to create roundtables in their regions denotes the importance they ascribe to this issue and their commitment to the protection of the local components of the medical mission.

***The Roundtable has had an impact on the adoption of specific legislation on the needs of protection of the medical mission in the framework of a non-international armed conflict. Why did the Roundtable consider it pertinent to work on the protection of the medical mission also in situations that do not reach the threshold of an armed conflict?***

*Dr Tatiana Flórez*

Over time, it has become apparent that access to health care for people who need it ought to be guaranteed in whatever situation may arise where the humanitarian consequences need to be addressed. The Colombian armed conflict has many diverse aspects and manifests itself differently in the different regions of the country. Therefore, there are parts of the territory in which violent situations occur that, although not necessarily amounting to violations of IHL, nevertheless impede people’s access to health-care services. This led us to realise that the humanitarian

consequences of these other forms of violence needed to be addressed in the same way as those that occur as a result of the armed conflict in order to improve victims' access to health care, which is the main aim of the Roundtable and of the Colombian institutions concerned.

***How would you assess the involvement of the Colombian Red Cross and the ICRC in the roundtables?***

*Dr Luis Fernando Correa*

State entities that are linked to the National Roundtable have realised that the Colombian Red Cross and the ICRC are their greatest allies in this process. It is important to emphasise their commitment over the years, their leadership in the National Roundtable and their ability to convene different entities.

The presence of these two institutions at the National Roundtable has proved a strength since their access to different areas of Colombia, facilitated by their neutral and independent nature, enables them to have the necessary first-hand information to take decisions in terms of mobilisation, with the aim of ensuring the protection of the medical mission in the field.

We consider that their permanent support during all these years has given visibility to the National Roundtable and we hope to continue counting on the support of both institutions, in the interest of promoting respect for and protection of the medical mission in Colombia.

*Dr Jorge Cubides*

It is also important to highlight that, in conjunction with the ICRC, the National Roundtable has promoted a series of talks with prosecutors from various parts of the country with the aim of raising awareness on the rules relevant to the protection of the medical mission, and in particular on the prohibition against punishing any person for having performed medical activities in accordance with medical ethics. This is a contribution for which the authorities are also grateful because it reinforces the right of the sick and wounded to be cared for and contributes to the implementation of IHL as well as Colombian domestic law.

# The legal framework applicable to insecurity and violence affecting the delivery of health care in armed conflicts and other emergencies

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## **Abstract**

*Ensuring respect for, and protection of, the wounded and sick and delivery of health care to them were at the origin of the Red Cross and Red Crescent Movement, as well as the development of international humanitarian law (IHL). In today's armed conflicts and other emergencies, the problem is not the lack of existing international rules but the implementation of relevant IHL and international human rights law (IHRL) which form a complementary framework governing this issue. Against the backdrop of the different manifestations of violence observed by the ICRC in the field and expert consultations held in the framework of the Health Care in Danger Project,*

\* The views expressed here are those of the author and do not necessarily reflect the position of the International Committee of the Red Cross. The author would like to thank Knut Doermann, Jean-François Quéguiner, Bruno Demeyere and Tristan Ferraro for their useful comments on earlier drafts of this article.

*this article identifies commonalities between the two legal regimes, including with respect to obligations to provide and facilitate impartial health care; prohibitions of attacks against wounded and sick and health-care providers; prohibitions to arbitrarily obstruct access to health care; prohibitions to harass health-care personnel, in violation of medical ethics; or positive obligations to ensure essential medical supplies and health-care infrastructure and protect health-care providers against violent interferences by others. The article concludes by indicating certain areas where implementation of existing IHL and IHRL is needed, including in domestic normative frameworks, military doctrine and practice, as well as training of health-care personnel on these international legal frameworks and medical ethics.*

**Keywords:** legal framework, delivery of health care, international humanitarian law, IHL, international human rights law, IHRL.

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Maintaining adequate medical services and achieving respect for, and protection of, the wounded and sick and medical personnel, units and transports in armed conflicts were the core concerns behind the foundation of the International Red Cross and Red Crescent Movement, 150 years ago. These concerns played a pivotal role in the development of international humanitarian law (IHL),<sup>1</sup> including in the four Geneva Conventions of 1949 and their Additional Protocols of 1977, which contain a detailed body of rules in this respect.<sup>2</sup>

The operational reality in today's armed conflicts and other emergencies (such as internal disturbances and tensions) shows that these concerns remain of timely relevance, as insecurity and violence associated with armed conflicts or other emergencies have a major impact on the provision of and access to health care. For instance, authorities or armed or security forces may impede or deny access to

- 1 See, e.g., Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, 22 August 1864, Arts. 6–8, 10, 11, 13; Convention (II) with Respect to the Laws and Customs of War on Land and its annex: Regulations concerning the Laws and Customs of War on Land, 29 July 1899, Art. 21; Convention (III) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention of 22 August 1864, 29 July 1899, Arts. 1–4, 6–8; Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, 6 July 1906, Arts. 1, 3, 5–9, 14, 15, 17; Convention (IV) respecting the Laws and Customs of War on Land and its annex: Regulations concerning the Laws and Customs of War on Land, 18 October 1907, Art. 21; Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, 27 July 1929, Arts. 1, 3, 5–9, 14, 15, 17.
- 2 References to the four Geneva Conventions and their three Additional Protocols will be abbreviated hereinafter as follows: GC I, II, III and IV; AP I, II and III. See GC I, Arts. 12, 15, 18, 19, 21, 22–27, 35, 36; GC II, Arts. 12, 18, 21–40; GC IV, Arts. 14–22; GC I–IV, Art. 3; AP I, Arts. 8, 10, 12, 13, 15–17, 21–28; AP II, Arts. 2, 7–11, 18. The conventional provisions related to health care largely reflect customary international law, as shown by the following rules of the ICRC Study on Customary International Humanitarian Law: Rule 25 – Medical Personnel; Rule 26 – Medical Activities; Rule 28 – Medical Units; Rule 29 – Medical Transports; Rule 35 – Hospital and Safety Zones and Neutralized Zones; Rule 109 – Search for, Collection and Evacuation of the Wounded, Sick and Shipwrecked; Rule 110 – Treatment and Care of the Wounded, Sick and Shipwrecked; Rule 111 – Protection of the Wounded, Sick and Shipwrecked against Pillage and Ill-Treatment.

the wounded and sick<sup>3</sup> by deliberately preventing or delaying the passage of medical transports<sup>4</sup> at checkpoints or imposing general administrative restrictions on the work of humanitarian organisations; health-care facilities<sup>5</sup> or wounded and sick may be subjected to direct or indiscriminate attacks; members of armed forces may forcibly enter hospitals for the purpose of interrogating patients, which may result in disturbing medical treatment; health-care personnel may be subjected to threats by members of armed forces or non-state armed groups, inhibiting them in their work; or health-care personnel<sup>6</sup> may refuse the provision of health care to the wounded and sick on account of the latter's political affiliation.

Importantly, the consequences of insecurity and violence in armed conflicts and other emergencies go beyond the direct consequences caused by individual incidents involving threats and violence against health-care personnel, facilities and medical transports. The indirect consequences of individual incidents or simply of generalised insecurity, although hard to measure, may be dire for entire communities in need of health care and for the public health-care system as a whole in countries affected by armed conflicts and other emergencies. For instance, the

- 3 The category of 'wounded and sick' is not limited to the wounded and sick in the strict sense of these terms but also covers, for instance, maternity cases. The term is used in this document in accordance with the definition in IHL, i.e. Art. 8(a) of AP I: "'Wounded' and 'sick' mean persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility. These terms also cover maternity cases, newborn babies and other persons who may be in need of immediate medical assistance or care, such as the infirm or expectant mothers, and who refrain from any act of hostility.' This definition accords with the broad understanding of the various dimensions of the right to health, interpreted by the Committee on Economic, Social and Cultural Rights (CESCR) in its 2000 General Comment on the right to health. For this reason, the same terminology of 'wounded and sick' expressly used only under IHL is also regarded as appropriate for persons in need of health care under international human rights law.
- 4 'Medical transports' is generally understood in this document in a broader sense than the technical IHL definition contained in Art. 8(g) of AP I (which requires an exclusive assignment to medical transportation and control of a competent authority of a party to the conflict) and also encompasses, for instance, private cars used to transport the wounded and sick to a health-care facility. However, where the legal situation of 'medical transports' is analysed specifically under IHL, the scope of the notion is limited to that found under IHL.
- 5 'Medical units' are defined in Art. 8(e) of AP I as facilities and other units, whether military or civilian, that are organised for medical purposes – that is, to search for, collect, transport, diagnose or treat (including first aid) the wounded, sick and shipwrecked, or for the prevention of disease. The term includes hospitals and other similar units, blood transfusion centres, preventive medicine centres and institutes, medical depots and the medical and pharmaceutical stores of such units. Medical units may be fixed or mobile, permanent or temporary. The term 'health-care facilities' is broader in that it covers the various facilities mentioned in Art. 8(e) of AP I, but without requiring an exclusive assignment to medical purposes by a party to the conflict.
- 6 'Health-care personnel' is understood in this document in the broadest possible sense and covers all persons engaged in care for the wounded and sick, such as nurses, physicians, first-aid workers and ambulance drivers. It is broader than the technical legal term 'medical personnel' as described in Art. 8(c) of AP I, which is defined as 'those persons assigned, by a Party to the conflict, exclusively to the medical purposes enumerated under subparagraph (e) or to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either permanent or temporary.' Where the term 'medical personnel' is used, it will be used in the sense of Art. 8(c) of AP I. It is to be emphasised that under IHL those who are not specifically assigned to medical functions by a party to a conflict would not benefit from specific protection as medical personnel, but – if they are civilians – would generally be protected as civilians. On the other hand, there is a broader protection of any persons engaged in medical activities compatible with medical ethics contained in Art. 16 of AP I and Art. 10 of AP II.

reaction of the management of a hospital to damage caused by an attack may be to close the hospital, henceforth making it unavailable to provide much-needed health care in the community. Also, health-care professionals may flee the country in large numbers due to threats against them or due to generalised insecurity as a result of ongoing armed hostilities; this may considerably reduce the sometimes already limited number of available health-care personnel. Insecurity, violence and threats may also lead to the suspension or termination of vaccination campaigns, and as a consequence, entire communities may suffer from a lack of access to such vital health-care services.<sup>7</sup> In the view of the International Committee of the Red Cross (ICRC), the humanitarian problem of insecurity of, and violence against, the delivery of health care in armed conflicts and other emergencies is still not sufficiently appreciated and acted upon, but is an issue of potentially significant proportions.

In view of the timeliness of the issue of insecurity and violence against the delivery of impartial<sup>8</sup> health care, there is a need for a specific emphasis on it by the Red Cross and Red Crescent Movement. Indeed, the Movement has been acting upon this need over the last few years. The Council of Delegates in its Resolution 8, adopted in Nairobi in 2009, called upon all parties to armed conflicts and all actors involved in other situations of violence to respect and ensure respect for health-care personnel, premises and means of transport, and to take all measures to ensure safe and prompt access to health care. It also called upon the ICRC and National Red Cross and Red Crescent Societies to promote, disseminate and support the national implementation of international humanitarian and human rights obligations to respect and protect health care in armed conflict and other situations of violence, and requested the ICRC to present a report on this issue to the 31<sup>st</sup> International Conference of the Red Cross and Red Crescent in 2011.

The 2009 Council of Delegates resolution was a stepping stone for the launch of a new four-year project called Health Care in Danger in 2011, initiated by the ICRC. This Red Cross and Red Crescent Movement project aims to address the serious humanitarian impact of insecurity and violence obstructing the delivery of health care in armed conflicts and other emergencies through the adoption of practical measures to help to ensure safe access by the wounded and sick to effective and impartial health care.<sup>9</sup>

A major milestone for this project was the 31<sup>st</sup> International Conference of the Red Cross and Red Crescent. In the run-up to the Conference, the ICRC published a sixteen-country study on the problem in which it identified patterns

7 ICRC, *Violent Incidents Affecting Health Care: January to December 2012*, p. 8, available at: [www.icrc.org/eng/assets/files/reports/4050-002\\_violent-incidents-report\\_en\\_final.pdf](http://www.icrc.org/eng/assets/files/reports/4050-002_violent-incidents-report_en_final.pdf); Robin Coupland, *Health Care in Danger: A Sixteen-Country Study*, ICRC, July 2011, p. 3. All internet references were last accessed in December 2013.

8 The term 'impartiality' generally refers to non-discrimination in the provision of health care to the wounded and sick, with differences in treatment only allowed on the basis of medical grounds. This is examined in more detail later in the article.

9 While the question of providing health care to persons deprived of their liberty also raises important issues, these are outside the scope of the Health Care in Danger project and will therefore be excluded from this article.



of insecurity and violence affecting the delivery of health care in armed conflict and other emergencies. This study's main message was that the problem of insecurity and violence affecting the delivery of health care is more than the sum of single incidents; it is a complex humanitarian thematic, a problem to which the solutions lie not exclusively with health-care professionals but more comprehensively in the domain of law and politics, in humanitarian dialogue, and in appropriate preventive measures devised by a variety of stakeholders, including state armed forces.<sup>10</sup> At the Conference participants adopted Resolution 5, entitled 'Health Care in Danger: Respecting and Protecting Health Care'.<sup>11</sup> The resolution calls upon the ICRC to initiate consultations with experts from states, the International Federation of Red Cross and Red Crescent Societies, National Red Cross and Red Crescent Societies, and other actors in the health-care sector, with a view to formulating practical recommendations for making the delivery of health care safer in armed conflicts and other emergencies, and to report to the 32<sup>nd</sup> International Conference in 2015 on the progress made.<sup>12</sup>

These practical measures are being devised during expert workshops organised by the ICRC from 2012 to 2014, in partnership with states, National Red Cross and Red Crescent Societies, health-care professional associations and non-governmental organisations (NGOs). A number of these workshops have already taken place and have helped to mobilise health professionals, National Red Cross and Red Crescent Societies, the World Medical Association, national medical associations, representatives of ministries of health and NGOs on this issue. Regional intergovernmental consultations to review the practical recommendations made in the workshops and encourage states to endorse and implement them are planned for 2014.<sup>13</sup> Furthermore, the ICRC and National Red Cross and Red Crescent Societies also seek to improve their operational practices and will promote implementation of certain of the recommendations emanating from the aforementioned expert workshops in their operational contexts.

The ICRC has also continued to increase understanding on the issue by collecting information on violent incidents in twenty-three of its operational contexts. The interim result of this endeavour was the publication in 2013 of a report on incidents collected throughout 2012. This report found that insecurity and violence against the delivery of health care is very much a global problem, but with strong local dimensions, as the vast majority (over 90%) of health-care providers affected by insecurity and violence against health-care delivery were local. According to the report, the perpetrators are on the whole not confined to one predominant actor but include both state armed and security forces, as well as non-state armed groups. Moreover, the report showed that most of the incidents

10 R. Coupland, above note 7, p. 12.

11 Resolution 5, 31<sup>st</sup> International Conference of the Red Cross and the Red Crescent, 30 November 2011, available at: [www.rcrcconference.org/docs\\_upl/en/R5\\_HCiD\\_EN.pdf](http://www.rcrcconference.org/docs_upl/en/R5_HCiD_EN.pdf).

12 *Ibid.*, op. para. 14.

13 These efforts are also supported by a communication project entitled the Life and Death Campaign, aimed at creating awareness of and mobilising support for this initiative.

related to health-care personnel involved threats rather than direct violence against them.<sup>14</sup>

The resolution adopted at the 2011 International Conference also recalls the applicable legal framework pertaining to respect and protection of the wounded and sick, as well as health-care personnel, facilities and medical vehicles, and to the provision of health care in armed conflicts or other emergencies.<sup>15</sup> It calls upon states to take the required domestic implementation measures and to ensure effective investigation and prosecution of crimes committed against health-care personnel, their facilities and their means of transportation.<sup>16</sup>

Importantly for the purposes of the present article, the ICRC also submitted a background report to the 2011 Conference which contained, besides a general description of the problem and a summary of the most important findings of the sixteen-country study, an analysis of legal issues pertaining to both armed conflict and other emergencies.<sup>17</sup> The present article elaborates on this analysis, also in light of subsequent discussions held in the expert workshops. It emphasises that the problem is not so much the lack of an adequate international legal framework but the implementation of existing IHL and international human rights law (IHRL).

In the first part of the article, general observations on the respective scope of application of IHL and IHRL to protecting the delivery of health care in situations of armed conflict and other emergencies will be made. These observations serve to highlight some important differences between the two legal regimes. Firstly, while IHL specifically protects medical personnel, units and transports, IHRL does not enshrine such specific protections. Secondly, IHL applies to all parties to the conflict, including (in the case of a non-international armed conflict) non-state organised armed groups. On the other hand, IHRL traditionally only applies to states and significant controversy exists as to whether, and if so, to what extent, non-state armed groups incur IHRL obligations. The ICRC's position is that non-state armed groups generally do not have IHRL obligations as a matter of law, subject to the exception where a non-state armed group's *de facto* responsibilities can be recognised by virtue of its *de facto* capacity to act like a state government.<sup>18</sup> Finally, IHRL generally foresees the possibility of derogations from certain rights, unlike IHL. On the other hand, there are areas where IHRL may usefully complement IHL in armed conflicts – for example, where a state's capacity to deal with certain indirect consequences of insecurity and violence in relation to the delivery of health care is not impaired by active hostilities, such as in situations of prolonged occupation characterised by a low level or absence of hostilities.

14 ICRC, *Violent Incidents Affecting Health Care*, above note 7.

15 *Ibid.*, op. para.1.

16 *Ibid.*, op. paras. 2 and 6.

17 Draft resolution and background document on 'Health Care in Danger: respecting and protecting health care in armed conflicts and other situations of violence', available at: [www.icrc.org/eng/31IC\\_Health\\_Care\\_in\\_danger\\_EN.pdf](http://www.icrc.org/eng/31IC_Health_Care_in_danger_EN.pdf).

18 Further elaboration is provided later in the article.

The remainder of this article is devoted to obligations common to both IHL and IHRL with regard to the delivery of health care, irrespective of the classification of the situation. This analysis of commonalities between the two international legal regimes is not necessarily exhaustive, and a deliberate choice was made in recognition of the main patterns of insecurity and violence identified in the Health Care in Danger project, including direct violence and threats, especially attacks; obstructions, including arbitrary delays, and denials of ambulances at checkpoints or armed entries into health-care facilities inhibiting the provision of health care; and harassments and threats against health-care personnel.

## **IHL and IHRL: general observations on the respective scope of application**

Expert workshops in the context of the Health Care in Danger project have confirmed the need to better implement existing international law for ensuring the security and delivery of effective and impartial health care.<sup>19</sup> At the workshops the importance of incorporating pertinent IHL and IHRL into domestic legal frameworks was repeatedly stressed, either by improving such frameworks where they exist or, where necessary, by adopting new domestic legal frameworks.<sup>20</sup> While the responsibility to enact changes in this domain lies with state legislative authorities, National Red Cross and Red Crescent Society staff and volunteers as well as other health-care personnel could play an important role in these endeavours by advocating for such improvements with state authorities. To achieve this, it is a prerequisite that internally, National Red Cross and Red Crescent Society staff and volunteers as well as health-care personnel receive adequate training on relevant IHL and IHRL, and that they are aware of their rights and responsibilities based on these international legal regimes. Moreover, these stakeholders could be involved in efforts to train weapon-bearers or other pertinent segments of the population like lawyers or the media on IHL and IHRL applicable to the delivery of health care in armed conflicts and other emergencies. This requires an understanding of the interaction of these two international legal regimes.

The following section will look at the general scope of IHL and IHRL in relation to the protection of the delivery of health care. It will emphasise important differences between the two bodies of law with regard to their respective material and personal scope of application in armed conflicts and other emergencies, and will indicate areas where IHL and IHRL may usefully complement each other to address certain indirect consequences arising from the insecurity and violence affecting the delivery of health care in armed conflicts.

19 For information on the expert workshops, see [www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-expert-consultations.htm](http://www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-expert-consultations.htm).

20 Specifically on the issue of domestic normative frameworks on access and safe delivery of health care in armed conflicts and other emergencies, a workshop took place in Brussels in January 2014.

## Material scope of application

While generally, both IHL and IHRL are applicable to armed conflicts, other emergencies below the threshold of armed conflicts are governed only by IHRL, and not IHL.

In order to provide clarity as to which set of rules to apply in situations of armed conflict, the principle of *lex specialis* was recognised as an interpretative and conflict-solving tool by the International Court of Justice (ICJ) in the *Nuclear Weapons*<sup>21</sup> and *Wall*<sup>22</sup> Advisory Opinions, as well as by the International Law Commission.<sup>23</sup> According to this principle, the norm explicitly addressing a problem prevails over the one that addresses it only implicitly, and the more specific norm over the one covering the entire subject matter but in a less detailed manner.<sup>24</sup> In this regard, *lex specialis* is the norm that is to be primarily applied because it is better suited to the context in which it operates.<sup>25</sup>

With regard to the particular issue of the delivery of health care in armed conflicts, the principle of *lex specialis* will here be used not as a conflict-solving tool but as a method permitting complementarity between IHL and IHRL. In that sense, these two legal regimes may mutually reinforce each other to provide more protection for the availability of health-care services to the wounded and sick. In the following section, IHL will be identified as *lex specialis* because it enshrines specific protections for medical personnel, units and transports. Subsequently, it will be examined where IHRL has a complementary role to play. In examining this complementary role of IHRL, it must be borne in mind that this should not be understood as applying IHRL in an unqualified manner in situations of armed conflict. Rather, IHRL should be applied alongside IHL in a manner respecting the specificities of situations of armed conflict, and the careful balance struck by IHL between humanitarian considerations and military necessity.<sup>26</sup>

### *Specific protection for medical personnel, units and transport under IHL, but not under IHRL*

From the very first IHL convention, the 1864 Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, IHL has enshrined specific protections not only for the wounded and sick, but also for medical personnel, units

21 International Court of Justice (ICJ), *Legality of the Threat or Use of Nuclear Weapons*, Advisory Opinion, 8 July 1996, *ICJ Reports 1996*, p. 226, para. 25.

22 ICJ, *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory*, Advisory Opinion, 9 July 2004, *ICJ Reports 2004*, p. 136, paras. 105–106.

23 International Law Commission, Report on the work of its 58<sup>th</sup> session to the General Assembly, UN Doc. A/61/10 (2006), p. 409.

24 Marco Sassoli and Laura M. Olson, 'The relationship between international humanitarian and human rights law where it matters: admissible killing and internment of fighters in non-international armed conflicts', in *International Review of the Red Cross*, Vol. 90, No. 871, 2008, p. 604.

25 International Law Commission, above note 23.

26 ICRC, *Expert Meeting: Occupation and Other Forms of Administration of Foreign Territory*, 2012, pp. 63–64.

and transports. The protection of medical personnel, units and transports is derived from the fact that they are used for ensuring medical care and attention to the wounded and sick in armed conflicts.<sup>27</sup> This is in line with the general rationale of IHL to provide protection to categories of persons on the basis of their specific status or function.<sup>28</sup>

In contrast, IHRL protects all individuals under a state's jurisdiction on a non-discriminatory basis.<sup>29</sup> Therefore, health-care personnel would generally enjoy IHRL protection as would everybody else under a state's jurisdiction, including from arbitrary deprivations of their right to life, from torture, cruel, inhuman, or degrading treatment or punishment, from arbitrary arrest and detention, or from arbitrary interferences with their freedom of movement.<sup>30</sup> However, they are not specifically protected on account of their function of providing health care, as opposed to their protection under IHL. Similarly, health-care facilities and medical transports as objects are not specifically protected under IHRL on account of their medical function.<sup>31</sup> Therefore, in armed conflicts, IHL constitutes the *lex specialis* to IHRL especially with regard to those specific protections of medical personnel, units and transports.

### *Complementarity between IHL on the protection of the wounded and sick, and medical activities, and IHRL on the right to health in armed conflicts*

It results from the above that IHL generally is more specific and better equipped than IHRL to prevent individual violent incidents against, and direct interferences

27 Commentary on GC I, Art. 12, p. 134.

28 It should be noted, however, that the fundamental guarantees enshrined in Common Art. 3 of the Geneva Conventions, Art. 75 of AP I and Arts. 4–6 of AP II apply to all persons who would not be entitled to any more expansive protections because they would not fall under more specific categories.

29 Art. 2(1) of the International Covenant on Civil and Political Rights (ICCPR) actually imposes this obligation on states in relation to individuals *within their territory and jurisdiction*. See ICCPR, 999 UNTS 171. Other IHRL treaties only speak of 'jurisdiction'. See, for instance, Convention against Torture (CAT), 10 December 1984, 1465 UNTS 85, Art. 2(1); Convention on the Rights of the Child (CRC), 20 November 1989, 1577 UNTS 3, Art. 2(1); American Convention on Human Rights (ACHR), 22 November 1969, OAS Treaty Series No. 36, 1144 UNTS 123, Art. 1(1); European Convention on Human Rights (ECHR), 4 November 1950, CETS No. 5, Art. 1. IHRL treaties on economic, social and cultural rights, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), do not contain an express requirement of jurisdiction for them to apply. However, both the ICJ and the Committee on Economic, Social and Cultural Rights (CESCR) reaffirmed the relevance of this notion to economic, social and cultural rights, especially in cases where states affect these rights outside of their own territory, for instance in situations of occupation. See, for example, ICJ, *Wall Advisory Opinion*, above note 22, para. 112; CESCR, General Comment No. 14 on the right to the highest attainable standard of health, UN Doc. E/C.12/2000/4, 11 August 2000, para. 51; and CESCR, General Comment No. 1 on reporting by states parties, 24 February 1989, para. 3, available at: [www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/38e23a6d-dd6c0f4dc12563ed0051cde7?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/38e23a6d-dd6c0f4dc12563ed0051cde7?Opendocument).

30 See, e.g., ICCPR, Arts. 6, 7, 9, 12.

31 Arbitrary interferences with their use may fall under Art. 17(2) of the Universal Declaration of Human Rights, which enshrines the right not to be arbitrarily deprived of one's property. However, the scope of this right has never been fleshed out on a universal level; only regional IHRL treaties further contain the right to property. See Protocol I additional to the ECHR, Art. 1; ACHR, Art. 21; African Charter on Human and People's Rights (ACHPR), 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, Art. 14.

with the delivery of, impartial health-care in armed conflicts because it enshrines specific protections for medical personnel, units and transports. As will be seen in more detail later in the article, these direct incidents against and interferences with access of the wounded and sick to health-care services are addressed in particular by the fundamental obligations under IHL to respect and protect the wounded and sick and medical personnel, units and transports.

Meeting the immediate needs of the wounded and sick requires parties to the conflict to provide them with the medical care and attention required by their condition on a non-discriminatory basis.<sup>32</sup> This, however, is an obligation of means which entails that where a party to the conflict is not itself able to provide such medical care and attention due to its own limited capacities, discharging this obligation includes permitting the ICRC or other impartial humanitarian organisations to provide medical care and attention.<sup>33</sup> A more general legal basis for meeting the immediate medical needs of wounded and sick civilians during armed conflicts is the obligations of parties to the conflict relating to humanitarian assistance (which may involve – apart from medical supplies – food, clothing, bedding, shelter, or other supplies essential for the survival of the civilian population) if a party to the conflict's own resources are inadequate.<sup>34</sup>

On the other hand, the question arises as to where IHRL has an added value to IHL with regard to the provision of health-care services during armed conflicts. It is argued here that IHRL may complement IHL rules in relation to the more indirect effects of insecurity and violence, such as the massive flight of doctors, the large-scale closure of health facilities, or the interruption or termination of preventive health-care programmes as a result of individual violent incidents or generalised insecurity.

IHRL, drawing from the foundations laid in the Universal Declaration of Human Rights (UDHR) and Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) – the main instrument in this area<sup>35</sup> – enshrines the 'right of everyone to the enjoyment of the highest attainable

32 GC I-IV, Common Art. 3(2); GC I, Art. 12; GC II, Art. 12; AP I, Art. 10(2); AP II, Art. 7(2); Jean-Marie Henckaerts and Louise Doswald-Beck, *Customary International Humanitarian Law*, ICRC, Cambridge University Press, Cambridge, 2005 (hereinafter Customary IHL Study), Rule 110, pp. 400–403.

33 Customary IHL Study, Commentary on Rule 110, p. 402. The legal basis for the initiatives undertaken by the ICRC or other impartial humanitarian organisations in this regard may be found in Common Art. 3(2) of GC I-IV and Arts. 9/9/9/10 of the Geneva Conventions.

34 The law of occupation contains specific rules in this respect in terms of the positive obligation of the occupier to ensure medical supplies for the population, to the fullest extent of the means available to it. Furthermore, humanitarian assistance efforts must be permitted by an occupying power; refusing consent is not an option at its disposal. The relevant provisions on humanitarian assistance are GC IV, Arts. 23, 55–56, 59; AP I, Arts. 69–71; AP II, Art. 18(2); Customary IHL Study, Rule 55.

35 Subsequent international and regional instruments also address the right to health, bearing witness to its general recognition under international law. See ACHPR, Art. 16; Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, 'Protocol of San Salvador', 17 November 1988, OAS Treaty Series No. 69, Art. 10; European Social Charter, and Revised European Social Charter, Arts. 11, 13; International Convention on the Elimination of All Forms of Racial Discrimination, 21 December 1965, 660 UNTS 195, Art. 5(e)(iv); Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979, 1249 UNTS 13, Arts. 11(1)(f), 14(2)(b); CRC, Art. 24; International Convention on the Protection of the Rights of All Migrant Workers and

standard of physical and mental health'. This right, like other economic, social and cultural rights, must be seen in a long-term perspective which is evident from the general obligation under Article 2(1) that each state party 'undertakes to take steps ... to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant'. Specifically, Article 12(2) of the ICESCR spells out, in a non-exhaustive manner, some of the long-term objectives to be progressively achieved under the right to health, including '(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child'; '(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases'; and '(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.'

In this regard, the Committee on Economic, Social and Cultural Rights (CESCR), the treaty monitoring body of the ICESCR, interpreted in great detail the nature of the general obligation under Article 2(1) of the ICESCR in its General Comment No. 3,<sup>36</sup> and the various components of the right to health as well as the specific obligations arising from Article 12 of the ICESCR in its General Comment No. 14.<sup>37</sup>

One of the fundamental contributions of the CESCR has been to recognise that even if the ICESCR provides for progressive realisation of economic, social and cultural rights and takes resource constraints of states into account, there are certain obligations which are of immediate application, including the guarantee that the right to health will be exercised without discrimination and the obligation to take deliberate, concrete and targeted steps towards fulfilment of the right to health.<sup>38</sup>

The CESCR also emphasised that despite the fact that obligations other than immediate ones are to be implemented progressively, taking into account available resources, there are so-called 'core obligations' to ensure the satisfaction of minimum essential levels of each right, including essential primary health care.<sup>39</sup> With regard to the core obligations relating to the rights to health and water, the CESCR stated that a state party cannot under any circumstances justify non-compliance with these obligations.<sup>40</sup> For the right to health, these core obligations include the obligations to ensure the right of access to essential health facilities, goods and services on a non-discriminatory basis; to provide essential drugs; to

Members of Their Families, 18 December 1990, 2220 UNTS 3, Arts. 28, 43(e), 45(c); Convention on the Right of Persons with Disabilities, 13 December 2006, UN Doc. A/61/611, Art. 25. In addition, key resolutions and declarations have reaffirmed and clarified commitments to achieve the concrete realisation of the right to health. See, for example, Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978, available at: [www.who.int/publications/almaata\\_declaration\\_en.pdf](http://www.who.int/publications/almaata_declaration_en.pdf); International Conference on Primary Health Care, Alma-Ata: 25th anniversary, 26 May 2003, available at: [http://whqlibdoc.who.int/wha/2003/WHA56\\_6.pdf](http://whqlibdoc.who.int/wha/2003/WHA56_6.pdf); UN General Assembly, Resolution A/RES/55/2, 18 September 2000, UN Millennium Declaration.

36 CESCR, General Comment No. 3: The nature of States parties obligations, 14 December 1990, Art. 2, para. 1, [www.unhcr.ch/tbs/doc.nsf/0/94bdbaf59b43a424c12563ed0052b664?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/0/94bdbaf59b43a424c12563ed0052b664?Opendocument).

37 CESCR, General Comment No. 14, above note 29.

38 *Ibid.*, paras. 30–31; CESCR, General Comment No. 3, above note 36, paras. 1, 2, 9.

39 *Ibid.*, para. 10; CESCR, General Comment No. 14, above note 29, para. 43.

40 *Ibid.*, para. 47.



ensure equitable distribution of all health facilities, goods and services; and to adopt and implement a national public health strategy and plan of action.<sup>41</sup>

In addition, the CESCR indicated that other obligations are of a comparable priority, notably the obligations to ensure reproductive, maternal and child health; to provide immunisation against major infectious diseases; to take measures to prevent, treat and control epidemic and endemic diseases; to provide education and access to information concerning the main health problems in the community; and to provide appropriate training for health personnel.<sup>42</sup>

The CESCR also fleshed out certain components in relation to the right to health, the precise application of which would depend notably on the prevailing capacities of a state: the *availability* of functioning public health and health-care facilities, goods and services; the *accessibility* of such health-care facilities, goods and services on a non-discriminatory basis, within safe physical reach of all sections of the population and affordable for all; the *acceptability* of health facilities, goods and services in terms of being respectful of medical ethics and cultural appropriateness; and a sufficient *quality* of health facilities, goods and services that are scientifically and medically appropriate.<sup>43</sup>

Finally, the CESCR specified that the obligations under the right to health may be divided into obligations to respect, to protect and to fulfil. The obligation to respect the right to health requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health, including to refrain from denying or limiting equal access for all persons to health-care services; the obligation to protect requires states to take measures that prevent third persons from interfering with the enjoyment of the right to health by, *inter alia*, adopting measures to ensure equal access to health care provided by third persons; and the obligation to fulfil requires states, *inter alia*, to give sufficient recognition to the right to health in their national legal and political systems and to take positive measures that enable and assist individuals and communities to enjoy this right.<sup>44</sup>

It would appear that during active hostilities in an armed conflict, due to the severe resource constraints that such a situation poses to the health system as a whole, it would not seem realistic to expect that any actions by the state would go much beyond the immediate concerns that IHL would already require it to address. Thus, there would be a substantial overlap between IHL obligations to respect and protect the wounded and sick and medical personnel, units and transports, and to provide medical care and assistance to the wounded and sick, and the core state obligations under IHRL to respect, protect and fulfil the right of access to health facilities, goods and services. In terms of the obligation to fulfil the right to health, the CESCR has specifically emphasised the importance of cooperation in providing humanitarian assistance in times of emergency and that each state should contribute to this task to the maximum of its capacities.<sup>45</sup>

41 *Ibid.*, para. 43.

42 *Ibid.*, para. 44.

43 *Ibid.*, para. 12.

44 *Ibid.*, paras. 30–37.

45 CESCR, General Comment No. 14, above note 29, para. 40.



During active hostilities, a state party to the conflict may not have the ability to deal with the more indirect and long-term effects of insecurity and violence affecting health care, like the massive flight of qualified health-care personnel or the lack of available vital health-care services, such as vaccination campaigns, that have been suspended or terminated.

On the other hand, the right to health as interpreted by the CESCR may be of particular significance in armed conflicts where the state's capacity to adopt measures to deal with such indirect consequences of insecurity and violence is not impaired by active hostilities; this may be the case, for instance, in prolonged calm occupations where control of the occupying power over the occupied territory has stabilised. In such scenarios, IHRL has value in complementing IHL when it comes to such indirect effects.<sup>46</sup>

It must be emphasised that beyond obligations applicable in all types of armed conflicts, the law of occupation does contain specific obligations to preserve the existing public health-care system in occupied territories. Thus, the occupying power must ensure, to the fullest extent of the means available to it, the medical supplies of the population of an occupied territory, as well as ensure and maintain, with the cooperation of national and local authorities, the medical and hospital establishments and services, and public health and hygiene in the occupied territory.<sup>47</sup> In particular, the occupying power is responsible for taking the necessary measures to combat contagious diseases and epidemics.<sup>48</sup> Despite these obligations under the law of occupation, this IHL regime remains vague when it comes to defining a long-term normative framework to address shortcomings in the availability of health-care personnel and services.<sup>49</sup> This becomes an issue precisely in prolonged occupations in which the occupying power exercises stable control over the occupied territory and which are characterised by the absence or low level of intensity of hostilities, where a more forward-looking approach to the availability of health-care services may be desirable.

Aside from situations of occupation, in other instances of armed conflicts IHL does not contain any specific obligations to address the availability and quality of public health-care services. It is true that the availability of some services is implicit in the IHL obligations in relation to the wounded and sick, but IHL does not provide any further guidance on the quantity and quality of health-care services. In situations where the state's capacity to adopt more far-reaching measures related to the availability and quality of the public health-care system is not impaired by active hostilities, the immediate IHRL obligations to ensure respect for non-discriminatory access to health care and to take deliberate, concrete and targeted steps towards full realisation of the right to health,

46 For an examination of the complementary role of the right to health in situations of occupation, see ICRC, *Expert Meeting*, above note 26, pp. 64–67; Sylvain Vité, in 'The interrelation of the law of occupation and economic, social and cultural rights: the examples of food, health and property', in *International Review of the Red Cross*, Vol. 90, No. 871, 2008, pp. 632, 636, 637, 639–641 and 651.

47 GC IV, Arts. 55, 56.

48 GC IV, Art. 56(1).

49 S. Vité, above note 46, pp. 640–642; ICRC, *Expert Meeting*, above note 26, pp. 66–67.

including the availability and quality of health-care services, take on additional importance; this is because these requirements would generally not allow a state to wait until the situation could no longer be regarded as an armed conflict to adopt such steps.<sup>50</sup>

More concretely, in such situations, one practical measure to address major shortcomings in the availability of qualified health-care personnel who have fled due to violent incidents or general insecurity would be to comply with the core obligation under the right to health to adopt and implement a national public health strategy and plan of action. Such a strategy must be drawn up with the participation of, and on the basis of the particular health concerns of, the local population, bearing in mind the specific needs of vulnerable people.<sup>51</sup> For instance, a health strategy and plan of action could specifically tackle the massive exodus of health-care personnel by foreseeing incentives to return, or by specifically training members of the local community (or providing support for such training) to ensure certain vital health-care services.<sup>52</sup>

A health strategy and plan of action could also prioritise the fight against endemic diseases and potential epidemics, such as by scaling up efforts to ensure the resumption of interrupted or terminated vaccination campaigns. This should include strategies to address the underlying security issues preventing such campaigns; for instance, it may involve comprehensive communication strategies developed in collaboration with religious and other community leaders to educate the population on the necessity of such campaigns, in order to counteract anti-vaccination propaganda by those who target health-care personnel providing such services.<sup>53</sup> Moreover, it should address the perception by weapon-bearers that vaccination campaigns are used for purposes other than those of health care; in this regard, it bears emphasis that states parties to the ICESCR have to ensure that all health facilities, goods and services are respectful of medical ethics, subject to the conditions prevailing in the respective state, and that medical practitioners and other health professionals meet appropriate ethical codes of conduct.<sup>54</sup> Appropriate training on medical ethics – and more generally on health and human rights, which is comparable in priority to the core obligations under the right to health<sup>55</sup> – would be an essential strategy to tackle this issue.

The underlying security issue is also generally addressed by the IHL obligation, as applicable to the state, to ensure respect for its norms in all circumstances by its agents – that is, by its armed forces, including military medical

50 ICRC, *Expert Meeting*, above note 26, p. 65; S. Vité, above note 46, pp. 632–633.

51 ICRC, *Expert Meeting*, above note 26, p. 67; S. Vité, above note 46, p. 641.

52 Paula E. Brentlinger, 'Health sector response to security threats during the civil war in El Salvador', in *British Medical Journal*, Vol. 313, 1996, p. 1472 (describing initiatives by Salvadorean and international aid agencies in training villagers as primary health-care workers, known as health promoters, who studied first aid but also responses to communicable diseases like malaria).

53 Mahmood Adil, Paul Johnstone, Andrew Furber, Kamran Siddiqi and Dilshad Khan, 'Violence against public health workers during armed conflicts', in *The Lancet*, Vol. 381, 26 January 2013, p. 293, available at: [www.thelancet.com/pdfs/journals/lancet/PIIS0140673613601270.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140673613601270.pdf).

54 CESCR, General Comment No. 14, above note 29, paras. 12 and 35.

55 *Ibid.*, paras. 12 and 44.

personnel, and other persons or groups acting in fact on its instructions, or under its direction and control, as well as the civilian population, including civilian health-care personnel.<sup>56</sup> Discharging this obligation more specifically requires instruction in IHL for states' armed forces, including military medical personnel, and efforts to disseminate IHL to the civilian population, including civilian health-care personnel over which a state exercises authority.<sup>57</sup> In this context, this means once again ensuring that health-care personnel themselves comply with IHL and medical ethics, as well as affirming the necessity of respecting those medical personnel carrying out vaccination campaigns when training state armed forces and the civilian population on the obligations to respect and protect medical personnel, units and transports and the rights and responsibilities of medical personnel under IHL.

## Derogations, limitations and scope of economic, social and cultural rights

One issue that also generally needs to be addressed in terms of the scope of application of IHL and IHRL is the issue of derogation. Certain IHRL treaties, but not IHL,<sup>58</sup> foresee the possibility of derogation from certain rights in times of public emergencies which threaten the life of the nation to an exceptional extent.<sup>59</sup> Derogations involve the complete or partial elimination of state obligations in relation to a certain right.<sup>60</sup> Both situations of armed conflict and other emergencies may constitute situations that may justify official proclamations by the state of derogations on the basis of public security concerns.<sup>61</sup>

However, some civil and political rights are non-derogable, most importantly the rights to life and the right to be free from torture or other ill treatment.<sup>62</sup> Even with regard to those rights that are subject to derogation in principle, such as the right not to be arbitrarily deprived of one's liberty or the right to freedom of movement, states must justify specific measures as being required by the exigencies of the situation.<sup>63</sup> Moreover, measures of derogation must not be inconsistent with other obligations of the state under

56 Geneva Conventions, Common Art. 1; AP I, Art. 1(1); Customary IHL Study, Rule 139, pp. 495–498.

57 Geneva Conventions, Arts. 47/48/127/144; Customary IHL Study, Rules 142 and 143, pp. 501–508.

58 One notable exception under IHL is contained in Art. 5 of GC IV, which allows a party to an international armed conflict to derogate from especially rights of communication in relation to protected persons who are suspected of or engaged in activities hostile to the security of the state.

59 ICCPR, Art. 4; ECHR, Art. 15; ACHR, Art. 27; European Social Charter, 18 October 1961, CETS No. 35, Art. 30; Revised European Social Charter, 3 May 1996, CETS No. 163, Art. F.

60 Dominic McGoldrick, 'The interface between public emergency powers and international law', in *International Journal of Constitutional Law*, Vol. 2, 2004, p. 383.

61 Human Rights Committee (HRC), General Comment No. 29: States of emergency, 31 August 2001, UN Doc. CCPR/C/21/Rev.1/Add.11; Manfred Nowak, *U.N. Covenant on Civil and Political Rights: CCPR Commentary*, 2<sup>nd</sup> ed., N. P. Engel, Kehl-Strasbourg-Arlington, 2005, pp. 89–91.

62 ICCPR, Art. 4(2).

63 ICCPR, Art. 4(1).

international law, particularly under IHL, where applicable, and must not involve discrimination.<sup>64</sup>

As opposed to treaties enshrining civil and political rights, treaties on economic, social and cultural rights, in particular the ICESCR, generally do not contain any express provisions on derogation.<sup>65</sup> The case for derogation given the nature of the rights of interest here, in particular the right to health, seems inherently less compelling than with certain civil and political rights.<sup>66</sup> This is confirmed by the view that economic, social and cultural rights, including the right to health, comprise, as has already been mentioned, core obligations that states parties to the ICESCR<sup>67</sup> must fulfil to ensure the survival and basic subsistence needs of their populations, such as essential health care.<sup>68</sup> In this regard, there is a close inter-relation between the non-derogable right to life and the core obligations relating to such economic, social and cultural rights.<sup>69</sup> With regard to the core obligations relating to the rights to health and water, the CESCR in General Comments No. 14 and 15 has expressly declared that these are ‘non-derogable’.<sup>70</sup>

The question of derogations must be distinguished from that of limitations under IHRL. Most human rights are not absolute even when not faced with a situation of public emergency, and thus allow for certain flexibility of restricting individual rights in the pursuit of public interests such as public order, public health, public morals, national security, or public safety, or to balance the exercise of rights with the rights of others.<sup>71</sup> Furthermore, unlike derogations, limitations are usually lighter interferences with human rights and would usually fall short of their complete elimination.

64 *Ibid.*; HRC, General Comment No. 29, above note 61, paras. 8–9.

65 The exception is the European Social Charter and its revised version. See European Social Charter, Art. 30; Revised European Social Charter, Art. F. This may be explained by the fact that some of the rights contained therein, in particular the right to freedom of association and the right to collectively bargain in the specific context of employment, bear great resemblance to some derogable civil and political rights such as freedom of association.

66 Philip Alston and Gerard Quinn, ‘The nature and scope of States Parties’ obligations under the International Covenant on Economic, Social and Cultural Rights’, in *Human Rights Quarterly*, Vol. 9, 1987, p. 217.

67 Some also hold the view that states have minimum core obligations under customary international law: see, for example, CESCR, Concluding Observations: Israel, 26 June 2003, UN Doc. E/C.12/1/Add.90; CESCR, Concluding Observations: Israel, 31 August 2001, UN Doc. E/C.12/1/Add.69; Eibe Riedel, ‘The human right to health: conceptual foundations’, in Andrew Clapham and Mary Robinson (eds), *Realizing the Right to Health*, Rüffer & Rub, Zurich, 2009, p. 32.

68 CESCR, General Comment No. 3, above note 36, para. 10.

69 Allan Rosas and Monika Sandvik-Nylund, ‘Armed conflicts’, in Asbjorn Eide, Catarina Krause and Allan Rosas (eds), *Economic, Social and Cultural Rights: A Textbook*, Kluwer Law International, The Hague, 2001, p. 414. This inter-relation between the rights to life and economic and social survival rights is also apparent in Art. 6 of the Convention on the Rights of the Child, in which states parties both recognise the inherent right to life of the child and are required to ensure to the maximum extent possible the survival and development of the child.

70 CESCR, General Comment No. 14, above note 29, para. 47; CESCR, General Comment No. 15: The right to water (Arts. 11 and 12), 20 January 2003, UN Doc. E/C.12/2002/11, para. 40.

71 See ICCPR, Arts. 12, 18, 19, 21, 22; ICESCR, Art. 8. Under IHRL, the scope of permissible limitations in specific cases is not spelt out, in contrast to IHL, where the rules must already be highly precise to be implemented by armed forces on the spot.

In contrast to civil and political rights, which typically enshrine limitation clauses for individual rights, the ICESCR contains a general limitation clause in Article 4 which provides that states may subject such rights only to such limitations as are determined by law, to the extent that this is compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.<sup>72</sup> The reference to ‘general welfare in a democratic society’ as the only legitimate purpose for limiting economic, social and cultural rights makes it clear that states parties cannot justify such limitations lightly on the basis of national security concerns. This is of particular relevance for the issue of insecurity and violence affecting the delivery of health care, as states may justify obstructions to the delivery of health care, such as the denial of passage to medical transports, on grounds of national security. Indeed, such concerns can only be invoked if they can be connected with the collective interest of protecting the economic and social well-being of states’ populations.<sup>73</sup> Moreover, the fact that limitations must be compatible with the nature of the rights in question constitutes a further restriction on invoking this clause. The connection between providing essential levels of economic, social and cultural rights and the survival of a person under the right to life, recognised by many,<sup>74</sup> makes it especially hard to justify wide-reaching limitations under Article 4 of the ICESCR.<sup>75</sup> In any event, states parties have the burden of proof of justifying the legitimacy of any limitations in relation to these elements, and must show that measures adopted to that effect are proportional; these measures should also be of limited duration and subject to review.<sup>76</sup>

One should also bear in mind that resource constraints in fulfilling the obligations related to economic, social and cultural rights do not fall within the

72 A specific limitation clause can be found in Art. 8 of the ICESCR with regard to the right to form trade unions and the right of trade unions to function freely for the interests of national security or public order or for the protection of the rights and freedoms of others. This is again justified by the fact that these rights closely resemble their civil and political counterparts, in particular the right to freedom of association.

73 The ICJ in its *Wall Advisory Opinion* has explicitly rejected Art. 4 of the ICESCR as a permissible basis for Israeli limitations on the economic, social and cultural rights of Palestinians in the occupied territories on the grounds of national security, since the condition of promoting the general welfare of the population was not met. See *Wall Advisory Opinion*, above note 22, para. 136. See also P. Alston and G. Quinn, above note 66, p. 202; Amrei Müller, ‘Limitations to and derogations from economic, social and cultural rights’, in *Human Rights Law Review*, Vo. 9, 2009, p. 573.

74 See, in addition to the sources cited in note 38 above, CESCR, Initial Report regarding Switzerland, 18 September 1996, UN Doc. E/1990/5/Add.33, para. 66(d); CESCR, Second Periodic Report regarding Brazil, 28 January 2008, UN Doc. E/C.12/BRA/2, para. 170; CESCR, Initial Report regarding Serbia and Montenegro, 26 November 2003, UN Doc. E/1990/5/Add.61, para. 24; CESCR, Third Periodic Report regarding Chile, 14 July 2003, UN Doc. E/1995/104/Add. 26, para. 142; Supreme Court of India, *Pt. Parmanand Katara v. Union of India*, Judgment of 28 August 1989, 4 SCC 286; Supreme Court of India, *Paschim Banga Khet Samity v. State of West Bengal*, Judgment of 6 May 1996, 4 SCC 37; Court of Appeals, *Mosetlhanyane and others v. Attorney General of Botswana*, Appeal No. CACLB-074-10, Judgment of 27 January 2011, para. 19; Inter-American Court of Human Rights (IACtHR), *Sawhoyamaxa Indigenous Community v. Paraguay*, Judgment of 29 March 2006, para. 153; IACtHR, *Yakye Axa v. Paraguay*, Judgment, Ser. C No. 125, 17 June 2005; European Court of Human Rights (ECtHR), *Cyprus v. Turkey*, Application No. 25781/94, Judgment of 10 May 2001, paras. 219–221.

75 Some would even consider the possibility that certain economic, social and cultural rights, by virtue of their nature, cannot be limited at all under Art. 4 of the ICESCR. See P. Alston and G. Quinn, above note 66, p. 201.

76 CESCR, General Comment No. 14, above note 29, paras. 28–29.

scope of limitations contemplated under Article 4 of the ICESCR. Such constraints are addressed by the aforementioned general obligations of states parties under Article 2(1) of the ICESCR. Armed conflicts or other emergencies may in principle qualify as an explanation for invoking resource constraints in this respect. The obligation to take steps to ensure the progressive realisation of economic, social and cultural rights ‘to the maximum of available resources’ refers not only to the resources existing within a state but also to those available from the international community through international cooperation and assistance.<sup>77</sup>

### Personal scope of application: the question of applicability of IHRL to non-state armed groups

Another crucial difference between IHL and IHRL is that IHL binds not only states’ armed forces but also non-state organised armed groups as parties to a conflict.

On the other hand, there is no consensus at present that IHRL imposes obligations on non-state armed groups. This difference is important in view of the fact that non-state armed groups have also committed a significant number of violent incidents affecting the delivery of impartial health care.<sup>78</sup> Therefore, it is necessary to make efforts to persuade them to refrain from such conduct and to involve them in a dialogue on practical recommendations that they could implement to make the delivery of health care safer in armed conflicts and other emergencies. Those engaging with non-state armed groups in a dialogue on this issue must accordingly be aware of the legal difficulties involved in order to know how to frame this dialogue in an appropriate manner.

In this regard, the overwhelming majority of IHRL treaties are clear in imposing obligations only on *states* towards individuals under their jurisdiction. While certain due diligence state obligations include protection against interferences with human rights by third parties, including non-state armed groups, these duties do not purport to impose an impossible burden on states. Thus, these obligations are regularly subject to what is reasonable, the scope of states’ powers, and the means at states’ disposal.<sup>79</sup>

This is particularly relevant where a state may no longer have effective control over part of its territory. In such situations, it may not have the ability to prevent interferences with human rights by non-state armed groups and hence it would be difficult to hold it responsible for a failure to protect the human rights of individuals under its jurisdiction. Certainly, individual members of non-state armed groups are bound by domestic and international criminal law. But firstly, it will often not be useful to involve them in a dialogue on the basis of domestic law, since they will not accept arguments based on a legal order that criminalises their

<sup>77</sup> CESCR, General Comment No. 3, above note 36, para. 10.

<sup>78</sup> See ICRC, *Violent Incidents Affecting Health Care*, above note 7, p. 6.

<sup>79</sup> See, for instance, IACtHR, *Velásquez-Rodríguez v. Honduras*, Judgment of 29 July 1988, Ser. C No. 4, paras. 174–75, 188; ECtHR, *Osman v. United Kingdom*, App. No. 23452/94, Judgment of 28 October 1998, para. 116; IACtHR, *Sawhoyamaya v. Paraguay*, above note 74, para. 155.



activities; and secondly, international criminal law only helps to address the most serious violations of international law, including war crimes, crimes against humanity and genocide. Therefore, the question is relevant if and to what extent non-state armed groups as entities are bound by IHRL.

International human rights treaty law that directly addresses non-state armed groups is still scarce. Article 4(1) of the Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflicts provides that armed groups that are distinct from the armed forces of a state should not in any circumstances recruit or use in hostilities persons under the age of 18 years.<sup>80</sup> However, it needs to be emphasised that the wording is ‘should’ rather than ‘shall’, and thus means something less than a legal obligation, although some suggest otherwise.<sup>81</sup>

Undeniably, the 2009 Convention for the Protection and Assistance of Internally Displaced Persons in Africa imposes direct obligations on non-state armed groups under its Article 7(5), such as the obligations not to deny internally displaced persons the right to live in satisfactory conditions of health, not to impede humanitarian assistance or their passage, and not to attack humanitarian personnel and resources deployed for humanitarian assistance.<sup>82</sup> Still, this provision makes it clear that it shall be governed by international law, and in particular IHL; it is thus intended to apply in armed conflicts, where frequently the more specific norms on this issue would be found in IHL, not IHRL, and many of the prohibited acts are couched in IHL rather than IHRL language.<sup>83</sup> Moreover, those explicitly addressed by the provision are individual members of armed groups and not the group as such.<sup>84</sup>

Increasingly, the United Nations (UN) Security Council and UN human rights experts have been grappling with the question of whether non-state armed groups are bound by IHRL. Since the 1990s, the UN Security Council has frequently called on non-state armed groups to uphold human rights.<sup>85</sup> Notwithstanding the lack of clarity as to whether the UN Security Council in specific country situations meant to actually make legal statements rather than political appeals, there are some nuanced examples of this. For instance, in resolutions adopted in the context of the

80 Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict, 25 May 2000, 2173 UNTS 222.

81 Paul C. Szasz, ‘General law-making processes’, in Oscar Schachter and Christopher C. Joyner (eds), *United Nations Legal Order*, Vol. 1, Cambridge University Press, Cambridge, 1995, p. 46. For the contrary view, see, in particular, Andrew Clapham, *Human Rights Obligations of Non-State Actors*, Oxford University Press, Oxford, 2006, p. 75 (with further references).

82 African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa (Kampala Convention), 22 October 2009, available at: [www.africa-union.org/root/au/Conferences/2009/october/pa/summit/doc/Convention%20on%20IDPs%20\(Eng\)%20-%20Final.doc](http://www.africa-union.org/root/au/Conferences/2009/october/pa/summit/doc/Convention%20on%20IDPs%20(Eng)%20-%20Final.doc).

83 Stephane Ojeda, ‘The Kampala Convention on Internally Displaced Persons: some international humanitarian law aspects’, in *Refugee Survey Quarterly*, Vol. 29, 2010, pp. 65–66.

84 Annyssa Bellal, Gilles Giacca and Stuart Casey-Maslen, ‘International law and armed non-state actors in Afghanistan’, in *International Review of the Red Cross*, Vol. 93, No. 881, 2011, pp. 66–67.

85 See, for instance, SC. Res. 1193, 28 August 1998, op. para. 14; SC. Res. 1216, 21 December 1998, op. para. 5; SC. Res. 1464, 4 February 2003, op. para. 7; SC. Res. 1804, 15 March 2008, Preamble para. 4 and op. para. 2; SC. Res. 1881, 30 July 2009, Preamble para. 8 and op. para. 7; SC. Res. 1935, 30 July 2010, Preamble para. 12 and op. para. 9; SC. Res. 1964, 22 December 2010, Preamble para. 17 and op. para. 15.

Democratic Republic of the Congo, the Council has maintained a strict distinction between ‘human rights violations’ committed by government armed forces, and ‘human rights abuses’ committed by non-state armed groups.<sup>86</sup> Moreover, in thematic resolutions on children in armed conflicts in the context of the Monitoring and Reporting Mechanism on children and armed conflict, the Security Council has been consistent in stressing that the resolutions do not seek to prejudge the legal status of non-state armed groups, and that they contrast ‘violations’ with ‘abuses’.<sup>87</sup>

The treatment of this issue by Special Procedures of the UN Human Rights Council and by other experts presents a mixed record. Among others, the Special Rapporteurs on Terrorism and Human Rights, on Extrajudicial, Summary, or Arbitrary Executions, and on Human Rights Defenders have dealt with the issue. The former Special Rapporteur on Terrorism and Human Rights concluded that she was unable to support fully suggestions that non-state actors are directly accountable under human rights law. However, she made the case that the international community increasingly requires non-state actors engaged in armed conflicts to promote and protect human rights in areas over which they exercise *de facto* control, and recommended further stocktaking in this regard.<sup>88</sup>

The former Special Rapporteur on Extrajudicial, Summary, or Arbitrary Executions was cautious to emphasise that neither the LTTE in Sri Lanka nor Hezbollah in Lebanon had legal obligations under the International Covenant on Civil and Political Rights (ICCPR), but that they remained subject to the demand of the international community, in line with the UDHR, that every organ of society respect and promote human rights. On the other hand, he suggested that it was especially appropriate and feasible to call for a non-state armed group to respect human rights norms when it exercises significant control over territory and population and has an identifiable structure.<sup>89</sup>

The UN Special Rapporteur on Human Rights Defenders argued that non-state actors had a responsibility to respect the rights of others in accordance with the UN Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society.<sup>90</sup> However, during the debate on the latter report in the

86 SC. Res. 1906, 23 December 2009, op. paras. 10–11; SC. Res. 1925, 28 May 2010, op. paras. 12(c) and 18. SC. Res. 1612, 26 July 2005, Preamble para. 8 and op. paras. 1, 2(a) and 5; SC. Res. 1882, 4 August 2009, Preamble para. 11 and op. paras. 1, 3, 5(a)(b)(c); SC. Res. 1998, 12 July 2011, Preamble para. 10 and op. paras. 3(b), 6(d) and 11.

88 Commission on Human Rights, Final Report of the Special Rapporteur, Kalliopi K. Koufa, on Terrorism and Human Rights, UN Doc. E/CN.4/Sub. 2/2004/40, 25 June 2004, paras. 54–64, 73.

89 Commission of Human Rights, Report of the Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions, Philip Alston, Mission in Sri Lanka, UN Doc. E/CN.4/2006/53/Add.5, 27 March 2006, paras. 25–27; Human Rights Council, Report of the Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions, Philip Alston; the Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Physical and Mental Health, Paul Hunt; the Representative of the Secretary-General on Human Rights of Internally Displaced Persons, Walter Kälin; and the Special Rapporteur on Adequate Housing as a Component of the Right to an Adequate Standard of Living, Milon Koothari, Mission to Lebanon and Israel, UN Doc. A/HRC/2/7, 2 October 2006, para. 19.

90 UN General Assembly, Report by Special Rapporteur Margaret Sekaggya on Human Rights Defenders, UN Doc. A/65/223, 4 August 2010, paras. 21–22.



Third Committee of the UN General Assembly, certain delegations, including the EU, the United Kingdom and Pakistan, made clear their position that only states, not non-state actors, have legal obligations under IHRL.<sup>91</sup>

More recently, in 2011, the Commission of Inquiry on Libya, mandated by the UN Human Rights Council to investigate alleged violations of IHRL in Libya, stated that although the extent to which IHRL binds non-state actors remains contested as a matter of international law, it was increasingly accepted that where non-state armed groups exercise *de facto* control over territory, they must respect the fundamental human rights of persons in that territory.<sup>92</sup> However, in the subsequent debates on a resolution in the Human Rights Council, a number of states were opposed to calling on the Transitional National Council, the authority at the head of the then non-state party to the conflict challenging the authority of the Qaddafi state armed forces party to the conflict, to respect IHRL obligations.<sup>93</sup>

The applicability of IHRL to non-state armed groups has also attracted controversy in scholarly legal writings in recent years, with some arguing in favour of expanding the scope of subjects bound by IHRL beyond states and state-created entities such as international organisations in order to include non-state actors, in particular non-state armed groups, while others have rejected the applicability of IHRL to non-state armed groups.<sup>94</sup>

This review shows that there is no consensus among states and experts that non-state armed groups incur legal obligations under IHRL. However, there is an enhanced recognition that where non-state armed groups as entities have the semblance of state authority and exercise *de facto* authority over a population, they are expected to respond positively to the moral rather than legal expectations of the international community to respect IHRL. In this regard, the ICRC, on its part, recognises a limited exception to its principled position that non-state armed groups do not incur IHRL obligations where a group, by virtue of stable control over

91 UN General Assembly, Third Committee, Summary Record of the 25th meeting, 21 October 2010, UN Doc. A/C.3/65/SR.25, Statements by Mr. Huth (European Union); Ms. Freedman (United Kingdom); and Mr. Butt (Pakistan), paras. 14, 21 and 24.

92 Human Rights Council, Report of the International Commission of Inquiry to investigate all alleged violations of international human rights law in the Libyan Arab Jamahiriya, UN Doc. A/HRC/17/44, 1 June 2011, para. 72.

93 Especially Argentina, Chile and Lebanon made the legal argument that IHRL does not bind non-state armed groups. Other states, including China, Nigeria (on behalf of the African Group), Brazil, Russia, Algeria, Indonesia, Botswana and Guatemala were opposed to calling on the Transitional National Council (TNC) to respect IHRL, as this may imply an implicit political recognition of the TNC as the new legal government of Libya. See Human Rights Council, 17<sup>th</sup> session, June 2011 (personal notes of this author).

94 In favour: see, for example, A. Clapham, above note 81; A. Bellal, G. Giacca and S. Casey-Maslen, above note 84, pp. 64–74; Christian Tomuschat, 'The applicability of human rights law to insurgent movements', in Horst Fischer *et al.* (eds), *Krisensicherung und Humanitärer Schutz – Crisis Management and Humanitarian Protection: Festschrift für Dieter Fleck*, Berliner Wissenschafts-Verlag, Berlin, 2004, pp. 573–591. Against: see Liesbeth Zegveld, *The Accountability of Armed Opposition Groups in International Law*, Cambridge University Press, Cambridge, 2002; Lindsay Moir, *The Law of Internal Armed Conflict*, Cambridge University Press, Cambridge, 2002, p. 194.

territory, has the ability to act like a state authority. In these circumstances, such a group's human rights *responsibilities* may be recognised *de facto*.<sup>95</sup>

That said, many questions remain unanswered in relation to the proposition that non-state armed groups may have responsibilities or – as some claim – obligations under IHRL: notably, what the precise threshold is, in terms of authority over population, territorial control and organisation of the non-state armed group, for triggering these responsibilities; what rights would be encompassed by these responsibilities (all human rights, only those rights which the non-state armed group is in a capacity to respect, or 'core' human rights, *inter alia*, by reference to the non-derogable provisions of IHRL treaties or *ius cogens* norms?); and whether these responsibilities would correspond merely with negative state obligations to respect, or whether they would also be equivalent to positive state obligations to protect and fulfil.<sup>96</sup>

With these differences between IHL and IHRL in mind, the next section looks at the commonalities between these legal regimes, irrespective of whether the situation at hand is one of armed conflict or another emergency.

## **Commonalities regarding the protection of the provision of health care under IHL and IHRL**

There are significant commonalities in the protective regime in relation to the delivery of impartial health care between the specific IHL protections for the wounded and sick and medical personnel, units and transports, and, in particular, the obligations to respect and protect the rights to life and health under IHRL, as far as states' armed or security forces involved in armed conflict and other emergencies are concerned. They include the basic obligation to provide essential medical care and attention, and more specific obligations and prohibitions that give effect to this basic obligation, including prohibitions against attacking, arbitrarily killing, or ill-treating the wounded and sick or medical personnel; the prohibition against arbitrarily limiting, or denying the passage of medical personnel and supplies; the prohibition against harassing or punishing health-care personnel for performing activities compatible with medical ethics; and the obligation to protect the wounded and sick and health-care personnel and infrastructure against harmful interferences with the provision of health care by third persons. This article will now present a commentary on each of these common obligations and prohibitions, outlining their legal bases and how they are interpreted.

95 Note that the terminology used by the ICRC is 'responsibilities' and thus falls short of recognising legally binding obligations. See ICRC, 'International Humanitarian Law and the challenges of contemporary armed conflicts', 31<sup>st</sup> International Conference of the Red Cross and Red Crescent, available at: [www.icrc.org/conf/2013/en/31IC\\_IHL\\_challenges\\_report\\_EN.pdf](http://www.icrc.org/conf/2013/en/31IC_IHL_challenges_report_EN.pdf).

96 A. Bellal, G. Giacca and S. Casey-Maslen, above note 84, pp. 71–72.

*All possible measures shall be taken to provide and facilitate essential health care on a non-discriminatory basis to the wounded and sick*

Under IHL, all parties to armed conflicts, including non-state parties, have the basic obligation to provide the wounded and sick with medical care and attention as far as practicable and with the least possible delay. Medical care and attention must be provided in an impartial manner – that is, without any adverse distinction based on grounds other than medical ones.<sup>97</sup> The qualification of ‘as far as practicable and with the least possible delay’ means that this obligation is not absolute, but rather requires parties to take all possible measures subject to their resources and to the feasibility of such measures in the midst of hostilities.<sup>98</sup> However, nobody may wilfully be left without medical assistance.<sup>99</sup>

As has been mentioned, beyond those obligations applicable in all types of armed conflicts, the law of occupation contains broader obligations to preserve the existing public health-care system in occupied territories, while IHL other than the law of occupation does not enshrine such far-reaching obligations. For addressing the most pressing needs – for instance, the shortage of essential supplies and services for the civilian population – parties to the conflict concerned must discharge their obligations relating to humanitarian assistance. Thus, in all situations of armed conflict, if the civilian population is inadequately supplied with items essential to its survival, humanitarian relief actions must be undertaken, subject to the consent of the parties concerned, in particular the territorial state.<sup>100</sup> However, such consent must not be withheld arbitrarily.<sup>101</sup>

IHL is also very specific in operationalising the facilitation of the provision of medical care, bearing in mind that the wounded and sick will be left on the battlefield after the fighting. In this regard, IHL prescribes that, whenever circumstances permit and particularly after an engagement, parties to armed conflicts must, without delay, take all possible measures to search for, collect and evacuate the wounded and sick without adverse distinction.<sup>102</sup>

In terms of IHRL, the immediate obligations and the core obligations emanating from the right to health provide the most obvious basis to argue for a fundamental obligation to take all possible measures to provide and facilitate essential health care to the wounded and sick in a non-discriminatory manner.

Furthermore, the obligation to ensure the provision of essential health care can also be based on the right to life under IHRL. In this regard, the Human Rights

97 GC I–IV, Common Art. 3(2); GC I, Art. 12; GC II, Art. 12; AP I, Art. 10(2); AP II, Art. 7(2); Customary IHL Study, Rule 110, pp. 400–403.

98 Commentary on AP I, Art. 10, pp. 146–147, paras. 446, 451.

99 GC I/GC II, Art. 12(2).

100 As noted above in footnote 34, in situations of occupation, an Occupying Power must permit humanitarian relief actions where basic needs of civilians are not met. Refusing consent is not an option. See Art. 59 of GC IV and Art. 69 of AP I. For situations of armed conflict other than occupation, see GC IV, Art. 23; AP I, Arts. 70–71; AP II, Art. 18(2); Customary IHL Study, Rule 55.

101 Commentary on Customary IHL Study, Rule 55, p. 197.

102 GC I, Art. 15(1); GC II, Art. 18; AP II, Art. 8; Customary IHL Study, Rule 109, pp. 396–399.

Committee, the treaty monitoring body of the ICCPR, in its General Comment No. 6 on the right to life, emphasised that ‘the right to life has been too often narrowly interpreted. The expression “inherent right to life” cannot be properly understood in a restrictive manner, and the protection of this right requires that states adopt positive measures.’<sup>103</sup> In connection to this, the Human Rights Committee noted, *inter alia*, the desirability for states parties to take all possible measures to increase life expectancy, including by adopting measures to eliminate epidemics.<sup>104</sup> Thus, the Human Rights Committee interprets the scope of the general obligation to ensure the right to life under Article 6 of the ICCPR as going beyond the protection against arbitrary killing and extending to other threats to human life, such as life-threatening illness.<sup>105</sup>

This scope of the positive obligations under the right to life has also been recognised by the European Court of Human Rights (ECtHR).<sup>106</sup> Specifically, in *Cyprus v. Turkey*, Greek Cypriots living in the occupied northern part of the island claimed that restrictions on the ability to receive medical treatment and the failure to provide or permit receipt of adequate medical services gave rise to a violation of their right to life.<sup>107</sup> The ECtHR recognised that ‘an issue may arise under Article 2 of the Convention where it is shown that the authorities of a Contracting State put an individual’s life at risk through the denial of health care which they have undertaken to make available to the population generally’.<sup>108</sup> The UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, a soft-law instrument that constitutes an authoritative interpretation on the modalities of the use of force, also confirm the inter-relation between the provision of essential health care and the protection of the right to life by emphasising that whenever the lawful use of force and firearms is unavoidable, law enforcement officials shall ensure that assistance and medical aid are rendered to any injured or affected persons at the earliest possible moment.<sup>109</sup>

International criminal law, especially on crimes against humanity, provides another basis on which to argue that the denial of life-saving health care may constitute a violation of the right to life. This is because it is now widely recognised that the underlying offences of crimes against humanity can be committed outside of an armed conflict and are thus linked to IHRL, as is apparent from the most elaborate codification of these crimes in Article 7 of the International Criminal

103 HRC, General Comment No. 6: The right to life, 30 April 1982, para. 5, available at: [www.unhchr.ch/tbs/doc.nsf/0/84ab9690ccd81fc7c12563ed0046fae3](http://www.unhchr.ch/tbs/doc.nsf/0/84ab9690ccd81fc7c12563ed0046fae3).

104 *Ibid.*

105 M. Nowak, above note 61, p. 123.

106 ECtHR, *Cyprus v. Turkey*, App. No. 25781/94, Judgment of 10 May 2001, para. 219; ECtHR, *Berktaş v. Turkey*, Judgment of 1 March 2001, para. 154; ECtHR, *Ilhan v. Turkey*, Judgment of 27 June 2000, para. 76; ECtHR, *L.C.B. v. United Kingdom*, Judgment of 9 June 1998, para. 36.

107 ECtHR, *Cyprus v. Turkey*, above note 106, para. 216.

108 *Ibid.*, para. 219. However, the Court was not prepared to find such a violation on the specific facts of the case since in its view it was not established that the lives of any patients were put in danger on account of delays in receiving medical treatment imposed by the Turkish Republic of Northern Cyprus authorities.

109 Principle 5(c), 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, Cuba, 27 August–7 September 1990, UN Doc. A/CONF.144/28/Rev. 1.

Court (ICC) Statute. Particularly interesting for the present purposes are the underlying offences of murder and extermination, which are specific manifestations of violations of the right to life. Apart from the general constitutive elements for crimes against humanity,<sup>110</sup> for murder it is necessary to show the causation of death through an act or an omission with the intention to kill or to cause serious bodily harm where the perpetrator was aware that death would occur in the ordinary course of events.<sup>111</sup> Thus, the deliberate denial of life-saving health care may constitute murder by omission. Even more interestingly, extermination involves mass killings, including by inflicting conditions of life calculated to bring about the destruction of part of a population. In this regard, the ICC Elements of Crimes on the crime against humanity of extermination expressly give the example of deprivation of access to food and medicine as inflicting such conditions of life.<sup>112</sup>

Unlike IHL, IHRL does not enshrine specific obligations to search for and collect the wounded and sick. However, the CESCR has emphasised that health facilities, goods, and services must be within safe physical reach for all sections of the population.<sup>113</sup> Further, it may be derived from the general obligations under the right to health and the right to life that states must take positive measures to facilitate access to health care on a non-discriminatory basis, especially in cases where persons are injured or affected by the prior use of force by law enforcement officials, as seen above.

These basic obligations to facilitate the provision of essential health care to the wounded and sick provide the basis for more specific conduct required for the benefit of the wounded and sick and health-care personnel, facilities and medical transports under IHL and IHRL.

*The wounded and sick and health-care personnel that pursue their exclusively medical function shall not be attacked, arbitrarily deprived of their lives or ill-treated. The use of force against health-care personnel is only justified in exceptional circumstances*

Under IHL, the basic obligation to respect the wounded and sick entails, in particular, not attacking, killing, ill-treating or harming them in any way.<sup>114</sup> By

110 In accordance with Art. 7(1) of the ICC Statute, crimes against humanity must be committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack.

Art. 7(2)(a) of the ICC Statute defines an ‘attack directed against any civilian population’ as a course of conduct involving the multiple commission of acts referred to in para. 1 against any civilian population, pursuant to or in furtherance of a state or organisational policy to commit such attack.

111 Elements of Crimes to Art. 7(1)(a) of the ICC Statute, available at: [www.icc-cpi.int/NR/rdonlyres/336923D8-A6AD-40EC-AD7B-45BF9DE73D56/0/ElementsOfCrimesEng.pdf](http://www.icc-cpi.int/NR/rdonlyres/336923D8-A6AD-40EC-AD7B-45BF9DE73D56/0/ElementsOfCrimesEng.pdf); ICC, *Prosecutor v. Bemba Gombo*, ICC-01/05-01/08, Decision Pursuant to Art. 61 (7)(a) and (b) of the Rome Statute on the Charges, 15 June 2009, paras. 131–138; International Criminal Tribunal for Rwanda, *Prosecutor v. Akayesu*, ICTR-96-4-T, Judgment of 2 September 1998, paras. 589–590; International Criminal Tribunal for the Former Yugoslavia, *Prosecutor v. Jelicic*, IT-95-10-T, Judgment of 14 December 1999, para. 51.

112 Elements of Crimes to Art. 7 (1)(b) of the ICC Statute, above note 111.

113 CESCR, General Comment No. 14, above note 29, paras. 12, 43.

114 GC I, Art. 12; GC II, Art. 12; GC IV, Art. 16; AP I, Art. 10; AP II, Art. 7; Commentary on AP I, Art. 10, p. 146, para. 446.

definition under IHL, persons must refrain from acts of hostility in order to benefit from the protected status of wounded and sick.<sup>115</sup>

From the basic obligations in relation to the wounded and sick flow the specific IHL protections of medical personnel, units and transports exclusively assigned to medical purposes by a competent authority of a party to the conflict.<sup>116</sup> In this regard, the obligation to respect medical personnel, units and transports pursuing their exclusively humanitarian task, whether military or civilian, means that they may not be attacked or harmed, even if no wounded and sick are contained in a medical unit or transport or even if medical personnel momentarily do not treat any wounded and sick at a given point in time.<sup>117</sup> The obligations to respect and to protect them further entail, in the context of the conduct of hostilities, that not only direct and indiscriminate attacks but also attacks which may be expected to cause excessive harm to medical personnel, units and transports, as persons and objects entitled to specific protection, are prohibited on account of the medical, non-combatant function of these persons and objects.<sup>118</sup>

Moreover, the obligations to respect and protect require parties to the conflict to take feasible precautions to spare the wounded and sick, as well as medical personnel, units and transports, in attacks and from the effects of attacks.<sup>119</sup> These obligations are also based on the general obligations under the rules on the conduct of hostilities. In this regard, parties to the conflict are required to do everything feasible to verify that objectives to be attacked are military objectives and are neither civilians nor civilian objects, nor *entitled to special protection*, such as medical personnel, units and transports. Furthermore, they are obliged to cancel or suspend an attack when it becomes apparent that the objective is not a military one or is *subject to special protection*.<sup>120</sup> Parties to the conflict must also take all feasible precautions in the choice of means (weapons) and methods of attack (the way in which weapons are used) with a view to avoiding, or in any event minimising, incidental civilian harm, which can also be applied, *mutatis mutandis*, to all medical personnel, units and transports, whether civilian or military.<sup>121</sup>

115 See AP I, Art. 8(a).

116 Commentary on GC I, Art. 12, p. 134.

117 GC I, Arts. 19(1), 24–26, 35; GC II, Arts. 23, 36; GC IV, Arts. 18, 20, 21; AP I, Arts. 12(1), 15, 21; AP II, Arts. 9, 11(1); Customary IHL Study, Rules 25, 28, 29, pp. 79, 84–85, 91, 97–98, 102.

118 Commentary on GC IV, Art. 18, pp. 147–148; Commentary on AP I, Art. 12, p. 171, paras. 539–540. Other persons not exclusively assigned to medical activities by a party to the conflict would also generally benefit from protection against direct, indiscriminate attacks and attacks which may be expected to cause excessive civilian harm compared to the anticipated concrete and direct military advantage if they are civilians. See AP I, Art. 51; Customary IHL Study, Rules 1, 11, 14.

119 Commentary on GC IV, Art. 18, p. 148; Commentary on AP I, Art. 12, p. 171, para. 540.

120 API, Arts. 57(2)(a)(i), 57(2)(b); Customary IHL Study, Rules 16 and 19.

121 See, for instance, Australia, *Manual of the Law of Armed Conflict*, Australian Defence Doctrine Publication 06.4, Australian Defence Headquarters, 11 May 2006, para. 5.9: 'Proportionality requires a commander to weigh the military value arising from the success of the operation against the possible harmful effects to *protected persons and objects*. There must be an acceptable relationship between the legitimate destruction of military targets and the possibility of consequent collateral damage'; Canada, *Law of Armed Conflict Manual*, 2001, para. 204.5: 'In deciding whether the principle of proportionality is being respected, the standard of measurement is the anticipated contribution to the military purpose of an attack or operation considered as a whole. The anticipated military advantage must be balanced against

These obligations are of particular importance in situations where first-aid personnel, who may or may not fall under the IHL category of medical personnel, rush to the scene of an attack or attacks to collect and evacuate wounded persons. In these circumstances, the importance of compliance with the obligation to do everything feasible to verify whether the object to be again attacked remains a military objective or whether it has effectively been destroyed or neutralised cannot be overemphasised. The fact that health-care personnel arrive on the scene after an attack or several attacks also inevitably influences the way attackers must discharge their precautionary obligations to choose methods of attack with a view to avoiding or at least minimising incidental harm to such personnel in a subsequent attack on the same military objective. This would call for restraint in particular with regard to the timing of an attack.<sup>122</sup> Consequently, an attacker should wait until first-aid personnel have collected and evacuated the wounded and sick from the scene of a prior attack. The presence of medical personnel must also be factored into the proportionality assessment of whether the harm expected from a follow-up attack to civilians and medical personnel, as well as medical units and transports, would be excessive in relation to the direct and concrete military advantage anticipated.

Unfortunately, several expert workshops convened in the Health Care in Danger project as well as the recent ICRC publication on violent incidents in 2012 have identified an emerging worrisome pattern by attackers that shows a manifest disregard for these precautionary obligations. It was observed that attackers, belonging to both states and non-states party to the conflict, rapidly directed unlawful intentional follow-up attacks against those coming to the aid of victims of a prior attack or attacks.<sup>123</sup> This severely restricts the circumstances and possibilities for a defending party to the conflict to discharge its obligation to search for and collect the wounded and sick without delay after an engagement. In the same vein, first-aid personnel from National Red Cross and Red Crescent Societies

other consequences of the action, such as the adverse effect upon civilians or civilian objects. It involves weighing the interests arising from the success of the operation on the one hand, against the possible harmful effects upon protected persons and objects on the other'; New Zealand, *Interim Law of Armed Conflict Manual*, DM 112, New Zealand Defence Force Headquarters, Directorate of Legal Services, Wellington, November 1992, para. 207: 'The principle of proportionality establishes a link between the concepts of military necessity and humanity. This means that the commander is not allowed to cause damage to non-combatants which is disproportionate to military need ... It involves weighing the interests arising from the success of the operation on the one hand, against the possible harmful effects upon protected persons and objects on the other'; Philippines, *Air Power Manual*, Philippine Air Force Headquarters, Office of Special Studies, May 2000, para. 1-6.4: 'However, LOAC should not serve as an obstacle in the conduct of operations. In fact, the law recognizes the belief that the destruction of vital targets, especially if it shortens the conflict, has its long term humane effects. The chief unifying principle always applies - that the importance of the military mission (military necessity) determines, as a matter of balanced judgment (proportionality), the extent of permissible collateral or incidental injury to [an] otherwise protected person or object'; Hungary, *Military Manual*, 1992, p. 45: 'All possible measures must be taken to spare civilian persons and objects [and] specifically protected persons and objects' (these manuals are all available at: [www.icrc.org/customary-ihl/eng/docs/v2\\_rul\\_rule14](http://www.icrc.org/customary-ihl/eng/docs/v2_rul_rule14) and [www.icrc.org/customary-ihl/eng/docs/v2\\_rul\\_rule15](http://www.icrc.org/customary-ihl/eng/docs/v2_rul_rule15)); AP I, Art. 57(2)(a)(ii); Customary IHL Study, Rule 17.

122 On the timing aspect in relation to this obligation, see Jean-François Quéguiner, 'Precautions under the law governing the conduct of hostilities', in *International Review of the Red Cross*, Vol. 88, No. 864, 2006, p. 800.

123 See, for example, ICRC, *Violent Incidents Affecting Health Care*, above note 7, pp. 9-10.



or other impartial health-care providers may be prevented from assisting a party to the conflict in the search for and collection of the wounded and sick. When faced with these practices, first-aid personnel may become reluctant to quickly search for, collect and evacuate the wounded and sick from the battlefield after a prior attack out of concern for their own safety. This would be detrimental to the wounded and sick and to entire communities who depend on effective and rapid assistance. Thus, in such situations, there is a heightened dilemma for health-care personnel regarding how to find an acceptable balance between ensuring their own safety and providing rapid, life-saving health-care services on the spot.

One particular precautionary obligation against the effects of attacks contained in IHL treaty law applicable in international armed conflicts is that parties to the conflict shall, as far as possible, ensure that medical units are situated in such a manner that attacks against military objectives do not endanger their safety.<sup>124</sup> While this obligation would naturally best be complied with if medical units were situated far away from any military objective, the caveat of ‘as far as possible’ makes it clear that it may be realistic in some circumstances but unrealistic in others that medical units would not operate in the vicinity of a military objective; in this regard, it is stressed that this precautionary obligation has its value especially in the context of aerial bombardment.<sup>125</sup> However, remoteness from military objectives may be unrealistic where, for instance, existing medical units are already located in the vicinity of military objectives, in the case of mobile medical units such as field hospitals or first-aid stations which may frequently operate in proximity to the battlefield, or where urban fighting comes close to a medical unit.<sup>126</sup>

Medical personnel, units and transports may lose their specific protection if they commit, outside their humanitarian functions, acts harmful to the enemy. ‘Acts harmful to the enemy’ may be understood as acts the purpose or effect of which is to harm the adverse party, by facilitating or impeding military operations.<sup>127</sup> The rationale for such a loss of protection is clear: medical personnel, units and transports should not become involved, in any way, in military operations in support of a party to the conflict. Such acts may engender a general climate of mistrust that also affects other health-care providers, who may face increased levels of insecurity and violence in their work. Ultimately this will have a negative impact on the wounded and sick, who may not receive the required medical care and attention.

The phrase ‘outside of their humanitarian functions’ as an additional requirement makes it clear that even if a certain conduct may appear to constitute

124 See GC I, Art. 19(2); GC IV, Art. 18(5); AP I, Art. 12(4); Customary IHL Study, p. 96. This may be considered a specific expression in the case of medical units of the general customary precautionary obligation, applicable in international and non-international armed conflicts, to the extent feasible, to remove civilians and civilian objects under the control of a party to the conflict from the vicinity of military objectives. See AP I, Art. 58(a); Customary IHL Study, Rule 24.

125 Commentary on GC I, Art. 19, p. 198; Commentary on GC IV, Art. 18, p. 153; Commentary on AP I, Art. 12, p. 171, para. 542.

126 Commentary on GC IV, Art. 18, p. 153; Commentary on AP I, Art. 12, p. 172, para. 545.

127 Commentary on GC I, Art. 21, p. 200; Commentary on GC I, Art. 24, p. 221; Commentary on GC IV, Art. 20, p. 161.



an ‘act harmful to the enemy’, it will still not lead to a loss of protection where it remains within the humanitarian tasks of medical personnel, units and transport. This would preclude an interpretation of ‘acts harmful to the enemy’ based on the mere presence of, for instance, mobile medical units on or near military objectives, as such presence could be due to purely humanitarian reasons.<sup>128</sup>

Examples of ‘acts harmful to the enemy, outside their humanitarian functions’ include the use of a medical unit as a shelter for able-bodied combatants or fugitives, as an arms or ammunition dump, as a military observation post, as a centre for liaison with fighting troops, or as a shield for a military objective;<sup>129</sup> the transport of able-bodied soldiers or weaponry and the collection or transmission of military information;<sup>130</sup> or firing at a military objective in combat.<sup>131</sup>

On the other hand, certain acts are not considered as acts harmful to the enemy – for instance, carrying or using light individual weapons for self-defence or defence of the wounded and sick; the presence of, or escort by, military personnel;<sup>132</sup> the possession of small arms and ammunition taken from the wounded and sick and not yet handed over to the proper authority; merely caring for enemy wounded and sick military personnel; or the mere wearing of the enemy’s military uniforms or bearing of its insignia.<sup>133</sup>

With regard to the notion of ‘light individual weapons’ whose use in self-defence or defence of the wounded and sick in one’s charge would not give rise to a loss of specific protection, this refers to weapons which are generally carried and used by a single individual. Thus not only hand weapons such as pistols are

128 Commentary on AP I, Art. 13, p. 175.

129 Commentary on GC I, Art. 21, pp. 200–201; Commentary on GC IV, Art. 19, p. 154; Commentary on Customary IHL Study, Rule 28, p. 97. An explicit prohibition to use medical units in an attempt to shield military objectives is contained in AP I, Art. 12(4).

130 Commentary on AP I, Art. 23, para. 925; Commentary on Customary IHL Study, Rule 29, p. 102.

131 Commentary on AP I, Art. 23, para. 925. Where the conduct of medical personnel amounts to what is considered for civilians to be direct participation in hostilities, in violation of the principle of strict neutrality and outside the humanitarian function of medical personnel, this would qualify as an act harmful to the enemy. See Commentary on Customary IHL Study, Rule 25, p. 85. It should be emphasised that the notion of ‘direct participation in hostilities’ has a different scope, as it applies to civilians only, from that of ‘acts harmful to the enemy’, which may be committed by both military or civilian medical personnel. In addition, ‘acts harmful to the enemy’ is also the standard governing loss of protection of medical objects, not only persons, i.e. medical units and transports.

132 The Red Cross and Red Crescent Movement has a principled stance against the use of any armed protection. This position was taken in Resolution 9 of the 1995 Council of Delegates, entitled ‘Armed Protection of Humanitarian Assistance’, and was more recently reaffirmed in Resolution 7 of the 2005 Council of Delegates, entitled ‘Guidance Document on Relations between the Components of the Movement and Military Bodies.’ The reason for this fundamental objection to armed escorts is that any armed protection for any component of the Movement is in conflict with the Fundamental Principles of humanity, independence, impartiality and neutrality. However, these Council of Delegates resolutions, and in particular the report on the use of armed protection annexed to Resolution 9 of the 1995 Council of Delegates, recognise that there may be exceptional situations in which human lives may be saved only by accepting an armed escort, and hence where the principle of humanity requires that the Movement accept changes to its normal operating procedures. The report lays down certain *minimum* conditions or questions that should be fulfilled and answered in the affirmative which are endorsed by the aforementioned resolutions before a decision by a component of the Movement is taken to accept an armed escort. Yet, medical transports that are not part of the Red Cross and Red Crescent Movement might operate with military convoys and in some cases be obliged to be part of a military convoy.

133 GC I, Art. 22; AP I, Art. 13; Commentary on Customary IHL Study, Rules 25 and 29, pp. 85 and 102.

permitted, but also rifles or even sub-machine guns; however, machine guns and other heavy arms which cannot easily be transported by an individual and which have to be operated by a number of people are not covered by the notion of 'light individual weapons'. Hence their use would give rise to a loss of specific protection.<sup>134</sup>

It needs to be emphasised that even light individual weapons can strictly only be used where necessary for self-defence or defence of the wounded and sick. This includes defence against violence by looters or marauders or unlawful attacks directed against the wounded and sick or medical personnel by enemy combatants or fighters, and actions aimed at the maintenance of order inside a medical unit, for instance to defend against violence among convalescent wounded and sick. In a similar vein, where civilians are involved in medical activities, the use of force in individual self-defence against unlawful attack or looting, rape and murder by marauding soldiers would not entail a loss of protection against direct attack, as such defence lacks a belligerent nexus and thus does not constitute a direct participation in hostilities.<sup>135</sup> However, the use of light individual weapons for purposes such as resisting a military advance by the enemy into territory where a medical unit is located or opposing the capture of such a unit by the adverse party would not be in line with this restrictive understanding of 'defence'; hence, this would amount to facilitating or impeding military operations by an adverse party to the conflict and would thus constitute an act harmful to the enemy.<sup>136</sup>

Similar considerations as to the permissible limits of carrying of weapons for medical personnel apply to the scenario of mounting weapons on medical units or transports. Thus, no armaments could be mounted that could potentially be used in an offensive fashion. On the other hand, purely deflective means of defence, such as chaff, infrared flares or jammers, may be permissible.<sup>137</sup> In a similar vein, the mere use by medical personnel or civilians involved in providing health care of personal protective equipment such as helmets, bulletproof vests or gas masks, or the use of armoured vehicles, would not go beyond the permissible limits of individual defence, as such items serve the exclusively defensive purpose of absorbing the impact of explosive devices or reducing exposure to chemicals or hazardous material.<sup>138</sup>

134 Commentary on AP I, Art. 13, para. 563.

135 ICRC, *Interpretive Guidance on the Notion of Direct Participation in Hostilities*, 2009, p. 61.

136 *Ibid.*, paras. 560–561; Commentary on GC I, Art. 22, p. 203. See also Bosnia and Herzegovina, *Military Instructions*, 1992, Item 15, para. 2; South Africa, *Law of Armed Conflict Manual*, 1996, para. 59 (both manuals are available at: [www.icrc.org/customary-ihl/eng/print/v2\\_rul\\_rule28](http://www.icrc.org/customary-ihl/eng/print/v2_rul_rule28)); United States, *Army Health System, Army Tactics, Techniques, and Procedures*, No. 4-02, August 2013, p. 3–9, para. 3.31; [http://armypubs.army.mil/doctrine/DR\\_pubs/DR\\_a/pdf/atp4\\_02.pdf](http://armypubs.army.mil/doctrine/DR_pubs/DR_a/pdf/atp4_02.pdf).

137 Louise Doswald-Beck (ed.), *The San Remo Manual on International Law Applicable to Armed Conflicts at Sea*, Cambridge University Press, Cambridge, 1995, Commentary on Rule 170, para. 170.3, p. 235.

138 However, what is legally possible to do without losing protection must still be analysed as to its benefits or negative impact in operational terms. In this regard, in the Health Care in Danger workshop in Mexico on ambulances and pre-hospital services, it was recommended that the wearing of such items should be evaluated as to its advantages and disadvantages in the specific context before authorising their use. When a decision is taken on the use of personal protective equipment, adequate training on its proper use should be provided. See Norwegian Red Cross, with support from the Mexican Red Cross and the ICRC,

A loss of specific protection of medical personnel, units and transports is subject to further conditions under IHL before it becomes effective – namely, non-compliance with a due warning that is accompanied, in all appropriate cases, by a reasonable time limit.<sup>139</sup> The purpose of this specific warning is to allow those committing an act harmful to the enemy to terminate such conduct, or – if they persist – to ultimately enable the safe evacuation of the wounded and sick who are not responsible for such conduct and who should not become the innocent victims of such acts.<sup>140</sup> Compared to the general protection of civilians and civilian objects in the conduct of hostilities, the condition of a ‘due warning’ for the purpose of a loss of specific protection of medical personnel, units and transports is not subject to the broad caveat ‘unless circumstances do not permit’, which would, for instance, permit a party to the conflict to dispense with a warning where surprise is of the essence in a particular attack.<sup>141</sup>

However, even in a situation where medical personnel, units or transports have lost their specific protection and may become liable to attack, the obligation to respect and protect the wounded and sick in their charge still requires that efforts are made to spare them and that active measures for their safety are taken.<sup>142</sup> Thus, attacks against medical personnel, units or transports that have lost their protection must comply with the principle of proportionality and the obligation to take all feasible precautions to avoid, or at least minimise, incidental loss of life and (further) injury to the wounded and sick.<sup>143</sup>

The commission of an act harmful to the enemy does not automatically amount to a violation of IHL, as there is no general prohibition under IHL against

*Ambulances and Pre-Hospital Services in Risk Situations*, 2013, pp. 35–38, available at: <http://www.icrc.org/eng/assets/files/publications/icrc-002-4173.pdf> (last visited in May 2014).

- 139 GC I, Art. 21; GC II, Art. 34(1); GC IV, Art. 19(1); AP I, Art. 13(1); AP II, Art. 11(2); Customary IHL Study, Rules 25, 28, 29.
- 140 Jean Pictet (ed.), *Commentary on the Geneva Conventions of 12 August 1949*, International Committee of the Red Cross, Geneva, 1960, Art. 21 of GC I, pp. 201–202; and Art. 19 of GC IV, p. 155. See also Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds.), *Commentary on the Additional Protocols*, ICRC, Geneva 1987, Art. 13 of AP I, p. 176; and Art. 11 AP II, p. 1436.
- 141 See AP I, Art. 57(2)(c). It would seem that the condition of a ‘warning’ for the loss of protection of medical personnel, units and transports would at least in the overwhelming majority of cases be a mandatory requirement that cannot be dispensed with. However, in exceptional circumstances, such as when there is an imminent and serious threat to the lives of advancing combatants or fighters (i.e. when they momentarily receive fire), it might not be realistic to expect an attacker to meet the warning requirement. See Australia, *The Manual of the Law of Armed Conflict*, 2006, para. 9.69; Peru, *International Humanitarian Law Manual*, 2004, Chapter V, para. 88(b)(2); Israel, Supreme Court, sitting as High Court of Justice, *Physicians for Human Rights v. IDF Commander in the West Bank*, No. 2936/02, Judgment of 8 April 2002 (all available at: [www.icrc.org/customary-ihl/eng/print/v2\\_rul\\_rule28](http://www.icrc.org/customary-ihl/eng/print/v2_rul_rule28)). On the other hand, as the time limit is subject to the explicit caveat ‘in all appropriate cases’, it follows that this requirement may be dispensed with more broadly where military necessity so requires.
- 142 See Peru, *International Humanitarian Law Manual*, above note 140, para. 88(b)(2), stating in the context of an attack as a result of a loss of protection of a medical unit: ‘In any event, an attempt must be made to protect the wounded and sick.’
- 143 Alexandra Boivin, *The Legal Regime Applicable to Targeting Military Objectives in the Context of Contemporary Warfare*, Research Paper Series No. 2, University Centre for International Humanitarian Law, 2006, p. 56; Jann K. Kleffner, ‘Protection of the wounded, sick and shipwrecked’, in Dieter Fleck (ed.), *The Handbook of International Humanitarian Law*, 2<sup>nd</sup> ed., Oxford University Press, Oxford, 2008, p. 344.

committing acts harmful to the enemy. However, depending on the circumstances, certain acts harmful to the enemy may, in addition to leading to a loss of protection of medical personnel, units or transports, amount to a violation of precautionary obligations to protect the wounded and sick, as well as health-care personnel and objects under their control, against the effects of attacks. Furthermore, such conduct may give rise to other IHL violations or even serious IHL violations – that is, war crimes. For instance, if medical personnel display one of the emblems as a protective device while committing acts harmful to the enemy, this constitutes a violation of the IHL prohibition against improper use of the distinctive emblem.<sup>144</sup> Moreover, where a protective emblem is displayed to invite the confidence of an adversary and lead him/her to believe that one is protected as medical personnel in order to kill or injure him/her, and this results in the death or injury of that adversary, this amounts to the war crime of perfidious killing or wounding of an adversary.<sup>145</sup>

Under IHRL, states have the obligation not to subject any individuals under their jurisdiction, including the wounded and sick and health-care personnel, to arbitrary deprivations of life.<sup>146</sup> The use of force by state agents against health-care personnel is justified only in law enforcement operations where it is absolutely necessary to defend a person from an imminent threat to their life or bodily integrity; to prevent the perpetration of a particularly serious crime involving grave threat to life; to arrest a person presenting such a danger and resisting authority or to prevent his or her escape; or to quell a riot or insurrection.<sup>147</sup> The ‘absolute necessity’ standard implies that force may only be used where less extreme means, especially an arrest, are insufficient to achieve these objectives.<sup>148</sup> Generally, neither the wounded and sick nor health-care personnel would pose such an imminent threat that warrants the use of force against them. Even when they perpetrate acts of violence other than for their own self-defence or the defence of others, law enforcement officials must issue a clear warning of their intent to use firearms, with sufficient time for the warning to be observed, unless to do so would create a risk of death or serious harm to the police officer concerned or third persons.<sup>149</sup> In contrast to the notion of proportionality under IHL, under IHRL this

144 AP I, Art. 38; AP II, Art. 12; Customary IHL Study, Rule 59.

145 Perfidy is defined as ‘acts inviting the confidence of an adversary to lead him to believe that he is entitled to, or obliged to accord, protection under the rules of international law applicable in armed conflict, with intent to betray that confidence’. See AP I, Art. 37; Customary IHL Study, Rule 65. Where the perfidious use of the distinctive emblem leads to death or serious injury this would amount to a grave breach, in accordance with Art. 85(3)(f) of AP I. Moreover, this also amounts to a war crime under customary international humanitarian law: see Customary IHL Study, Rule 156, pp. 575, 597 and 599. See also the war crime of treacherous killing or wounding in Arts. 8(2)(b)(xi) and 8(2)(e)(ix) of the ICC Statute. Furthermore, making improper use of the distinctive emblems of the Geneva Conventions, resulting in death or serious injury, is also recognised as a war crime in international armed conflicts in Art. 8(2)(b)(vii) of the ICC Statute and under customary IHL. See Customary IHL Study, Rule 156, p. 575.

146 ICCPR, Art. 6(1); ECHR, Art. 2; ACHR, Art. 4; ACHPR, Art. 4.

147 ECHR, Art. 2(2); HRC, *Guerrero v. Colombia*, Communication No. R.11/45, UN Doc. Supp. No. 40(A/37/40), 31 March 1992, paras. 13.2 and 13.3; IACtHR, *Las Palmeras*, Judgment, 26 November 2002, Ser. C No. 96, 2002; M. Nowak, above note 61, p. 128; Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Principles 9 and 10.

148 *Ibid.*, Principle 9.

149 *Ibid.*, Principles 9 and 10.

concept is used not to justify incidental harm to the people and objects surrounding the target of the use of force but rather to minimise the effect of the use of force against the person targeted.<sup>150</sup>

Finally, under IHRL, where the use of force inflicts severe pain or suffering and is out of proportion in relation to a legitimate purpose – for example, to counter an imminent threat to the life or bodily integrity of another person or to quell a riot or an insurrection – it may also offend the obligation of states not to subject any individuals under their jurisdiction to cruel, inhuman or degrading treatment (CIDT). This is because the prohibition on CIDT, as opposed to the prohibition on torture, may also come into play in cases of the use of police force outside detention.<sup>151</sup> Even if less severe pain or suffering is inflicted by such force in a humiliating manner, this may constitute degrading treatment.<sup>152</sup> However, as soon as a wounded or sick person or health-care professional is under the direct physical control of the police by being arrested or detained, no use of force whatsoever is permissible against him or her.<sup>153</sup>

*Access to health facilities, goods and services shall not be arbitrarily limited and denials to such access must be avoided as much as possible*

Under IHL, the obligation to care for the wounded and sick does not only encompass medical treatment, including first-aid treatment, but also entails, for instance, handing them over to a medical unit or ensuring their transport to a place where they can be adequately cared for.<sup>154</sup> Therefore, arbitrarily limiting, or denying medical transports without providing any alternative for conveying the wounded and sick or medical personnel or supplies would violate this obligation. The word ‘arbitrarily’ reflects the extent of the obligation to provide care ‘as far as practicable and with the least possible delay’; this allows for considerations not only of material possibility but also of military necessity,<sup>155</sup> such as controlling medical transports for security reasons at checkpoints, including to ensure that they are not used for committing acts harmful to the enemy. While inevitably military necessity would entail a certain degree of delay, this would then have to be balanced against the humanitarian imperative that medical evacuations imply, so as to minimise delays and avoid denials as much as possible. A prohibition on arbitrarily blocking medical transports may also be derived from the obligation to respect medical personnel, units and transports, as this requires parties to a conflict not to unduly

150 Noam Lubell, ‘Challenges in applying human rights law to armed conflict’, in *International Review of the Red Cross*, Vol. 87, No. 860, 2005, pp. 745–746.

151 ICCPR, Art. 7; CAT, Art. 16; Manfred Nowak, ‘Challenges to the absolute nature of the prohibition of torture and ill-treatment’, in *Netherlands Quarterly of Human Rights*, Vo. 23, 2005, pp. 676–678.

152 *Ibid.*, p. 678.

153 *Ibid.*

154 Commentary on GC I, Art. 12, p. 137; Commentary on AP III, Art. 8, p. 1415, para. 4655.

155 J. K. Kleffner, above note 142, p. 331.

interfere with their work, for example by preventing supplies from reaching medical units.<sup>156</sup>

Furthermore, such a prohibition results from the general obligation of parties to the conflict that whenever circumstances permit, and particularly after an engagement, they must, without delay, take all possible measures to search for, collect and evacuate the wounded and sick.<sup>157</sup> This obligation includes permitting impartial humanitarian organisations to assist in searching for and collecting the wounded and sick; while such humanitarian organisations in practice will need permission from the parties to the conflict concerned to carry out such activities, permission must not be denied arbitrarily.<sup>158</sup> Where wounded and sick civilians, and impartial civilian health-care providers are involved, the prohibition may also be based more generally on the obligations of parties to a conflict in relation to humanitarian assistance, already reviewed above.<sup>159</sup>

Under IHRL, the non-derogable obligation to respect the right to access health-care infrastructure, goods and services on a non-discriminatory basis as part of the right to health requires states to abstain from arbitrarily limiting, or denying such access by the wounded and sick, for instance as a punitive measure against political opponents.<sup>160</sup> Restrictions on access by doctors to the wounded and sick on account of the fact that they are opposed to a government constitute an arbitrary limitation. This is because such restrictions would first and foremost run counter to the fundamental principle of non-discrimination of persons in need of health care. Besides, it is hardly conceivable that states parties could justify such a far-reaching limitation under the limitation clause of Article 4 of the ICESCR, as this would seem to be incompatible with the nature of the right of access to essential health care which again is closely inter-related to the obligations of states to protect the right to life.<sup>161</sup> Moreover, limitations on the grounds of national security could not be invoked where a part of the population would be deprived of urgently needed health care. This is because such a limitation would not serve the economic and social well-being of the state's general population as a whole.<sup>162</sup> Finally, limitations must be proportional, in the sense of seeking the least restrictive alternative where various types of limitations are available.<sup>163</sup> This condition would call for avoiding outright denials of passage to health-care transports and for the minimum possible delay, for instance, of such passage at checkpoints.<sup>164</sup>

156 See, for instance, Commentary on AP I, Art. 12, para. 517.

157 GC I, Art. 15; GC II, Art. 18; AP II, Art. 8; Customary IHL Study, Rule 109.

158 Customary IHL Study, commentary on Rule 109, p. 398.

159 See note 35 above.

160 CESCR, General Comment No. 14, above note 29, paras. 34, 43, 47 and 50.

161 *Ibid.*, para. 28.

162 ICESCR, Art. 4; P. Alston and G. Quinn, above note 66, p. 202.

163 ICESCR, Art. 5; CESCR, General Comment No. 14, above note 29, para. 29.

164 One of the thematic areas with which the Health Care in Danger project is concerned, notably the improvement of standard operating procedures to expedite controls at military and security checkpoints, may lead to a strengthening of respect for the prohibition against arbitrarily limiting or denying, as much as possible, access to health care. This will be among the issues to be discussed in the Health Care in Danger military expert workshop in Sydney in December 2013. Under the right to health, the adoption of



*Health-care personnel shall not be hindered in the performance of their exclusive medical tasks. They shall not be harassed for the simple fact of assisting the wounded and sick, and must not be compelled to denounce wounded and sick in their care, subject to exceptions expressly provided under IHL, IHRL and national law*

The IHL obligation to respect medical personnel and medical units performing their exclusively humanitarian function also means that parties to a conflict must allow medical personnel to treat the wounded and sick and not unduly impede the functioning of a medical unit.<sup>165</sup>

In this regard, IHL does not prohibit entry into medical units by security forces, armed forces or armed groups carrying weapons *per se*. This is a manifestation of the pragmatic approach that IHL takes, and a recognition that such armed entries may be undertaken for legitimate purposes such as searching for alleged criminals; interrogating and arresting suspects; searching for and arresting combatants or fighters posing an imperative threat to their security; or verifying that a medical unit is not used for military purposes.<sup>166</sup> Armed entry may also occur when, for instance, already detained combatants or fighters, upon seeking medical treatment in a civilian medical unit, are accompanied by armed combatants or fighters of the detaining power. Such armed entries are not prohibited by IHL either – on the contrary, this may even be necessary to preserve the ability to effectively implement the obligation to provide medical care and attention to the wounded and sick without adverse distinction. To recall, differences in medical treatment must be based only on medical grounds, and not on whether the patient is civilian or military or whether he or she has previously directly participated in hostilities.

On the other hand, from a humanitarian perspective, a significant presence of weapon-bearers in a medical unit may contribute to a sense of insecurity of health-care personnel and the wounded and sick cared for in the unit. This relates to the fact that armed entries may have the effect of disrupting the normal functioning of a medical unit. As a result, access by doctors to patients may be obstructed, health-care personnel and the wounded and sick threatened, and vital medical treatment to the wounded and sick delayed or denied. Furthermore, a significant armed presence inside a medical unit may raise suspicion with an opposing party to the conflict. Accordingly, medical units risk being subjected to attack because of the perception by such an opposing party to the conflict that the medical unit is used to commit acts harmful to the enemy.

legal, administrative, and other measures to this effect falls within the scope of the obligation to fulfil. See CESCR, General Comment No. 14, above note 29, para. 33.

165 Commentary on GC I, Arts. 19, 24, 35, pp. 196, 220 and 280; Commentary on AP I, Arts. 12 and 21, pp. 166 and 250, paras. 517 and 840–842; Commentary on AP II, Art. 11, p. 1433, para. 4714.

166 Some state practice is explicit in that medical units may be inspected to ascertain their content and actual use, in particular that they are not used for non-medical purposes. See Benin, *Military Manual*, 1995, Fascicule II, p. 8; Nigeria, *International Humanitarian Law*, 1994, p. 45, para. (f); Senegal, *Le DIH adapté au contexte des opérations de maintien de l'ordre*, 1999, p. 17; Togo, *Le Droit de la Guerre*, 1996, Fascicule II, p. 8 (all available at: [www.icrc.org/customary-ihl/eng/docs/v2\\_rul\\_rule28](http://www.icrc.org/customary-ihl/eng/docs/v2_rul_rule28)).

The problem is not the fact that armed entries are undertaken *per se*; in any event, as such armed entries may well be conducted for legitimate purposes, it may be unrealistic to attempt to prevent such operations altogether. The problem is the manner in which such operations may be conducted, with the consequence of unduly delaying or denying medical treatment to the wounded and sick. Where this consequence results from an armed entry, this would be incompatible with the IHL obligation to respect medical personnel and medical units. Naturally, the obligation to respect the wounded and sick would also be violated if they were to be harmed due to the delay or denial of the medical treatment that their medical condition requires. While these general IHL obligations are clear, they need to be translated into concrete procedures by state armed or security forces and non-state armed groups, so that legitimate armed entries are conducted in a manner which ensures that the work of medical personnel and the functioning of medical units are thereby not unduly impeded, and that the wounded and sick are not harmed or unduly denied the medical care they require.<sup>167</sup>

One specific challenge, which often comes to the fore with armed entries into health-care facilities for the purpose of interrogation and arrest, is that health-care personnel may be harassed and threatened with punishment in order to obtain information on wanted wounded and sick individuals that they may have come across when providing medical care to them.

In relation to this issue, IHL contains specific rules aimed at removing fear or any compulsion of medical personnel for performing activities compatible with medical ethics, including for the benefit of wounded and sick enemies of a party to a conflict. In this regard, it is prohibited to molest or punish any person, including medical personnel, for performing medical activities compatible with medical ethics.<sup>168</sup> While the term ‘punish’ covers not only penal but also, for instance, administrative sanctions, the term ‘molest’ is still broader in encompassing ‘any form of annoyance, threat or harassment’.<sup>169</sup> It is also prohibited to compel medical personnel to perform activities contrary to medical ethics or to compel them to refrain from performing acts required by medical ethics, such as withholding medical care to a wounded combatant or fighter because he or she has directly participated in hostilities.<sup>170</sup>

The term ‘medical ethics’ refers to the moral duties of medical professionals, usually decreed by the professional medical associations of each state.<sup>171</sup>

167 Search operations in health-care facilities are one of the major themes of an ICRC consultation with state armed forces in the Health Care in Danger project, which will culminate in the military expert workshop in Sydney in December 2013.

168 The coverage of this prohibition is thus larger than for purposes of the specific category of medical personnel under IHL, which must be assigned by a party to the conflict, exclusively to serve the medical purposes exhaustively defined by IHL. For the IHL definition of ‘medical personnel’, see note 6 above. Therefore, persons not having been so assigned would also be protected by the rule analysed here. This prohibition is based on GC I, Art. 18(3); AP I, Art. 16(1); AP II, Art. 10(1); Customary IHL Study, Rule 26, pp. 86–88.

169 Commentary on AP I, Art. 16, p. 200, para. 650; Commentary on AP II, Art. 10, p. 1426, para. 4691.

170 AP I, Art. 16(2); AP I, Art. 10(2); Customary IHL Study, Rule 26, pp. 86–88.

171 Commentary on AP I, Art. 16, p. 200, para. 655.



On the international level, the World Medical Association has adopted certain guidelines relevant to this issue, including the International Code of Medical Ethics,<sup>172</sup> the Declaration of Geneva, a modern version of the Hippocratic Oath,<sup>173</sup> and the Regulations in Times of Armed Conflict, which proclaim that medical ethics are the same in times of armed conflict and in times of peace.<sup>174</sup> While these guidelines have not been adopted by states and thus have no binding force under international law, they nevertheless constitute an important point of reference for interpreting what the notion of medical ethics entails.<sup>175</sup> In essence, medical ethical duties, just like IHL, are inspired by the overarching concern for the best interests of the wounded and sick. Thus, for instance, medical ethics would require medical personnel to strive to use health-care resources in the best way to benefit the wounded and sick; to respect the rights and preferences of the wounded and sick, including the right to accept or refuse treatment and the right to confidentiality of health-related information, unless there is a real and imminent threat of harm to the patient or others and this threat can only be removed by a breach of confidentiality; and not to allow their professional judgement to be influenced by personal profit or discrimination.<sup>176</sup> Naturally, medical ethics also require medical personnel to observe IHL and IHRL – for example, not to condone, facilitate or participate in practices of torture or other ill-treatment.<sup>177</sup> While there are thus significant overlaps between IHL rules and medical ethics, the latter have added value, for instance, in guiding health-care personnel in difficult decisions regarding the order in which the wounded and sick will be treated (triage).<sup>178</sup>

A specific dilemma concerns the protection from compulsory denunciation to national authorities of medical confidentiality in relation to information that health-care personnel may have obtained on the wounded and sick in their charge. This relates not only to health-related information concerning the wounded and sick but also to other information such as on the activities, connections, position, or simply the existence of the wounded.<sup>179</sup>

On this question, medical ethics is in tension with IHL. Medical ethics generally require absolute confidentiality with regard to the patient's identity and other personal information as well as health-related information subject to the

172 World Medical Association (WMA), International Code of Medical Ethics, adopted by the 3<sup>rd</sup> General Assembly of the WMA, London, England, 1949 and last revised by the 57<sup>th</sup> WMA General Assembly, Pilanesberg, South Africa, October 2006.

173 WMA, Declaration of Geneva, adopted by the 2<sup>nd</sup> General Assembly of the WMA, Geneva, Switzerland, 1948, and last revised by the 173<sup>rd</sup> WMA Council Session, Divonne-les-Bains, France, 2006.

174 WMA, Regulations in Times of Armed Conflict, adopted by the 10<sup>th</sup> World Medical Assembly, Havana, Cuba, 1956 and last editorially revised by the 173<sup>rd</sup> WMA Council Session, Divonne-les-Bains, France, 2006.

175 Commentary on AP I, Art. 16, p. 201, para. 656.

176 WMA, International Code of Medical Ethics, Duties of Physicians to Patients, above note 171; Commentary on AP I, Art. 16, pp. 201–202, para. 658.

177 WMA, Regulations in Times of Armed Conflict, above note 173.

178 For instance, the Commentary on AP I, Art. 10, p. 148, para. 454, gives the example of an overburdened doctor in armed conflict who faces the difficult decision of whether to treat an extremely seriously wounded patient requiring a long and hazardous operation first or to sacrifice this patient for the benefit of others whose chances of survival are better.

179 Commentary on AP I, Art. 16, p. 206, para. 682.

above-mentioned discretion of health-care personnel when there is a real and imminent threat to the patient or others and this threat can only be removed by breaching confidentiality.<sup>180</sup>

On the other hand, while IHL generally imposes the obligation to respect medical confidentiality, Article 16(3) of AP I and Article 10(3) of AP II subject this general obligation to the exception that protection of health-care personnel from such denunciation towards their own authorities is subject to national law.<sup>181</sup> This may constitute a potentially far-reaching possibility of imposing limitations under national law because the wording of these provisions does not contain any guidance on how national legislative authorities must exercise this discretion. As a result, this may lead to variations across different domestic legal orders in the regulation of this issue.<sup>182</sup>

However, it is important to bear in mind that the overall object and purpose of protecting information that became known to health-care personnel in the course of their medical activities from compulsory disclosure is that without such protection many of the wounded and sick would rather risk suffering and dying than being denounced and may therefore refrain from seeking access to health-care services. Moreover, it must be considered that the discretion given to national legislative authorities must not lead to the result that an obligation to systematically reveal the identity of the wounded and sick renders medical confidentiality essentially meaningless.<sup>183</sup> It has also been observed that national legislation may not impose an obligation to violate the minimum standards imposed by general rules of medical ethics;<sup>184</sup> one of these minimum requirements would certainly be not to do anything to harm a patient.

In this regard, Article 16(3) of AP I specifies for international armed conflicts that in relation to the medical personnel's authorities and the authorities of the adverse party, medical personnel may be compelled to reveal this type of information in the case of communicable diseases. This case is not explicitly mentioned in the corresponding provision of Article 10(3) of AP II applicable to non-international armed conflicts regulated by AP II, since such exceptions are usually enshrined in national legislation. In that particular case, compulsory denunciation may be justified by the fact that in the case of communicable diseases, the collective public interest takes precedence over the individual interest of the patient.<sup>185</sup> Some countries also require the reporting of gunshot wounds for purposes of criminal investigations.<sup>186</sup>

180 WMA, International Code of Medical Ethics, Duties of Physicians to Patients, above note 171.

181 In this regard, the wording of the two provisions is different. While Art. 16(3) of AP I explicitly speaks of an 'exception' under national law, Art. 10(3) uses the formulation of 'subject to national law'.

182 Commentary on AP I, Art. 16(3), p. 207, para. 688.

183 Commentary on AP II, Art. 10(3), p. 1428, para. 4700.

184 Commentary on AP I, Art. 16(3), p. 208, para. 688.

185 See Commentary on AP I, Art. 16(3), p. 208, para. 689; Commentary on AP II, Art. 10(3), p. 1428, para. 4702.

186 ICRC, *Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflicts and Other Emergencies*, 2012, p. 78.

While for humanitarian reasons it may be desirable that the scope of required denunciations under national law be limited as much as possible in order to preserve the discretion of health-care professionals on medical confidentiality, where this is not the case medical ethics would demand from health-care professionals that they are at least aware of legal requirements to report certain information to the authorities. Furthermore, medical ethics enjoin them to consider potential dilemmas in advance, and to inform the wounded and sick concerned when they must disclose information about them.<sup>187</sup>

IHRL only vaguely deals with the issues related to armed entries reviewed in this section through the non-derogable obligation to respect the right of non-discriminatory access of the wounded and sick to health facilities, goods and services. This obligation requires states to refrain from direct or indirect interferences with the enjoyment of that right.<sup>188</sup> Armed entries resulting in delayed or denied required medical treatment for the wounded and sick; threatening, harassing or punishing health-care personnel who perform their exclusively medical tasks; or undue impediments to the functioning of health-care facilities would fall within the scope of prohibited interferences.

More specifically, as has already been mentioned, the CESCRC has emphasised that states parties to the ICESCRC have to ensure that all health facilities, goods and services are respectful of medical ethics, subject to the conditions prevailing in the respective state, and that medical practitioners and other health professionals meet appropriate ethical codes of conduct.<sup>189</sup> Furthermore, states have an obligation to provide appropriate training for health personnel, including education on health and human rights, which is comparable in priority to the core obligations under the right to health.<sup>190</sup> It is worth noting that IHRL thus requires states not only to abstain from certain acts compromising medical ethics but – subject to their available resources – to take active measures to guarantee respect for medical ethics.

As regards the protection of treatment in accordance with medical ethics, it is also clear that health-care personnel who refuse to obey orders to, for instance, subject persons to medical procedures which rise to the level of torture or other ill treatment not necessitated by their condition must not be punished for such a refusal.<sup>191</sup> In relation to medical confidentiality, the right not to be subjected to arbitrary or unlawful interferences with their privacy protects persons under the jurisdiction of a state against undue disclosure of medical and other private data to persons not privy to the physician–patient

187 WMA, Regulations in Times of Armed Conflict and Other Situations of Violence, Code of Conduct: Duties of Physicians Working in Armed Conflict and Other Situations of Violence, above note 173; ICRC, *Health Care in Danger*, above note 185, pp. 10 and 78.

188 CESCRC, General Comment No. 14, above note 29, paras. 33 and 43.

189 *Ibid.*, paras. 12 and 35.

190 *Ibid.*, paras. 12 and 44.

191 ICCPR, Art. 7; CAT, Art. 2(3); HRC, General Comment No. 20 concerning prohibition of torture and cruel treatment or punishment, 3 October 1992, paras. 3, 8 and 13, available at: [www.unhcr.ch/tbs/doc.nsf/0/6924291970754969c12563ed004c8ae5?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/0/6924291970754969c12563ed004c8ae5?Opendocument).

relationship.<sup>192</sup> Thus, such disclosure cannot take place except where it is explicitly based on national law, and the protection from ‘arbitrary’ interference adds that even interference legitimised by law must be in conformity with the object and purpose of IHRL and reasonable in the particular circumstances of the case.<sup>193</sup>

While this would generally lead to a similar scope of protection from denunciation of information on the wounded and sick as under IHL, it must additionally be taken into account that the right to privacy as part of the right to privacy, family, home and correspondence under IHRL may be derogated from in times of public emergencies, including in armed conflicts and in emergencies falling below the threshold of armed conflicts. Even then, however, there must be adequate justification not only for the general decision to proclaim a state of emergency (as well as its duration and geographical and material scope), but also for specific measures based on the derogation of the rights in question.<sup>194</sup>

*The wounded and sick, as well as health-care personnel and infrastructure, must also be protected against interferences with health care by third persons*

Under IHL, the obligation of parties to a conflict to protect the wounded and sick and medical personnel, units and transports means they are also bound to ensure that these persons and objects are respected by third persons and to take measures to assist medical personnel, units and transports in the performance of their functions. This requires, for instance, removing the wounded and sick from the scene of combat and sheltering them, and ensuring the delivery of medical supplies by providing a vehicle or facilitating the supply of a medical unit with resources such as water or electricity critical to its functioning.<sup>195</sup> In particular, the wounded and sick must be protected against ill treatment and pillage of their personal property.<sup>196</sup>

Under IHRL, the obligation of states to ensure individuals’ right to access health facilities, goods and services on a non-discriminatory basis also means that they must take positive measures to enable and assist individuals to enjoy their right to health.<sup>197</sup> Furthermore, states must take appropriate measures to prevent

192 HRC, General Comment No. 16: The right to respect of privacy, family, home and correspondence, and protection of honour and reputation, 4 August 1988, para. 10, available at: [www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/23378a8724595410c12563ed004aeecd?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/23378a8724595410c12563ed004aeecd?Opendocument); HRC, Concluding Observations: Portugal, UN Doc. CCPR/CO/78/PRT, 7 May 2003, para. 18; ECtHR, *Z v. Finland*, App. No. 22009/93, Judgment of 25 February 1997, para. 95; ECtHR, *S and Marper v. United Kingdom*, App. Nos. 30562/04, 30566/04, Grand Chamber Judgment, 4 December 2008.

193 HRC, General Comment No. 16, above note 191, paras. 3–4.

194 HRC, General Comment No. 29, above note 61, paras. 4–5.

195 Commentary on GC I, Arts. 19, 24 and 35, pp. 196, 220 and 280; Commentary on AP I, Arts. 12 and 21, pp. 166 and 250, paras. 518 and 840–842; Commentary on AP II, Arts. 7, 9 and 11, pp. 1408, 1421 and 1433, paras. 4635, 4674 and 4714.

196 GC I, Art. 15; GC II, Art. 18; GC IV, Art. 16; AP II, Art. 8; Customary IHL Study, Rule 111, pp. 403–405.

197 CESCR, General Comment No. 14, above note 29, para. 37; Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Principle 5(c).

third persons from interfering with medical treatment given to the wounded and sick, including where third persons limit access to health services.<sup>198</sup>

*The red cross, red crescent and red crystal emblems shall not be employed except to identify protected health-care personnel, facilities, medical transport, and associated medical equipment or medical supplies authorised to use them in armed conflicts or to indicate that persons or objects are linked to the Red Cross and Red Crescent Movement. All necessary measures shall be taken to prevent and repress misuse of the emblems*

Under IHL, the protective use of the emblems constitutes the visible sign of protection in armed conflicts.<sup>199</sup> In contrast, the indicative use is intended to show that persons or objects are linked to the Red Cross and Red Crescent Movement.<sup>200</sup> While the protective emblem must be identifiable from as far away as possible, and may be as large as necessary to ensure recognition,<sup>201</sup> the indicative emblem shall be comparatively small in size and may not be placed on armlets or on the roofs of buildings.<sup>202</sup>

It must be emphasised that a protective emblem is not constitutive of the protection of medical personnel, units and transports; it is applicable IHL that confers specific protection on account of their function.<sup>203</sup> There is also no

198 Cf. CESCR, General Comment No. 14, above note 29, paras. 33 and 35.

199 The authorised users of the protected emblems are: medical services of armed forces and sufficiently organised armed groups; medical personnel units and transports of National Red Cross and Red Crescent Societies that have been duly recognised and authorised by their governments to assist the medical services of the armed forces, when they are employed exclusively for the same purposes as the latter and are subject to military laws and regulations; civilian hospitals (public or private) that are recognised as such by state authorities and authorised to display the emblem; in occupied territories and in zones of military operations, persons engaged in the operation and administration of such civilian hospitals (and also in the search for, removal, and transport of and provision of care for wounded and sick civilians, the infirm and maternity cases); civilian medical personnel in occupied territories and where fighting takes place or is likely to take place; civilian medical units and transports, as defined under AP I, recognised by the competent authorities and authorized by them to display the emblem; other recognised and authorised voluntary aid societies, subject to the same conditions as those for National Red Cross and Red Crescent Societies. The ICRC and the International Federation of Red Cross and Red Crescent Societies may use the emblem for protective purposes in armed conflicts without further restrictions. See GC I, Arts. 39–44; GC II, Arts. 22–23, 26–28, 34–37, 39 and 41–44; AP I, Art. 18(1)(4); AP II, Art. 12; AP III, Art. 2.

200 GC I, Art. 44; Regulations on the Use of the Emblem of the Red Cross and Red Crescent by the National Societies, last revised November 1991, Art. 1. The authorised users are: National Red Cross and Red Crescent Societies; and ambulances and first-aid stations operated by third parties, when exclusively assigned to provide free treatment to the wounded and sick, as an exceptional measure, on condition that the emblem is used in conformity with national legislation and that the National Red Cross and Red Crescent Society has expressly authorised such use. See GC I, Art. 44 (2); GC I, Art. 44(4). The ICRC and the International Federation of Red Cross and Red Crescent Societies may use the emblem for indicative purposes with no restriction. See GC I, Art. 44(3).

201 GC I, Arts. 39–44; AP I, Art. 18; Regulations on the Use of the Emblem of the Red Cross or the Red Crescent by the National Societies, adopted by the 20<sup>th</sup> International Conference of the Red Cross and the Red Crescent, Vienna, 1965, and revised by the Council of Delegates, Budapest, 1991, Art. 6.

202 GC I, Art. 44(2); Regulations on the Use of the Emblem, Arts. 4, 16.

203 Commentary on AP I, Art. 18, pp. 225 and 228, paras. 746 and 763; Commentary on AP II, Art. 12, p. 1440, para. 4742; Customary IHL Study, commentary on Rule 30, pp. 103–104.

obligation to wear or display an emblem; it is generally recognised as an option, despite the wording under various IHL provisions that medical personnel, units and transports ‘shall’ be identified by a protective emblem.<sup>204</sup>

Accordingly, should a commander decide for tactical reasons – for instance, where military medical units or transports are systematically targeted or in order to conceal the presence or real strength of armed forces – that medical units or transports should remove or cover up (camouflage) the distinctive emblem, this does not take away the protection to which medical units or transports are entitled under IHL.<sup>205</sup> However, it is evident that it will then be difficult for the opposing party to the conflict to recognise that certain objects are protected as medical units or transports; given this difficulty, the existing Geneva Convention commentaries already recommended that this option should only be used when the tactical situation on the ground would make it absolutely necessary.<sup>206</sup>

The distinction between protective and indicative use of the emblems is necessary to avoid any confusion as to who is entitled to bear the visible sign of protection in armed conflicts.<sup>207</sup> Therefore, the Regulations on the Use of the Emblem of the Red Cross or the Red Crescent by the National Societies stipulate that National Red Cross and Red Crescent Societies shall endeavour, even in peacetime, to take necessary measures to ensure that the indicative emblem is comparatively small.<sup>208</sup>

However, the Commentary to these Regulations makes it clear that this has the character of a recommendation and that ‘the use of a large-size emblem is not excluded in certain cases, such as events where it is important for first-aid workers to be easily identifiable’.<sup>209</sup> In this regard, the ICRC *Study on Operational and Commercial and other Non-operational Issues Involving the Use of the Emblems* recommended that first-aid workers (and facilities) belonging to National Red Cross and Red Crescent Societies display a large-sized indicative emblem in situations of internal disturbances and tensions if (a) it might enhance their medical assistance to victims of violence, and (b) it is authorised, or at least not forbidden, by national legislation.<sup>210</sup>

204 GC I, Art. 39; GC IV, Art. 18(3); AP I, Art. 18(4); AP II, Art. 12; however, see Commentary on GC I, Art. 39, p. 307; Commentary on GC IV, Art. 18, p. 149; Commentary on AP II, Art. 12, p. 1440, para. 4742.

205 See Commentary on GC I, Arts. 39, 42 and 44, pp. 307, 320 and 325.

206 See Commentary on GC I, Art. 42, p. 325. Military doctrine has followed up on this recommendation. For instance, North Atlantic Treaty Organization (NATO) Standardization Agreement (STANAG) 2931 provides that a decision to camouflage medical facilities may only be ordered at a certain level of the military hierarchy, i.e. brigade level or equivalent. Secondly, such an order is to be temporary and local in nature only and must be rescinded as soon as the security situation on the ground permits. Finally, this possibility is not envisaged for fixed, large medical establishments.

207 GC I, Art. 44(2).

208 Regulations on the Use of the Emblem, Art. 4.

209 Commentary on Regulations on the Use of the Emblem, Art. 4.

210 ICRC, *Study on the Use of the Emblems: Operational and Commercial and Other Non-Operational Issues*, Geneva, 2011, pp. 117–121.

All necessary measures, including adopting national legislation, shall be taken by competent authorities to prevent and repress – at all times – misuses,<sup>211</sup> including imitations,<sup>212</sup> improper use,<sup>213</sup> or perfidious use of the emblems.<sup>214</sup>

## Conclusion

The analysis of IHL and IHRL applicable to insecurity and violence against the delivery of impartial health care in armed conflicts and other emergencies shows that generally these international legal regimes adequately address the various manifestations of violence identified in this context.

Indeed, there are significant commonalities between the specific obligations to provide care for the wounded and sick, and to respect and protect them, as well as medical personnel, units and transports, under IHL and applicable non-derogable IHRL, in particular under the right to health and the right to life in both armed conflicts and other emergencies. IHL and IHRL may also be usefully resorted to, and complement each other, in addressing certain specific indirect consequences of general insecurity and individual violent acts affecting impartial health-care delivery in armed conflicts, like the loss of available health-care personnel due to their exodus in massive numbers or the termination and interruption of essential health-care programmes, where the state's capacity to adopt far-reaching measures to ensure the availability and quality of health-care services is not impaired by active hostilities, such as in situations of prolonged calm occupation.

Given that these international legal frameworks comprehensively address these various challenges, the focus should not be on the development of new international legal rules but on how to better implement the existing ones. In this regard, there is a need to develop – or where they already exist, strengthen – domestic normative frameworks, policy and operational practices, and sharing of good practices to that effect. For instance, not only should domestic criminal repression of attacks on, and other violent interferences with, health-care personnel be strengthened, but it would also be desirable to foresee preventive operational protection mechanisms for threatened health-care personnel by state authorities, which should be based on domestic systems for collecting information on threats and violence against health-care providers.<sup>215</sup> Another area where domestic normative frameworks should be strengthened is in ensuring an adequate balance

211 GC I, Art. 54; AP II, Art. 12; AP III, Art. 6.

212 This refers to the use of a sign which, owing to its shape and/or colour, may be confused with the emblem.

213 This refers to the use of the emblem by people usually authorised to do so, but in a manner inconsistent with IHL provisions on its use; or to the use of the emblem by entities or persons not entitled to do so (commercial enterprises, pharmacists, private doctors, NGOs, ordinary individuals, etc.) or for purposes that are inconsistent with the Fundamental Principles of the Movement. For the relevant IHL treaty provisions, see above note 144.

214 For the definition of perfidy, see above note 144.

215 See, as good practice in this regard, Colombia, Resolución No. 4481, 28 December 2012, 'Por la cual se adopta el Manual de Misión Médica y se establecen normas relacionadas con la señalización y divulgación de su Emblema', section 2.2.



between protecting the discretion of health-care personnel with regard to medical confidentiality, and legal obligations to disclose information on the wounded and sick. Obligations under national legislation of health-care personnel to denounce information on the wounded and sick to public authorities should be limited to cases where a justifiable collective interest, like public health reasons, prevails over the individual right of a patient to have the confidentiality of his or her personal information preserved. In any event, such obligations should not result in facilitating subsequent harm to a patient. There is also a need to review overly broad offences against public order, for instance under domestic anti-terrorism legislation, that have the effect of criminalising the mere fact of providing health care to certain parts of the population. The scope of domestic normative frameworks is also critical to ensure that all health-care providers are encompassed, in particular those delivering health care in their own local communities, as well as to ensure that these frameworks properly take the challenges of insecurity and violence in armed conflicts and other emergencies into account. In terms of identification, it is important to properly prevent and address misuses of the emblems; one vital prerequisite in this regard is the adoption of the domestic regulations required for designating the national authorities competent to issue the necessary authorisations for the use of the emblem.

Better implementation of existing international legal obligations also requires work on military doctrine and practice, for instance on military manuals and standard operating procedures to prevent arbitrary delays, and denials to the passage of medical transports or armed entries into health-care facilities that result in the undue delay or in the denial of medical treatment to the wounded and sick. Moreover, military doctrines and practice should reflect respect for the specific IHL precautionary obligations in relation to the delivery of impartial health care.

While there are significant commonalities between IHL and IHRL, one fundamental difference between the two is the controversy over the applicability of IHRL to non-state armed groups. This controversy is not likely to be resolved in terms of greater consensus on applying IHRL as a matter of law to non-state armed groups, not least because of political sensitivities on the part of states that doing so would imply political recognition of these actors as having legitimate authority over their territory. Still, non-state armed groups must also be addressed by efforts to improve respect for impartial health-care delivery because they are very much part of the problem of insecurity and violence against health-care personnel, facilities and medical transports, and their perspectives must be taken into account in devising solutions. This must be done in a manner that does not alienate states. Where a legal dialogue with non-state armed groups is possible, such a dialogue must be framed in a manner that reflects their specificities. This is not a new challenge – the ICRC, for example, has engaged with non-state armed groups on IHL issues for a long time.<sup>216</sup>

<sup>216</sup> On the specific challenges in ensuring compliance for IHL by non-state organised armed groups that are party to the conflict, see, for example, ICRC, *Increasing Respect for International Humanitarian Law in Non-International Armed Conflicts*, 2008.



The behaviour of health-care providers themselves is also critical, as their access to the wounded and sick depends very much on acceptance of their work by all parties to the conflict, actors in other emergencies, and local communities. In this regard, they must of course scrupulously respect relevant IHL and IHRL rules and medical ethics that overlap significantly with IHL and IHRL, particularly in the fundamental requirement to provide care in an impartial/non-discriminatory manner. It must also be emphasised that they should exclusively remain engaged in health-care activities, as becoming involved in the military operations of parties to the conflict or violence emanating from one of the opposing actors in other emergencies may cause a loss of their own protection as well as endanger the safety and security of colleagues and the wounded and sick they are caring for. For these purposes, it is of the utmost importance that health-care personnel possess knowledge on the international legal frameworks relevant to them, and that they are aware of any possible ethical dilemmas before they arise during their work in armed conflicts and other emergencies. The need to specifically train health-care personnel on IHL and IHRL, as well as the ethical dilemmas they may face, cannot be overemphasised. One of those dilemmas, notably that of how to strike an acceptable balance between their own safety and the need to rapidly provide life-saving health-care services, which is especially accentuated in unlawful intentional follow-up attacks against health-care personnel arriving on the scene of a prior attack, requires adaptation of existing security procedures for first responders.

The various expert workshops conducted as part of the Health Care in Danger project will continue to enable us to discuss these and other challenges and provide possible recommendations. Ultimately, however, the success of this project and other efforts in seeking to strengthen respect for impartial health-care delivery in armed conflicts and other emergencies will depend on whether improvements can be felt by the wounded and sick, and by health-care providers on the ground.



# States' obligations to mitigate the direct and indirect health consequences of non-international armed conflicts: complementarity of IHL and the right to health

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## **Abstract**

*Armed conflicts have numerous adverse health consequences for the affected populations, many of which occur in the long-term. This article analyses in detail how international humanitarian law (IHL) and the right to health complement each other in obliging states to mitigate the direct and indirect health consequences of non-international armed conflicts. With its historical origin and purpose of protecting wounded and sick combatants of standing governmental armies, IHL focuses on the protection of the wounded and sick suffering from the direct health consequences*

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*of armed conflicts, such as injuries resulting from ongoing hostilities. The right to health is more expansive: it obliges states to prioritise the provision of primary health care through creating and maintaining an accessible basic health system. This focus enables it to highlight and address the indirect health consequences of armed conflicts, such as the spreading of epidemic and endemic diseases and rising child and maternal mortality and morbidity.*

**Keywords:** right to health, wounded and sick, medical personnel, medical transports, medical units, non-international armed conflict, primary health care, prevention and treatment of disease, health systems.



Armed conflicts continue to cause civilian and military deaths and have grave consequences for human health, interfering greatly with people's ability to enjoy their rights to life and health. Among the direct and indirect effects of armed conflicts on public health that are the focus of this article are injuries resulting from hostilities, long-term physical disabilities and mental health problems, increasing rates of epidemic and endemic diseases, insufficient health care for mothers and children, substantial reductions of public health budgets, the departure of trained medical professionals, and the interruption of medical and food supplies. These effects are associated with a complete or partial breakdown of health systems and the destruction of essential infrastructure in armed conflicts.

In particular, the indirect and long-term adverse impact of armed conflicts on public health have often been underestimated and overlooked.<sup>1</sup> This is despite the fact that frequently rising death rates in armed conflicts are predominantly due to the conflict's indirect impacts on public health: the great majority of victims of war worldwide die from diseases (mainly acute respiratory infections, diarrhoeal diseases, maternal and neonatal morbidity, tuberculosis, and malaria) and malnutrition.<sup>2</sup>

This contribution asks whether, and if so, how, the law applicable to non-international armed conflicts takes account of the direct and indirect health effects of armed conflicts and contributes to their mitigation. This is intrinsically linked to the question of the parallel application of international humanitarian law (IHL) and international human rights law (IHRL), in particular IHL and the right to health. The analysis focuses on the complementarity of IHL rules relating to the protection of the wounded and sick and medical personnel, units, and transports, and relevant aspects of the right to health as set out in Article 12 of the

1 Bethany Lacina und Nils Petter Gleditsch, 'Monitoring trends in global combat: a new dataset of battle deaths', in *European Journal of Population*, Vol. 21, 2005, pp. 158 ff.

2 See e.g. *ibid.*, p. 159; Geneva Declaration, *Global Burden of Armed Violence*, Report, September 2008, available at: [www.genevadeclaration.org/fileadmin/docs/Global-Burden-of-Armed-Violence-full-report.pdf](http://www.genevadeclaration.org/fileadmin/docs/Global-Burden-of-Armed-Violence-full-report.pdf) (last visited 15 June 2013); Hazem Adam Ghobarah, Paul Huth, and Bruce Russett, 'Civil wars kill and maim people – long after the shooting stops', in *American Political Science Review*, Vol. 97, No. 2, 2003; and the findings of the reports of the International Rescue Committee on Mortality in the Democratic Republic of the Congo between 1998 and 2007, available at: [www.rescue.org/special-reports/congo-forgotten-crisis](http://www.rescue.org/special-reports/congo-forgotten-crisis) (last visited 15 June 2013).

International Covenant on Economic, Social and Cultural Rights (ICESCR).<sup>3</sup> It will be shown that, overall, IHL and the right to health complement each other well in setting out the obligations of states to mitigate the mentioned direct and indirect health consequences of armed conflicts. To this end, first the applicability of economic, social, and cultural (ESC) rights to situations of non-international armed conflict is briefly outlined, as well as their relationship to IHL. Second, the protection of the wounded and sick and the possible scope of health services to be provided in non-international armed conflicts under IHL and the right to health are explored in some detail. Third, the special protection that is given to medical personnel, facilities, and transports is examined. In the concluding remarks, the main findings on the complementarity between IHL and the right to health are summarised.

In articles of limited scope, choices have to be made between either focusing on certain aspects in detail or giving a general overview of the subject. This article has opted for the former. This is also the main reason why concessions concerning the scope of the analysis had to be made: first, the article focuses on the law applicable to non-international armed conflicts, leaving the law of international armed conflicts aside. This choice was made because the vast majority of armed conflicts are of a non-international character today,<sup>4</sup> and because it is this type of conflict in which IHL and IHRL have to interact most for the effective protections of affected individuals.<sup>5</sup> Second, this contribution mainly concentrates on *states'* obligations in non-international armed conflicts. The obligations of non-state armed groups and possibly international humanitarian organisations are only touched upon, since no sufficiently thorough research could be conducted into the actual practice of diverse non-state armed groups in regard to socio-economic issues (IHL and ESC rights), or into the opinion of states and international organisations on these matters and the approach adopted in national and international jurisprudence. Such research would be needed to draw persuasive conclusions on the scope of the IHL obligations of diverse non-state armed groups, and possibly their obligations by virtue of the right to health and other socio-economic rights.<sup>6</sup> Third, the question of whether accepting the parallel application of IHL and the

- 3 Other questions, for example whether obligations flowing from the right to health have to be factored into the process of making military targeting decisions, cannot be discussed here. The question of the circumstances under which parties to a conflict are obliged under IHL and the right to health to accept humanitarian and impartial assistance are also beyond the scope of this study. For an analysis of these and other questions concerning the parallel application of IHL and the right to health, see Amrei Müller, *The Relationship between Economic, Social and Cultural Rights and International Humanitarian Law: An Analysis of Health-Related Issues in Non-International Armed Conflicts*, Martinus Nijhoff, Leiden, 2013.
- 4 Lotta Themner and Peter Wallenstein, 'Armed conflict – 1946–2011', in *Journal for Peace Research*, Vol. 49, No. 4, 2012.
- 5 This does not imply that the present author is of the view that IHRL does not apply to international armed conflicts. On the contrary, many of the findings of this article are as relevant for international armed conflicts as they are for non-international armed conflicts.
- 6 For a recent study on this matter, see Sandesh Sivakumaran, *The Law of Non-International Armed Conflict*, Oxford University Press, Oxford, 2012, covering non-state armed groups' obligations under IHL, including in relation to the protection of the wounded and sick (pp. 273–277), medical personnel (pp. 277–280), and medical units and transports (pp. 373–375). Also see below for some further initial observations on the scope of non-state armed groups' obligations under IHL and possibly IHRL.

right to health to armed conflict situations results in a right to human rights-based humanitarian assistance of the affected populations cannot be explored in all its details.

## The applicability of ESC rights to armed conflict situations and their relationship to IHL

The parallel applicability of IHL and IHRL, including ESC rights, in times of armed conflict is widely accepted today.<sup>7</sup> Most prominently, this was pronounced by the International Court of Justice (ICJ) in its Advisory Opinion on the *Legal Consequences of the Construction of a Wall in Occupied Palestinian Territory*, where the ICJ referred directly to the applicability of the ICESCR and other international human rights treaties containing socio-economic rights to armed conflict situations.<sup>8</sup> In its 2012 fourth periodic report to the United Nations (UN) Human Rights Committee (HRC), even the United States signalled a departure from its previous position on the non-applicability of IHRL to armed conflict situations.<sup>9</sup> Together with Israel, the United States had on occasion denied the applicability of IHRL to conflict situations, in particular its extraterritorial applicability.<sup>10</sup>

Questions can be asked about the scope of states' obligations under the ICESCR in times of armed conflict. In this context, it has to be noted that the ICESCR does not contain a derogation clause. A tendency can be observed that states, the UN Committee on Economic, Social and Cultural Rights (CESCR), and other international bodies nonetheless accept derogations from labour rights<sup>11</sup> in times of armed conflicts and other emergencies that 'threaten the life of the nation'.<sup>12</sup> If accepted, such derogations shall arguably conform to the derogation principles set out in Article 4 of the International Covenant on Civil and Political Rights (ICCPR).<sup>13</sup> The non-derogability of all other ESC rights, in particular

7 For a recent overview of the practice of states and UN Charter bodies, including the International Court of Justice, see Louise Doswald-Beck, *Human Rights in Times of Conflict and Terrorism*, Oxford University Press, Oxford, 2011, chapter I; see also S. Sivakumaran, above note 6, p. 83.

8 ICJ, *Legal Consequences of the Construction of a Wall in Occupied Palestinian Territory*, Advisory Opinion, 9 July 2004, *ICJ Reports 2004*, paras. 106 and 112.

9 United States of America, Fourth Periodic Report to the United Nations Human Rights Committee, UN Doc. CCPR/C/USA/4, 22 May 2012, paras. 506–509.

10 HRC, Concluding Observations – Israel, UN Doc. CCPR/C/ISR/CO/3, 3 September 2010, para. 5; CESCR, Concluding Observations – Israel, UN Doc. E/C.12/ISR/CO/3, 16 December 2011, para. 8; and HRC, Concluding Observations – United States of America, UN Doc. CCPR/C/USA/CO/3/Rev.1, 18 December 2006, para. 10.

11 As set out, for example, in ICESCR, Arts. 6, 7, and 8(1).

12 See an analysis in Amrei Müller, 'Limitations to and derogations from economic, social and cultural rights', in *Human Rights Law Review*, Vol. 9, 2009, pp. 594–597, examining *inter alia* the practice of the UN Committee on Economic, Social and Cultural Rights and the opinions of states in the reports to the same Committee, and of the International Labour Organization, on this question.

13 *Ibid.*, pp. 595–597. ICCPR, Art. 4, allows for derogations of some rights set out in the ICCPR in times of 'public emergency which threatens the life of the nation and the existence of which is officially proclaimed'. Derogations are only permitted 'to the extent strictly required by the exigencies of the situation'; they shall not be 'inconsistent with' states' 'other obligations under international law' and shall 'not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin'.

of so-called survival rights (the rights to food and health), is substantiated primarily by the fact that it seems inherently unnecessary to derogate from these rights to protect or restore public order.<sup>14</sup>

The non-derogability of most ESC rights in times of armed conflict does not, however, require states to do the impossible and to guarantee these rights in all their sometimes very detailed aspects to the same extent as in peacetime. The notion of progressive realisation in Article 2(1) of the ICESCR and the Covenant's general limitation clause (Article 4 of the ICESCR) offer sufficient flexibilities for states to adapt their implementation strategies for ESC rights in difficult situations of armed conflict. The requirements of Article 4 of the ICESCR<sup>15</sup> have to be followed in such possible adaptation processes, and have been understood in the literature<sup>16</sup> as follows: first, states must show that limitations are necessary for the 'purpose of promoting general welfare' – or at least that their implementation preserves 'general welfare' to the greatest extent possible. Based, *inter alia*, on the *travaux préparatoires* of the ICESCR, general welfare primarily refers to the economic and social well-being of individuals and the community, and excludes notions of 'public morals', 'public order', and 'national security'. Second, states must ensure that limitations are determined by national law that conforms to all their international human rights obligations and is sufficiently clear and publicly accessible. Third, the requirement that limitations must be acceptable in a democratic society calls upon states to legitimise any limitations of ESC rights through a participatory and transparent decision-making process. Fourth and most importantly, limitations should 'be compatible with the nature of these [ESC] rights'. This can reasonably be interpreted to exclude limitations which infringe upon minimum core obligations/rights as defined by the CESCR in its respective General Comments and as concretised through national legislation.<sup>17</sup> National particularities, including the availability of resources, can be taken into account in domestic law. And lastly, limitations must respect the principle of proportionality. This requires states to show that the scope and severity of a limitation is proportionate to the aim it seeks to pursue (that is, the promotion of general welfare).<sup>18</sup>

The parallel application of IHL and IHRL is often described as being regulated by the *lex specialis* maxim. There is, however, no agreement on the actual

14 See *ibid.*, p. 599; Allan Rosas and Monika Sandvik-Nylund, 'Armed conflicts', in Asbjørn Eide, Catarina Krause, and Allan Rosas (eds), *Economic, Social and Cultural Rights: A Textbook*, Martinus Nijhoff, Dordrecht, 2001, p. 414; and Philip Alston and Gerard Quinn, 'The nature and scope of States Parties' obligations under the International Covenant on Economic, Social and Cultural Rights', in *Human Rights Quarterly*, Vol. 9, 1987, p. 217. These sources also contain more detailed discussions of the possibility of derogating from ESC rights in times of armed conflict.

15 ICESCR, Art. 4, reads: 'The States Parties to the present Covenant recognise 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.'

16 See P. Alston and G. Quinn, above note 14; and A. Müller, above note 12.

17 *Ibid.*, pp. 579–583; A. Rosas and M. Sandvik-Nylund, above note 14, p. 412.

18 For more details on all of these aspects of limitations to ESC rights, see P. Alston and G. Quinn, above note 14; and A. Müller, above note 12.



meaning of this maxim.<sup>19</sup> Nonetheless, as an operational tool, *lex specialis* can be useful to guide the simultaneous application of IHL and IHRL. This is most clearly set out in the International Law Commission's (ILC) study on *Fragmentation of International Law*,<sup>20</sup> which sums up the two main functions of the maxim. In its first function, *lex specialis* is applicable to conflicts of norms, where it promotes the setting aside of the more general rule to an extent that it is inconsistent with the more special rule. The second function of the *lex specialis* maxim comes into play when the two norms are consistent with each other, but when one rule is more detailed or tailored to the particular situation at hand. In this case, any tension between the rules is solved through interpretation, and the more specific rule is an application of the general rule. In practice, it will often be difficult to determine whether one rule is more special than another, whether there is indeed a direct conflict between the two, and thus whether the special rule sets aside the general rule or applies in addition to the general rule.<sup>21</sup> The ILC study also highlights that even in cases where the more special law sets aside the more general rule, the general rule remains in the background and 'provide[s] interpretative direction'<sup>22</sup> to the special rule. Moreover, the exact function of the *lex specialis* maxim depends on the character of the two rules at hand, the specific situation to which those rules shall be applied, and any additional rule of treaty interpretation that might be taken into account in the parallel application of two norms.<sup>23</sup> From this, it is clear that the application of the *lex specialis* maxim to the relationship between IHL and IHRL is not a schematic exercise; it does not mean that IHL must always be given absolute preference in armed conflict situations, and that IHRL can simply be ignored.

For the context of this article, the *lex specialis* maxim seems to be limited to the second function mentioned above. With regard to the issues to be examined in this article – states' obligations under IHL and the right to health to mitigate the direct and indirect health consequences of armed conflicts – no direct conflicts arise between IHL and the right to health. As will be shown, they seem to complement each other well. Thus, the *lex specialis* maxim will rather promote a harmonious parallel application of both bodies of law, furthering the situation-dependent interpretation of relevant IHL rules in the light of the right to health and vice versa in situations of non-international armed conflict.<sup>24</sup>

19 See, among others, Anja Lindroos, 'Addressing norm conflicts in a fragmented legal system: the doctrine of *lex specialis*', in *Nordic Journal of Human Rights*, Vol. 74, 2005; Marko Milanovic, 'A norm-conflict perspective on the relationship between international humanitarian law and human rights law', in *Journal of Conflict and Security Law*, Vol. 14, No. 3, pp. 473–476; and Nancie Prud'homme, 'Lex specialis: oversimplifying a more complex and multifaceted relationship?', in *Israel Law Review*, Vol. 40, No. 2, 2007.

20 *Fragmentation of International Law: Difficulties Arising from the Diversification and Expansion of International Law*, Report of the ILC's Study Group on Fragmentation, A/CN.4/L.682, 13 April 2006 (hereinafter ILC Report), paras. 56–58.

21 *Ibid.*, paras. 91–92. See also S. Sivakumaran, above note 6, pp. 89–92; and A. Müller, above note 3, pp. 24–25.

22 See ILC Report, paras. 102–103; and A. Müller, above note 3, pp. 28–29 for more details.

23 ILC Report, paras. 36, 106–107, 112, and 119–120; A. Müller, above note 3, pp. 25–33.

24 See also *ibid.*, pp. 192–194.

Another issue to be touched on before entering into the substantive discussion of states' obligations to mitigate the direct and indirect health consequences of non-international armed conflicts is the scope of non-state armed groups' obligations under IHL and, in particular, the ICESCR. It is not questioned that non-state armed groups have obligations under IHL (as long as they meet the organisational requirements provided for by IHL), but it remains unclear whether non-state armed groups are bound by IHRL, and if so, to what extent.<sup>25</sup> The possibility shall not be excluded that well-organised non-state armed groups can have (limited) obligations flowing from IHRL, in particular when they control territory or even establish a functioning administration.<sup>26</sup> It seems problematic, however, to demand that all types of non-state armed groups are obliged to implement, for example, the sometimes far-reaching obligations that states have under the right to health. It is questionable whether non-state armed groups regularly have the capacity to devise and implement a comprehensive public health policy and to build an accessible public health system, as states are required to do under their obligations flowing from the right to health. Rather, the current author assumes that non-state armed groups are primarily bound by IHL rules, complemented and reinforced by the ICESCR, that allow the smooth delivery of humanitarian assistance to individuals under their control. In other words, arguably non-state armed groups will primarily have obligations towards national and international humanitarian organisations that may take on the implementation of many obligations under IHL and the right to health that will be discussed below, when they themselves lack the capacity for implementation.<sup>27</sup> However, as mentioned above, the obligations of non-state armed groups are not the main focus of this article. Their obligations will possibly take the form of a 'sliding scale'<sup>28</sup> of obligations, providing for non-state armed groups' increasing obligations according to their degree of organisation, the intensity of violence in which they are involved, and the extent to which they control territory.

With these general observations on the scope of states' obligations flowing from the ICESCR in times of armed conflict as well as their relationship to IHL in mind, we will now move to discuss the protection of the wounded and sick and the possible scope of health services to be provided to individuals

25 In the affirmative, see e.g. Andrew Clapham, 'Human rights obligations of non-state actors in conflict situations', in *International Review of the Red Cross*, Vol. 88, No. 863, September 2006, pp. 491–523; for a rejection, see Liesbeth Zegveld, *Accountability of Armed Opposition Groups in International Law*, Cambridge University Press, Cambridge, 2002, pp. 38–54.

26 Several resolutions of the UN Security Council suggest that non-state armed groups are bound by IHRL. See e.g. the Report of the UN Secretary-General's Panel of Experts on the Accountability in Sri Lanka, 31 March 2011, para. 188, available at: [www.un.org/News/dh/infocus/Sri\\_Lanka/POE\\_Report\\_Full.pdf](http://www.un.org/News/dh/infocus/Sri_Lanka/POE_Report_Full.pdf) (last visited 16 June 2013); the discussion by A. Clapham, above note 25, pp. 500–508; and S. Sivakumaran, above note 6, pp. 96–98.

27 For more details, see A. Müller, above note 3, pp. 4–5 and chapter VIII; see also S. Sivakumaran, above note 6, pp. 329–333, confirming that non-state armed groups are bound and consider themselves bound by IHL rules relating to the delivery of humanitarian assistance.

28 As contemplated by Marco Sassòli, 'Taking armed groups seriously: ways to improve their compliance with international humanitarian law', in *International Humanitarian Legal Studies*, Vol. 1, 2010, p. 20.

affected by non-international armed conflicts under IHL and the right to health. First, the article explores who is covered by the protection offered by the right to health and by relevant IHL rules. Second, the question of the possible scope of health services, facilities, and goods that states are obliged to provide under these rules are discussed, addressing the direct and indirect health consequences of armed conflicts.

## **The protection of the wounded and sick and the possible scope of health services to be provided in non-international armed conflicts**

### Personal scope of application

Reflecting the realities of the 1859 Battle of Solferino, IHL applicable to international armed conflicts has historically focused on the protection of wounded and sick combatants.<sup>29</sup> Although the Fourth Geneva Convention (GC IV) already provided some protection to wounded and sick civilians in international armed conflicts, it is only with the adoption of the First Additional Protocol to the Geneva Conventions (AP I) in 1977 that wounded and sick civilians benefited from the full protection traditionally guaranteed to wounded and sick combatants.<sup>30</sup> Due to the absence of a combatant status in the law of non-international armed conflicts, protection offered to the ‘wounded and sick’ in Common Article 3 of the First to Fourth Geneva Conventions (GC I–IV) and the Second Additional Protocol to the Geneva Conventions (AP II) of 1977 applies to all persons ‘whether or not they have taken part in the armed conflict’.<sup>31</sup> Thus, treaty rules on the wounded and sick were more inclusive in non-international than in international armed conflicts already in 1949, when Common Article 3 of GC I–IV was adopted.<sup>32</sup>

29 At Solferino, wounded soldiers roused Henry Dunant’s compassion, and it was for their protection that the first Geneva Convention was adopted in 1864: the Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field. The civilian population in and around Solferino had not been directly affected by the battle.

30 As most clearly expressed in Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, 8 June 1977, 1125 UNTS 3 (entered into force 7 December 1978) (hereinafter AP I), Art. 8, which refers to ‘the “wounded” and “sick”, whether military or civilian’.

31 AP II, Art. 7(1); GC I–IV, Common Art. 3(1) includes protection of those placed *hors de combat* by sickness or wounds; GC I–IV, Art. 3(2) provides for the collection and care for the wounded and sick; see also ICRC, *Customary International Humanitarian Law, Vol. I: Rules*, Jean-Marie Henckaerts and Louise Doswald-Beck (eds.), ICRC and Cambridge University Press, Cambridge, 2005 (hereinafter ICRC Study), Rule 109, pp. 396–399.

32 GC IV introduced some provisions aimed at the amelioration of the condition of wounded and sick civilians in international armed conflicts (in particular Arts. 14–22), but these provisions lagged behind the detailed regulation in GC I and GC II on the protection of wounded, sick, and shipwrecked members of armed forces.

As is clear from Article 8(a) of AP I, the definition of 'wounded and sick' in IHL covers everyone who (a) requires medical care and (b) does not engage in any act of hostility:<sup>33</sup>

'Wounded' and 'sick' mean persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility. These terms also cover maternity cases, new-born babies and other persons who may be in need of immediate medical assistance or care, such as the infirm or expectant mothers, and who refrain from any act of hostility.<sup>34</sup>

Though originally applicable to international armed conflicts only, this definition is usually resorted to for situations of non-international armed conflict as well.<sup>35</sup> It can also be assumed that it underlies rules 109–111 of the ICRC Study on Customary IHL (hereinafter ICRC Study), which do not give a customary definition of the 'wounded and sick'.<sup>36</sup> The definition is not restricted to those conflict-affected individuals who are wounded and sick for reasons related to the armed conflict, but covers all persons in need of medical treatment: the ICRC Commentary on Article 8(a) of AP I observes that 'this criterion – being in need of medical care – is the *only valid one* for determining whether a person is "wounded" or "sick" in the sense of the Protocol (insofar as the second condition [to refrain from any act of hostility] is fulfilled)'.<sup>37</sup> Article 8(a) of AP I even allows the inclusion not only of individuals who do not require *immediate* medical care in the sense of emergency medical treatment, but also of those who need other curative or rehabilitative

33 Yves Sandoz, Christophe Swinarski, and Bruno Zimmermann (eds), *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949*, ICRC, Geneva, 1987, para. 4638 (hereinafter ICRC Commentary to AP I/AP II); Jann Kleffner, 'Protection of the wounded, sick and shipwrecked', in Dieter Fleck (ed.), *The Handbook of International Humanitarian Law*, Oxford University Press, Oxford, 2nd edition, 2008, pp. 328–329.

34 AP I, Art. 8(a).

35 ICRC Commentary to AP II, above note 33, para. 4637; Michael Bothe, Karl Josef Partsch, and Waldemar Solf, *New Rules for Victims of Armed Conflict*, Martinus Nijhoff, The Hague, 1982, p. 656.

36 ICRC Study, Vol. I, Rules 109–111, pp. 396–405. It is not clear why the ICRC Study does not comment on the customary status of this definition. The present author assumes that this is because the 'practice' cited in Vol. II of the Study (mainly military manuals) does usually refer to the 'wounded and sick' without restating the definition of AP I, Art. 8(a) (see ICRC Study, Vol. II, chapter 34, pp. 2590–2654).

37 ICRC Commentary to AP I, Art. 8(a), para. 304 (emphasis added). This is reiterated for situations of non-international armed conflicts in the ICRC Commentary to AP II, Art. 7(1), para. 4639, holding that '[a]ny person, military or civilian, fulfilling these two conditions is included amongst the wounded or sick'. See also Jean Pictet, *Commentary to the Geneva Conventions of 12 August 1949*, Geneva, ICRC, 1952–1959 (hereinafter ICRC Commentary to GC I–IV) on GC IV, Art.16, p. 134. AP I, Art. 9(1) should not be understood as limiting the definition of the 'wounded and sick' to those who are in this condition for reasons directly related to the armed conflict. The ICRC Commentary to AP I, Art. 9(1) sets out the complex drafting history of this Article, and concludes in para. 417 that '[t]he expression "all those who are affected by a situation referred to in Article 1" is . . . insufficiently precise to determine exactly the field of application "*ratione personae*" of Part II [of AP I]. Only an examination, article by article, of the whole of this Part, makes it possible to provide a more precise list of the persons to whom it applies in various circumstances.' In any event, even if it was meant to limit the definition of the 'wounded and sick' to those who are in this condition because they are directly affected by the hostilities, it is not clear whether AP I, Art. 9(1) applies to non-international armed conflicts – the types of conflict that are of interest to us here – as a matter of custom. The ICRC Study does not contain a provision in this regard.

treatment, for example because of chronic sickness or disability. The adjective ‘immediate’ does not qualify ‘medical assistance’ in the first sentence, and moreover, the definition refers to ‘physical and mental disorder or disability’. As the ICRC Commentary to Article 8(a) of AP I explains, the second sentence of this Article aims to cover those persons who are ‘neither wounded nor sick in the usual sense of these words’ but ‘whose condition may at any moment necessitate immediate medical care’,<sup>38</sup> and thus it includes the adjective ‘immediate’.

The right to the highest attainable standard of physical and mental health is held by ‘everyone’<sup>39</sup> under the jurisdiction of states that have ratified the ICESCR, including in times of armed conflict. Article 12(2)(d) of the ICESCR specifies that the right to health poses an obligation on the state to create the ‘conditions that assure to *all* medical service and medical attention in the event of sickness’<sup>40</sup> – the element of the right to health that is particularly relevant here. The health system and goods, services, and programmes that states should ensure under their minimum core and non-core obligations must be available, accessible, acceptable, and of good quality.<sup>41</sup>

The right to access various elements of the health system made available through the implementation of the right to health is clearly not limited to those in need of emergency medical treatment because they have been injured in ongoing hostilities, but includes those in need of preventive, curative, and rehabilitative care. Yet it must be recalled that the scope of health care provided under the right to health in a particular situation can rarely meet the health needs of everyone because this scope depends on the availability of resources and the related definition of the national minimum core right to health.<sup>42</sup> The question of the likely material scope of the obligations flowing from Article 12 of the ICESCR, in particular the scope of the emerging international minimum core right to health in situations of non-international armed conflict, will be discussed next, together with relevant states’ obligations under IHL.

## Obligations to mitigate the direct health consequences of armed conflicts

IHL obligations and those flowing from the right to health aiming to alleviate the direct health consequences of armed conflicts can be divided into obligations to search for and collect those in need of medical care, and obligations describing the

38 ICRC Commentary to AP I, Art. 8(a), paras. 305–306. See also ICRC Commentary to AP II, Art. 7, para. 6439.

39 ICESCR, Art. 12(1); and Universal Declaration of Human Rights, Art. 25(1). In its ‘jurisprudence’ the CESCR made clear that this includes an obligation to give nationals and non-nationals access to the health system on an equal footing; see e.g. CESCR, Concluding Observations – Sweden, UN Doc. E/C.12/SWE/CO/5, 1 December 2008, para.10; Cyprus, UN Doc. E/C.12/CYP/CO/5, 12 June 2009, para.18; UK, UN Doc. E/C.12/GBR/CO/5, 2 June 2009, para. 27; and France, UN Doc. E/C.12/CO/FRA/CO/3, 9 June 2008, paras. 26 and 46.

40 Emphasis added.

41 CESCR, General Comment 14 – The Right to the Highest Attainable Standard of Health (ICESCR, Art. 12), E/C.12/2000/4, 11 August 2000, para. 12.

42 See the observations above.

scope of medical attention and care that is to be provided to those suffering the direct health consequences of armed conflict.

### *Obligations to search for and collect the wounded and sick*

Article 7(1) of AP II contains the general obligations toward the wounded and sick in IHL: it requires that the wounded and sick shall be 'respected and protected'.<sup>43</sup> This entails that they are not made the subject of any attack, that they are not mistreated, and that their belongings are not taken away.<sup>44</sup> It also implies an obligation on the parties to the conflict to take more proactive measures to safeguard the protection of the wounded and sick against harmful acts by third parties, and their removal from the scene of combat as soon as possible.<sup>45</sup> Both obligations are confirmed in Article 8 of AP II, which specifies that the wounded and sick shall be protected against pillage<sup>46</sup> as well as searched for and collected. These obligations extend to non-state armed groups.<sup>47</sup>

The obligation to ensure physical and economic access to minimum health-care facilities and services for everyone under the right to health includes an obligation not to unduly interfere with existing access, and thus reinforces the IHL obligations. As highlighted by the CESCR, this obligation entails that states refrain from 'limiting the access to health services as a punitive measure, for instance during armed conflicts'.<sup>48</sup> The UN HRC considers that a similar obligation flows from the right to life under the ICCPR.<sup>49</sup>

As specified in Article 8 of AP II, states' IHL obligations to search for and collect the wounded and sick imply that 'whenever circumstances permit, and in particular after an engagement, all possible measures shall be taken, without delay, to search for and collect the wounded, sick and shipwrecked [in order] to ensure

43 This obligation forms part of customary IHL, as is clear from Rules 109–111 of the ICRC Study, Vol. I, pp. 396–405. These rules – and Rules 25–26 and 28–30 relating to the protection of medical personnel, medical units, and medical transports – are backed by extensive state practice collected in Vol. II of the ICRC Study, and their customary status is therefore undisputed in most aspects; see also Susan Breau, 'Protected persons and objects', in E. Wilmschurst and S. Breau (eds), *Perspectives on the ICRC Study on Customary International Humanitarian Law*, Cambridge University Press, Cambridge, 2007, pp. 175–179.

44 ICRC Commentary to AP II, above note 33, para. 4635; ICRC Study, Vol. I, Rule 111, pp. 403–405; J. Kleffner, above note 33, p. 330; Leslie Green, *The Contemporary Law of Armed Conflict*, Manchester University Press, Manchester, 3rd edition, 2008, pp. 358–359.

45 ICRC Commentary to AP II, above note 33, para. 4635; ICRC Study, Vol. I, Rule 109, pp. 396–399; J. Kleffner, above note 33, p. 330; and L. Green, above note 44, pp. 358–359.

46 See also ICRC Study, Vol. I, Rules 52 and 111, pp. 182 and 403.

47 S. Sivakumaran, above note 6, pp. 273–277. See also below note 66 and above note 27.

48 CESCR, General Comment 14, above note 41, para. 34, where the CESCR directly observes that such interference would also amount to a violation of IHL. This is also reiterated in its Concluding Observations – Sri Lanka, UN Doc. E/C.12/LKA/CO/2-4, 9 December 2010, para. 28. See also the examples from national case law given in International Commission of Jurists, *Courts and the Legal Enforcement of Economic, Social and Cultural Rights – Comparative Experience of Justiciability*, Human Rights and Rule of Law Series No. 2, 2008, p. 43, available at: [www.icj.org/dwn/database/ESCR.pdf](http://www.icj.org/dwn/database/ESCR.pdf) (last visited 26 July 2012). States' direct threats to or interference with the health of individuals or health care given to them can also amount to inhuman or degrading treatment or a violation of the right to life. See the remarks below on ICCPR, Art. 6, and jurisprudence of the ECtHR, below note 108.

49 See below note 54.



their adequate care'.<sup>50</sup> The phrase 'whenever circumstances permit' implies that the duty to search for and collect the wounded and sick extends beyond the duty to do so on the battlefield, in particular because in contemporary armed conflicts it is 'difficult to determine where exactly the battlefield is in place and time'.<sup>51</sup> Moreover, it makes clear that there is a duty to search for the wounded and sick not only after each engagement, but also in other situations – for instance, when civilians have been injured by mines or unexploded ordnance outside an area of active combat.

Similarly to IHL, obligations flowing from the right to health require states to undertake more proactive measures to safeguard the health of those suffering direct health consequences of hostilities. As part of their obligation to ensure equal access to existing health facilities, goods, and services, in an armed conflict situation states should arguably pay priority attention to those particularly vulnerable persons who have been wounded in ongoing hostilities.<sup>52</sup> States are moreover obliged under the right to health to directly ensure access to health facilities when individuals are unable, for reasons beyond their control, to realise that element of the right to health themselves.<sup>53</sup> There is no reason why the measures that are to be taken to ensure these individuals' access to medical treatment required by their condition should differ from the mentioned obligations under IHL: obligations to search for and collect the wounded and sick, with all the implications described above.

This would also be strengthened by states' obligations under the right to life, a right closely connected to the right to health. The HRC has long observed that ICCPR Article 6(1) should not be interpreted narrowly and requires states to adopt 'positive' measures to safeguard lives, including ensuring access to medical assistance.<sup>54</sup> In addition, the UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officials stipulate that law enforcement officials shall,

50 AP II, Art. 8, corresponds to GC I, Art. 15(1) and GC II, Art. 18(1), and introduced the explicit duty to search for the wounded and sick into IHL of non-international armed conflicts for the first time; see M. Bothe, K. J. Partsch, and W. Solf, above note 35, p. 659; ICRC Study, Vol. I, Rule 109, pp. 396–399; ICRC Commentary to AP II, above note 33, para. 4635; J. Kleffner, above note 33, p. 330; and L. Green, above note 44, pp. 358–359.

51 ICRC Commentary to AP II, above note 33, para. 4653; with this, AP II, Art. 8 goes further than GC II, Art. 18, which only requires taking such action 'after each engagement'; see also M. Bothe, K. J. Partsch, and W. Solf, above note 35, p. 659.

52 CESCR, General Comment 14, above note 41, para. 43(a); Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, para. 42.

53 CESCR, General Comment 14, above note 41, para. 37.

54 HRC, General Comment No. 6 – The Right to Life, 30 April 1982, para. 5; and HRC, Concluding Observations – Israel, UN Doc. CCPR/ISR/CO/3, 3 September 2010, para. 8; UN Doc. CCPR/CO/78/ISR, 21 August 2003, para. 19; HRC, Concluding Observations – United States of America, UN Doc. CCPR/C/USA/3/Rev.1, 18 December 2006, para. 26. This is also reiterated by the HRC's Concluding Observations that do not directly concern armed conflict situations, see e.g. HRC, Concluding Observations – Mali, UN Doc. CCPR/CO/77/MLI, 16 April 2003, para. 14; HRC, Concluding Observations – Uganda, UN Doc. CCPR/CO/80/UGA, 4 May 2004, para. 14; HRC, Concluding Observations – Kenya, UN Doc. CCPR/CO/83/KEN, 29 April 2005, paras. 14, 15, and 19; HRC, Concluding Observations – Mauritius, UN Doc. CCPR/CO/83/MUS, 27 April 2005, para. 9. See also Manfred Nowak, *UN Covenant on Civil and Political Rights – CCPR Commentary*, Kehl am Rhein, N. P. Engel, 2nd edition, 2005, pp. 123–124. And see the Inter-American Court of Human Rights' jurisprudence on 'the right to a dignified life', encompassing many aspects of the right to health, as discussed by Steven Keener and Javier Vasquez, 'A life worth living: enforcement of the right to health through the right to life in the Inter-American Court of Human Rights', in *Columbia Human Rights Law Review*, Vol. 40, 2009, pp. 595–624.

‘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’.<sup>55</sup>

The jurisprudence of the European Court of Human Rights (ECtHR) shows that obligations under the right to life (Article 2) of the European Convention on Human Rights (ECHR) can equally reinforce and specify obligations under the right to health. The ECtHR has long found that Article 2(1) of the ECHR obliges states not only ‘to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within [their] jurisdiction’.<sup>56</sup> More concretely, in *Cyprus v. Turkey*, the ECtHR held that ECHR Article 2 may be violated ‘where it is shown that the authorities of a Contracting State put an individual’s life at risk through the denial of health care which they have undertaken to make available to the population generally’.<sup>57</sup> In this case, the restrictions placed on the freedom of movement of Greek Cypriot and Maronite populations by the Turkish Republic of Northern Cyprus (TRNC) in northern Cyprus resulted in some delay in their access to health care, and hampered medical visits.<sup>58</sup> That this is equally valid for situations of non-international armed conflict is clear from another judgement, *Albekov and Others v. Russia*. In this judgement, the ECtHR found that Russia had violated its ‘positive’ obligations to take appropriate steps to safeguard the lives of victims who had died from landmine explosions in Chechnya.<sup>59</sup> The finding was based on the Russian authorities’ ‘failure to endeavour to locate and deactivate the mines, to mark and seal off the mined area so as to prevent anybody from freely entering it, and to provide the villagers with comprehensive warnings concerning the mines laid in the vicinity of their village’.<sup>60</sup>

The ECtHR did not mention, as a further violation of Russia’s ‘positive’ obligations to safeguard lives, the repeated refusal<sup>61</sup> of the Russian military unit stationed close to the applicants’ village to search for one villager who had been wounded by a landmine, but such a finding is conceivable. This would be the case in

55 Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Adopted by the 8th UN Congress on the Prevention of Crime and the Treatment of Offenders, Havana, Cuba, 27 August to 7 September 1990, available at: [www.unrol.org/files/BASICP~3.PDF](http://www.unrol.org/files/BASICP~3.PDF) (last visited 18 June 2013). The Principles are *inter alia* designed to give effect to the right to life in domestic law.

56 ‘Positive’ obligations to safeguard the right to life are a well-established part of the ECtHR’s jurisprudence, see e.g. ECtHR, *Cyprus v. Turkey*, Appl. No. 25781/94, Judgement (Grand Chamber), 10 May 2001, para. 219; ECtHR, *L.C.B. v. UK*, Appl. No. 23413/94, Judgement, 9 June 1998, para. 36; *Osman v. UK*, Appl. No. 23452/94, Judgement (Grand Chamber), 28 October 1998, para. 115; discussed in more detail in Harris *et al.* (eds.), *Harris, O’Boyle and Warbrick, Law of the European Convention on Human Rights*, Oxford University Press, Oxford, 2nd edition, 2009, pp. 42–46.

57 ECtHR, *Cyprus v. Turkey*, Appl. No. 25781/94, Judgement (Grand Chamber), 10 May 2001, para. 219.

58 The ECtHR did not, however, find a violation of the right to life since it ‘was unable to establish on the evidence that the “TRNC” authorities deliberately withheld medical treatment from the population concerned or adopted a practice of delaying the processing of requests of patients to receive medical treatment in the south’ (*ibid.*, paras. 219–221). Instead, it took the TRNC’s interference with access to medical facilities into account as one factor in its finding that the overall living conditions of enclaved Greek Cypriots in northern Cyprus amounted to a violation of Art. 8 (right to private and family life) (paras. 299–301).

59 ECtHR, *Albekov and Others v. Russia*, Appl. No. 68216/01, Judgement, 6 April 2009, para. 90.

60 *Ibid.*, para. 90.

61 *Ibid.*, paras. 18, 19, and 21.



particular when aforementioned IHL obligations to search for and collect the wounded and sick as well as obligations under the right to health were taken into consideration.<sup>62</sup> In this specific case it was even known to the military that a wounded villager was in need of medical assistance, since residents of the village had explicitly approached the military unit with the request to search and collect the wounded villager. The villagers were afraid of triggering more landmine explosions when searching for him on their own without the help of sappers. Since the IHL duty to search and collect the wounded and sick usually rests with the governmental armed forces operating military and civilian medical services – including independent national Red Cross and Red Crescent Societies – the residents’ appeal to the military unit stationed in the region should have been responded to.

Rule 109 of the ICRC Study includes an obligation to take all possible measures to evacuate the wounded and sick when circumstances permit,<sup>63</sup> an obligation closely related to the obligation to search for and collect the wounded and sick. It can be argued that this obligation also includes a duty to create the conditions in which searches and evacuations can be carried out successfully. The more detailed provisions applicable to international armed conflicts in GC I can, by analogy, give more specific indications as to what an obligation to evacuate the wounded and sick could entail: for example, GC I Article 15(2) suggests that parties to the conflict arrange ‘an armistice or a suspension of fire’ or make ‘local arrangements’ to ‘permit the removal, exchange and transport of the wounded’. Reinforced by states’ obligations under the right to health to undertake actions to restore the health of the population,<sup>64</sup> these measures should be applied to non-international armed conflicts as well.<sup>65</sup> This would also allow national and international humanitarian organisations to take care of the wounded and sick in territories where parties to the conflict are unable to provide necessary medical care themselves, including in territories under the control of armed groups. In fact, both state and non-state parties to conflicts have frequently agreed that humanitarian organisations could assist in the search, collection, and evacuation of the wounded and sick in non-international armed conflicts.<sup>66</sup> This obligation is strengthened by Article 2(1) of the ICESCR, which calls on states to request and accept international assistance for the implementation of in particular minimum core ESC rights when they are unable to secure these rights themselves.<sup>67</sup>

The analysis now turns to the scope of the medical attention and care that states must provide to those wounded or psychologically traumatised by ongoing hostilities under IHL and the right to health.

62 The CESCR also points to this direction in its Concluding Observations – Colombia, UN Doc. E/C.12/COL/CO/5, 7 June 2010, para. 16; Angola, UN Doc. E/C.12/AGO/CO/3, 1 December 2008, para. 33; and Bosnia and Herzegovina, UN Doc. E/C.12/BIH/CO/1, 24 January 2006, para. 48.

63 ICRC Study, Vol. I, Rule 109, p. 396.

64 CESCR, General Comment 14, above note 41, paras. 16 and 37.

65 As suggested in the commentary to ICRC Study, Vol. I, Rule 109, pp. 398–399.

66 See *ibid.*, p. 398, and the wealth of examples given by S. Sivakumaran, above note 6, pp. 276–277.

67 For more details, see A. Müller, above note 3, pp. 243–245.

## The scope of medical attention and care to be provided to those suffering from direct health consequences of armed conflicts

Article 7(2) of AP II requires that the wounded and sick are 'treated humanely' in all circumstances and that they 'receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition'.<sup>68</sup> Article 8 of AP II confirms this, emphasising the obligation 'to ensure their adequate care'.

The phrase 'in all circumstances' leaves no doubt that military necessity cannot be invoked to justify non-compliance with this obligation.<sup>69</sup> However, as pointed out in the ICRC Commentary on AP II, the provision 'to the fullest extent practicable and with the least possible delay' is informed by realism, since sometimes it might be impossible to provide the care that is immediately necessary due to the prevailing circumstances. Nonetheless, the provision clearly requires that the parties to the conflict act in good faith and that they make their best efforts to provide the required medical care to the wounded and sick as quickly as possible.<sup>70</sup>

Explaining the obligation to provide wounded and sick persons with adequate care, the ICRC Commentary to Article 8 of AP II further holds that

'adequate care' is first aid given on the spot, which may be of the utmost importance to avoid wounded, sick or shipwrecked succumbing during evacuation, which must take place as quickly as possible. Obviously such care includes ensuring the transport of the wounded to a place where they can be adequately cared for.<sup>71</sup>

Beyond the provision of first aid and emergency medical treatment, the details and types of medical care that have to be given to the wounded and sick are rarely specified in commentaries on relevant provisions of IHL.<sup>72</sup> One reason for this is presumably IHL's focus on protecting mainly the traditional function of medical services attached to governmental armed forces, which is primarily concerned with caring for those who have been wounded in battles and focuses on first aid, surgeries, and amputations.

However, the inclusive definition of the 'wounded and sick' given above shows that 'adequate care' today goes beyond first aid and emergency medical treatment for those suffering from the direct health consequences of armed conflicts: it may, for example, include short- and long-term medical, mental, and rehabilitative care for those with conflict-related physical and psychological health

68 See also ICRC Study, Vol. I, Rule 110, pp. 400–403.

69 J. Kleffner, above note 33, p. 331.

70 ICRC Commentary to AP II, above note 33, para. 4645; interpretation of ICRC Study, Vol. I, Rule 110, p. 402; and J. Kleffner, above note 33, pp. 330–331, referring to the analogous provision in AP I, Art. 10(2).

71 ICRC Commentary to AP II, above note 33, para. 4655.

72 Most sources do not comment on what constitutes 'medical care and attention required' (AP II, Art. 7(2)) or 'adequate care' (AP II, Art. 8), e.g. J. Kleffner, above note 33, p. 330. The ICRC Study's comment on Rule 110 does not clarify the extent of this obligation either.

problems, including for victims of sexual violence.<sup>73</sup> Non-state armed groups' obligations in this area are most likely concentrated on obligations to give consent to the work of national and international humanitarian organisations implementing these and other obligations discussed below, in particular when the non-state armed group in question is relatively weak.<sup>74</sup>

The question of whether obligations to provide long-term rehabilitative care lie outside the regulatory realm of IHL is intrinsically linked to the question of the temporal scope of application of IHL of non-international armed conflicts. Conventional rules of IHL fail to determine the point in time at which IHL of non-international armed conflicts ceases to operate, but the ICRC Commentary and the jurisprudence of the International Criminal Tribunal for the Former Yugoslavia (ICTY) give some further guidance on the temporal scope of application of IHL of non-international armed conflicts. The ICRC Commentary suggests that IHL is no longer applicable 'after the end of hostilities',<sup>75</sup> leaving the question open as to whether this refers to the point in time when a ceasefire agreement has been reached or to the time at which general hostilities have come to a close, typically through a peace agreement.<sup>76</sup> The latter interpretation is supported by the ICTY, which held that the application of IHL of non-international armed conflicts 'extends beyond the cessation of hostilities until . . . a peaceful settlement is achieved'.<sup>77</sup> Such an interpretation is further backed by the fact that IHL of both international and non-international armed conflicts contains provisions that are explicitly meant to have effect beyond the cessation of hostilities.<sup>78</sup> While the present author agrees with Sivakumaran that the temporal application of IHL should ultimately be determined by the existence or non-existence of certain facts (an armed conflict), which have to be judged on a case-by-case basis,<sup>79</sup> some more recent IHL treaties suggest that longer-term obligations could flow from IHL that are of relevance even after the end of hostilities and even when the fact-condition 'armed conflict' is no longer met. This is particularly so in regard to treaties that draw from IHL as well as from IHRL,<sup>80</sup> and whose temporal scope of application is not limited to armed

73 See also the section below, further analysing the question of the extent to which IHL obligations also include the provision of health care aiming to mitigate the indirect public health impact of armed conflicts.

74 See S. Sivakumaran, above note 6, pp. 275 and 333–334 for accounts of non-state armed groups' practice in this regard. The assumption is also supported by the ICRC Commentary to AP II, above note 33, para. 4878. On states' and non-state armed groups' obligations to give consent to the delivery of humanitarian assistance by humanitarian organisations, see also A. Müller, above note 3, chapter VIII.

75 ICRC Commentary to AP II, para. 4492.

76 See the observations by S. Sivakumaran, above note 6, p. 252.

77 ICTY, *Prosecutor v. Dusko Tadić*, Decision on the Defence Motion for Interlocutory Appeal on Jurisdiction, IT-94-1-AR72, 2 October 1995, para. 70; and *Prosecutor v. Ramush Haradinaj, Idriz Balaj and Lahi Brahimaj*, Judgement (Trial Chamber), IT-04-84-T, 3 April 2008, para. 100.

78 AP II, Art. 2(2); GC I and GC III, Art. 5; GC IV, Art. 6; and ICTY, *Tadić*, Decision on Interlocutory Appeal on Jurisdiction, para. 67.

79 S. Sivakumaran, above note 6, pp. 253–254; cp. also ICTY, *Prosecutor v. Ante Gotovina, Ivan Čermak, Miladen Markač*, Judgement (Trial Chamber), IT-06-90-T, 15 April 2011, para. 1694.

80 E.g. the 1997 Ottawa Convention, 2056 UNTS 211, entered into force on 1 March 1999; the 2003 Protocol V to Conventional Weapons Convention, 2399 UNTS 100, entered into force on 12 November 2006; and the 2008 Convention on Cluster Munitions (CCM).

conflict situations.<sup>81</sup> For example, in his foreword to the Convention on Cluster Munitions (CCM), the ICRC's former president Jakob Kellenberger observes that the CCM 'established a broader norm that those who engage in armed conflict can no longer walk away from the long-term consequences of the weapons they use, leaving local communities to carry the burden'.<sup>82</sup> Article 5(1) of the CCM obliges each state party to 'adequately provide age- and gender-sensitive assistance, including medical care, rehabilitation and psychological support' to cluster munition victims, as well as to 'provide for their social and economic inclusion'. From CCM Article 5(2)(e) it is furthermore clear that this obligation is not limited to victims of cluster munitions, but includes all 'who have suffered injuries or disabilities from other causes'. The recognition of the parallel application of ESC rights to armed conflicts is made explicit in the CCM.<sup>83</sup>

To explore this further, the discussion will now move to analyse the extent to which states' obligations flowing from the right to health address the mentioned direct impacts of armed conflicts on public health. This is linked to the difficult question about the more exact scope of the health facilities, goods, and services that states are most likely obliged to grant equal access to under an emerging internationally defined minimum core right to health, possibly encompassing the provision of emergency as well as longer-term rehabilitative care to those who have been injured in hostilities. To recall, the implementation of the right to health in non-international armed conflicts will in most cases inevitably be limited to the implementation of a nationally defined minimum core right to health that mirrors the internationally defined minimum core as closely as possible, in accordance with ICESCR Articles 2(1) and 4.<sup>84</sup>

The first question to be asked for the conflict context is whether emergency medical treatment is part of the international minimum core content of the right to health, strengthening the mentioned IHL obligations. The CESCR's General Comments 3 and 14 seem rather to regard 'essential primary health care'<sup>85</sup> as the minimum core of the right to health. Trauma care and surgery that require specialised training and sophisticated technology and resources are not usually part of 'primary health care'.<sup>86</sup> General Comment 14 refers to the Alma-Ata

81 See e.g. CCM, Arts. 1 and 4; Ottawa Convention, Arts. 1 and 5; Protocol V to Conventional Weapons Convention, Art. 1(3).

82 Entered into force on 1 August 2010, reprinted by the ICRC, with a foreword by Jakob Kellenberger, p. 7, available at: [www.icrc.org/eng/assets/files/other/icrc\\_002\\_0961.pdf](http://www.icrc.org/eng/assets/files/other/icrc_002_0961.pdf) (last visited 26 July 2012).

83 E.g. in the preamble, paras. 6 and 22 and Art. 5(1) of the CCM; it should be recalled, however, that these obligations are subject to 'progressive realisation' in accordance with available resources; see also below text accompanying notes 116–118.

84 As outlined in the section 'The applicability of ESC rights . . .', above.

85 CESCR, General Comment 3 – The Nature of States Parties' Obligations, contained in document E/1991/23, 14 December 1990, para. 10; and General Comment 14, above note 41, para. 43; see also CESCR, Concluding Observations – Bolivia, UN Doc. E/C.12/BOL/CO/2, 8 August 2008, para. 34.

86 WHO, *World Health Report 2008 – Primary Health Care (Now More Than Ever)*, p. 55, including figure 3.5, available at: [www.who.int/whr/2008/en/index.html](http://www.who.int/whr/2008/en/index.html) (last visited 26 July 2012); see also the definition of 'primary health care' in John M. Last (ed.), *A Dictionary of Public Health*, Oxford University Press, Oxford, 2007, accessed via *Oxford Reference Online* at: [www.oxfordreference.com/views/ENTRY.html?subview=Main&entry=t235.e3639](http://www.oxfordreference.com/views/ENTRY.html?subview=Main&entry=t235.e3639) (last visited 26 July 2012).

Declaration<sup>87</sup> as a ‘compelling guidance on the core obligations arising from Art. 12<sup>88</sup> of the ICESCR – that is, on what constitutes ‘essential primary health care’:

at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.<sup>89</sup>

The Humanitarian Charter and Minimum Standards in Humanitarian Response of the Sphere Project, which claim to be built on the minimum core right to health,<sup>90</sup> also suggest that health interventions by humanitarian organisations should emphasise community-based public health and primary care. This is based on the aforementioned fact that the indirect impacts of armed conflicts on public health often constitute a far greater health threat to the people affected than violent injury, especially in poorer countries.<sup>91</sup> This is further discussed in the section ‘Obligations to mitigate the indirect health consequences . . .’, below.

The focus of the international minimum core right to health on primary health-care does not exclude emergency medical treatment and specialised surgical services from being considered immediately accessible services under a nationally defined minimum core, in particular in high-income countries. For example, the existence of an effective referral system has been named as a decisive component of a health system that conforms with the right to health, even if this health system prioritises primary care.<sup>92</sup> This presumes the existence of primary (community-based), secondary (district-based), and tertiary (specialised) facilities and services, providing a continuum of prevention and care.<sup>93</sup> It also reflects an understanding

87 The Declaration of Alma-Ata was adopted by the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978, available at: [www.searo.who.int/LinkFiles/Health\\_Systems\\_declaration\\_almaata.pdf](http://www.searo.who.int/LinkFiles/Health_Systems_declaration_almaata.pdf) (last visited 26 July 2012).

88 CESCR, General Comment 14, above note 41, para. 43.

89 Declaration of Alma-Ata, above note 87, para. IV(3); the CESCR’s understanding of states’ minimum core obligations set out in paras. 43 and 44 of General Comment 14 follow this definition; see also Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, para. 51; and WHO, *World Health Report 2008*, above note 86, pp. 55–56.

90 Sphere Project, *Humanitarian Charter and Minimum Standards in Humanitarian Response*, 2011, available at: [www.sphereproject.org/handbook/](http://www.sphereproject.org/handbook/) (last visited 26 July 2012), p. 291, holds that: ‘The Minimum Standards . . . are not a full expression of the right to health. However, the Sphere standards reflect the core content of the right to health and contribute to the progressive realisation of this right globally.’

91 *Ibid.*, pp. 292, 311, and 331–333. See also the table on p. 293, indicating the public health impact of selected disasters; and the sources cited in above notes 1 and 2.

92 See, e.g. Gunilla Backman *et al.*, ‘Health systems and the right to health: an assessment of 194 countries’, in *The Lancet*, 10 December 2008, p. 6; and Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, paras. 22(e), 55, and 66. See also WHO, *World Health Report 2008*, above note 86, pp. 55–56.

93 See Backman *et al.*, above note 92; and WHO, *World Health Report 2000 – Health Systems: Improving Performance*, available at: [www.who.int/whr/2000/en/](http://www.who.int/whr/2000/en/) (last visited 26 July 2012). In addition, even if not

of primary care as a hub from which patients are guided through a health system.<sup>94</sup> As noted by the World Health Organization (WHO), even in resource-constrained settings it is 'not acceptable that . . . primary care would be reduced to a stand-alone health post or isolated community-health worker',<sup>95</sup> although the notion of 'progressive realisation' recognises that a comprehensive health system cannot be constructed immediately.<sup>96</sup> Moreover, there are indications from constitutions, state practice, and cases at the national level that states may regard the provision of emergency medical care, including specialised surgeries, as forming part of the minimum core right to health, whether defined nationally or internationally.

The South African<sup>97</sup> Constitution contains a right to emergency medical treatment.<sup>98</sup> In other countries, access to emergency medical treatment has been recognised in case law: the Supreme Court of India found that there was a constitutional duty of government-run hospitals to provide timely emergency treatment to those who are seriously ill, derived from the right to life.<sup>99</sup> Similar cases are known from Colombia,<sup>100</sup> Argentina,<sup>101</sup> and Venezuela.<sup>102</sup> Many countries that restrict access to health care for non-citizens seem to at least allow for their access to emergency medical treatment,<sup>103</sup> a requirement that is reiterated in Article 28 of the Convention on Migrant Workers.<sup>104</sup>

The right to emergency medical treatment could also flow from the right to life and the prohibition of torture or cruel, inhuman, or degrading treatment. The UN HRC has held that states are under an obligation to provide such treatment to persons in detention,<sup>105</sup> and it has voiced its concern about inadequate health

mentioned as part of the international minimum core of the right to health, General Comment 14, above note 41, holds that the right to treatment in ICESCR, Art.12(2)(c), para. 16, includes 'the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations'.

94 WHO, *World Health Report 2008*, above note 86, pp. 55–56.

95 *Ibid.*, p. xvii, box 2, warns that 'what has been considered primary care in well-resourced contexts has been dangerously oversimplified in resource-constrained settings'.

96 Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, para. 46.

97 Chapter II, Section 27(3) of the South African Constitution reads: 'No one may be refused emergency medical treatment.'

98 See also the Moldovan Constitution, analysed in ECtHR, *Pentiacova and 48 Others v. Moldova*, Appl. No. 14462/03, Decision, 4 January 2005.

99 Supreme Court of India, *Paschim Banga Khet Majoor Samity v. State of West Bengal*, Judgement, 6 May 1996, AIR SC 2426/ (1996) 4 SCC 37, para. 6.

100 Magdalena Sepulveda, 'Colombia – the Constitutional Court's role in addressing social justice', in M. Langford (ed.), *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law*, Cambridge University Press, Cambridge, 2008, p. 125.

101 Christian Courtis, 'Argentina – some promising signs', in M. Langford (ed.), above note 100, pp. 174–176.

102 Enrique Gonzalez, 'Venezuela – a distinct path towards social justice', in M. Langford (ed.), above note 100, p. 203.

103 See the discussion by Birgit Toebes, *The Right to Health as a Human Right in International Law*, Intersentia, Antwerp, 1999, pp. 318–319; and European Committee of Social Rights (ECSR), Complaint 15/2003, *European Roma Rights Centre (ERRC) v. Greece*, Decision on the Merits, 8 December 2004, paras. 33–38.

104 2220 UNTS 3, entered into force on 1 July 2003.

105 To name but a few examples, see e.g. HRC, *Lantsov v. Russian Federation*, Communication No. 763/1997, UN Doc. CCPR/C/74/D/763/1997, 15 April 2002, para. 9.2; HRC, *Fabrikant v. Canada*, Communication No. 970/2001, UN Doc. CCPR/C/79/D/970/2001, 11 November 2003, para. 9.3, where Canada had



facilities in different countries in its concluding observations.<sup>106</sup> An obligation to provide emergency medical treatment to individuals against which force or firearms have been used lawfully by law enforcement officials is also reinforced by the UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officials.<sup>107</sup> Several cases decided by the ECtHR also suggest that the right to emergency medical treatment could be contained in the right to life and the prohibition of torture or inhuman and degrading treatment.<sup>108</sup> The ECtHR is, however, not consistent in this regard.<sup>109</sup> The South African *Soobramoney* case moreover shows that it is not always easy to agree on what constitutes ‘emergency medical treatment’. In this case, the South African Constitutional Court held that Mr. Soobramoney, in need of dialysis treatment because of renal failure, was not an ‘emergency’ in the sense of an accident or sudden illness, but that his condition was rather an ‘ongoing state of affairs’ and was thus not entitled to this treatment.<sup>110</sup> The package of services that constitute ‘emergency medical treatment’ has to be determined at the national level, with the help of human rights principles such as participation, non-discrimination, and concentration on marginalised and disadvantaged groups, and the resources available to a particular country.<sup>111</sup>

Thus, at least in high-income countries, it can be expected that the provision of specialised emergency medical treatment will form part of a nationally defined minimum core right to health that can be accessed by everyone. Every effort must be made to continue the provision of such treatment in times of armed conflict in order to address direct health consequences, if necessary with assistance from humanitarian organisations.<sup>112</sup> This would also be in line with the requirement of ICESCR Article 4 to limit the right to health only for the reason of ‘promoting general welfare’. Cutting down on specialised medical care when there are numerous victims suffering from serious injuries in a non-international armed conflict would not be conducive to the ‘promotion of general welfare’. If high- and middle-income countries are affected by armed conflicts, the main cause of excess mortality and

provided appropriate surgery to a prisoner and the communication was therefore held inadmissible; and HRC, Concluding Observations – Portugal, UN Doc. CCPR/CO/78/PRT, 17 September 2003, para. 11. See also Sarah Joseph, Jenny Schultz, and Melissa Castan, *The International Covenant on Civil and Political Rights*, Oxford University Press, Oxford, 2nd edition, 2004, p. 197.

106 See above note 54; and S. Joseph, J. Schultz, and M. Castan, above note 105, pp. 184–187.

107 See above note 55.

108 ECtHR, *Cyprus v. Turkey*, App. No. 25781/94, Judgement (Grand Chamber), 10 May 2001, para. 219; *Calvelli and Ciglio v. Italy*, Appl. No. 32967/96, Judgement, 17 January 2002, para. 49; *D v. UK*, Appl. No. 30240/96, Judgement, 2 May 1997, paras. 51–54; and *Bensaid v. UK*, Appl. No. 44599/98, Judgement, 6 February 2001, para. 40.

109 ECtHR, *Nitecki v. Poland*, Appl. No. 65653/01, Decision, 21 March 2002, para. 1; *Pentiacova and 48 Others v. Moldova*, Appl. No. 14462/03, Decision, 4 January 2005; see also the analysis by Harris *et al.*, above note 56, p. 47. On the approach of the Inter-American Court of Human Rights, see S. Keener and J. Vasquez, above note 54, p. 617.

110 Constitutional Court of South Africa, *Soobramoney v. Minister of Health (Kwazulu-Natal)*, Judgement, 27 November 1997, 1998 (1) SA 765 (CC), paras. 20–21. See also the discussion of the South African constitutional provisions in Marius Pieterse, ‘Enforcing the right not to be refused emergency medical treatment: towards appropriate relief’, in *Stellenbosch Law Review*, Vol. 18, 2007, pp. 75–90.

111 As suggested in the section ‘The applicability of ESC rights . . .’, above.

112 Cp. ICESCR, Art. 2(1), referring to international assistance and cooperation in the implementation of ESC rights; see also above notes 27 and 67.



morbidity is often violence, at least when the conflict is limited to a short period of time.<sup>113</sup> This would justify prioritising the provision of emergency medical services in these situations.<sup>114</sup>

Even in resource-poorer countries where definitive trauma and surgical care may not (yet) be available even in peacetime, there are simple procedures that can increase the survival chances of severely injured individuals, as pointed out in the Sphere Charter. These include 'clearing the airway, controlling haemorrhage and administering intravenous fluids' as well as 'cleaning and dressing wounds, and administering antibiotics and tetanus prophylaxis'.<sup>115</sup> These measures can stabilise patients until adequate assistance arrives from national or international humanitarian actors.

The provision of long-term medical care, rehabilitation, and psychological support for those who have been injured in armed conflicts seems not to be part of the emerging internationally defined minimum core right to health. These obligations appear rather to be part of non-core obligations, the implementation of which is more dependent on resources and therefore subject to progressive realisation to a greater extent than minimum core obligations.<sup>116</sup> This is clear from General Comment 14, which does not list such care under the heading of 'minimum core obligations', as well as from Article 5(2)(c) of the CCM. The latter seems to recognise that the mentioned obligation established in CCM Article 5(1) to 'provide age- and gender-sensitive assistance, including medical care, rehabilitation and psychological support' to cluster munition victims cannot be realised immediately; states must therefore 'develop a national plan and budget, including time-frames to carry out these activities',<sup>117</sup> reflecting the notion of progressive realisation. Moreover, as noted in the CESCR's Concluding Observations on Bosnia and Herzegovina, under the right to health and other rights of the ICESCR, social assistance provided to victims of war should be distributed equally among different groups of victims.<sup>118</sup> In this particular case, considerably lower social assistance was given to civilian victims of the 1990s armed conflicts than to military victims.

113 Data collected from Kosovo, a relatively well developed country, between February 1998 and June 1999 showed that the increase in the mortality rate in this case was mainly due to an increase in deaths resulting from direct violence: see Paul Spiegel and Peter Salama, 'War and mortality in Kosovo, 1998-99: an epidemiological testimony', in *The Lancet*, 24 June 2004; Richard Garfield, 'The epidemiology of war', in B. Levy and V. Sidel (eds), *War and Public Health*, Oxford University Press, New York, 2nd edition, 2008, pp. 29-32; and for a similar finding in regard to Lebanon's cancer care system, see Khahir Ahmad, 'Conflict puts pressure on cancer-care resources in Lebanon', in *The Lancet*, September 2006.

114 The Sphere Charter, above note 90, p. 309, also suggests that humanitarian organisations address the major causes of morbidity and mortality prevalent in a particular conflict situation.

115 *Ibid.*, p. 332.

116 For more details on the relationship between states' core and non-core obligations under the ICESCR, see David Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights*, Oxford University Press, Oxford, 2007, pp. 208-215; and A. Müller, above note 3, pp. 96-99.

117 CCM, Art. 5(2)(c).

118 CESCR, Concluding Observations - Bosnia and Herzegovina, UN Doc. E/C.12/BIH/CO/1, 14 January 2006, paras. 18, 19, and 39.

## Obligations to mitigate the indirect health consequences of armed conflicts

Among the indirect health effects of armed conflicts are the spreading of infectious diseases (epidemic and endemic), rising numbers of maternal and neonatal deaths, increasing prevalence of mental illness, and complications from chronic diseases. As already observed, civilian deaths and suffering resulting from these indirect health effects tend to be far greater than those from violent injuries, and some of them may occur only in the long term.<sup>119</sup> However, the exact scope of this indirect impact on public health depends very much on the circumstances, including the state of the health system of the country in which the armed conflict takes place. The question arises as to whether and to what extent IHL and the right to health place obligations on states to mitigate these indirect health consequences.

### *States' obligations under IHL to alleviate the indirect health consequences of armed conflicts*

Due to its historical origins, IHL focuses primarily on the protection of military medicine and the mitigation of the direct health effects of armed conflicts. However, there are several indications that obligations to alleviate armed conflicts' indirect impacts on public health are also part of IHL.

First, the broad definition of 'wounded and sick' referred to in the above section is not restricted to those who suffer from injuries sustained in ongoing hostilities, but also includes maternity cases, newborn babies, and other persons who may be in need of medical assistance or care. Moreover, Article 7(2) of AP II contains the obligation to ensure that medical care is provided to the wounded and sick as '*required by their condition*', no matter whether this 'condition' is due to violence or other illness, as well as the requirement that the wounded and sick are treated humanely.<sup>120</sup> The 'requirement of humane treatment is an overarching concept',<sup>121</sup> demanding in general terms that a human being is provided with the things that are necessary for his or her 'normal maintenance as distinct from that of an animal' and treated 'as a fellow human being and not as a beast or a thing'.<sup>122</sup> It is clear that the concrete prohibitions listed in common Article 3 of GC I–IV and Part II of AP II are manifestations of the obligation to treat persons *hors de combat* humanely, but also that the principle as such and therefore the obligations under IHL are broader.<sup>123</sup> It can thus be argued that as an obligation flowing from the requirement of humane treatment, parties to the conflict should do everything that

119 See above notes 1 and 2.

120 See Art. 3(1) common to all four Geneva Conventions; AP II, Part II; and ICRC Study, Vol. I, Rule 87, pp. 306–308.

121 ICRC Study, Vol. I, pp. 307–308.

122 ICRC Commentary to GC I–IV, above note 37, Common Art. 3, p. 53; Jean Pictet, *The Fundamental Principles of the Red Cross: Commentary*, 1979, 'I – Principle of Humanity', available at: [www.icrc.org/eng/resources/documents/misc/fundamental-principles-commentary-010179.htm](http://www.icrc.org/eng/resources/documents/misc/fundamental-principles-commentary-010179.htm) (last visited 26 July 2013).

123 See ICRC Study, comment to Rule 87, p. 308; ICRC Commentary to GC I–IV, Common Art. 3, pp. 53–54; and S. Sivakumaran, above note 3, p. 258, citing relevant ICTY jurisprudence and academic literature.

'is feasible'<sup>124</sup> in order to address the indirect health effects of armed conflicts in a similar way as violent injuries.

Second, this is further confirmed by the wide understanding of 'medical activities' protected by Article 10 of AP II. The ICRC Commentary on this Article holds that the term 'medical activities' should be interpreted broadly – that is, in addition to medical care and treatment of the wounded and sick, it includes acting to 'vaccinate people, make diagnoses, give advice *etc.*'.<sup>125</sup> These activities are vital for mitigating indirect health consequences of non-international armed conflicts.

Third, IHL protects all medical units and transports, no matter whether they care for the war-wounded or other patients. Although more complex than the protection of medical units and transports, the IHL protection of medical personnel is also not restricted to the protection of military doctors and nurses. It includes all 'persons assigned, by a Party to the conflict, exclusively to . . . medical purposes',<sup>126</sup> for example 'the prevention of disease'.<sup>127</sup>

All these IHL obligations to address indirect health consequences are clearly reinforced and specified by the simultaneous application of the minimum core right to health, as will be shown in the following section.

### *Minimum core obligations under the right to health addressing indirect health consequences of non-international armed conflicts*

As suggested, under the international minimum core obligations flowing from the right to health, states are to concentrate on building a basic health system that ensures the provision of 'essential primary health care'.<sup>128</sup> This includes a prioritisation of 'immunisation against major infectious diseases occurring in the community', of taking 'measures to prevent, treat and control epidemic and endemic diseases', and of ensuring 'reproductive, maternal (pre-natal as well as post-natal) and child healthcare'.<sup>129</sup> Moreover, the internationally defined minimum core right to health emphasises the great importance of protecting the underlying determinants of health: 'access to a minimum essential food which is nutritionally adequate and safe' as well as 'access to basic shelter . . . and sanitation, and an adequate supply of safe and potable water'.<sup>130</sup>

This focus seems particularly helpful for averting some of the most dreadful indirect health consequences of armed conflicts. This shall be illustrated with the example of infectious diseases, which account for a great majority of preventable

124 ICRC Commentary to GC I-IV, Common Art. 3, p. 53.

125 ICRC Commentary to AP II, above note 33, para. 4687.

126 AP I, Art. 8(c). This is also of relevance for non-international armed conflicts; see the section on 'The IHL definition of "medical personnel" . . .', below.

127 AP I, Art. 8(e). See also below note 197, on the importance of the protection of medical personnel for the mitigation of not only direct but also indirect health consequences of armed conflicts.

128 CESCR, General Comment 14, above note 41, para. 43; and General Comment 3, above note 85, para. 10.

129 CESCR, General Comment 14, above note 41, paras. 44(a)–(c); see also the above section 'The scope of medical attention and care . . .'.

130 *Ibid.*, paras. 43(b) and (c).

indirect deaths.<sup>131</sup> As public health experts observe, armed conflicts create conditions that are conducive to their transmission, progression, and lethality.<sup>132</sup>

Among the most deadly infectious diseases in times of armed conflict are, according to the Sphere Charter, measles, diarrhoea, acute respiratory infections, and malaria.<sup>133</sup> Checchi *et al.* add tuberculosis.<sup>134</sup> Epidemiologists explain that different diseases have different routes of transmission: by air droplet (breathing, sneezing, and coughing), faecal-orally, sexually, vector-borne (through insect bites), through blood, from mother to child, or through unclean wounds.<sup>135</sup> Various risk factors can increase the likelihood of an outbreak and of transmission. Among the risk factors that are recognised to cause the majority of excess morbidity and mortality from infectious diseases in armed conflict situations are ‘overcrowding; inadequate shelter; insufficient nutrient intake; insufficient vaccination coverage; poor water, sanitation and hygiene conditions; high exposure to and/or proliferation of disease vectors; [and] lack of and/or delay in treatment’.<sup>136</sup>

Different risk factors are linked to an increased risk of an outbreak of certain infectious diseases, depending on their route of transmission, and to faster transmission. To name but a few examples, overcrowded settings favour the spread of diseases that are transmitted by air droplet (particularly acute respiratory infections, measles, meningitis, tuberculosis, and flu) and by the faecal-oral route (diarrhoeal diseases including *Shigella* and cholera).<sup>137</sup> Vector-borne diseases such as malaria do not particularly depend on overcrowding,<sup>138</sup> but inadequate shelter can increase exposure to disease vectors. Insufficient nutrition intake increases the risk of outbreak of almost all infectious diseases<sup>139</sup> due to its immediate effect on the human immune system.<sup>140</sup> Inadequate water, sanitation, and hygiene conditions primarily increase the infection rate of faecal-oral diseases.<sup>141</sup>

131 As recognised e.g. by the CESC in its Concluding Observations – Democratic Republic of the Congo, UN Doc. E/C.12/COD/CO/4, 20 November 2009, para. 34. See also above notes 1 and 2.

132 Checchi *et al.*, *Public Health in Crisis-Affected Populations: A Practical Guide for Decision Makers*, Network Paper 61, Humanitarian Practice Network, December 2007, p. 2; Sphere Charter, above note 90, p. 311; Oscar Thoms and James Ron, ‘Public health, conflict and human rights: towards a collaborative research agenda’, in *Conflict and Health*, Vol. 1, 2007, p. 16.

133 Sphere Charter, above note 90, p. 311; WHO, *Manual on Communicable Disease Control in Emergencies*, 2005, p. 1, available at: [www.who.int/hac/techguidance/pht/communicable\\_diseases/field\\_manual/en/](http://www.who.int/hac/techguidance/pht/communicable_diseases/field_manual/en/) (last visited 26 July 2012).

134 Checchi *et al.*, above note 132, pp. 26–27.

135 *Ibid.*, p. 4; and WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, chapter 5.

136 Checchi *et al.*, above note 132, p. 20; WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, p. 110; and WHO, *World Health Report 2008*, above note 86, pp. 20–21.

137 Checchi *et al.*, above note 132, pp. 20–21; WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 47–48.

138 Checchi *et al.*, above note 132, pp. 20–21; WHO, *World Health Report 2008*, above note 86, pp. 21–22.

139 See e.g. Helen Young and Susanne Jaspars, *The Meaning and Measurement of Acute Malnutrition in Emergencies: A Primer for Decision-Makers*, HPN Network Paper 56, HPN, London, 2006, pp. 23–33; WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 1, 65, and 68; and Checchi *et al.*, above note 132, p. 23.

140 Described in detail by Checchi *et al.*, above note 132, p. 29.

141 *Ibid.*, p. 25; WHO, *World Health Report 2008*, above note 86, pp. 21–22; WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 27 and 33.

Control measures for infectious diseases must consider both transmission routes and risk factors. The provision of adequate shelter, access to sufficient and safe food and water, and adequate sanitation facilities are recognised as measures that will always be conducive to the affected population's health status, since they reduce risk factors regardless of the specificities of the situation.<sup>142</sup> This is in harmony with the internationally defined minimum core obligations flowing from the right to health that call on states to prioritise the implementation of the 'underlying determinants of health'.<sup>143</sup>

The further priority measures that epidemiologists recommend to prevent the spread of infectious diseases in emergencies depend on the local context:<sup>144</sup> the climate of a region, the health status of the population prior to the armed conflict, whether the population has been displaced and is living in camps, the extent to which affected populations can be accessed by health workers, the relative importance of prevention and treatment, the available financial and human resources, and so on.<sup>145</sup> This flexibility conforms to the international minimum core obligations formulated in broad terms in General Comment 14. It does not specify against which infectious diseases the state has to provide immunisation, it just requires that immunisation covers 'the major infectious diseases occurring in the community'.<sup>146</sup> Likewise, it does not specify the exact measures that are to be taken to 'prevent, control and treat epidemic and endemic diseases'.<sup>147</sup>

Nonetheless, human rights principles as well as public health principles seem to reasonably guide the choice of priority health interventions. States should define what health services they provide for individuals under their jurisdiction as part of a nationally defined minimum core right to health, in accordance with available resources, and guided by the internationally defined minimum core which is inevitably formulated in broad terms. Such definition should be the outcome of a consultative process which includes health professionals, should take equal account of the health-care needs of all members of society (particularly marginalised

142 See e.g. recommendation in Sphere Charter, above note 90, p. 312; Checchi *et al.*, above note 132, p. 39; and WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 1, 33, and 40.

143 CESCR, General Comment 14, above note 41, paras. 11 and 43–44; Report of the UN Special Rapporteur on the Right to Health, UN Doc. E/CN.4/2003/58, 13 February 2003, para. 23; Manisuli Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Hart Publishing, Oxford and Portland, Oregon, 2009, pp. 327–330.

144 See the Sphere Charter, above note 90, pp. 61, 294, and 309; Checchi *et al.*, above note 132, p. 39; and mentioned time and again in WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, e.g. pp. 18–19.

145 For more details see Checchi *et al.*, above note 132, pp. 35–39; and WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133.

146 CESCR, General Comment 14, above note 41, para. 44(b); Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, para. 52.

147 CESCR, General Comment 14, above note 41, para. 44(c). It should be noted that in higher-income countries rising mortality rates due to indirect health consequences are caused by complications with the treatment of chronic diseases. Responding to this as a matter of priority in times of armed conflict is not excluded under the minimum core right to health. On this see e.g. Sphere Charter, above note 90, p. 336; and Andrew Miller and Bonnie Arquilla, 'Chronic disease and natural hazards: impact of disasters on diabetic, renal and cardiac patients', in *Prehospital and Disaster Medicine*, Vol. 23, 2008, p. 187 (analysing the context of natural disasters).

groups), and should address the most common health issues prevailing in a community.<sup>148</sup>

These priorities will not necessarily change in times of armed conflict, and, if existent, a nationally defined minimum core will remain relevant for guiding priority health interventions in non-international armed conflicts.<sup>149</sup> Diseases that are common in a community may become even more prevalent in non-international armed conflicts. Yet adaptations will sometimes have to be made, if only to accommodate the fact that national health-care providers are supported by international actors in order to cope with the strains put on the health system by the armed conflict, in accordance with states' obligations to seek international assistance under ICESCR Article 2(1).<sup>150</sup> This obligation gains importance when states are unable to implement minimum core obligations by utilising their maximum available resources.<sup>151</sup> In some cases, priorities need to be shifted if the armed conflict brings about diseases that were previously absent from a community<sup>152</sup> or if the health system has to treat a large number of people wounded and traumatised in hostilities.

Human rights and public health principles can equally guide those adaptation processes: the Sphere Charter stipulates that the principle of participation shall be followed in the form of consulting affected populations on priority health interventions as far as possible.<sup>153</sup> Likewise, ensuring non-discriminatory/equal access to health services, and their acceptability and quality, remains relevant.<sup>154</sup> Guaranteeing equal access to health care may also require

148 CESCR, General Comment 14, above note 41, paras. 11, 17, and 54.

149 See Sphere Charter, above note 90, p. 298, suggesting that interventions to address the health impact of armed conflicts shall e.g. make use of national standards and guidelines, including treatment protocols and essential drug lists, as far as these are up to date and reflect evidence-based practice.

150 This obligation has been confirmed by the CESCR in many of its concluding observations, e.g. Concluding Observations – Afghanistan, UN Doc. E/C.12/AFG/CO/2-4, 7 June 2010, paras. 26, 35, and 45; Democratic People's Republic of Korea, UN Doc. E/C.12/1/Add.95, 12 December 2003, paras. 27 and 42; Democratic Republic of the Congo, UN Doc. E/C.12/COD/CO/4, 20 November 2009, para. 16; and Sri Lanka, UN Doc. E/C.12/LKA/CO/2-4, 9 December 2010, paras. 28–29.

151 Resources 'available' to the state under ICESCR, Art. 2(1) regularly include those resources that are made available by international organisations and through bilateral development assistance. For more details see A. Müller, above note 3, pp. 99–102.

152 E.g. when internally displaced persons/refugees bring a disease to their host community; see WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 18–19, 47, 104, 110; and Stefan Elbe, 'HIV/AIDS and the changing landscape of war in Africa', in *International Security*, Vol. 27, 2002, pp. 171–175.

153 Sphere Charter, above note 90, pp. 55–57 and 255; WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 30, 46, and 88; Report of Four UN Special Rapporteurs on Their Mission to Lebanon and Israel, UN Doc. A/HRC/2/7, 2 October 2006, paras. 103(e) and 104(e); CESCR, Concluding Observations – India, UN Doc. E/C.12/IND/CO/5, 8 August 2008, para. 72. This is also recognised in other literature relating to the provision of humanitarian assistance: see e.g. Paul Harvey and Jeremy Lind, *Dependency and Humanitarian Relief: A Critical Analysis*, Humanitarian Policy Group Report 19, London, Overseas Development Institute, 2005, pp. 40–41; Marion Harroff-Tavel, 'Do wars ever end? The work of the International Committee of the Red Cross when the guns fall silent', in *International Review of the Red Cross*, Vol. 58, No. 851, September 2003, pp. 482–483.

154 Sphere Charter, above note 90, pp. 55–57, 296; see also CESCR, Concluding Observations – Sri Lanka, UN Doc. E/C.12/1/Add.24, 16 June 1998, para. 22; and Democratic People's Republic of Korea, UN Doc. E/C.12/1/Add.95, 12 December 2003, para. 42; and HRC, Concluding Observations – USA, UN Doc.



particular attention to disadvantaged groups, which in conflict situations can include children, pregnant women, and elderly or disabled people, but also members of a specific ethnic or religious group, people with a particular political affiliation, internally displaced persons, and people living in areas with damaged infrastructure.<sup>155</sup> The strict application of the equality/non-discrimination principle becomes exceedingly important in the implementation of the right to health in highly politicised armed conflict situations.<sup>156</sup>

These principles will interact with public health principles such as the maxim to ensure the greatest health benefits to the greatest number of people through priority health interventions in non-international armed conflicts.<sup>157</sup> For instance, epidemiologists have methods to determine high-risk infectious diseases and assess which will be a priority.<sup>158</sup> However, difficult decisions that involve inevitably utilitarian considerations in view of limited available resources and capacities will always remain to be made in armed conflicts.

To conclude, the minimum core right to health as well as other human rights and public health principles promise to help states (and humanitarian actors) to set priorities in their efforts to mitigate one of the most prevalent indirect health consequences of non-international armed conflicts: the spread of epidemic and endemic diseases. Similar analyses could be conducted with regard to other elements of the internationally defined minimum core right to health, such as the obligation to 'ensure reproductive, maternal and child healthcare'<sup>159</sup> and 'to provide education and access to information concerning main health problems in the community, including methods of preventing and controlling them'.<sup>160</sup> The right to health thereby broadens and complements the scope of protection as well as giving further specification to the aforementioned IHL rules that indicate states' obligations to address the indirect impact that armed conflicts can have on public health. Moreover, the right to health thereby complements the obligations under IHL that continue to operate beyond the cessation of active hostilities and arguably beyond the existence of the fact-condition of 'armed conflict'.<sup>161</sup>

CCPR/C/USA/CO/3/Rev.1, 18 December 2006, para. 26 (referring to the assistance provided to people affected by Hurricane Katrina).

155 Sphere Charter, above note 90, pp. 63–64 and 294–295; M. Harroff-Tavel, above note 153, p. 471; Report of Four UN Special Rapporteurs on Their Mission to Lebanon and Israel, UN Doc. A/HRC/2/7, 2 October 2006, paras. 63, 89, and 104(d); and CESCR, Concluding Observations – Algeria, UN Doc. E/C.12/DZA/CO/4, 7 June 2010, paras. 19–20; Afghanistan, UN Doc. E/C.12/AFG/CO/2-4, 7 June 2010, paras. 40 and 42; and Sudan, UN Doc. E/C.12/1/Add.48, 1 September 2000, para. 37.

156 This is also recognised in the Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, para. 63.

157 Sphere Charter, above note 90, pp. 309–310.

158 See Checchi *et al.*, above note 132, pp. 35–36, describing a systematic epidemiological assessment of disease risk designed to guide interventions in emergency settings; see also WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, chapter 5.

159 CESCR, General Comment 14, above note 41, para. 44(a); and Sphere Charter, above note 90, pp. 320–330.

160 *Ibid.*, para. 44(d). In armed conflict situations, health-related information provided should for example relate the risks posed by land mines, cluster munitions, and unexploded ordnance.

161 See the discussion above, in the text accompanying notes 75–81.



## Medical personnel, medical facilities, and medical transports

Mitigating the direct and indirect health consequences of non-international armed conflicts discussed so far is impossible without the presence of skilled medical personnel and functioning medical units (facilities) and transports. In the following, it is shown that IHL gives detailed definitions of ‘medical personnel’, ‘medical units’, and ‘medical transports’ and offers them special protection from the effects of hostilities, *inter alia* by giving them the right to display the distinctive emblem (Red Cross/Crescent/Crystal) to render their protected status visible. These detailed definitions can be regarded as a very valuable specification of the components of a health system that states have to create and maintain for individuals to enjoy their minimum core and non-core rights to health. However, the IHL definitions also have some limits that can be complemented by the simultaneously applicable right to health. For example, obligations under the right to health would strengthen some of the more proactive state obligations to facilitate the work of medical personnel, units, and transports under IHL, and would offer some protection to medical personnel, units, and transports that have not been recognised and authorised by a competent authority.

IHL of non-international armed conflicts protects medical personnel,<sup>162</sup> medical units,<sup>163</sup> and medical transports<sup>164</sup> in a similar way as the wounded and sick themselves (they must be respected and protected), and also gives them the right to make their protected status visible.<sup>165</sup> Violations of these rules in non-international armed conflicts are criminalised under Articles 8(2)(e)(ii) and (iv) of the ICC Statute.

### The IHL definitions of ‘medical units’ and ‘medical transports’ – specifying obligations under the right to health

Because there is no IHL definition of medical units and medical transports in AP II, the comprehensive definitions set out in GC I, GC IV, and AP I are resorted to, as suggested in the ICRC Commentary on Article 11 of AP II<sup>166</sup> and affirmed by the ICRC Study.<sup>167</sup> Thus, based on GC I Article 19, GC IV Article 18, AP I Article 8(e), and Rule 28 of the ICRC Study, ‘medical units’ include all medical establishments and other units, be they permanent or temporary, military or civilian, fixed or mobile. Moreover, under Article 8(e) of AP I these medical establishments and other

162 AP II, Art. 9(1); ICRC Study, Vol. I, Rule 25, p. 79.

163 AP II, Art. 11(1); ICRC Study, Vol. I, Rule 28, p. 91.

164 AP II, Art. 11(1); ICRC Study, Vol. I, Rule 29, p. 98. S. Breau, above note 43, p. 176, analysing the ICRC Study, does not doubt the customary status of these rules, but holds that the ICRC Study could have cited much more evidence for state practice and *opinio iuris* dating from the earliest military manuals and Geneva Conventions, to further support their customary status.

165 AP II, Art. 12.

166 ICRC Commentary to AP II, above note 33, paras. 4711–4712.

167 ICRC Study, Vol. I, p. 95 (medical units) and p. 100 (medical transports); see also J. Kleffner, above note 33, p. 340.

units must be 'organised for medical purposes';<sup>168</sup> and Rule 28 of the ICRC Study requires that they are 'exclusively assigned to medical purposes'. While the reasons behind this change in wording in Rule 28 are not entirely straightforward,<sup>169</sup> it is clear that for medical establishments and other units to count as 'medical units' under customary and conventional IHL, they must first and foremost be assigned for a medical purpose (interpreted very flexibly<sup>170</sup>), and such assignment must be made to the exclusion of any other assignment.<sup>171</sup> In particular, medical units should not be used for activities that lie outside their humanitarian functions.<sup>172</sup> Examples of 'medical units' that are assigned for medical purposes include hospitals, laboratories, transfusion and rehabilitation centres, equipment depots, preventive medicine centres and institutes, medical and pharmaceutical stores, and first aid posts.<sup>173</sup>

Based on Articles 8(f)–(g) of AP I and Rule 29 of the ICRC Study,<sup>174</sup> 'medical transport' means any means of transportation on land, water, or air assigned exclusively to transporting the wounded, sick, and shipwrecked, medical personnel, and medical equipment and supplies, be they military or civilian, permanent or temporary. Medical transports should be under the control of a competent authority.<sup>175</sup> Ambulances or other medical land vehicles (such as trucks or trains), hospital ships, and medical helicopters are examples of such 'medical transports'.

These are all important elements of a well-developed health system for the realisation of the minimum core and non-core components of the right to health. In particular, they can be seen as a specification of what states are obliged to provide under ICESCR Article 12(2)(d), which calls on states to take steps to create

168 AP I, Art. 8(e); GC I, Art. 19, refers to 'medical units of the Medical Service'; and GC IV, Art. 18, refers to 'civilian hospitals organised to give care'.

169 It can be assumed that leaving out the direct reference to 'organised for medical purposes' reflects the possibility that even unauthorised medical units could be protected under Rule of the 28 ICRC Study, or at least that it is not to be regarded as a requirement under customary IHL that medical units must be authorised and recognised in order to benefit from protection. This is supported by the commentary to Rule 28, holding that 'a lot of [state] practice does not expressly require medical units to be recognised and authorised by one of the parties'. This may, in particular, be the case in non-international armed conflicts, where medical units could be set up in form of makeshift hospitals or other 'improvised' medical establishments, including in territories under the control of non-state armed groups, and including by international and local humanitarian organisations that may not have direct links with one of the parties to the conflict. In contrast to AP I, Arts. 8(e) and 12(2)(b), Rule 28 applies to international and non-international armed conflicts. See also the discussion below, on the IHL obligation to recognise medical personnel, units and transports.

170 ICRC Commentary to AP I, Art. 8(e), above note 33, para. 379.

171 *Ibid.*, para. 371, refers to the requirements that medical units must be both "'organised for medical purposes" and exclusively assigned to these purposes'. Similarly, the commentary to ICRC Study, Vol. I, Rule 28, p. 95, refers to the criterion 'organised for medical purposes', in addition to the criterion 'exclusively assigned to medical purposes' that is directly included in Rule 28.

172 AP II, Art. 11(2); ICRC Study, Rule 28; and AP I, Art. 13(1).

173 The customary status of this definition is endorsed by ICRC Study, Vol. I, Rule 28, p. 91; and is confirmed also by S. Breau, above note 43, pp. 177–178. The ICRC Commentary to AP I, Art. 8(e), above note 33, para. 378, adds that establishments where dental care is administered are also considered as 'medical units'.

174 See in particular the commentary to ICRC Study, Rule 29, p. 100.

175 On this requirement see also the section 'The IHL obligation to recognise medical personnel ...', below.

‘conditions which would assure to all medical service and medical attention in the event of sickness’. Direct destruction or dismantling of such facilities not in conformity with the requirements of ICESCR Article 4 in armed conflicts would violate the right to health as well as IHL requiring respect for and protection of medical units and transports ‘at all times’<sup>176</sup> – that is, prohibiting their direct attack.

By giving special attention to the protection of medical transports, IHL highlights the importance of this particular medical service for the protection of the right to health during non-international armed conflicts, when potentially more injured or sick individuals have to be transported to hospitals for emergency care than is normal, under more challenging conditions. The ICRC Commentary on Article 11 of AP II specifies that medical transports cannot be attacked even when they are not being used to transport any wounded or sick,<sup>177</sup> nor can their work or movement be interfered with arbitrarily in any other manner. While not always respected by them, it is clear that this rule also binds non-state armed groups.<sup>178</sup> The IHL provisions on medical transports are a good example of how IHL imposes obligations that aim to mitigate the direct health consequences in the specific situation of armed conflict, specifying also the content of the right to ensure access to health-care facilities, goods, and services in this particular situation. As mentioned, an effective, integrated referral system is an important part of a health system functioning in accordance with the right to health,<sup>179</sup> which arguably includes sufficient medical transport. Yet a detailed protection of medical transports as given in IHL might be less relevant for ensuring the health of conflict-affected individuals in poorer countries, where effective medical transport are frequently absent even in peacetime, *inter alia* because of insufficient roads. In these situations the protection of the activities of international and local humanitarian organisations not linked to any party to the conflict<sup>180</sup> may be more important for safeguarding the health of conflict-affected communities.

### The IHL definition of ‘medical personnel’ – specification of the different health professionals needed to ensure comprehensive health care

The definition of ‘medical personnel’ in IHL applicable to non-international armed conflicts is rather complex. While AP II does not contain a definition of medical personnel, the definition given in Articles 8(c) and (e) of AP I is regularly relied on.<sup>181</sup> Accordingly, medical personnel covers ‘those persons assigned, by a Party to the conflict, exclusively to . . . medical purposes’<sup>182</sup> – that is, to ‘the search for,

176 AP II, Art. 11(1).

177 ICRC Commentary to AP II, Art. 11, above note 33, para. 4716.

178 S. Sivakumaran, above note 6, p. 375.

179 See above note 92; and Report of the UN Special Rapporteur on the Right to Health on His Mission to India, UN Doc. A/HRC/14/20/Add.2, 15 April 2010, para. 54.

180 On this requirement see the section ‘The IHL obligation to recognise medical personnel . . .’, below.

181 ICRC Commentary to AP II, above note 33, para. 4661; similarly, see M. Bothe, K. J. Partsch, and W. Solf, above note 35, p. 656; commentary on ICRC Study, Vol. I, Rule 25, p. 82; and J. Kleffner, above note 33, p. 345.

182 AP I, Art. 8(c).

collection, transportation, diagnosis or treatment – including first-aid treatment – of the wounded, sick and shipwrecked, or for the prevention of disease',<sup>183</sup> and 'to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either permanent or temporary.'<sup>184</sup> The ICRC Study suggests that the definition of 'medical personnel' has been further specified through developments in customary law applicable to non-international armed conflicts. It holds that the definition of 'medical personnel' that was originally suggested in the drafting process of AP II, but which was removed during the simplification process shortly before the Protocol was adopted, could be relied on.<sup>185</sup> According to this definition, in non-international armed conflicts the term 'medical personnel' includes:

- (i) medical personnel of a party to the conflict, whether military or civilian;
- (ii) medical personnel of Red Cross or Red Crescent organisations recognised and authorised by parties to the conflict;
- (iii) medical personnel of other aid societies recognised and authorised by a party to the conflict and located within the territory the conflict is taking place.<sup>186</sup>

The definition differs in two ways from the more specific definition of medical personnel given in Articles 8(c) and (e) of AP I,<sup>187</sup> and reflects states' ongoing fear of undue foreign intervention in non-international armed conflicts. First, the phrase 'Red Cross and Red Crescent organisations'<sup>188</sup> was introduced 'to cover not only assistance available on the government side, but also groups or sections of the Red Cross on the other side which already existed, and even improvised organisations which might be set up during the conflict'.<sup>189</sup> Second, the phrase 'aid societies . . . located within the territory the conflict is taking place' discloses the intention of states to avoid situations in which obscure private groups from outside the country establish themselves by claiming the status of a relief society, and are then recognised by the insurgents.<sup>190</sup> Thus, in non-international armed conflicts it is only

183 AP I, Art. 8(e).

184 AP I, Art. 8(c).

185 Commentary on ICRC Study, Vol. I, Rule 25, p. 83; while this seems to be a reasonable suggestion, none of the 'practice' collected in Vol. II, pp. 453–480 of the ICRC Study suggest that states regard this definition as customary.

186 ICRC Commentary to AP II, above note 33, para. 4667, based on the wording of the official records from the drafting conference of AP I/II; see also commentary on ICRC Study, Vol. I, Rule 25, p. 83.

187 These two differences are noted in ICRC Commentary to AP II, above note 33. To compare, in AP I the term 'medical personnel' includes: '(i) medical personnel of a Party to the conflict, whether military or civilian, including those described in the First and Second Conventions, and those assigned to civil defence organisations; (ii) medical personnel of national Red Cross or Red Crescent Societies and other national voluntary aid societies duly recognised and authorised by a Party to the conflict' (AP I, Art. 8(c)), and '(iii) medical personnel of medical units or medical transports made available to a party to the conflict for humanitarian purposes by: (a) a neutral State which is not Party to that conflict; (b) a recognised and authorised aid society of such a State; (c) by an impartial international humanitarian organisation' (AP I, Art. 9(2)).

188 Emphasis added.

189 ICRC Commentary to AP II, above note 33, para. 4666; the phrase 'Red Cross and Red Crescent Organisations' is also used in AP II, Art. 18(1).

190 ICRC Commentary to AP II, above note 33, para. 4667.

the personnel of those (recognised and authorised) aid societies (other than Red Cross or Red Crescent organisations) that are located *within* the territory of the state where the conflict takes place that enjoy protection as ‘medical personnel’ under AP II.<sup>191</sup>

Similar to medical units and transports, the CESCR’s General Comment 14 recognises the existence of ‘trained medical and professional personnel’<sup>192</sup> as essential for the realisation of the right to health<sup>193</sup> – and the definitions given in IHL can be regarded as a helpful specification of the range of health professionals needed to ensure comprehensive health care of the population. Unlike the more general protection that is afforded to all persons under the jurisdiction of a state under the right to health, including to medical personnel,<sup>194</sup> the specific protection that IHL gives to the specific category of persons of ‘medical personnel’ highlights the utmost importance of the work of these personnel in the exceptional context of an ongoing armed conflict, where the number of persons in need of medical care is particularly high. The IHL prohibition of direct attacks on these personnel is well established in conventional and customary IHL, addressing both state and non-state parties to armed conflicts.<sup>195</sup> The observance of these rules is important not only for ensuring the care of those whose health is directly affected by the hostilities, but also for minimising interruption of the work of medical personnel engaged in, for example, the treatment, control, and prevention of diseases, in order to reduce the indirect health consequences of armed conflicts discussed above.<sup>196</sup> The recent killing of several doctors who were conducting an anti-polio vaccination campaign in Nigeria serves as a tragic illustration of this point.<sup>197</sup> States’ obligations under the right to health not to arbitrarily interfere with the work of health professionals<sup>198</sup> will reinforce these IHL obligations. For example, reports of the UN Special Rapporteur on the Right to Health express concern that ‘in some countries, on account of their professional activities, health workers have been victims of discrimination, arbitrary detention, arbitrary killings and torture, and have their freedom of opinion, speech and movement curtailed’.<sup>199</sup> The right to health will also

191 Further, see the section ‘The IHL obligation to recognise medical personnel . . .’, below.

192 CESCR, General Comment 14, above note 41, paras. 12(a) and (d), 36, and 44(e).

193 The importance of health professionals in the realisation of the right to health is also recognised in various reports of the UN Special Rapporteur on the Right to Health, e.g. UN Doc. E/CN.4/2003/58, 13 February 2003, para. 95; UN Doc. A/60/347, 12 September 2005, from para. 8; UN Doc. A/HRC/4/28, 17 January 2007, para. 41; and UN Doc. A/HRC/7/11, 31 January 2008, paras. 68(b) and 75–86.

194 See the section ‘Personal scope of application’, above.

195 AP II, Art. 9(1); ICRC Commentary on AP II, Art. 9(1), paras. 4673–4674; ICRC Study, Rule 25, including the commentary thereto, pp. 81–84; ICC Statute, Article 8(2)(e)(ii); see also S. Sivakumaran, above note 6, p. 278.

196 See in particular the section ‘Minimum core obligations . . .’, above.

197 ‘Three DPRK doctors killed in northern Nigeria: police’, in *Xinhua*, 10 February 2013, available at: [http://news.xinhuanet.com/english/africa/2013-02/10/c\\_132163579.htm](http://news.xinhuanet.com/english/africa/2013-02/10/c_132163579.htm) (last visited 27 June 2013); see also reports from e.g. Afghanistan: Reuters, ‘Thousands lack health services since attack on Afghan Red Crescent’, 28 May 2013, available at: [www.trust.org/item/20130528165900-ulpb3](http://www.trust.org/item/20130528165900-ulpb3) (last visited 27 June 2013).

198 CESCR, General Comment 14, above note 41, paras. 28 and 50.

199 Report of the UN Special Rapporteur on the Right to Health, UN Doc. E/CN.4/2003/58, 13 February 2003, para. 97.

extend its protection to medical personnel that may not directly fall under the customary IHL definition of 'medical personnel' applicable to non-international armed conflicts – for example, to those (medical) personnel that belong to humanitarian organisations not located *within* the territory of the state where the conflict takes place.<sup>200</sup> Before this is discussed below in the section 'The IHL obligation to recognise medical personnel, units, and transports', we will now examine further aspects of the protections offered to medical personnel, units, and transports under IHL and the right to health, in particular states' obligations to promote and facilitate their work.

### Obligations to promote and facilitate the work of medical personnel, units and transports

States are obliged to actively promote and facilitate the work of medical personnel, units, and transports. Under IHL, these obligations flow from the general obligations to respect and protect medical personnel, units, and transports, which have achieved customary status<sup>201</sup> and are to be interpreted in a similar manner as the obligation to respect and protect the wounded and sick themselves.<sup>202</sup> These obligations are strengthened and complemented by the parallel application of the right to health, in particular in those areas where some uncertainty exists as to the exact scope of the more proactive obligations under IHL applicable to non-international armed conflicts, as well as to their customary status in these types of conflicts.

For example, Article 9(1) of AP II requires that medical personnel be granted 'all available help for the performance of their duties'. Article 15(2) of AP I further specifies, in the context of international armed conflicts, that civilian medical personnel shall be granted all available help in particular in areas where civilian medical services have been disrupted due to hostilities; and Article 15(4) of AP I explicitly gives 'civilian medical personnel access to any place where their services are essential' albeit 'subject to such supervisory and safety measures as the relevant Party to the conflict may deem necessary'.<sup>203</sup> The question can be asked about the extent to which these more far-reaching obligations to grant all available help to medical personnel are applicable to non-international armed conflicts, and whether they have attained customary status, given that rules 25, 28, and 29 of the ICRC Study limit themselves to restating the general obligation to 'respect and protect' medical personnel, units, and transports. The commentary to Rule 25 reiterates the treaty obligation under Article 9(1) of AP II, suggesting that it may have attained customary status.<sup>204</sup> Some of the military manuals relied on in the ICRC Study also indicate that states recognise more far-reaching, proactive IHL obligations towards medical personnel, units, and transports in international and non-international

200 See the section 'The IHL obligation to recognise medical personnel . . .', below.

201 See above notes 162–164.

202 See the section 'Obligations to search for and collect the wounded and sick', above.

203 AP I, Art. 5(4); and J. Kleffner, above note 33, p. 347.

204 ICRC Study, commentary to Rule 25, p. 84.

armed conflicts. For instance, Argentina's military manual stipulates that 'medical personnel shall be respected, protected and *assisted* in the performance of their duties';<sup>205</sup> Spain's military manual states that medical personnel shall be 'defend[ed], assist[ed] and support[ed] when needed';<sup>206</sup> and the German military manual formulates a 'positive' duty towards medical transports, holding that 'their unhampered employment shall be ensured at all times'.<sup>207</sup> There are indications that non-state armed groups have also accepted some more proactive obligations toward medical personnel, units, and transports.<sup>208</sup> However, the ICRC Commentary's observation on Article 11 of AP II, proposing that the obligation to respect and protect medical units and transports includes a proactive obligation 'to actively take measures to ensure that medical units and transports are able to perform their functions and to give them assistance where necessary',<sup>209</sup> are not affirmed in the commentaries to rules 28 and 29 of the ICRC Study.<sup>210</sup>

Any proactive obligations under conventional IHL applicable to non-international armed conflicts are reinforced by, and any possible gaps in customary IHL in this area are closed by, the parallel application of the right to health, in particular as far as the state party to the conflict is concerned. State parties to the ICESCR clearly have an obligation to take proactive measures to facilitate the work of medical personnel, transports, and units, in particular in their endeavours to guarantee the implementation of the minimum core right to health, including in territories under the control of non-state armed groups.<sup>211</sup> It starts with the obligation to 'provide appropriate training to health personnel', which the CESCR considers part of the international minimum core right to health.<sup>212</sup> Guaranteeing physical accessibility to at least the essential health services contained in the minimum core right to health and relevant IHL rules discussed above in the section 'Obligations to mitigate the indirect health consequences of armed conflicts' would for example imply an obligation to support medical personnel and transports in their efforts to reach populations in areas where infrastructure is damaged, who would otherwise be denied their right to treatment.<sup>213</sup> The CESCR's Concluding Observations on Israel point in this direction. Referring to Israel's closures of the Occupied Palestinian Territories, the CESCR recalled Israel's obligation to 'give full effect to its obligations under the Covenant and, as a matter of priority, to undertake

205 ICRC Study, Vol. II, chapter 7, p. 457 (emphasis added); likewise, see the Canadian military manual, in *ibid.*, p. 459; the Netherlands military manual, in *ibid.*, p. 462; and the New Zealand military manual, in *ibid.*, p. 463.

206 *Ibid.*, p. 464.

207 *Ibid.*, p. 551.

208 S. Sivakumaran, above note 6, pp. 227–278, 375.

209 ICRC Commentary to AP II, above note 33, para. 4714.

210 ICRC Study, Vol. I, p. 96 (units) and 101–102 (transports).

211 States are arguably obliged to allow independent humanitarian organisations to negotiate access to conflict-affected civilian populations in territories under the control of a non-state armed group. For more details see the sources cited in above notes 27, 67, and 74.

212 CESCR, General Comment 14, above note 41, paras. 44(e) and 36; see also the reports of the UN Special Rapporteur cited in above note 193.

213 This is observed e.g. by Victor Correa-Lugo, 'Protecting the health sector in Colombia: a step to make the conflict less cruel', in *International Review of the Red Cross*, Vol. 83, No. 844, December 2001, p. 1122.



to ensure safe passage at checkpoints for Palestinian medical staff<sup>214</sup> – an obligation that includes a proactive dimension. Similarly, in its Concluding Observations on Russia, the CESCR for instance called on the government 'to allocate sufficient funds to reinstate basic services, including the health and education infrastructure' in Chechnya despite the 'difficulties posed by on-going military operations'.<sup>215</sup> Reinstating basic health services would surely include an obligation to actively facilitate the work of medical personnel, transports, and units in conflict-affected areas.

### The IHL obligation to recognise medical personnel, units, and transports – a restricting requirement in situations where many medical tasks are fulfilled by international actors

The right to health has the potential to partially compensate for another limit of IHL of non-international armed conflicts. In IHL, the special protected status, including the right to display the distinctive emblem is reserved for those civilian medical personnel, transports, or units (in addition to military medical personnel, units, and transports) that have been 'recognised' (that is, they must have been regularly trained, constituted, and registered in accordance with national legislation) and 'authorised' (that is, the party to the conflict must agree that the personnel are employed as medical personnel) by one of the parties to the conflict.<sup>216</sup> This includes medical personnel, units, and transports of Red Cross and Red Crescent organisations.<sup>217</sup> The recognition and authorisation requirement, together with the restricted definition of 'medical personnel' given above, focuses IHL's protection on recognised and authorised *national* medical personnel, units, and transports that were present in a particular territory before a non-international armed conflict started.<sup>218</sup> As is clear from the drafting records of AP II, this was mainly due to the fear of states that broader definitions of in particular 'medical personnel' could be exploited by foreign forces to intervene in non-international armed conflicts.<sup>219</sup>

214 CESCR, Concluding Observations – Israel, UN Doc. E/C.12/1/Add.27, 4 December 1998, para. 39.

215 CESCR, Concluding Observations – Russia, UN Doc. E/C.12/1/Add.94, 12 December 2003, paras. 10 and 39; similarly, Colombia, UN Doc. E/C.12/COL/CO/5, 7 June 2010, para. 7.

216 While AP II, Art. 11 does not – in contrast to AP I, Arts. 12(2) and 9(2) – explicitly include the requirement of authorisation and recognition by a party to the conflict, from AP II, Art. 12, it is clear that only recognised and authorised medical units and transports can display the distinctive emblem. AP II, Art. 12, holds that the distinctive emblem can only be displayed 'under the direction of the competent authority concerned'. Moreover, the ICRC Study's commentary, Vol. I, p. 95 (on Rule 28) and p. 100 (on Rule 29), holds that authorisation and recognition remain a precondition for displaying the distinctive emblem. See also S. Sivakumaran, above note 6, p. 278.

217 ICRC Commentary to AP II, above note 33, paras. 4739–4740; ICRC Commentary to AP I, para. 334; and J. Kleffner, above note 33, p. 346.

218 For a more detailed analysis of the limited protection of international humanitarian organisations (non-ICRC, non-UN, and non-national Red Cross/Red Crescent Societies) under IHL of international and non-international armed conflict, see also Kate Mackintosh, 'Beyond the Red Cross: the protection of independent humanitarian organisations and their staff in international humanitarian law', in *International Review of the Red Cross*, Vol. 89, No. 865, March 2007, pp. 113–123.

219 However, it shall be noted that the recognition requirement also aims to prevent exploitation of the distinctive emblem, as is noted in the ICRC Commentary, above note 33, to AP II, Art. 9, para. 4660; see also the commentary on the ICRC Study, Vol. I, Rule 25, p. 82; and J. Kleffner, above note 33, p. 345.

While undoubtedly important, in many low-income countries such (restricted) protection might be less appropriate for guaranteeing minimal health care for conflict-affected populations.<sup>220</sup> A functioning health system built of these nationally recognised and authorised medical personnel, units, and transports may not (yet) exist. In these settings, the protection of (international) medical personnel and medical units of international humanitarian organisations, as well as the promotion and facilitation of these organisations' activities, becomes more important for providing the minimum health services described above in the section 'The protection of the wounded and sick . . . '.

While the simultaneous applicability of the right to health will not give foreign medical personnel, units, or transports of international humanitarian organisations the right to display the distinctive emblem, the obligation not to attack them and the more proactive obligations to facilitate their work that were discussed above will extend to them. It can also be argued that this includes an obligation on states affected by non-international armed conflicts to speed up the process of recognising foreign medical qualifications to ensure that the civilian population can get access to basic health care under their minimum core right to health.<sup>221</sup> This should not exclude the possibility of states setting up mechanisms to monitor foreign medical interventions in order to prevent conflict-affected populations from being exposed to the danger of unskilled or inappropriate treatment.<sup>222</sup> Moreover, medical personnel deployed by international humanitarian organisations are protected under Article 10 of AP II, as humanitarian relief personnel<sup>223</sup> and by their status as civilians.<sup>224</sup>

## Concluding remarks

This contribution analysed some elements of states' obligations under IHL and the right to health that aim to mitigate the direct and indirect health consequences of non-international armed conflicts. In sum, relevant IHL rules and obligations flowing from the right to health complement each other well in this endeavour.

In general terms, due to its historical origin and purpose of protecting wounded and sick soldiers of standing governmental armies, IHL focuses on the protection of the wounded and sick, and those civilians and persons *hors de combat*

220 This is not to say that it is of *no* relevance, since IHL protects all kind of health facilities, including primary care points at the community level which might exist in poor countries.

221 See also the discussion in David Fisher, 'Domestic regulation of international humanitarian relief in disasters and armed conflict: a comparative analysis', in *International Review of the Red Cross*, Vol. 89, No. 866, June 2007, pp. 363–364; and IFRC, *Guidelines for the Domestic Facilitation and Regulation of International Disaster Relief and Initial Recovery Assistance*, 30 November 2007, available at: [www.ifrc.org/PageFiles/41203/introduction-guidelines-en.pdf](http://www.ifrc.org/PageFiles/41203/introduction-guidelines-en.pdf) (last visited 26 July 2012), which suggest that states adopt procedures which allow for temporary recognition of foreign medical personnel (Section 16, para. 1(c)).

222 For example see D. Fisher, above note 221, p. 363.

223 See ICRC Study, Rule 31, pp. 105–109. However, international humanitarian relief personnel have to be authorised as well before they can profit from the special protection given to them under IHL.

224 See also S. Sivakumaran, above note 6, p. 279.

suffering from the *direct* health consequences of armed conflicts. For example, the IHL obligations to 'respect and protect' as well as 'search for and collect' the 'wounded and sick' give welcome details on how to implement the right to access minimum health facilities, goods, and services in an armed conflict context. IHL obliges states to immediately provide emergency medical treatment to the wounded and sick.

The right to health, on the other hand, is more expansive, and takes better account of the fact that the relationship between health and armed conflict is not confined to medical attention to the war-wounded. The internationally defined minimum core right to health encourages states parties to the ICESCR to prioritise the provision of primary health care by creating and maintaining an accessible basic health system. This focus enables it to highlight and address the *indirect* health consequences of non-international armed conflicts, such as the spreading of epidemic and endemic diseases and rising child and maternal mortality and morbidity. These may occur in the long term, and are – particularly in low-income countries – the main causes of death during and after armed conflicts. Moreover, the minimum core right to health gives flexibility to states to adopt the measures required to address the specific indirect health problems in a particular situation, which can vary substantially. In particular, the human rights principles of non-discrimination and the concentration on disadvantaged and marginalised groups can guide this process. Consultation with public health professionals is equally essential for pinpointing the exact measures that are to be taken to implement minimum core obligations under the right to health in non-international armed conflicts.

Complementarity between IHL and the right to health can also be observed in the protection offered to medical personnel, facilities/units, and transports. The detailed definitions of these entities given in IHL can be regarded as a welcome specification of the components of a well-developed health system that states have to create under minimum core and non-core obligations flowing from the right to health. On the other hand, obligations under the right to health can compensate for some uncertainties in the scope of the more proactive obligations to facilitate and promote the work of medical personnel, units, and transports in the customary rules 25, 28, and 29 of the ICRC Study, and offer some protection to (international) medical personnel, units, and transports that may not be covered by the IHL definitions of these terms.



# A human rights approach to health care in conflict

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## Abstract

*Attacks on and interference with health care services, providers, facilities, transports, and patients in situations of armed conflict, civil disturbance, and state repression pose enormous challenges to health care delivery in circumstances where it is most needed. In times of armed conflict, international humanitarian law (IHL) provides robust protection to health care services, but it also contains gaps. Moreover, IHL does not cover situations where an armed conflict does not exist. This paper focuses on the importance of a human rights approach to addressing these challenges, relying on the highest attainable standard of health as well as to civil and political rights. In particular we take the Committee on Economic, Social and Cultural Rights General Comment No. 14 (on Article 12 of the International Covenant on Economic, Social and Cultural Rights) as a normative framework from which states' obligations to respect, protect and fulfil the right to health across all conflict settings can be further developed.*

**Keywords:** human rights, right to health, conflict, violence, health worker, hospital, ethics.

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During armed conflicts and internal disturbances such as political protests, civil rioting or state repression, health care facilities are often subjected to violent attacks, obstructed access, interference with operations, and looting. Health care workers may be arrested or intimidated for offering care impartially to those in greatest need.

Many who provide care in conflict-affected regions of the world, where the risk of attack is becoming a daily occurrence, have begun to see violence as an occupational hazard. A national health worker in the Democratic Republic of the Congo (DRC) explained their situation as follows: ‘What can we do? There are no means to protect us – nothing can be done to stop this, so we just complain to each other and help each other as much as we can’.<sup>1</sup>

International humanitarian law (IHL) has provided a framework for assuring protection and respect for medical personnel, medical facilities, and ambulances, as well as the wounded and sick, in international and non-international armed conflicts. Over the 150 years since the original 1864 Geneva Convention, these protections have become more extensive and detailed, for example, by prohibiting interference with practices required by medical ethics. Nevertheless, the legal framework for protection under IHL does not comprehensively address the problem of attacks or interference with health services. In some circumstances of political volatility or violence, attacks on health care providers, facilities, transports, and patients take place, but IHL does not apply at all, because no armed conflict exists. For example, during political protests in the Kingdom of Bahrain in 2011, state forces responded by obstructing the capital’s main hospital, and arresting, torturing, and prosecuting doctors and nurses for allegedly using their medical roles to commit hostile acts against the state.<sup>2</sup> In Syria, before the threshold of a non-international armed conflict was reached,<sup>3</sup> attacks on patients, the medical community, and medical institutions by state forces created a climate of fear in which patients would not attend hospitals, leading instead to an underground network of makeshift clinics that could not replace the sophisticated medical services needed.<sup>4</sup> In volatile regions in Nigeria, vaccination workers have been attacked and killed, severely disrupting vaccination programmes.<sup>5</sup>

Even in armed conflict, IHL does not fully address needs for availability of and access to health services for civilian populations. In Iraq, for example, the killing and kidnapping of doctors committed during the period of armed conflict<sup>6</sup> clearly violated IHL – to the extent that these acts were committed as part

1 Merlin, *A Grave New World*, 2010, p. 6, available at: [www.who.int/workforcealliance/news/agravenewworld\\_report.pdf](http://www.who.int/workforcealliance/news/agravenewworld_report.pdf) (last visited 22 August 2012).

2 Physicians for Human Rights, *Do No Harm: A Call for Bahrain to End Systematic Attacks on Doctors and Patients*, April 2011, available at: [https://s3.amazonaws.com/PHR\\_Reports/bahrain-do-no-harm-2011.pdf](https://s3.amazonaws.com/PHR_Reports/bahrain-do-no-harm-2011.pdf) (last visited 19 August 2012), and Human Rights Watch, *Targets of Retribution Attacks against Medics, Injured Protestors, and Health Facilities*, July 2011, available at: [www.hrw.org/sites/default/files/reports/bahrain0711webcover.pdf](http://www.hrw.org/sites/default/files/reports/bahrain0711webcover.pdf) (last visited 27 August 2012).

3 See *inter alia* International Committee of the Red Cross (ICRC), ‘Syria: ICRC and Syrian Arab Red Crescent maintain aid effort amid increased fighting’, Operational Update, 17 July 2012, available at: [www.icrc.org/eng/resources/documents/update/2012/syria-update-2012-07-17.htm](http://www.icrc.org/eng/resources/documents/update/2012/syria-update-2012-07-17.htm); see also Geneva Academy, ‘Syria’, in *Rulac Project*, available at: [www.geneva-academy.ch/RULAC/applicable\\_international\\_law.php?id\\_state=211](http://www.geneva-academy.ch/RULAC/applicable_international_law.php?id_state=211) (last visited 27 August 2012).

4 Physicians for Human Rights, *Syria: Attacks on Doctors, Patients, and Hospitals*, December 2011, p. 8, available at: [https://s3.amazonaws.com/PHR\\_Reports/syria-attacks-on-drs-patients-hospitals-final-2011.pdf](https://s3.amazonaws.com/PHR_Reports/syria-attacks-on-drs-patients-hospitals-final-2011.pdf) (last visited 12 June 2012).

5 Donald G. McNeil Jr., ‘Gunmen kill Nigerian polio vaccine workers in echo of Pakistan attacks’, in *New York Times*, 8 February 2013, available at: [http://www.nytimes.com/2013/02/09/world/africa/nigeria-polio-vaccine-workers-are-killed-by-gunmen.html?\\_r=0](http://www.nytimes.com/2013/02/09/world/africa/nigeria-polio-vaccine-workers-are-killed-by-gunmen.html?_r=0) (last visited 27 May 2013).

of the armed conflict. However, these acts also contributed to the emigration of health professionals in the period 2004–2007, meaning access to health care services and maintenance of an adequate workforce also deteriorated. The state’s responsibility to assure protection of health workers and provide for adequate health professional coverage to meet the health needs of the population may not have been fully covered by IHL.

In Sri Lanka, during the final stages of the war, allegations that the Sri Lankan army undertook large-scale and widespread shelling of civilian areas, resulting in large numbers of civilian deaths, as well as the systematic shelling of hospitals on the front lines, were found ‘credible’ by the United Nations (UN) Secretary-General’s Panel of Experts on Accountability in Sri Lanka. If proven, these allegations would constitute serious violations of IHL.<sup>7</sup> But how does international law address the state’s failure to provide adequate care to the Tamil population prior to the ceasefires? An assessment of health infrastructure carried out following the 2002 ceasefire revealed that of a total of 400 health institutions, 55 had been destroyed and 49 were not functioning. The remaining facilities experienced severe shortages of essential drugs and a breakdown in health information and monitoring systems.<sup>8</sup> Further, while the number of physicians per 100,000 members of the population dramatically increased in the country as a whole in the years of the conflict, in the Northern Province it substantially declined, severely compromising needed access to health services.<sup>9</sup> Except in cases of occupation,<sup>10</sup> IHL is silent on obligations to assure continuity of health services.

The provision of health services is also frequently compromised during armed conflicts indirectly through curfews, reduced geographical access due to roadblocks and checkpoint closures, and reduced social access based on patients’ fear of seeking care in areas of insecurity. Moreover, marginalised and vulnerable populations, even if not overtly denied health care, often experience lower access to care, and their health suffers additionally from social exclusion. Not all of these acts and omissions are covered by IHL.

Public health programmes, including infectious disease control and eradication strategies and vaccination campaigns, are often disrupted in conflict settings.

6 Gilbert M. Burnham, Riyadh Lafta, and Shannon Doocy, ‘Doctors leaving 12 tertiary hospitals in Iraq, 2004–2007’, in *Social Science & Medicine*, Vol. 69, 2009, pp. 172–177.

7 UN Secretary-General, Report of the Secretary-General’s Panel of Experts on Accountability in Sri Lanka, 31 March 2011, pp. ii–iii, available at: [www.un.org/News/dh/infocus/Sri\\_Lanka/POE\\_Report\\_Full.pdf](http://www.un.org/News/dh/infocus/Sri_Lanka/POE_Report_Full.pdf) (last visited 24 August 2012).

8 Mayan Vije and Dr Suppiah Ratneswaren, *Enduring War and Health Inequity in Sri Lanka*, Tamil Information Centre, 2009, p. 22, available at: [www.tamilinfo.org/healthreport.pdf](http://www.tamilinfo.org/healthreport.pdf) (last visited 24 June 2012).

9 Mari Nagai, Sandirasegaram Abraham, Miyoko Okamoto, Etsuko Kita, and Atsuko Aoyama, ‘Reconstruction of health service systems in the post-conflict Northern Province in Sri Lanka’, in *Health Policy*, Vol. 84, 2007, pp. 84–93.

10 See Art. 56 of Convention (IV) relative to the Protection of Civilian Persons in Time of War, Geneva, 12 August 1949 (hereafter ‘GC IV’). Art. 56 GC IV provides that ‘the Occupying Power has the duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishments and services, public health and hygiene in the occupied territory, with particular reference to the adoption and application of the prophylactic and preventative measures necessary to combat the spread of contagious diseases and epidemics’.



In Nepal, low uptake in tuberculosis treatment and diagnostic services among conflict-affected populations was associated with the closure of health services and curfews in areas of fighting that limited patient access and led to an increase in the prevalence of tuberculosis.<sup>11</sup> Such disease control programmes may not be the subject of direct attacks or threats, nor within the scope of an occupying power's duty to maintain public health within an occupied territory,<sup>12</sup> and so may escape the coverage of IHL.

Human rights law (HRL) applies in all of these contexts. Its applicability to interference with health care in situations of armed conflict or other situations of violence, however, has not been sufficiently explored. For instance, what is the extent of protection afforded to health care workers, facilities and ambulances in situations of civil violence or state repression in the absence of an armed conflict? In armed conflicts, do states have responsibilities to ensure access and availability of health services beyond those required by IHL? If health care services are to be truly respected in situations of violence, these questions require answers, but they have generated little discussion – likely because the other major source of protection, HRL, is not nearly as explicit on these questions as IHL. When properly understood, however, HRL not only requires broad respect and protection for health by states in situations of civil violence, but can offer additional protections in armed conflict beyond those provided by IHL. This article explores how HRL can address violence, both real and threatened, against health care workers, services, and beneficiaries, as well as other forms of deprivation of access to health care services in situations of armed conflict or internal disturbances falling short of armed conflict.

## Application of IHL and HRL

### Overview of IHL and HRL

Both IHL and HRL derive from international treaties, and from customary international law (CIL). IHL treaties represent agreements between states on the conduct of war and on the protection of individuals that apply to the parties to an armed conflict. Key principles include distinguishing between civilian and military targets, proportionality in the use of force, and precautions in attack. HRL, on the other hand, establishes the obligations and rights as between a state and the individuals over which it has jurisdiction. Despite differences in their evolution and purpose, both have the aim of protecting and preserving the life, well-being, and human dignity of the person.<sup>13</sup>

In times of international armed conflict, the First, Second, and Fourth Geneva Conventions of 1949 and the Protocol Additional to the Geneva

11 S. K. Tiwari, *et al.*, 'Prevalence of TB and service utilization in conflict affected areas of Nepal', in *Journal of Nepal Health Research Council*, Vol. 3, No. 1, 2005, pp. 45–57.

12 GC IV, Art. 56.

13 United Nations Human Rights Office of the High Commissioner for Human Rights, *International Legal Protection of Human Rights in Armed Conflict*, New York and Geneva, 2011, p. 7.

Conventions of 12 August 1949, and Relating to the Protection of Victims of Armed Conflicts (Additional Protocol I), provide a framework for the respect and protection of sick, wounded, and shipwrecked military and civilian medical personnel, units, and transports. Article 3 common to the four Geneva Conventions (Common Article 3) and the Protocol Additional to the Geneva Conventions of 12 August 1949 relating to the Protection of Victims of Non-International Armed Conflicts (Additional Protocol II) offer less detailed protections in non-international armed conflict. As there was apparent uncertainty in the scope of protection offered in the two types of armed conflicts, the International Committee of the Red Cross (ICRC) study on customary international law (hereafter ‘the ICRC Customary Law Study’) has provided much-needed clarification. The study indicates that rules of CIL regarding respect for and protection of health apply in both international and non-international armed conflicts.<sup>14</sup>

As will be discussed more fully below, among other provisions, parties to a conflict must respect and protect medical personnel, units, and transports, meaning that these must not be attacked or interfered with and shall have access to any place where their services are essential. Parties may not make distinctions in care based on considerations other than medical ones. Nor may they punish a person for engaging in medical care activities consistent with medical ethics or compel a person to engage in acts prohibited by medical ethics.<sup>15</sup>

Unlike IHL, which has rules designed specifically to address the respect and protection of health care in armed conflict, HRL instruments are formulated in more general terms. Civil and political rights are the foundation of protection against violence, discrimination, and denial of rights of citizenship and due process committed or tolerated by the state. The rights to life, to liberty, to security of person, and not to be subjected to torture or cruel, inhuman, or degrading treatment or punishment are of special relevance to attacks on health services and are enshrined in major international and regional human rights treaties, as well as in a number of subject-specific treaties.<sup>16</sup> These treaties also contain and affirm the rights to equality and non-discrimination. A growing body of CIL supports this treaty law – indeed, many of the rights set out in the Universal Declaration of Human Rights (UDHR) are now widely regarded as such.

14 Jean-Marie Henckaerts and Louise Doswald-Beck (eds), *Customary International Humanitarian Law, Vol. I: Rules*, ICRC/Cambridge University Press, Cambridge, 2005 (hereafter ‘ICRC Customary Law Study’), p. 197.

15 See Art. 12 of Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, Geneva, 12 August 1949 (hereafter ‘GC I’); Art. 12 of Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea, Geneva, 12 August 1949 (hereafter ‘GC II’); Arts. 18, 20, and 21 of GC IV; Arts. 12(1), 15, and 21 of Protocol Additional to the Geneva Conventions of 12 August 1949 and relating to the Protection of Victims of International Armed Conflicts, 8 June 1977 (hereafter ‘AP I’); Arts. 8, 10, and 11(1) of Protocol Additional to the Geneva Conventions of 12 August 1949 and relating to the Protection of Victims of Non-International Armed Conflicts, 8 June 1977 (hereafter ‘AP II’); CIL, Rules 25, 28, and 29.

16 See International Covenant Civil and Political Rights (ICCPR); African Charter on Human and People’s Rights (ACHPR); Convention on the Rights of the Child (CRC); and Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

The right to the highest attainable standard of health as articulated in Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) is the principal framework from which to understand states' obligations regarding the availability of, access to, and quality of health services. Other sources of interpretation, especially General Comment No. 14 of the Committee on Economic, Social, and Cultural Rights (CESCR), illuminates the scope and application of this right, and can play a critical role in assuring respect and protection of health services, health personnel, and patients, both in armed conflict and in other circumstances where civil violence or state repression is taking place.

## The relationship between IHL and HRL

### *Complementarity*

Attention to human rights law is especially germane as the debate over whether human rights law applies in situations of armed conflict is now settled, and application of human rights law alongside IHL well accepted.<sup>17</sup> The complementary application of both legal bodies is no better evidenced than by the inclusion of HRL in the ICRC Customary Law Study, which identified HRL's role as being to 'support, strengthen and clarify analogous principles of international humanitarian law'.<sup>18</sup> As pointed out by Cordula Droege, the relationship between the two bodies of law is often 'described as a relationship between the general and specialized, in which humanitarian law is *lex specialis*'.<sup>19</sup> This does not prevent a complementarity approach, but will on occasion provide a 'conflict solving method'<sup>20</sup> for situations where norms cannot be reconciled.

### *Rights holders and duty bearers in IHL and HRL*

Lack of respect for health care, in the form of attacks and interferences, whether in times of armed conflict or other situations of violence, can be attributed to both state entities and armed non-state actors.<sup>21</sup> The focus of IHL is the protection of civilians and others not taking part in combat – such as prisoners of war or the sick and wounded – as well as civilian objects, which include hospitals and other health facilities. Under IHL, parties to an armed conflict are the primary, although not exclusive, duty bearers. Obligations extend to all those participating in hostilities and to those individuals to whom one party to the conflict has delegated

17 See, *inter alia*, International Court of Justice (ICJ), *Legal Consequences of the construction of a Wall in the Occupied Palestinian Territory*, Advisory Opinion, ICJ Reports 2004, 9 July 2004, para. 106.

18 ICRC Customary Law Study, Vol. 1, p. xxxvii.

19 Cordula Droege, 'The interplay between international humanitarian law and international human rights law in situations of armed conflict', in *Israel Law Review*, Vol. 40, No. 2, December 2007, p. 340.

20 Noëlle Quénivet, 'The history of the relationship between international humanitarian law and human rights', in Roberta Arnold and Noëlle Quénivet (eds), *International Humanitarian Law and Human Rights Law: Towards a New Merger in International Law*, Martinus Nijhoff, Dordrecht, 2008, p. 7.

21 ICRC, *A Sixteen-Country Study: Health Care in Danger*, July 2011, available at: [www.icrc.org/eng/assets/files/reports/4073-002-16-country-study.pdf](http://www.icrc.org/eng/assets/files/reports/4073-002-16-country-study.pdf) (last visited 28 April 2013).

responsibility, for example in relation to the treatment of protected persons. Non-state parties to a non-international armed conflict are bound by Common Article 3, the provisions of Additional Protocol II, and CIL.<sup>22</sup> The ICRC Customary Law Study reflects a large body of CIL rules applicable in non-international armed conflicts. Although some controversy remains as to whether state custom creates binding obligations for non-state actors, it is recognised that a number of rules relating to the conduct of hostilities, such as proportionality and distinction, apply to armed non-state actors regardless of whether or not they have agreed to abide by the Geneva Conventions or their Additional Protocols.<sup>23</sup>

Under HRL, human rights belong to individuals. The responsibility to meet human rights obligations rests primarily with the state – including justice authorities, the police, and its health ministry as far as the right to health is concerned. However, with the increasing threat posed by non-state actors, such as attacks on vaccine workers by militias in Pakistan and Nigeria,<sup>24</sup> greater attention has been given to these actors' HRL obligations in conflict. Rather than viewing the extension of human rights to armed groups as lending dangerous legitimacy or quasi-governmental status, there is broadening agreement that armed groups can be bound by at least standards or principles of HRL, if not specific legal rules. This shift is evidenced in the evolving practice of the UN Security Council and the reports of some Special Rapporteurs, who increasingly identify circumstances where non-state armed groups are bound to abide by both IHL and HRL obligations.<sup>25</sup> Human rights monitors are also including conduct by armed opposition groups in their reports.<sup>26</sup> Another pertinent example of the application of human rights principles to non-state actors is the UN Security Council mechanism to monitor and report on the 'six grave violations' committed by states and non-state parties to an armed

22 In *Nicaragua v. United States of America*, Judgement of 27 June 1986, ICJ Reports 1986, para. 219, the ICJ confirmed that Common Article 3 applied directly to the non-state armed group fighting the government. With respect to AP II it should be noted that the threshold for its application is higher than for Common Article 3; for further details see Yves Sandoz, Christopher Swinarski, and Bruno Zimmermann (eds), *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949*, ICRC, Geneva/Martinus, Martinus Nijhoff, Dordrecht, 1987.

23 Annysa Bellal, Gilles Giacca, and Stuart Casey-Maslen, 'International law and armed non-state actors in Afghanistan', in *International Review of the Red Cross*, Vol. 93, No. 881, March 2011, p. 62.

24 See, *inter alia*, 'Pakistan suspends polio-vaccination program after deadly attack', in *Radio Free Europe*, 28 May 2013, available at: [www.rferl.org/content/polio-pakistan-killing-vaccination/24999412.html](http://www.rferl.org/content/polio-pakistan-killing-vaccination/24999412.html); and 'Nigerian polio vaccination centers attacked', in *Radio Free Europe*, 8 February 2013, available at: [www.rferl.org/content/nigerian-polio-vaccination-centers-attacked/24896626.html](http://www.rferl.org/content/nigerian-polio-vaccination-centers-attacked/24896626.html) (last visited June 2013).

25 The Report of the UN Special Rapporteur on extrajudicial, summary or arbitrary executions indicated in the context of his mission to Sri Lanka that, 'As a non-State actor, the Liberation Tigers of Tamil does not have legal obligations under [the ICCPR], but it remains subject to the demands of the international community, first expressed in the UDHR, that every organ of society respect and promote human rights'. The Special Rapporteur further indicated that: 'It is increasingly understood, however, that the human rights expectations of the international community operate to protect people, while not thereby affecting the legitimacy of the actors to whom they are addressed. The UN Security Council has long called upon various groups that the Member States do not recognize as having the capacity to formally assume international obligations to respect human rights'. UN Doc. E/CN.4/2006/53/Add. 5, 27 March 2006, paras. 25 and 27.

26 Human Rights Watch has reported on the human rights abuses of armed opposition groups; see Human Rights Watch, *No Exit: Human Rights Abuses inside the MKO Camps*, May 2005, available at: [www.unhcr.org/refworld/docid/45d085002.html](http://www.unhcr.org/refworld/docid/45d085002.html) (last visited 3 June 2011).

conflict against children, including ‘attacks on schools and hospitals’.<sup>27</sup> All six violations are grounded in IHL and HRL. For armed non-state actors a violation carries the same consequences as it would for a state, namely listing in the Annex of the Report of the Secretary-General on children and armed conflict, which can in turn lead to sanctions being imposed against such groups.<sup>28</sup>

In highlighting the links between human rights norms and health care in conflict situations, the focus of this paper will be on the obligations of states. However, the increasing recognition of armed groups as violators of human rights represents an important shift in discourse, and expands the scope of human rights protection to include health care, especially when considering other features of a rights-based approach such as monitoring and accountability.

### *Concurrent application: the example of the use of force*

One area where the rule of *lex specialis* plays a role is that of the use of force and its consequences. One key element of IHL is that combatants cannot be punished for using lethal force against enemy combatants as long as they are in compliance with proportionality and precaution requirements. Moreover, incidental loss of civilian life caused by an armed attack is permissible so long as the principles of distinction and proportionality are respected, the latter requiring that the expected loss of civilian life not be excessive in relation to the concrete and direct military advantage anticipated.<sup>29</sup> The attacker must also comply with the requirements of taking precautions to minimise harm to civilians.<sup>30</sup> The incidental killing or injury of medical personnel or their patients is subject to these proportionality and precaution requirements. The same rules apply in relation to civilian objects, which include medical facilities.<sup>31</sup>

HRL rules regarding the use of force for law enforcement purposes or in the framework of an armed conflict are, in contrast, rooted in the protection of individuals from abuse by the state. The state may not subject any individual under its jurisdiction, including the wounded and sick or health care personnel, to arbitrary deprivation of life.<sup>32</sup> In using force for law enforcement purposes, states have an obligation to use the smallest amount of force necessary and with tight restrictions

27 The other grave violations are: killing or maiming of children; recruitment or use of children as soldiers; sexual violence against children; denial of humanitarian access for children, and abduction of children. See, *inter alia*, Office of the Special Representative of the Secretary-General for Children and Armed Conflict, ‘The six grave violations’, available at: <http://childrenandarmedconflict.un.org/effects-of-conflict/the-most-grave-violations/> (last visited 22 July 2013).

28 See UN Security Council Resolution 1612, 26 July 2005, and UN Security Council Resolution 1998, 12 July 2011.

29 See AP I, Arts. 51(5)(b) and 57(2)(a)(iii); and CIL, Rule 14.

30 See AP I, Art. 57.

31 See AP I, Arts. 48 and 51(4), (5); and CIL, Rules 7, 11–15.

32 See the right to life as enshrined in Art. 6(1) of the ICCPR; Art. 4 of the American Convention on Human Rights (ACHR); Art. 4 of the ACHPR; and Art. 2 of the European Convention on Human Rights (ECHR). Note that the ECHR does not use the term ‘arbitrary’ but specifies a general right to life and gives an exhaustive list of circumstances under which a deprivation of the right to life may be lawful.

on the use of lethal force.<sup>33</sup> This prohibition is non-derogable and therefore applicable at all times.<sup>34</sup> There are some circumstances, however, where unwelcomed entry into a health facility for law enforcement purposes is permissible under HRL as a reasonable exercise of state authority, if certain safeguards are in place.

### *Monitoring and accountability*

Accountability and enforcement mechanisms are more advanced under HRL than IHL in terms of formal compliance reviews, rights to individual remedy, reparation, and the obligation to investigate.<sup>35</sup> Achieving compliance with IHL obligations mainly focuses on incorporation in national law and military policies, training, and negotiation, though of course serious violations can be prosecuted as war crimes. As noted above, the UN Security Council has also created monitoring, reporting, and accountability mechanisms regarding the six grave violations against children in armed conflict, which should over time result in greater compliance with international law.

Under HRL, accountability is provided through institutions established within the UN and regional bodies, who engage with states and civil society, receive reports on adherence from States Parties and others, conduct field investigations, issue findings and recommendations, and condemn violations. These accountability mechanisms are explored more fully below.

## **Protection of health under IHL**

In both international and non-international armed conflicts, the Geneva Conventions and Additional Protocols, as well as CIL, provide that medical personnel, facilities, and transports, and the wounded and sick, may not be the subject of attack or harm, and the provision of health care may not be unnecessarily interfered with.<sup>36</sup>

### **Medical personnel**

Medical personnel pursuing their exclusively humanitarian task, whether military or civilian, must be respected and protected from attack and harm unless they commit, outside of their humanitarian work, acts harmful to the enemy.<sup>37</sup> The phrase

33 For more details, see, *inter alia*, Louise Doswald-Beck, *Human Rights in Times of Conflict and Terrorism*, Oxford University Press, Oxford, 2012, pp. 163–177.

34 See Art. 4(2) of the ICCPR; Art. 27(2) of the ACHR; and Art. 15(2) of the ECHR. It should be noted that Art. 15(2) of the ECHR provides for the exception of ‘lawful acts of war’ in situations amounting to armed conflict.

35 C. Droege, above note 19, p. 340.

36 See GC I, Arts. 19, 18, 24–26; GC II, Art. 36; GC IV, Arts. 18 and 20; AP I, Arts. 12 and 15; 1949 GC Common Article 3; AP II, Art. 9(1); and CIL, Rules 25, 28, and 29.

37 See GC I, Art. 21; AP I, Art. 13; and AP II, Art. 11. Acts not considered ‘harmful to the enemy’ include carrying light individual weapons for self-defence or defence of the wounded and sick; the presence of, or

‘medical personnel’ has a relatively narrow meaning in the Geneva Conventions and Additional Protocols, referring to individuals, whether temporary or permanent, exclusively assigned to medical duties by a party to a conflict as well as health workers affiliated with the Red Cross and Red Crescent societies or certain other humanitarian organisations.<sup>38</sup>

Other persons performing medical duties, however, broadly enjoy protection against attack and interference. The two Additional Protocols expand protection to all health professionals who act in accordance with their professional ethical obligations, such as the duty to provide impartial care to all, regardless of whether they meet the definition of ‘medical personnel’.<sup>39</sup> They cannot be punished for acting in accordance with the rules of medical ethics, compelled to refrain from acts required by medical ethics, or required to act against the mandates of medical ethics. This is a key protection, as in many places around the world, including Chechnya, Kosovo, Burma, and Syria, health workers have been threatened, arrested, prosecuted, or killed for having adhered to their ethical obligation to provide care impartially, regardless of the affiliation or political belief of the patient. The only limitation concerns medical confidentiality, where disclosure of information concerning the wounded and sick under a health worker’s care is subject to national law.<sup>40</sup> Finally, insofar as they are civilians, it is a rule of CIL that medical personnel are protected from attack, unless and for such time as they take a direct part in hostilities.<sup>41</sup>

## The wounded and sick

Under the Geneva Conventions and Additional Protocols, parties to a conflict have an obligation to respect the wounded and sick by providing them with medical care and attention as far as practicable and with the least possible delay. The requirement is not absolute and instead requires parties to take all possible measures subject to resources and feasibility in the midst of hostilities.<sup>42</sup> Further, non-discrimination is a fundamental principle of IHL. The Geneva Conventions and Additional Protocols stipulate that, among others, the wounded and sick must be treated humanely and cared for by a party to the conflict without any adverse distinction, with decisions being made on medical grounds alone.<sup>43</sup> By definition the wounded and sick refrain from any act of hostility,<sup>44</sup> but like civilians they may also lose their protection against attack when and for such time as they take a direct part in hostilities.

escort by, military personnel; and the possession of small arms and ammunition taken from the wounded and sick and not yet handed over to the proper authority. See ICRC Customary Law Study, commentaries of Rules 25 and 29.

38 See AP I, Art. 8(c).

39 See AP I, Art. 16; and AP II, Art. 10.

40 See AP I, Art. 16; and AP II, Art. 10.

41 See AP I, Art. 51(3); AP II, Art. 13(3); and CIL, Rule 6.

42 See AP I, Art. 10, commentary.

43 See GC I, Art. 12; GC II, Art. 12; AP I, Art. 10(2); AP II, Art. 7(2); GC Common Article 3.

44 See AP I, Art. 8(a).



The First and Fourth Geneva Conventions provide for the protection of the civilian population from the consequences of war. This includes the establishment of hospital safety zones and the protection of civilian hospitals and their staff, again without any adverse distinction based, in particular, on race, nationality, or religion.<sup>45</sup> These provisions have become part of CIL.<sup>46</sup>

## Medical units and transports

Under IHL, medical units such as hospitals, clinics, and pharmacies, whether military or civilian, fixed or mobile, permanent or temporary, must be respected and protected in all circumstances.<sup>47</sup> In the same way, medical transports assigned exclusively to the conveyance of the wounded and sick or of medical personnel, equipment, or supplies must be respected and protected.<sup>48</sup> The meaning of the term 'respect and protect' according to military manuals requires that medical units must not be attacked, fired upon, or harmed in any way.<sup>49</sup> Nor should they be used to shield military objectives from attack.<sup>50</sup> State practice generally indicates that medical transports enjoy the same protection as mobile medical units.<sup>51</sup> They both lose their protection if they are being used, outside of their humanitarian function, to commit acts harmful to the enemy, such as by using a hospital for a military purpose or transporting weapons in ambulances.<sup>52</sup> A deliberate attack on a hospital or other place where there are sick and wounded people, provided the location is not a military objective, is a war crime under the Statute of the International Criminal Court,<sup>53</sup> as is an attack on an ambulance displaying the distinctive emblem of the Geneva Conventions.<sup>54</sup>

As noted above, in cases where medical facilities and transports are misused for military purposes, such as hospitals used as military outposts or ambulances used to transport weapons, they lose their protection, but a party must issue a warning before attack and take steps to minimise harm to civilians in the facility.<sup>55</sup>

## Protection of health under HRL

### Civil and political rights

Medical personnel and the wounded and sick are protected from violence by Article 6 of the International Covenant on Civil and Political Rights (ICCPR), under

45 See GC I, Art. 23; GC IV, Art. 14; CIL, Rule 35.

46 See CIL, Rule 35.

47 See GC I, Art. 19; GC IV, Art. 18; AP I, Art. 12; AP II, Art. 11(1), CIL, Rule 28.

48 See GC I, Art. 35; GC IV, Art. 21; AP I, Art. 21; AP II, Art. 11(1); CIL, Rule 29.

49 See ICRC Customary Law Study, Vol. I, commentary of Rule 28.

50 Art. 12 (4) AP I.

51 See ICRC Customary Law Study, Vol. I, commentary of Rule 29.

52 See CIL, Rules 28 and 29.

53 See Rome Statute of the International Criminal Court, Arts. 8(2)(b)(ix) and 8(2)(e)(iv).

54 See Rome Statute of the International Criminal Court, Arts. 8(2)(b)(xxiv) and 8(2)(b)(e)(ii).

55 See GC I, Art. 21; GC IV, Art. 19; AP I, Art. 13(1); AP II, Art. 11(2).

which states have a non-derogable obligation not to subject any individuals under their jurisdiction or control to arbitrary deprivation of life. A prohibition of torture and cruel, inhuman, or degrading treatment or punishment is found in Article 7 of the ICCPR and specific treaties that address the problems of torture and disappearances.<sup>56</sup> These treaties outlaw the killings, beatings and other forms of torture, and abductions of health workers and patients such as those documented in recent human rights reports.<sup>57</sup> In certain circumstances, the denial of medical treatment might also constitute cruel, inhuman, and degrading treatment, or even torture.<sup>58</sup> Arrests of medical personnel for providing impartial care can also constitute a violation of the protection against arbitrary arrest and detention.<sup>59</sup>

### Economic, social, and cultural rights

Equally powerful and often overlooked protections of health care in conflict and other situations of violence stem from the right to the highest attainable standard of health (referred to here as the 'right to health'). A number of human rights instruments address the protection and promotion of health as a human right. The UDHR provided the first affirmation that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care'.<sup>60</sup> All key international and regional human rights treaties adopted since contain provisions designed to protect and promote the right to health. The most widely cited is the ICESCR of 1966, Article 12, which states:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Other UN human rights treaties enshrining the right to health include the Convention on the Elimination of All forms of Discrimination against Women and the Convention on the Rights of the Child. Examples of regional human rights treaties include the European Convention on Human Rights, the African Charter on

56 See ICCPR, Art. 7; and CAT.

57 Physicians for Human Rights, above note 2.

58 Report of the Special Rapporteur on torture and other cruel, inhumane or degrading treatment or punishment, Juan E. Mendez, 1 February 2013, A/HRC/22/53.

59 See UDHR, Art. 9; and ICCPR, Art. 9.

60 See UDHR, Art. 25.

Human and People's Rights, and the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social, and Cultural Rights (the Protocol of San Salvador). The shift from expansive aspirational language to a right with firm content and standards to address access, availability, quality, and cultural appropriateness of health services and the underlying determinants of health accelerated in 2000 when the (Committee on Economic, Social and Cultural Rights) CESCR issued General Comment No. 14, an interpretation of Article 12 with important normative force. It clarifies states' obligations and remains the most comprehensive articulation of the right to health in HRL.

The CESCR recognised the widening scope of notions of health, and proposed an approach that 'takes into account such socially-related concerns as violence and armed conflict'.<sup>61</sup> Achieving respect, protection, and fulfilment of the right to health in armed conflict and other situations of violence is a colossal challenge, but as the International Court of Justice has expressly affirmed, economic, social, and cultural rights obligations remain in force in armed conflict alongside IHL.<sup>62</sup>

### *Three layers of obligations*

The right to health, like all human rights, imposes three layers of obligations on states: the responsibility to respect – to refrain from directly interfering with a right; to protect – to prevent third-party interference with the enjoyment of a right; and to fulfil – to take steps to ensure the fullest possible realisation of a right. Put simply, these duties 'define what governments can do to us, cannot do to us and should do for us'.<sup>63</sup> They provide a powerful framework for assessing to what extent human rights are reflected in states' norms, institutions, legal frameworks, and political and policy environments. States must respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons and abstaining from enforcing discriminatory practices as a state policy.<sup>64</sup> The example above of Bahrain's state security forces denying impartial care to protestors is a clear illustration of a state's failure to respect the right to health.

Under the duty to protect, states are under an obligation to prevent third parties from interfering with the right to health, which includes such practices as perpetrating violence against health care providers and patients, within their capacity to do so. Further, states should ensure that health workers have the appropriate standards of education and skill and ethical codes of conduct to meet the challenges of their work in these difficult environments.<sup>65</sup>

61 CESCR, General Comment No. 14 on the right to the highest attainable standard of health, 11 August 2000, UN Doc. E/C.12/2000/4 (hereafter CESCR, General Comment No. 14), para. 10.

62 See, *inter alia*, ICJ, *Legal Consequences of Construction of the Wall in Occupied Palestine Territory*, Summary of Advisory Opinion, 9 July 2004, paras. 102–113.

63 Sofia Gruskin and Daniel Tarantola, 'Health and Human Rights', in Sofia Gruskin (ed.), *Perspectives on Health and Human Rights*, Routledge, London, 2005, p. 8.

64 CESCR, General Comment No. 14, para. 34.

65 *Ibid.*, para. 35.

Finally, the obligation to fulfil requires State Parties to take appropriate legislative, administrative, budgetary, judicial, and other measures towards full realisation of the right to health.<sup>66</sup> Disinvestment, assault, and persecution in times of conflict have often led to the migration of skilled health care personnel. Fulfilment of the right to health requires investment and protection in the health workforce within the scope of progressive realisation and non-retrogression requirements. The obligation to fulfil provides for broader states' obligations than exist under IHL, where parties to the conflict generally have obligations to ensure medical services such as are available, including humanitarian aid, to the wounded and sick, without distinction except on medical grounds. Only an occupying power has the duty to fulfil the obligations of ensuring public health standards and the provision of medical supplies.<sup>67</sup>

In conflict settings, disease control programmes are often stalled through the interruption of a patient's ability to seek care, breakdown of drug supply chains, or the diversion of economic resources by the state to military ends. These obstacles do not, however, relieve states of their 'right to health' obligations. For example, the three countries where polio remains endemic – Afghanistan, Nigeria, and Pakistan – are experiencing war or severe political conflict, disrupting vaccination programmes and leading to new outbreaks.<sup>68</sup> The right to health requires states to avoid interfering directly with polio immunisation programmes (respect), and to take steps to prevent interference with the right by third parties (protect). Finally, ensuring full realisation of the right to health requires policies to ensure that polio immunisation programmes can continue in times of unrest or violence. After the US-led invasion of Afghanistan in 2001, the Afghanistan Ministry of Public Health took active steps to cooperate, through the intermediary of the ICRC, with the Taliban in order to help facilitate the movement of vaccinators and increase access to children living in Taliban strongholds. The ministry administered the campaign with the support of the World Health Organization and UNICEF, enabling coverage to reach some of the most volatile areas of Afghanistan.<sup>69</sup>

### *Elements of the right to health*

The right to health has been interpreted as consisting of key entitlements and state responsibilities, including the interrelated and essential elements of availability, accessibility, acceptability, and quality of health care services, facilities, and goods.<sup>70</sup> Availability requires that a state provide functioning public health and health care

66 *Ibid.*, para. 36.

67 See GC IV, Arts. 55–57.

68 Leonard Rubenstein, 'Defying expectations: Polio vaccination programs amid political and armed conflict', United States Institute of Peace, *PeaceBrief*, Vol. 64, 3 November 2010, p. 2, available at: [www.usip.org/sites/default/files/PB%2064%20%20Polio%20Vaccination%20Programs%20Amid%20Political%20and%20Armed%20Conflict.pdf](http://www.usip.org/sites/default/files/PB%2064%20%20Polio%20Vaccination%20Programs%20Amid%20Political%20and%20Armed%20Conflict.pdf) (last visited 27 August 2012).

69 *Ibid.*, p. 3.

70 CESCR, General Comment No. 14, para.12.

facilities, goods, and services, to include adequate hospitals and clinics, trained health care professionals, and essential medicines.<sup>71</sup> The destruction or closure of health facilities as a result of attacks, violence, or insecurity, the loss of trained medical personnel who migrate from these dangerous situations as explained above, and the destruction or stealing of drugs or disruption of supply chains all undermine availability.

Accessibility requires that health facilities, goods, and services be accessible to all without discrimination within the jurisdiction of the State Party. Discrimination in access to health care on the grounds of, among others, race, colour, sex, language, religion, political or other opinion, national or social origin, or civil, political, social, or other status, which has the intention of nullifying or impairing the quality, enjoyment, or exercise of the right to health is prohibited.<sup>72</sup>

Non-discrimination is also a basic tenet of both the right to health and civil and political rights. In the context of health, the obligation expands on the requirement of accessibility and obliges the state to assure that government or private health care providers do not discriminate on the basis of ethnic, religious, racial, national, or other prohibited grounds.<sup>73</sup> Further, the right to health, like other economic, social, and cultural rights, seeks to address and remedy the marginalisation and disenfranchisement of women and ethnic, religious, and national groups, as well as others, both in the exclusion from equal access to quality health services and in the material and social determinants of health.

In conflict situations, discriminatory practices are frequently employed. During Libya's uprising in 2011, for example, cars were stopped to prevent patients belonging to opposing ethnic groups reaching hospitals.<sup>74</sup> Discrimination may also be less obvious, but with potentially far-reaching public health consequences. In Burma, ethnic minorities along the eastern border have been struggling for independence against the Burmese government for over three decades in one of the longest and most forgotten civil conflicts. In these conflict regions the state appears to have abdicated responsibility for providing health care services, while at the same time interfering with indigenous groups seeking to provide those services. This basic lack of access to health services has increased the risk of multi-drug-resistant diseases such as tuberculosis and malaria.<sup>75</sup> Such consequences are the result of a denial of health care that is rooted in a policy of systematic discrimination aimed at undermining and suppressing the ethnic uprising.<sup>76</sup>

71 *Ibid.*, para. 12(a).

72 *Ibid.*, para. 12(b).

73 *Ibid.*, para. 18.

74 Paul-Henri Arni, 'Health care in danger: Today's Solferinos', interview, 20 July 2012, available at: [www.icrc.org/eng/resources/documents/interview/2012/health-care-in-danger-todays-solferinos-2012-07-20.htm](http://www.icrc.org/eng/resources/documents/interview/2012/health-care-in-danger-todays-solferinos-2012-07-20.htm) (last visited 3 August 2012).

75 Back Pack Health Worker Team, *Ten Years Report 1998–2009: Life, Liberty and the Pursuit of Health*, 2009, p. 9, available at: [http://www.burmalibrary.org/docs11/BPHWT10yearReport\\_1998-2009.pdf-red.pdf](http://www.burmalibrary.org/docs11/BPHWT10yearReport_1998-2009.pdf-red.pdf) (last visited 12 August 2012).

76 Physicians for Human Rights, *Life Under the Junta: Evidence of Crimes Against Humanity in Burma's Chin State*, January 2011, p. 40, available at: [http://s3.amazonaws.com/PHR\\_Reports/life-under-the-junta-burma-chin-state.pdf](http://s3.amazonaws.com/PHR_Reports/life-under-the-junta-burma-chin-state.pdf) (last visited 28 April 2013).

IHL does not generally cover these dimensions of health services, as it focuses on impartiality in responding to individuals in immediate need of care rather than on the structure and availability of services. For example, while IHL would forbid turning away a woman in labour based on her ethnic or political affiliation, it does not address entrenched practices that limit the availability, accessibility, and quality of facilities and services to members of her group and may make it dangerous for her to seek care. HRL can assist in powerfully addressing these infringements.

Physical accessibility includes the requirement that health facilities, goods, and services be within safe physical reach for all sections of the population.<sup>77</sup> Conflict often leads to general insecurity and oppression, making it unsafe for patients to seek care or for health care workers to access areas or engage in home visits where care is needed, or for goods such as essential medicines to be delivered.<sup>78</sup> Using again the example of eastern Burma, the Burmese army has targeted patients and health workers affiliated (or thought to be affiliated) with opposition groups, confiscating medical supplies, preventing patients from travelling to clinics to seek care, and denying health workers free passage to deliver care.<sup>79</sup> While there are limits to the state's ability to preserve access in circumstances where armed groups undermine it, such as in the case of vaccination programmes in volatile areas of Pakistan, the state must nevertheless take practical steps to provide the security needed to permit campaigns where feasible. Further, where the state itself limits physical access to health care to certain groups either as a political strategy or simply as an abdication of responsibilities because of the challenges of doing so, it is in violation of its human rights obligations.

Acceptability requires that the state's health facilities, goods, and services be operated in accordance with the standards of medical ethics and cultural traditions.<sup>80</sup> That includes refraining from interfering with health care providers' ethical duty to provide impartial care, reflected in international medical ethics standards, as well as respecting the duty of confidentiality, which under the right to health is both an ethical obligation of health providers and a right of the patient, both to be assured by the state.<sup>81</sup> In Bahrain, state security forces interfered with medical decision-making, restricting access to patients in need of treatment where wounds were protest-related, and interfering with doctors' autonomy to decide if and where ambulances should be sent to assist the wounded.<sup>82</sup> Security forces in Bahrain also reviewed confidential medical records, compromising doctors' ethical duties towards patient confidentiality.

77 CESCR, General Comment No. 14, para. 12(b).

78 ICRC, *Violent Incidents Affecting Health Care: Health Care in Danger, January–December 2012*, available at: [www.icrc.org/eng/assets/files/reports/4050-002\\_violent-incidents-report\\_en\\_final.pdf](http://www.icrc.org/eng/assets/files/reports/4050-002_violent-incidents-report_en_final.pdf) (last visited 22 May 2013).

79 Back Pack Health Worker Team, above note 75.

80 CESCR, General Comment No. 14, para. 12(c).

81 *Ibid.*, paras. 12(b) and 12(c).

82 Human Rights Watch, above note 2, p. 31.

Finally, the entitlement to quality under the right to health requires that health facilities, goods, and services must also be scientifically appropriate and of good quality, to include skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.<sup>83</sup> Particularly in regions of sustained conflict, the destruction of health facilities, collapse of health infrastructure, and depletion in the health workforce means that quality is often undermined during and for decades after the conflict itself. South Sudan, for instance has just begun the transition from emergency response to post-conflict health systems development.<sup>84</sup> However, the intimate relationship a country's poverty has to the presence of a conflict does not absolve a state from guaranteeing the right to health, including providing health services of an appropriate quality, subject to the availability of resources even where these are constrained, as discussed in the next section.

### *Progressive realisation and core obligations*

The principle of progressive realisation contained in Article 2(1) of the ICESCR requires that States Parties are to undertake steps, to the maximum of their available resources, with a view to progressive realisation of the rights contained in the Covenant, including the right to health. The concept of progressive realisation underscores that there are circumstances where full realisation of the right cannot be achieved. As noted, this limitation is particularly relevant to countries in protracted conflicts or emerging from the aftermath of conflict. Conflict alone, however, is not a blanket excuse for not meeting obligations, as the burden remains on the state to justify limitations on services and to show that it has made every effort to use all available resources at its disposal in order to meet its obligations. Further, progressive realisation involves international assistance and cooperation, providing a human rights basis for action at the global level to assure health services in places where they are under severe strain.

There are, moreover, some obligations with immediate effect regardless of resources, requiring concrete and targeted steps towards realisation of economic, social, and cultural rights.<sup>85</sup> Applied to the right to health, states have a core obligation to ensure the satisfaction of a minimum essential level of services without delay and on a non-discriminatory basis,<sup>86</sup> which should be realised forthwith. These are known as core obligations.<sup>87</sup> Although, to some extent, these non-derogable core obligations are still resource-dependent and challenged by conflict, a state cannot ignore them because of the existence of conflict.

83 CESCR, General Comment No. 14, para. 12(d).

84 Andrew Green, 'Healthcare in South Sudan at a crossroads', in *The Lancet*, Vol. 379, No. 9826, April 2012, p. 1578.

85 CESCR, General Comment No. 3 on the nature of States Parties' obligations, 14 December 1990, fifth session, para. 2.

86 CESCR, General Comment No. 14, paras. 43 and 44.

87 *Ibid.*, para. 10.



General Comment No. 14 identifies a number of core obligations arising from the right to health, which are of special importance to addressing health care in conflict. These include access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalised groups; provision of essential drugs; equitable distribution of all health facilities, goods, and services; adoption and implementation of a national public health strategy; reproductive, maternal (pre-natal as well as post-natal), and child health care; immunisation against the major infectious diseases occurring in the community; and treatment and control of epidemic and endemic diseases.<sup>88</sup>

The ICESCR has no derogation clause, and the CESCR does not, on the whole,<sup>89</sup> allow derogations from economic, social, and cultural rights, especially from the minimum core obligations under these rights. The CESCR makes clear that there is a strong presumption that retrogressive measures taken in relation to these core obligations are not permissible, with the burden being on the state to prove that any such measures taken deliberately were justified by reference to the totality of the Covenant.<sup>90</sup> In times of conflict there will be limits to a state's ability to fulfil all of these core obligations where it is under attack from other states or armed groups. However, it is sometimes the case that states retain the capacity to meet at least some obligations, yet abdicate their responsibilities to their own health system as a means of repressing all or particular groups of their citizens. In those circumstances these core obligations are an important framework for assessing adherence to human rights responsibilities.

## Requirements for human rights

### *Participation*

Aside from its substantive requirements, the right to health, like other human rights, has process requirements, especially participation and accountability. Informed participation of local communities as well as health care providers who are often at the front line of providing care in conflict is an important but neglected requirement. The right to health includes a specific entitlement of individuals and groups to participate in health policy-making processes that affect them.<sup>91</sup> Scholars who have promoted community participation as part of a rights-based approach in conflict have noted the challenges that fragmentation within the community, displacement, and erosion to services pose to effective participation.<sup>92</sup> Nevertheless, meaningful participation by communities and health providers at the local, national, and

88 *Ibid.*, para. 43.

89 States and the CESCR have allowed derogation from the ICESCR's labour rights. For an interesting discussion of derogations from economic, social, and cultural rights, see Amrei Muller, 'Limitations to and derogations from economic, social and cultural rights', in *Human Rights Law Review*, Vol. 9, No. 4, 2009, pp. 557–601.

90 CESCR, General Comment No. 14, para. 32.

91 CESCR, General Comment No. 14, para. 54.

92 Emily Waller *et al.*, 'Rights-based approaches in conflict-affected settings', in Elvira Beracochea *et al.* (eds), *Rights-Based Approaches to Public Health*, Springer Publishing, New York, 2011, p. 236.

international levels can help promote the reduction in incidence of attacks and interference with health care services. Greater participation of national health workers and communities can influence decisions by ministries of health and justice, as well as militaries, to strengthen protection and security in health care services and improve field practices in dangerous health care settings.

Participation is also germane to health worker security. In many contexts, whether involving conflict or other situations of violence, there are few effective or genuinely enforced policies directed towards the security of national health workers. A human rights approach can encourage the active involvement of the local health workforce in helping to establish plans and programmes for protection, identifying and sharing strategies on how to increase security, and holding duty bearers to account. This sort of effective participation is not easily generated. It should involve the participation of national and international medical associations, as well as non-governmental organisations – many of which are heavily involved in the delivery of essential health care in times of conflict, and employ a large number of national health care staff. Engagement of these actors is essential to making progress on an issue that often attracts outcry from the international community but little concerted action or formulation of policies to address the problem. Participation can also ensure that law enforcement agencies do not penalise or harass health care workers for offering impartial care to patients deemed to be hostile to the state, both in circumstances of armed conflict and in civil disturbances. Participation in these decisions also empowers health workers with a better understanding of their rights.

### *Monitoring and accountability*

A second and important process feature of a human rights approach is monitoring of and accountability for duty bearers. Monitoring is a pre-condition of accountability, yet there has been a surprising lack of attention from global institutions regarding the need to systematically report on attacks and interference with health care in conflict situations.<sup>93</sup> A human rights approach provides a framework for assessing and developing innovative methodologies for reporting that can incorporate the right to health as a central component. Accountability comes in a variety of forms – from international treaty bodies' own reporting processes and compliance procedures<sup>94</sup> to national and international judicial or quasi-judicial mechanisms such as ombudsmen. A human rights approach to health care in conflict provides a spotlight for identifying what accountability mechanisms exist and how they might be better utilised in respect to attacks on and interferences with health care.

Within the UN system, treaty bodies play a crucial role in monitoring and accountability, such as the Human Rights Committee, the Committee Against Torture, the CESCR, and the Committee on the Rights of the Child.

93 Leonard S. Rubenstein and Melanie D. Brittle, 'Responsibility for protection of medical workers and facilities in armed conflict', in *The Lancet*, Vol. 375, 2010, p. 336.

94 See ICESCR, Arts. 16–23.

Thematic mechanisms include the United Nations Special Representative of the Secretary-General on Children in Armed Conflict, which, as noted above, monitors and promotes accountability for six categories of violations, including attacks on schools and hospitals, and has its legal foundations in both the laws of armed conflict and human rights law.<sup>95</sup> UN Security Council Resolution 1998, adopted in 2011,<sup>96</sup> provides for the listing of parties who engage in persistent attacks on schools and hospitals, reaffirming the need to enhance monitoring and reporting of such incidents and giving concrete impetus towards actions to protect such facilities. Monitoring activities of the Office of the High Commissioner for Human Rights include violations of IHL and HRL, but its activities could be expanded based on a more thorough reflection of the applicability of HRL. The creation of a formal UN tool of accountability that addresses health care facilities and personnel in all conflict settings, not just armed conflict, and not just in relation to children, would be an important step forward in accountability.

The systematic monitoring of attacks on and interference with health care as a health systems and protection issue also needs to be addressed. Collecting information on the scale and nature of the problem would provide an evidence base from which to evaluate the impact of attacks and interference on elements like health infrastructure, health workforce and drug supply chains. In conflict-affected environments, such monitoring presents a challenge. The World Health Assembly passed a resolution in 2012 calling on the Director-General to take leadership at the global level in order to collect data on attacks on health facilities, health workers, health transports, and patients in complex emergencies.<sup>97</sup> Such monitoring should take place within a human rights as well as an IHL framework. This requires that information on attacks and interference be collected and assessed against human rights and humanitarian norms, including the right to health.

A decade ago, the medical and nursing community urged the Human Rights Commission to create a Special Rapporteur on attacks on health workers. The commission (now the Human Rights Council) chose a more general mandate to monitor and report on the right to health. Among other roles, the Special Rapporteur on the right to health presents annual reports to the Human Rights Council and to the General Assembly – these reports often have a particular theme. The Special Rapporteur can use this opportunity to look at attacks on health care as a particular theme, or a new rapporteur could be established on the issue.

Human rights accountability extends to the national level – judicial mechanisms could elevate the priority of prosecutions of crimes perpetrated against health care providers and their beneficiaries. Indeed, human rights accountability

95 United Nations Office of the Special Representative of the Secretary-General for Children and Armed Conflict, *Working Paper No 1: The Six Grave Violations Against Children During Armed Conflict – The Legal Foundation*, October 2009, available at: <http://www.crin.org/docs/SixGraveViolationspaper.pdf> (last visited 22 August 2012).

96 See above note 28.

97 World Health Organization Executive Board, 'WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies', 21 January 2012, available at: [http://apps.who.int/gb/ebwha/pdf\\_files/EB130/B130\\_R14-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_R14-en.pdf) (last visited 13 August 2012).

mechanisms can and should provide a welcome addition to the more limited number of mechanisms available to enforce compliance with IHL.

## Conclusion

Assuring the health care of people in situations of armed conflict or other situations of violence is complex, and requires multiple strategies founded on protection, respect, and affirmative steps to respond to insecurity. In circumstances of conflict, health care providers and their beneficiaries have increasingly become highly vulnerable as they are either targeted directly as a means of state action or as part of the activities of armed groups, or suffer indirectly on account of the failure of states to live up to their obligations under the right to health. IHL remains a critically important set of rules through which to address obligations with respect to health in armed conflict, with HRL acting as a powerful complement to it; and in circumstances where no armed conflict exists, but where health workers, facilities, patients, and ambulances are subject to threats, attacks, and other forms of interference and denial, HRL fills an important gap.

One of the greatest contributions of human rights is its role in ensuring that the interests and needs of the powerless and vulnerable are addressed. The essential elements of a human rights approach to health care in conflict include principles of non-discrimination and equality, coupled with entitlements to availability, accessibility, acceptability, and quality in health care. The obligations to respect, protect and fulfil can be promoted through participation and enforced through accountability, providing a powerful means of addressing the plight of health care workers and patients in conflict situations. Indeed, this is a strong framework through which to engage with many of the recommendations emerging from the 31st International Conference of the Red Cross and Red Crescent, which included support for the dissemination and promotion of obligations under both IHL and HRL.<sup>98</sup> Human rights bodies have also begun to play a role in strengthening respect and accountability for IHL as well as HRL violations in armed conflict. With careful oversight, human rights mechanisms can be employed to strengthen humanitarian law principles of respect and protection of medical personnel and patients as individual victims in armed conflict.

The time has come to properly grasp human rights' role in redressing the powerlessness experienced by those seeking care and those trying to provide it, across all conflict settings.

98 ICRC, *Healthcare in Danger: Respecting and Protecting Healthcare in Armed Conflict and Other Situations of Violence, Resolution*, adopted at the 31st International Conference of the Red Cross and Red Crescent, 28 November – 1 December 2011, Geneva, Switzerland, available at: [http://www.rcrcconference.org/docs\\_upl/en/R5\\_HCID\\_EN.pdf](http://www.rcrcconference.org/docs_upl/en/R5_HCID_EN.pdf) (last visited 30 August 2012).



# Medical ethics in peacetime and wartime: the case for a better understanding

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## Abstract

*Health-care workers face ethical dilemmas in their decision-making in every clinical intervention they make. In times of armed conflict the decisions may be different, and the circumstances can combine to raise ethical tensions. This article looks at the tensions in peacetime and in times of armed conflict and examines the types of cases that doctors and other health-care workers will face. It also discusses the common ethical decision-making framework and the role of communication within both clinical care and ethical analysis.*

**Keywords:** ethical dilemma, ethical analysis, decision making, consent, confidentiality, communication, trust.



Health-care workers worldwide follow the same ethical codes and principles, developed to protect patients from abuse and to make clear the limits that those professionals will apply to their decision-making. A broad understanding by the whole community, including those in positions of power and authority, of what those rules are and their universality is an essential tool in ensuring compliance even in the most difficult circumstances.

Clinical practice in any circumstance raises ethical dilemmas for the doctors, nurses, and other health-care professionals caring for patients, and for those organising the delivery of care. There is a wealth of material on medical ethics in literature published over many centuries; the last half of the twentieth century and the beginning of the twenty-first have brought a particularly rich collection of new material on the subject.<sup>1</sup> Increasingly the usefulness of that material to clinicians in their everyday work has risen as advice and, indeed, explanation of ethical principles has been linked to cases both real and theoretical. This enables the clinician to consider the principles, the background, and the case within a clinical framework, making it easier to translate and adapt those concepts to the clinical situation facing him or her.

But these materials have been based on clinical care in normal circumstances, or in cases where the delivery of care is not threatened or challenged by armed conflict or other situations of violence. In ‘normal’ practice clinicians often have time to stop and think about the decisions inherent in offering care, and indeed to take advice from others. In conflict situations such opportunities for reflection are almost always more limited. The very fact that the situation is unstable, possibly threatening and certainly different to everyday practice makes reflection more difficult, and the challenges that are faced are either subtly or substantially distorted by the conflict or unrest. Doctors in these circumstances will rarely have the opportunity to discuss their concerns contemporaneously with others, or to consult on the approach needed. It is therefore even more important that they are aware of ethical principles and feel able to identify and analyse the ethical challenges they face.

Many may face these circumstances for the first time, and wonder if ‘normal’ ethical rules apply. They may be confronted with others from outside the clinical environment who demand particular actions from them, and may be unsure of whether those actions are ethically acceptable in these circumstances. They may

1 British Medical Association (BMA), *Medical Ethics Today: the BMA's Handbook of Ethics and Law*, 3rd edition, BMJ Books, London, February 2012; J. R. Williams, *World Medical Association Medical Ethics Manual*, 2nd edition, WMA, Ferney-Voltaire, 2009; International Committee of the Red Cross (ICRC), *Health Care in Danger: the Responsibilities of Health-Care Personnel Working in Armed Conflicts and Other Emergencies*, ICRC, Geneva, 2012.



also fear for their own safety and that of others – their families and other health-care professionals as well as patients.

Demands, for example, for access to detailed patient information made in peacetime will usually be accompanied by time to consider whether such demands fall within legal requirements or indeed legal exemptions to the right to confidentiality. In times of armed conflict and serious unrest, other factors may come into play. Those demanding the information may say it is essential to them in order to provide safety and security to the health-care workers, the institution, and the broader environment. Where do the rights of the patient, and the duty of the doctor to uphold those rights, lie in such cases? How does the health worker cope emotionally with being told that he or she may be the cause of risk to others?

Similarly, while health-care workers use the concept of triage, especially during major epidemics or after mass casualty events such as multi-vehicle road crashes, in many such cases they are able, by careful use of resources, to arrange treatment for everyone. In conflict situations resources are more likely to be exhausted, it may be difficult to replenish them, and triage decisions are more likely to be literal life or death decisions. In addition, health-care workers are more likely to face pressure to give priority to one group over another in these situations, and that pressure may also be accompanied by threats to the workers, the institution, and other patients. How far should health workers go to protect confidentiality when it might put others, including themselves, at serious physical risk?

In conflict situations, workers may become exhausted by a constant stream of patients. While this can happen in other emergencies, few are as long or sustained, and the opportunity for rest and recovery may be far more limited. What should doctors and others do when they are tired? Or when they are running out of equipment or drugs? Or when they are faced with cases beyond their clinical competence?

Health-care workers can face related challenges at other times. In some countries attacks on health-care institutions, their workers, and their patients are tragically commonplace. Discussions with doctors around the world make it clear that organised criminal gangs and disgruntled family members may attack health-care professionals seeking compensation for injuries caused to friends, family members, or others, or simply to extort money. These are criminal activities in situations where there is no specific conflict or general unrest, but where violence within society as a criminal act is common. Ethical understanding and an ethical aid to local engagement with social leaders are as necessary here as in situations of conflict.

In all these situations the help and support of others may be present, as it would be in normal times, but it can equally be unavailable. Health-care workers can be or feel very isolated in their decision-making. A solid ethical framework to decision-making can help them to feel supported and to know that their decision would be supported by colleagues around the world.

The ability of health workers to understand and adapt ethical principles becomes an invaluable tool. It helps to ensure that ethical standards do not slip, and

in doing so that patients are protected from unintended or unthinking exploitation. It helps to reinforce the professionalism of the health-care workers and the trust that must exist between doctor and patient. And it helps when decisions have to be made that breach general ethical principles in order to protect other lives. Most importantly, it also forms the basis of discussions and negotiations with others on the way in which the health-care institution and its staff and patients should be treated.

The idea that ethics is a luxury which has no importance during emergencies must be challenged; ethics is the principal construct that ensures that medicine remains a force for good, designed and delivered within a humanitarian framework to protect the interests of the vulnerable, the ill, and the injured.

Whenever and wherever health care is delivered, there must be an ethical framework which will delineate the principles surrounding that care delivery. Health care is delivered to people in need, who may be afraid, whose lives might be at risk, and who are almost always more vulnerable than those delivering the care. Those delivering care will have different levels of power relative to those to whom they offer care. The delivery of care is bounded by ethical principles that limit the freedoms of those offering care and which offer patients a framework within which they can expect to see care offered. The ethical principles are designed to ensure that there is no abuse of that power differential and that both parties to the therapeutic relationship understand the basis upon which decisions will be made.

## **Medical ethics in peacetime and wartime**

General definition: what is medical ethics?

There are many definitions that explain what is usually understood by the concept of medical ethics. It can be most readily understood as a set of principles which apply to professional work and which set boundaries to the freedom of a health-care professional in their decision-making. Increasingly, it is also seen as an agreement between those health-care professionals and the societies they serve. These boundaries are not set by the professions working alone but are negotiated with society, taking into account social mores and values, the law, systematic belief systems, and the expressed fears, hopes, and expectations of society generally. Beneath all these variables is a remarkably consistent value-based set of principles. Given that law changes and develops regularly and that it impacts upon ethical rules, there is a continual adjustment of some ethical boundaries; generally speaking, these changes are minor. In countries where the development of law, through parliament, is substantial, there is usually a lively multi-party dialogue about how a potential law fits into publicly accepted limits on health-care practice. Governments that wish, for example, to legislate on the management and confidentiality of information will be required by health-care professionals to ensure that the new law does not undermine accepted norms, including legal protections for patient/doctor confidentiality.

Clearly the academic discipline of philosophy has had a major influence, and such formal analyses are an increasing part of modern ethical discourse. Ethical rules have historically emerged over time. Early rules of health-care ethics such as the Hippocratic oath or the prayer of Maimonides set out lists of acceptable, and unacceptable, actions for doctors. These were constant, except for the variability introduced by successive translations, for many centuries. The connection to broad philosophy is hidden in these texts, and much of the early twentieth-century literature on ethics takes the same position, setting out lists and rules of behaviour but not describing the reasons behind those limits, or the debate which led to their emergence. Frequently such texts would say explicitly that doctors would know automatically what was ethically right. In practice few doctors were able to analyse medical situations sufficiently to expose the ethical challenges involved, but they often learned where the boundaries lay within relatively narrow medical fields.

Nevertheless, the power of these ancient codes is considerable, and the Hippocratic oath in particular remains a descriptor of the binding ethical principles that surround modern medical practice. In many but not all medical schools, part of the process of becoming a doctor is taking the oath. Despite the fact that a significant number of doctors do not formally swear this or a similar oath, the public perception is that all doctors are bound by it. More modern codes are largely derived from these and similar ancient codes. The Declaration of Geneva<sup>2</sup> of the World Medical Association (WMA) and its associated International Code of Medical Ethics<sup>3</sup> are overarching broad codes which cover the work done by health-care professionals in all circumstances. None of these isolate times of war or work in warfare as being different, or imply that ethical principles and rules change as circumstances vary.

In much of the world the major descriptor of ethical principles is 'Primum non nocere', or 'Above all, do no harm'. A variety of different expressions are used to outline other factors, such as 'patient-centred' or 'person-centred' medicine. At the same time, law surrounding medical practice has also largely been based upon supporting the rights of patients.

Ethical analysis often requires an assessment of the best interest of the patient. How best interest or benefit is assessed is also culturally sensitive. Western society tends to use concepts that are heavily biased towards the rights of individuals and self-determination. Balance enters the equation, as the rights of the individual are not the only rights that need assessment. Society (and hence other individuals) also has rights, and these can be in conflict with the rights of the individual. In the Western tradition, the best interests of the individual are a holistic measure, looking at the person within their family, workplace, and social and cultural setting. But what those best interests or benefits actually are should depend upon the views and beliefs of the individual, which in themselves will be culturally predicated. Much modern work deals with the importance of ensuring that the assessment of best interests is based upon what the patient believes is best for him or herself,

2 WMA Declaration of Geneva, adopted September 1948, last revised May 2006.

3 WMA International Code of Medical Ethics, adopted October 1949, last amended October 2006.

not another person's judgement, especially of whether a life severely limited by illness or injury is 'worth living'.

Doctors look after patients in every possible circumstance, in every country in the world. While the circumstances vary very widely, it is commonly said that the ethical rules or obligations are identical. Indeed, the WMA states that medical ethics is identical in times of peace and of war.<sup>4</sup> There are also frequently asked questions about the balance between law and ethics. Again, the WMA takes the apparently simple approach that ethics trumps law, meaning that when law and ethics collide, doctors should obey ethical precepts.

The reality is far from simple. While ethical principles can and do remain constant, they are, in essence, merely a framework surrounding the decisions that need to be made in clinical practice. Those decisions themselves are significantly affected by and related to the circumstances in which the clinical practice takes place. This is most clearly seen when an analysis is undertaken of the clinical circumstances in which the doctor is making decisions. In every case, doctors and others considering the ethical issues will use analysis to consider the various elements involved. Very often different duties, values, or principles will be in conflict with one another. It is only by examining the whole picture, including the specific circumstances of the case and of the conflict situation, that the best answer can be found.

In times of armed conflict these decisions will differ because of the specific threats and circumstances of warfare. Crucially the decisions that the doctor has to make will sometimes be very different from those in times of peace. On other occasions the decisions will be identical and the circumstances of the conflict will have no impact on the decision-making. In all circumstances doctors have to make decisions about which patient to treat first. Such decisions are especially likely to occur when the number of patients exceeds the number of trained health-care professionals or when resources are scarce. This dilemma may affect an emergency room doctor faced with multiple casualties from a road traffic crash, in the same way that it may affect a doctor dealing with multiple injured from a roadside explosive device during an armed conflict. The circumstances are remarkably similar, even if more commonly occurring in conflict situations.

Much of the historical discussion of ethics in the health-care sector has been written under the heading of 'medical ethics'. The implication is that it applies to medical doctors, and some would understand this as implying that other rules might apply to other health-care professionals. Modern discourse tends to use the title 'health-care ethics', with the necessary implication that it applies to all health-care professionals. In practice both titles cover all health-care professionals. Differences are sometimes seen in some discussions, and these often reflect the various roles of health-care professionals, which can lead to a different point of view affecting the analysis.

4 WMA Regulations in Times of Armed Conflict and Other Situations of Violence, adopted October 1956, last revised October 2012.

## Same general ethical principles in peacetime and wartime

The statement that ethics is the same in war and peace does not mean that the decisions doctors make will be identical. The dilemmas that they face will often differ, but the general principles that will be applied to the decisions will be the same.

In essence, the principles are designed to respect the rights of the individual who is currently the patient, ensuring they are enabled to take control of decisions about them and the treatment they will receive. While historically many principles will relate to the etiquette of medical practice, increasingly ethics also looks at decision-making in relation to complex and high-risk medical procedures or to public health.

In modern conflict settings, especially in the presence of the armed forces of developed countries, the medical capability is such that very severe injuries can be treated. As lives become increasingly salvageable, the sequelae of that salvage become important. This mirrors decisions in peacetime, though the nature of the injuries which are commonly seen, and of the people in whom those injuries are seen, may be very different. In civilian practice the balance between the genders is likely to be more even and a wider spread of age groups will be seen with injuries. During armed conflict, proportionately more of the injured will be members of armed forces, and therefore young and previously fit men. The impact that devastating injury may have on them and their future life choices may be very different to the impact of such injuries in a different cohort. The very fact of their relative youth and previous fitness may make them more able to survive appalling trauma. Is enough thought given to the psychological consequences of the devastating injury they have survived? While this is not a primary concern for the medical professionals at the time of the original emergency treatment, it is certainly their role to seek to ensure that the importance of psychological support is well understood.

One scenario that arises in conflict situations that is not seen elsewhere is when the environment becomes so dangerous for the carers, and for their patients, that continuing to keep delivering care becomes untenable, and the hospital, first aid centre, dispensary, or other facility has to be closed. This is a situation that some care providers, such as the ICRC and MSF, have faced: real threats to their staff, including of abduction or of injury or death, are such that it is unacceptable for the institution to continue to expose the staff to them. These threats are compounded by the fact that if there are attacks on health-care workers, their non-clinician colleagues and their patients are also implicitly at risk.

## Impartiality

One of the fundamental tenets of medical practice in peace and war is that of impartiality. In terms of medical ethics, this means that health-care workers must treat patients on the basis of need and not on the basis of ethnicity, religion, gender, age, or any other factor that might lead to unfair discrimination. It also overlaps

with medical neutrality, as referring to the non-involvement of health-care workers in political parties and issues related to the conflict within their workplaces. Doctors and other health-care workers are, of course, free to be as politically involved as any other citizen provided they do not let it impinge in any way upon their clinical role.

While the concept is the same in war as in peace, the reality is that in war the health-care worker is more likely to face real challenges to their impartiality. The military doctor, faced with two casualties needing urgent attention – one of whom wears the uniform of his own troops and the other that of the enemy – is likely to find it difficult not to be swayed by a loyalty to the person he serves alongside. But a doctor in peacetime confronted with two victims of a road traffic crash might face the same dilemma: one might be a friend, neighbour, or family member, and the other, the person who caused the accident. It is equally inevitable that the latter doctor's impartiality will be threatened.

The ethical rule is clear and simple. Care should be offered based upon need; the person most in need is treated first. This is the basis of triage in both wartime and peacetime.

### Adapting decisions to armed conflict configurations

Ethical teaching is based upon understanding a system of analysis and using that system (and there are many competing systems) to examine the decision that is to be made. No one system is better than the others; each has strengths and weaknesses and each has devotees and opponents. What matters is that the individual is able to use one system to examine an issue. As different situations arise, he or she can then unpick the clinical circumstances, identify the ethical tensions, analyse them, and seek to find the best resolution. There are usually no right or wrong answers, but there are solutions that adhere more or less closely to general ethical principles.

In armed conflict the nature of the problem is likely to vary, as set out in some of the examples given earlier in this paper. As a general rule, however, there are some differences likely to be faced more commonly during armed conflict than at other times.

Health-care workers may well be personally conflicted because of loyalty to a cause, a group, or an ideology, in a way that will rarely impinge on their practice in peacetime. Separating out personal beliefs and prejudices is essential within any ethical decision; in conflicts when those beliefs may well include seeing those with the same loyalties or ideologies at risk of serious injury or death, it is much more difficult to remain neutral. Without neutrality, specific tasks such as performing triage (see below) become impossible, as does a fair assessment of the reasonableness of requests such as for the release of patient data.

A strong grounding in an ethical system, and an understanding and knowledge of ethical codes and principles, can help those under pressure to maintain the necessary clarity of vision and analysis.

Although, as stated earlier, ethics in peace and war are essentially the same, the pressures are different. Failure to treat a particular individual rarely threatens the

life of the health-care professional in peacetime; in time of armed conflict, however, this might occur. But there are situations in peace as in war when health-care workers are at risk as they undertake their duties. Health-care workers entering the scene of a natural disaster, such as a collapsed building, to render care may be at risk as much as those continuing to provide care while their institution is being bombarded, but as in war, the former are not expected to ignore their own safety. In peacetime doctors are expected to listen to advice, such as whether the risk level of entering the collapsed building is low or high, and not to take serious risks. While they are expected to accept some risk – for example, treating people with contagious diseases exposes health workers to some risks – they are also expected to take steps to minimise that risk (in the case of contagious diseases, by using barrier nursing methods, vaccines, and so on).

### How are ethical rules made?

Ethical rules have historically emerged over time. Early rules of health-care ethics such as the Hippocratic oath and the prayer of Maimonides set out lists of acceptable and unacceptable actions for doctors. Many more modern codes are largely derived from these.

For much of the last three decades, ethical debate has been widespread but doctors have fought to keep the development of ethical rules and norms as a medically led process. This is gradually breaking down as doctors recognise that given the nature of ethical codes, as a bargain with the society they serve, it is at the very least helpful to involve others in developing such codes.

Those who should be involved can be classified in a variety of ways. One simple mnemonic consists of eight 'P's. The profession of medicine (the first 'P'), is inevitably involved. Doctors must contribute; they will know best what a treatment or diagnosis involves, and must ensure that the adaptation of the ethical principles fits with normal clinical practice. Practitioners (the second 'P') should also be involved. The same ethical principles should bind all health-care professionals, especially those working together to offer care to the patient. Doctors, nurses and others have a different view of the clinical process, seeing it from slightly different perspectives, which helps in ensuring the matter is examined from all directions. Similarly, patients (the third 'P') or their representatives should be involved, and their perspectives should be considered. Public views (the fourth 'P') involve a wider group, including non-patients, potential patients, and carers. While most of the world's countries are not theocracies, priests (the fifth 'P') or other religious leaders can also add to the debate, bringing in a view informed by the dominant faiths and the constraints they might offer. The importance of religious views will vary widely between different cultures, but an understanding of how the main religious groups might view a medical ethical dilemma is an important part of any debate. As some areas of debate will touch on the interface between law and ethics, lawmakers and law 'managers' are also relevant interlocutors. Generally this means the involvement of parliamentarians (the sixth 'P'), but also of other policy people; those who work on legislative initiatives are especially important participants. Throughout this



mnemonic the public have appeared in various guises. They are most often informed through media stories, making the press (the seventh 'P') another contributor. The final 'P' is one of process; partnership is the aim of the best medical practice. Good ethics means a partnership of equals between health-care professionals and their patients; the ethical consideration process must work toward this end.

At the patient-doctor interface these different individuals and groups are not seen or heard from, but doctors, including those offering treatment in conflict situations, should consider how they can contribute to the development of ethical thinking. Doctors who have worked in conflict often contribute to, for example, journals considering surgical approaches to trauma, based upon their conflict experience. They should equally consider how they can contribute to journals of medical and health-care ethics.

## Legal considerations

While law and ethics are different, both establish a set of principles which set limits on the freedom of medical personnel, and others, to undertake actions.

National laws increase in number every year. Many are written by governments in pursuit of a variety of policies. These can encompass areas which have a strong impact on medical practice, such as confidentiality and the management of data, or the age of consent. Other areas of law may have no immediately apparent impact upon medical practice.

While doctors recognise the importance of law, it is a common statement that ethics 'trumps' law. By this doctors mean that the law might allow doctors to do something which ethical analysis will state is unacceptable, and that ethics is the more important regulatory principle for them as health-care professionals.

In many countries this can lead to a conflict between statute law and the regulations established by the medical regulatory body, which might in and of itself have a quasi-legal weight. Doctors who break the limits set by a regulatory body, but stay within the law, may find their careers ended through erasure from the medical register, which gives them license to practise, or another serious punishment.

In general, where doctors collectively see that a law would require them to breach ethical standards, they should campaign to have that law changed. This is a task for collective bodies of doctors such as medical associations. A major role that medical associations fill around the world is to advocate on behalf of their members, including advocacy to ensure that doctors are able to practice in accordance with ethics and law.

In addition to statute law, emerging case law and common law, including from judgments in courts, also sets limits. Recent cases in many jurisdictions relate to consent to medical treatment,<sup>5</sup> especially in terms of end-of-life decisions. There is also law in every jurisdiction on confidentiality of personal data. These laws vary

5 For case law relevant to the question of medical consent, see references in BMA, above note 1, especially chapters 2, 3, and 4.

widely, while the ethical principles are the same throughout the world. So, while in some jurisdictions the law might allow the sharing of patient data with or without the patient's consent, in others such activity is prohibited.

There is also an increasing body of decisions relating to human rights. Many countries have national legislation that addresses the human rights of their citizens and is subject to decisions by international and regional judicial or quasi-judicial bodies. More specifically, there is an increasing body of case law and literature on the 'human right to health'. While this is not an absolute right to access to health-care, 'Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity'.<sup>6</sup> This non-derogable right encourages non-discriminatory state approaches to health-care access.

In times of armed conflict, international humanitarian law (IHL) also comes into play. This body of law consists of treaty rules (mainly the four Geneva Conventions from 1949 and their Additional Protocols), and customary rules which bind all states. IHL contains a number of rules related to the provision of health care and addresses the protection of health-care personnel, units, and transport.<sup>7</sup>

In many ways, ethics codes have achieved a status similar to customary law. The acceptance of certain standards by doctors throughout the world gives those codes international status, so that they cover all doctors whether or not each individual doctor has sworn to follow them.

## Specific ethical challenges in times of armed conflict and situations of violence

### Triage

Triage is the process that enables the sorting of patients into priority order for treatment. It is classically used when a service is overwhelmed by the arrival of multiple casualties, and is designed to ensure that medical needs are addressed effectively.

In civilian practice – and increasingly in warfare, in facilities serviced by well-equipped military field hospitals – triage identifies those in most urgent need of immediate lifesaving treatment, those in moderate need, and those effectively needing first aid. This can include the identification of those who are likely to die

6 See Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), adopted on 11 August 2000, E/C.12/2000/4, para. 1 (emphasis added).

7 For a summary of IHL and human rights law rules related to the respect and protection of health care, see ICRC, 'Respecting and protecting health care in armed conflicts and in situations not covered by international humanitarian law', Legal Fact Sheet, 31 March 2012, available at: [www.icrc.org/eng/resources/documents/legal-fact-sheet/health-care-law-factsheet-2012-03.htm](http://www.icrc.org/eng/resources/documents/legal-fact-sheet/health-care-law-factsheet-2012-03.htm) (last visited November 2012).

regardless of treatment. These patients may receive no active attempts to preserve life, but should always receive care, including pain control. In more classical conflict situations a variance of this was to identify and prioritise those needing first aid in order to render them suitable for an immediate return to active fighting. This can mean that those in immediate need of life-sustaining treatment may find a delay in obtaining such treatment, while those in lesser need are helped so they may return to active duty. Many modern military forces would deny that this situation ever arises nowadays, but in practice most military medics will recognise that there are times of military emergency when getting soldiers back to the active front may be essential, not least because it will help to save other injured people by protecting the hospital or treatment centre.

Triage systems developed by military medical personnel are the basis of systems used in non-military situations, especially of emergency. Again the concept is one of identifying those for whom treatment is futile (an increasingly rare concept), those needing immediate treatment, those needing serious medical intervention soon, and those requiring little more than basic first aid.

The ethical concept is that those in most need are prioritised. It can readily be understood that identification of need is in itself time- and therefore resource-consuming. Triage systems understand this and usually place the most experienced clinician as the triage lead, the person who assesses and categorises the arriving injured people. This maximises efficiency and reinforces the concept of need driving priority.

The decision not to use resources on those who are inevitably going to die is also consistent with ethical principles; resources are always limited, even in peacetime or in developed countries. Using resources where they cannot provide benefit to the patient is always a potential denial of resources to others who might benefit from them. Equally, it exposes the patient who cannot benefit to risks; the treatment itself might be uncomfortable, diminish their dignity, or do them some other harm.

While the ethical principle is exactly the same in all situations, the key difference in wartime is one of resources; it is rare outside armed conflict for well-resourced countries to experience so many people competing for care at one time that access by one means denial to another. So the reality of triage is more about sorting patients into groups that will experience different levels of care from different types of health-care workers. In armed conflict situations it is all too common for health-care personnel to have more patients with urgent needs than can readily be managed; triage thus becomes life-determining.

## The challenges for doctors working in a culturally different environment

The law, including individual rights, can vary between countries and even within countries. The law is based upon country- and culture-specific rights and duties, as well as local enactment of international law. Where law and ethics come together, there are often local differences from international standards. Those working as doctors within a conflict zone may come from countries where human rights are

widely respected, where autonomy is the basis of most medical decision-making, and where men and women are treated equally. They may find themselves in a culture – and treating patients from that culture – where decisions are made by local leaders or by heads of families, and where women are not fully entitled to act autonomously.

Doctors who are trained to understand that patients have the right to make all decisions about their own health will find it difficult to work in cultures where such decision-making is given to a civic leader or to, for example, the husband or father of a woman. Ethical practice requires the patient's agreement, but local law and custom might require that of someone else.

It is clearly important, not least because of the essential importance of trust in the relationship between the doctor and the patient, that the doctor does not act in a way that will shock or otherwise unsettle the patient. In matters such as consent (see also below) this is easily resolved by discussion with the patient and with the appropriate cultural surrogate decision-maker.

Ignoring different cultural norms can impact on trust. One example is the treatment of women by male health-care workers in societies where such treatment is either generally unacceptable or only acceptable with specific permission from, for example, the husband. Most Western societies do not share this cultural norm, and health-care workers treat all patients on a needs-based priority system. Adjusting to this cultural norm is ethically acceptable and is likely to reinforce trust as it demonstrates respect for local cultural traditions.

More problematic is when a local norm would ask a health-care worker to do something ethically unacceptable. Female genital mutilation (FGM, also known as infibulation or female genital cutting) is common in parts of North Africa. It is prohibited by law in many countries – for example, in Europe – and is ethically unacceptable in the advice from the WMA and the International Federation of Gynaecologists and Obstetricians. But when offering health-care to people in parts of North Africa riven by conflict, expatriate health-care workers might be asked to undertake FGM as it is 'better' that it is done with clean medical instruments and with appropriate skills than by a local village leader with no access to antiseptics, treatment for haemorrhage, or other necessary medical resources. Some also say it helps to build trust that the imported health workers respect this local tradition, but here the ethical issue is clear: this is a practice which has no place in medicine, and which is dangerous, damaging, and has no benefit to the girl concerned (there is an additional factor that the patient is usually a child and is denied the right to take part in the decision). The role of the health-care worker here is one of attempting to educate the population so that this practice is discontinued, and to educate especially on the medical reasons for its discontinuation. Discussions should also emphasise the value placed on not doing harm to anyone, something which is valued in most traditions.

Attitudes to sexual violence vary widely; in many cultures, such issues cannot even be discussed. Any person reporting them will be unlikely to be treated sympathetically and may even find their life endangered. Standards recognised in law in many nations, including definitions of rape that include rape within marriage,

are not universal. People who have been harmed and who are in need of medical support may receive no support within their community; health-care professionals may find this a very difficult dilemma. Their role is to treat the victim to the best of their ability, and they need to be aware of the cultural norms around this issue so that they do not inadvertently endanger their patient. Anger about such abuse is common, but doctors should ensure that such anger is kept under control until they are away from the situation and can advocate appropriately without endangering their patients or colleagues.

Medical officers should ask before deployment for information about and training in relation to any local cultural practices that they are likely to encounter. Discussion before deployment will make responses to these challenges easier and more uniform.

### Lack of resources and sending patients back to under-resourced areas

A major ethical constraint that affects the delivery of medical care can be a shortage of resources. Such resources may consist of trained personnel, including doctors, or physical resources, including operating rooms, drugs, dressings, hospital beds, and essential equipment such as anaesthetic machines. The concept of triage is used to allocate such resources on the basis of need.

In times of armed conflict, and especially of asymmetric warfare, military doctors may find themselves looking after patients from an opposing force in the knowledge that the follow-up care these patients will receive when returned home is likely to be significantly less than would be available to patients from the doctors' own forces. The differences might be a matter of life and death; for example, dialysis or similar life-sustaining treatment may not be available, or they might relate to post-injury rehabilitation including physiotherapy and the provision of prostheses.

Doctors who undertake life-saving treatment during acute injury may not be able to take into account the treatment options that might be available later, but where possible should amend their treatment plan to take such factors into account. In other words, when selecting the treatment option, doctors should bear in mind the consequences of that treatment and the longer-term needs it will generate for the patient.

### Consent

It is a mainstay of treatment in the developed world, and especially in Europe, the Americas, and 'Australasia', that any and all treatment must only go ahead with the real and valid consent of the patient or of an appropriate surrogate decision-maker as allowed by local laws. Not all societies treat consent with this degree of respect. Patients may be used to others deciding for them, or to a paternalistic medical profession that tells them what will be done. Helping patients to understand why they are being asked to consent, and how and why their decision will be respected, can be challenging if it is culturally surprising.

There will be circumstances where the patient cannot consent – for example, because of the seriousness of his or her immediate injury. In such cases medical treatment can continue to sustain the life of the patient, but as soon as the patient regains an ability to participate in decision-making, he or she must be told what has been done and given the opportunity to make future decisions. Very many patients arriving at conflict-area field hospitals will have already received some emergency first aid, which might include powerful analgesics such as opiates. Some will have had their consciousness clouded by this treatment, and indeed by shock associated with the injury, and may be temporarily less competent. While treatment can continue, as much involvement as possible by the patient in decision-making should be enabled.

Where language is the principal barrier to consent, attempts should be made to find a translator or to otherwise enable communication. In circumstances where the delay in getting such translation might endanger the life of the patient, treatment might go ahead, but as with patients suffering some diminished capacity, attempts must be made to explain what was done, and why, as soon as is feasible.

There may also be some patients who make decisions with which the doctor disagrees. The fundamental point is that a patient has the right to refuse treatment, even life-sustaining treatment, provided they are competent. The fact that they disagree with the recommendation of the doctor does not make them incompetent and cannot be used as an excuse for so classifying them. As with such cases in non-conflict-area practice, attempts should be made to discover why they are refusing treatment. Is this about fear? Is this because of a lack of trust in the doctor, or the medical system, or for some other reason which means that they need extra time and help with understanding and coming to trust the advice they have been given?

Doctors and other health-care professionals in all areas of practice find the refusal of life-saving treatment the most ethically and spiritually challenging event. The fact of being challenged does not mean that a retreat from ethical core values is acceptable, nor does it mean that doctors should immediately withdraw from attempting to help the patient. Rather, doctors should continue to attempt to help the patient and to gently persuade him or her to allow more such help to be given. At the very least, they should explore what the individual would find acceptable so that help can be offered.

Doctors cannot be forced by anyone, including the patient, to offer a form of medical care which they believe to be inappropriate or contrary to the interests of the patient. An example given in general ethics texts is that a patient with abdominal pain cannot demand that a doctor amputate his big toe. Such a treatment would clearly not help the patient and it would be unethical to provide such a treatment; the same would apply in conflict situations.

While consent is a process, with offers of information and exploration of issues, it often ends with a consent form being signed by the patient. The intent is that this form signifies that the patient has understood the information being offered, including their right to refuse a recommended treatment, and is agreeing to

a specific treatment being undertaken. In conflict situations where it is likely that the injured might come from a variety of groups speaking different languages, consent forms should be available in these languages or at the very least translated before being signed by the patient. Medical language cards in other locally common languages can be an invaluable aid to the process of getting agreement between patient and doctor on future treatment. Given the frequency of functional illiteracy in all cultures, doctors should be able to undertake the process without recourse to the words on a consent form.

There will be circumstances in conflict as in peacetime practice where the patient is unable to consent because of, for example, the nature of the illness or injury that has brought them to the care giver. In these circumstances, life-sustaining treatment can be given. The health-care provider should be sure it is 'mainstream' care – that is, what any other care provider would offer in the circumstances – and should tell the patient as soon as possible what was done.

Consent is also relevant regarding media intrusion. Some areas of conflict are used by politicians and others in the public eye as media opportunities. In some cases the celebrity might seek to be photographed or filmed metaphorically mopping the brows of the sick and injured. While some patients might welcome the opportunity to meet someone famous, very many will not, especially at a time when they are suffering. Even being filmed by the media in the absence of a celebrity requires the free consent of the patient. It should never be assumed that the sick and injured will welcome what many will see as an intrusion into their private matters.

## Dual obligations

In some roles doctors find that they have a duty to their employer as well as a duty towards the patient. In general terms the duty to the patient comes first, but key for the doctor is recognising that there is a potential conflict. A military doctor might find that he or she is asked by local commanding officers about the health of members of his or her forces. The doctor owes a duty of confidentiality to the individual patient, but is also a member of that forces group and has a responsibility to ensure they are not put at risk because of that confidentiality. The doctor also has a legal duty to keep senior officers informed of the state of health of the troops. In practice this tension is understood and dealt with by telling the commanding officer whether or not a specific individual's health concerns will prevent them from carrying out their duties, not what those health concerns are. It is entirely legitimate to ask the patient/soldier whether he consents to information being given to the commanding officer, but he has the right to refuse, unless there is a specific legal duty to tell.

Different legislatures regard confidentiality and the rights of soldiers differently; in some circumstances the soldier might have given up the right of confidentiality. Doctors need to know the local law that applies to such situations. While the ethics is clear – there is a duty of confidentiality – this might be overridden by law.



Obligations to an employer cannot override law and ethics. No employer can require a doctor to break the law – for example, to cooperate with or ignore human rights abuses – or to breach ethical obligations to treat patients with consent and maintain their confidentiality.

While employers of health workers in conflict zones, including the military, may ask their employees to breach ethical standards on confidentiality, on neutrality, on non-discrimination, or other areas, the fact of being asked is not a requirement to obey, and ethical standards should be followed. A health worker asked to prioritise members of his or her troops or followers, for example, must point out that care is offered based upon need, and that triage is an expression of this when the number of casualties or presenting patients exceeds the capacity to treat everyone immediately. As with other ethical dilemmas, such pressures should be discussed in advance of crises so that employers or others seeking to affect health-care decisions are aware of the ethical principles that will be followed.

There are examples of good practice in many armed forces settings. In the UK forces there is a clear statement from the Chief of the Defence Medical Services (the most senior medical officer in the three parts of the armed forces) that doctors concerned about an ethical issue should raise it with their local field commander, but if the field commander does not act appropriately, the doctor should then raise the issue through the medical chain of command.<sup>8</sup>

## Confidentiality

Medical confidentiality is a poorly understood concept. It is not an absolute right in any country, but is a weighted right; that is to say, doctors obtain sensitive and highly personal information from patients for the purposes of making a diagnosis and suggesting treatment. Any other use of that information is subject to the agreement of the patient to its sharing. Indeed, even sharing with other health-care professionals should be done with care and only as essential to the care of the patient. This means that rather than offering full access to the complete record, doctors should consider what the health-care professional needs to know to do his or her job.

There are of course exceptions to confidentiality. These are principally where the patient agrees, where it is required by law, and where there is a compelling public interest reason.

It is assumed for the purposes of this article that laws are passed in accordance with good practice and that laws would not expect a breach of confidence which doctors generally felt to be unacceptable or inappropriate. If such unacceptable laws are in place, it is the role of the medical profession to campaign for their repeal.

8 Ministry of Defence, *Medical Support to Persons Detained by UK Forces Whilst on Operations*, Joint Service Publication 950, leaflet 1-3-4, March 2011.

Public interest disclosures need to be considered on an individual basis. In advice to UK military doctors, the British Medical Association advises that they should:

- Consider how the benefits of making the disclosure balance against the harms associated with breaching the patient's confidentiality;
- Assess the urgency of the need for disclosure;
- Consider whether the patient can be persuaded to disclose voluntarily;
- Inform the patient before making the disclosure and seek his or her consent, unless doing so would increase the risk of harm or prejudice the reason for disclosure;
- Document the steps taken to seek or obtain consent and the reasons for disclosing without consent;
- Reveal only the minimum information necessary to achieve the objective;
- Be able to justify the disclosure; and
- Document both the extent of and the grounds for disclosure.<sup>9</sup>

In civilian practice a doctor might disclose to a driver licensing body the fact that a person continues to drive when they are medically unsafe to do so, if the patient refuses either to stop driving or to tell the agency themselves. The risk of harm to themselves and to others justifies the breach of confidence, which is specific and limited. In military practice, where a soldier is expressing suicidal or homicidal ideation and has access to weapons, the doctor may be able to justify disclosure to a commanding officer. In this case he might limit the information by expressing concern about an individual and recommending they be taken away from access to weapons for the immediate future or medically 'downgrading' the soldier's fitness for duty.

## Experimental treatment

Health-care professionals are aware of the times within clinical practice when patients are least able to voice their own opinions or to act autonomously. The history of medicine in the twentieth century was one of unethical and abusive medical experimentation, including during attempts to better understand the natural history of disease and to develop new treatments. This led to the Nuremberg code, and eventually to the development through the WMA of the Declaration of Helsinki.<sup>10</sup> In conflict situations there are a variety of groups who are especially vulnerable to abuse. These include wounded enemy combatants and civilians from a defeated group or state. Ensuring that their rights are not ignored is one element of avoiding unethical, and almost certainly illegal, human experimentation.

The nature of health care in conflict is such that many patients will be seen in a short time with injuries that are fairly specific to the nature of that

9 BMA, *Ethical Decision-Making for Doctors in the Armed Forces: a Tool Kit*, London, 2012.

10 WMA Declaration of Helsinki, *Ethical Principles for Medical Research Involving Human Subjects*, adopted June 1964, last amended October 2008.

conflict situation. Health-care professionals may well start to develop new ideas for treatment options. Development of new treatments should follow the same path as in peacetime. Truly experimental treatments require research ethics approval. Modifications from well-established and understood norms require careful consideration, and doctors with ideas for such changes should discuss them with colleagues and ensure that they are rigorously assessed. Those wounded in conflict are not experimental animals; they are people with all the rights that flow from that, including the right to willingly participate in or decline involvement in research trials.

There is a vast literature on human experimentation, including on the methodology for obtaining the necessary ethical clearance to the research. In brief, this methodology requires the researchers to apply to an appropriate local research ethics committee for approval. That group will want to be certain of matters such as the soundness of the underlying science, the freedom of participants to refuse involvement, confidentiality, follow-up, and safety. Those engaging in research should make themselves aware of local approval structures; understanding the detail of the Declaration of Helsinki is an excellent start to writing a research protocol. It should be readily understood that the intention of the ethical principles is to prevent abusive research and to give the public confidence that if they are asked to participate in research it will be properly designed, delivered, controlled, and monitored.

## Trust and language

The basis of all medical treatment is that patients and health-care professionals, especially doctors, trust one another. Doctors trust their patients to tell them the truth, to give accurate medical histories, and to cooperate with the care they are offered. Patients trust doctors to do their best for them, and not to unfairly discriminate against them on any grounds. Fair discrimination, however, is not only ethically acceptable but is a requirement of good practice; this means discrimination based upon need.

Trust is earned. Given that many patient–doctor relationships are established at the time of a health-care emergency, the earned trust is generic; it relates not to that patient with that doctor, but to that patient and his or her experience of doctors in general. Trust may not be present if the patient has had previous negative experiences of medical interventions, or comes from a culture where that trust has not generally been earned. Given that in many conflicts young soldiers will have little personal experience of or interactions with health-care professionals and may also see them as part of an establishment against which they are rebelling, trust may not exist.

Where patients and health-care workers come from opposing sides in a conflict, the trust can be undermined by suspicion, and indeed by fear, coercion, or violence. This should be understood and directly addressed in communications between patient and doctor.

The health-care professional may then find themselves during an emergency having to spend an unexpectedly large amount of time explaining who

they are, how they reach decisions, what they can offer, how they will support the patient, and how the patient will be helped and enabled to make his or her own decisions.

Good communication is always essential in any patient–doctor relationship. Given that the role of the doctor is to make a diagnosis and, based upon his or her clinical experience and knowledge of the evidence, make a treatment recommendation, an ability to discuss options with the patient is clearly essential. In the absence of inherent trust, that communication will be both more difficult and even more important. In conflicts where international forces are present, including in so-called peacekeeping roles, major providers of health care are unlikely to speak the same language as local people, who will constitute a variable but often high percentage of the wounded. In some conflict situations, communication will be inhibited by such language difficulties. While translators can help, they may not be readily accessible to all, or indeed at all hours of the day or night when the need for them arises. Translators may be employed to work primarily in areas away from the clinical front line and may struggle with explaining all of the nuanced clinical information.

Other combatants, or in some cases family members, village elders, and others might be enlisted to help with translation. This can be very dangerous; the doctor cannot know how accurate the translation is, nor can they know whether the patient is comfortable talking through these individuals. Nor can the doctor know whether the informal translator is conveying the subtleties and nuances of his role and in particular the respect he will pay to the patient's decision-making.

If, for example, the patient is seeking medical advice after a sexual assault, an incident which occurs commonly in conflict as well as in peacetime, confidentiality is a prerequisite for those seeking help. In many societies the victim may be blamed as much as the aggressor, and the assault may bring shame on his or her family or even threaten his or her life. Asking family members to translate is clearly inappropriate in these circumstances. Other informal translators are equally unacceptable as they may have connections to the victim's family and social setting that are unknown to the health-care worker. Professional translators should be trained to understand their role as well as to ensure that they are able to translate the necessary medical language.

This essay has already discussed consent, based upon the concept that nothing should be done to an individual without their prior agreement or consent, freely given. If the health worker cannot communicate to the patient what the diagnosis is, what the treatment options are, and what the consequences of that treatment or its refusal might be, and subsequently answer the patient's questions, then consent cannot be given. Treatment given in these circumstances is probably illegal and constitutes battery. It certainly is unethical. If only an informal translation is available, neither the doctor nor the patient can know if what is passed on is accurate and complete; incomplete or inaccurate information is likely to undermine trust.

Much of communication is non-verbal. This is often highly culturally and socially specific; signs taken as assent or dissent in one population may not read

directly across in another. Where this is added to linguistic difficulties, serious misunderstandings can arise.

In cases where health-care workers are going to treat those with whom they have no common language, they should ensure that translators are provided and should rely as little as possible on informal or family-based assistance. When only such informal assistance is available, they should attempt to ensure that the patient is satisfied with the person providing help.

## Attacks on health-care institutions, personnel, and patients

Attacks against health-care institutions, personnel, and patients are becoming increasingly common and are the subject of the major ICRC project Health Care in Danger.<sup>11</sup> Those working in conflict zones must be aware of the risks they and their colleagues face. They are not expected to continue despite all dangers, but should bear in mind their safety and that of others. Developing trust and understanding with the local community may play a major role in avoiding such attacks.

## Specific ethical challenges for military doctors working outside their area of competence

Military physicians work as clinicians in a variety of clinical sectors. They may also work in fields of warfare and undertake roles which are less traditional, or within areas otherwise seen as specialist, and for which they have received less training. It is often while undertaking roles for which they are less well prepared, through postgraduate and continuing medical education, that doctors might make errors of ethical judgement.

Within the traditional clinician role, military doctors face dilemmas that differ from those of routine civilian medical practice. These will include coping with different cultural expectations, matters of trust, confidentiality, assessments of capacity, and dual obligations. There are also issues of triage, complicated by factors such as the pre-morbid role of the patient and the options for treatment outside the military setting. The nature of work during armed conflict is such that there may be occasions where the doctor feels that the necessary treatment for the injured or sick person is outside his or her area of competence. The doctor might, for example, be a good general surgeon but with little experience in dealing with chest injuries or head injuries, and be presented with such a patient.

The ethical duty of the doctor is to work within his or her level of competence and not to take on, or agree to undertake even if ordered by others, something outside that area of competence. If the doctor who feels less than competent to undertake a task also recognises that the injury is such that only immediate intervention can save the life of the patient, or potentially prevent very

11 For more information, see the website of the Health Care in Danger project: [www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-health-care-in-danger-project.htm](http://www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-health-care-in-danger-project.htm) (last visited May 2013).

serious sequelae, and he is the only person present or able to be present within a reasonable timescale, then the doctor might decide that his semi-skilled intervention is a better option for the patient than no intervention at all or the intervention of someone even less skilled. The decision is based upon an honest assessment of what is best for the patient, and of the alternative options available. The well-being of the patient is, as always, the first consideration of the doctor.

If this was a commonly seen injury then the chain of command should have provided a suitably experienced practitioner. Those working in areas where specific injuries are commonly seen should also take reasonable steps to increase their own skill sets to deal with such injuries.

## Detainees

In armed conflict situations, doctors and other health-care workers may find themselves caring for enemy combatants and non-combatants, and may unexpectedly become responsible for prisoners. In most such circumstances the doctor or other health-care worker is in that location because he or she is, for example, a skilled field surgeon with probably no experience or training in the mixed public health and primary care role needed when caring for the health of detainees.

The key factor to remember is that persons deprived of their liberty as a result of armed conflict are protected by IHL.<sup>12</sup> Doctors in the armed forces asked to look after detainees should understand their IHL obligations,<sup>13</sup> as well as the rules binding the detaining authorities in order to protect detainees.

As patients, those detainees still enjoy the right to ethically proffered medical care; they have the same rights to consent, to refuse treatment, to expect confidentiality, to be treated by competent practitioners, and so on.

One area that doctors should be considering is the public health and preventative care needs of prisoners. Doctors need to be aware in detail of the conditions of detention and consider what the medical implications might be. Tuberculosis is a common disease around the world. Overcrowded prisons, especially with dampness and poor ventilation and with inadequate nutrition for the prisoners, become very rapid breeding grounds for cross-infection. Doctors need to look closely at these conditions, and if they suspect a prisoner might be a potential source of infection, to seek ways of protecting other inmates.

12 In situations of international armed conflict, prisoners of war and civilian detainees are protected by the Third Geneva Convention relative to the Treatment of Prisoners of War, and the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War, as well as by customary rules (see ICRC, *Customary International Humanitarian Law, Vol. I: Rules*, Jean-Marie Henckaerts and Louise Doswald-Beck (eds.), Cambridge University Press, Cambridge, 2005, specifically chapter 37). In situations of non-international armed conflict, persons deprived of liberty for reasons related to the conflict are protected by Article 3 common to the Geneva Conventions, and by the Protocol Additional to the Geneva Conventions of 12 August 1949 and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), as well as by applicable customary rules.

13 For more information about the responsibilities of health-care personnel working in armed conflicts and other emergencies, see ICRC, above note 1.

Given that abuse of detainees is sadly commonplace, it is strongly advised that detainees should be medically examined as soon as possible after their placement in detention and a record kept of any injuries that might, for example, have been sustained at the time of placement in detention. If medical aid is needed, whether for an injury or for another incidental illness, the doctor must ensure that this is provided in a timely manner. Such an examination should ideally be performed by a doctor, but in the absence of a doctor any other health worker, including a first-aider, should be called upon to record the prisoner's condition at the time of detention. Prisoners must, as with all other medical examination or treatment, have the right to refuse. On occasion the prisoner may refuse to be examined. Given that trust between the prisoner and the detaining authorities is unlikely to be high, this is completely understandable. In such cases only the information about what can be seen from an inspection can be recorded, but the doctor should seize the opportunity to try to build some trust, not least by explaining that his role is not as an enemy military officer but as a doctor with an interest solely in the welfare and well-being of the prisoner.

Ideally such examinations of the detainee's current medical condition should be performed every time a detainee is moved from one site to another, upon leaving the site, and upon arrival at the destination to ensure abuse does not occur during the transportation. A regular review of the health of all detainees should be part of the general duties of the medical officer in charge of the detention facility.

### Ill-treatment

Doctors are often the first to see evidence of the abuse of detainees, or of vulnerable members of their own forces. Such signs may well be subtle; abused persons often develop skills at concealing their abuse. Health workers may well also be reluctant to suspect abuse, especially where the abusers may be their comrades or friends. The WMA in its Tokyo Declaration has set out ethical *Guidelines for Physicians Concerning Torture and other Cruel, Inhuman and Degrading Treatment or Punishment in relation to Detention and Imprisonment*.<sup>14</sup>

In such cases the doctor must understand that their role is not simply to treat the signs and symptoms but to intervene to stop the abuse. This is both good preventative medicine and an ethical requirement. Medical examinations should be repeated from time to time, and whenever a detainee is moved to a new institution, as part of both a general health check and as a preventative against abuse.

As stated above in the case of detainees, doctors must also be aware of the conditions of detention (which may amount to degrading or even cruel or inhuman treatment). Without such knowledge, they will be unlikely to know what diseases or injuries are likely or to be able to ensure that interventions are undertaken to reduce

14 WMA Declaration of Tokyo, *Guidelines for Physicians Concerning Torture and other Cruel, Inhuman and Degrading Treatment or Punishment in relation to Detention and Imprisonment*, October 1975, adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975, and last revised at the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006, available at: [www.wma.net/en/30publications/10policies/c18/](http://www.wma.net/en/30publications/10policies/c18/) (last visited November 2012).



the medical risks. If the doctor does not know that a detainee is being held in a place that is cold and damp, he or she may ignore risks of specific illnesses, including for example tuberculosis. Similarly, if the doctor does not know about the other threats to detainees, including of beatings by guards or by fellow inmates, he or she will be unable to look for and act on the injuries that might be sustained.

In terms of deliberate ill-treatment, doctors have a key role to play. Everyone is protected from torture and cruel, inhuman, and degrading treatment under both IHL and human rights law. Where torture or cruel treatment (involving severe pain or suffering) is perpetrated, doctors are likely to see the results: bruises, burns, other marks, and equally some of the psychological sequelae. At this point they must intervene and voice their suspicions to the local military chain of command, and if the abuse does not stop immediately, to the medical chain of command. Senior officers in both of these chains of command have obligations with respect to the prohibition of torture and ill-treatment; the medical chain consists of officers who also have an ethical duty to ensure a humane treatment of prisoners. Doctors taking such steps must also be protected from attacks by colleagues or others aimed at discouraging such intervention.<sup>15</sup>

It is understandable that doctors who are primarily working in the military as field surgeons, anaesthesiologists, and related specialists may find acting as a prison doctor confusing. There should be good learning materials available from their medical military command lines to ensure they have the necessary advice. Keeping in their minds that the welfare of their patient, the detained person, remains their first ethical duty helps to ensure the right instinctive behaviour.

Medicine in armed conflict offers great challenges to doctors, in clinical terms and in ethical terms. Keeping in mind that the patient is the most important person, that his or her duty as a doctor is to care holistically for that patient, will help keep the doctor to remain on the right ethical track.

## Conclusion

Medical ethics is an agreed system that both sets limits on the freedom of doctors and other health-care professionals, and forms the basis of what the public can expect from the people they go to for their health needs. It is not a set of simple rules, but involves the need to balance rights and duties to individual patients and to society. Practitioners need to consider every day and in every decision they make what the ethical dilemmas are and how best to resolve them in each particular case.

For ethical principles to work, health-care practitioners need to be comfortable and skilled with using them and with analysing problems in order to apply them. Ethical principles also need to be understood by the people who employ

15 WMA Declaration of Hamburg, *Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment*, adopted by the 49th WMA General Assembly, Hamburg, Germany, November 1997, and reaffirmed by the 176th WMA Council Session, Berlin, Germany, May 2007.

and direct the work of those health-care practitioners who are those most able to ensure that the best conditions are in place to allow their application. Health-care practitioners need training throughout their medical careers in ethical analysis based upon real clinical situations. There is a real opportunity for dialogue after such training with those in a position to change the situation to one conducive to high ethical principles being applied.

Untrained health-care professionals can get into real difficulties; it is clear that in the recent UK engagement in Iraq, doctors in charge of detainees were not trained in handling such duties and were not directed to relevant training or policy material. Since then the Ministry of Defence has committed to ensuring that such doctors are trained and aware of the specifics, especially if they are to be responsible for detainees.

Given that, as shown above, it is easy to identify situations in which ethical principles are placed under specific tensions during conflict, it is especially important that those going into conflict zones are aware of these tensions and have help in applying the specific tools necessary. The British Medical Association toolkit and the ICRC publication on the responsibilities of health-care personnel<sup>16</sup> are especially valuable, as both are designed to help people working in just these circumstances. Health-care workers are also advised to read more widely about medical ethics, and to practise using ethical analysis while still in situations where they can get the benefit of advice from others.

Ethics protects the public, but it also protects doctors and other health-care workers who have entered their professions to help others. Ethics, above all, underpins the humanitarian and caring elements of medical practice; it is a tool that aids in ensuring high quality of care to all.

16 See BMA, above note 9; and ICRC, above note 1.



## OPINION NOTE

# Can the incidental killing of military doctors never be excessive?

**Laurent Gisel\***

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### Abstract

*Military medical personnel and objects, as well as wounded and sick combatants, are protected against direct attack under the principle of distinction in international humanitarian law. However, some authors argue that they are not covered by the principles of proportionality and precautions. This opinion note explains that military medical objects constitute civilian objects under the rules governing the conduct of hostilities. It also demonstrates that, in view of the object and purpose of the First Additional Protocol to the Geneva Conventions, expected incidental casualties of military medical personnel and wounded and sick combatants must be included among the relevant incidental casualties under the principles of proportionality and precautions. This stems in particular from the interpretation of the obligation ‘to respect and protect’ as the overarching obligation of the special protection afforded to all medical personnel and wounded and sick. Support for this conclusion can be found in a number of military manuals and in the Additional Protocol’s preparatory work and Commentaries. This conclusion also reflects customary law.*

**Keywords:** international humanitarian law, conduct of hostilities, proportionality, precautions, incidental casualties, civilian objects, military objectives, military medical personnel, military medical objects, wounded and sick combatants, respect and protection of the medical mission.

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A century and a half ago, the first codification of what became known as ‘Geneva Law’ afforded protection to military medical personnel and objects, as well as wounded and sick combatants.<sup>1</sup> It is today undisputed that they are all protected against direct attack, under the specific rules protecting medical personnel, units, and transports, and the wounded and sick (hereinafter ‘the special protection’),<sup>2</sup> as well as under the rules governing the conduct of hostilities.<sup>3</sup>

However, some authors have recently claimed that military medical personnel and objects or wounded and sick combatants would not be protected by the principles of proportionality and precautions because the relevant rules in the First Additional Protocol refer only to incidental loss of *civilian* life, injury to *civilians*, and damage to *civilian* objects. Solis notably states that ‘the presence of noncombatant members of the armed forces at a military objective does not require an attacking enemy to take any special precautionary measures, as would the presence of civilians’,<sup>4</sup> while Henderson<sup>5</sup> and Bartels<sup>6</sup> argue that military medical units, military medical personnel, or persons *hors de combat* such as wounded soldiers do not benefit from the protection of the principle of proportionality. This reading would mean that, except for the prohibition on indiscriminate attacks, the rules governing the conduct of hostilities would not restrain the incidental killing or injuring of military medical personnel and wounded and sick combatants, nor

- 1 Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, Geneva, 22 August 1864. In this note, the terms ‘wounded and sick’ are used as defined in Art. 8(a) of the Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, 8 June 1977, 1125 UNTS 3 (entered into force 7 December 1978) (hereinafter AP I). This definition is also relevant for non-international armed conflicts: see Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds.), *Commentary on the Additional Protocols*, ICRC, Geneva, 1987 (hereinafter ICRC Commentary), para. 4637.
- 2 Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950) (hereinafter GC I); Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of 12 August 1949, 75 UNTS 85 (entered into force 21 October 1950) (hereinafter GC II); Arts. 8ff of AP I; Arts. 7ff of the Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts, 8 June 1977, 1125 UNTS 609 (entered into force 7 December 1978) (hereafter AP II); ICRC, *Customary International Humanitarian Law, Vol. I: Rules*, Jean-Marie Henckaerts and Louise Doswald-Beck (eds), Cambridge University Press, Cambridge, 2005 (hereinafter ICRC Customary Law Study), Rules 25–30 and 109–111.
- 3 Arts. 41 and 48 *in fine* of AP I; Rule 1, second sentence, of the ICRC Customary Law Study, above note 2.
- 4 Gary D. Solis, *The Law of Armed Conflict: International Humanitarian Law in War*, Cambridge University Press, Cambridge, 2010, p. 191.
- 5 Ian Henderson, *The Contemporary Law of Targeting: Military Objectives, Proportionality and Precautions in Attack under Additional Protocol I*, Martinus Nijhoff Publishers, Leiden, 2009, pp. 195–196 (for medical units) and p. 206 (for medical personnel).
- 6 Rogier Bartels, ‘Dealing with the principle of proportionality in armed conflict in retrospect: the application of the principle in international criminal trials’, in *Israel Law Review*, Vol. 46, No. 2, July 2013, p. 304. While Bartels argues on the basis of Art. 50 of AP I that persons *hors de combat* other than civilians, such as wounded soldiers, do not benefit from the protection of the principle of proportionality under AP I or the Rome Statute, he is not entirely clear on whether he considers that this protection exists under customary IHL; he indeed asserts that ‘[i]t is submitted here that the principle of proportionality is broader than the rules that codified the principle in Additional Protocol I. The principle underlying Articles 52 and 57 of Additional Protocol I would include prohibited attacks on military objects that would cause excessive damage to any person who cannot be targeted directly under IHL; not only civilians but also persons *hors de combat*’ (p. 304). Bartels’ arguments with regard to Art. 8(2)(b)(iv) of the Rome Statute are outside of the scope of this opinion note.

incidental damage to military medical objects, when attacks are directed against able-bodied combatants or military objectives.

The International Committee of the Red Cross (ICRC) holds the opposite view.<sup>7</sup> To be able to provide with the least possible delay the medical care and attention required by the wounded and sick, medical personnel, units, and transports – especially military ones – often have to operate in proximity to the fighting, especially during urban warfare. It is thus particularly important to uphold their protection against incidental loss of life, injury, or damage.

The issue at stake is limited to military medical personnel and objects, as well as wounded and sick combatants. Indeed, civilian medical personnel and objects, as well as wounded and sick civilians, remain civilian persons and objects and are protected as such under the rules governing the conduct of hostilities. This opinion note will thus consider the question of whether the expected incidental killing or injury of *military* medical personnel or wounded and sick *combatants* and damage to *military* medical objects are relevant under the principles of proportionality and precautions.

After recalling the content of the principles of proportionality and precautions, this note discusses the question of whether military medical objects fall under the definition of military objectives or actually constitute civilian objects. It then turns to persons, and analyses the protection against incidental loss of life or injury under both the specific rules protecting medical personnel and the wounded and sick, and the rules governing the conduct of hostilities. This note argues that it would run counter to these rules to exclude military medical personnel and objects as well as wounded and sick combatants from the evaluation of the relevant incidental harm for the purposes of applying the principles of proportionality and precautions. It finally shows that some support for an inclusive position can be found in state practice and in the preparatory work of the First 1977 Additional Protocol to the Geneva Conventions (AP I). This note thus concludes that all feasible precautions must be taken to avoid, or at least minimise, incidental harm to military medical personnel and objects as well as wounded and sick combatants. If such incidental harm is expected to be excessive compared to the direct and concrete military advantage, it renders the attack unlawful by virtue of the principle of proportionality.

This note assumes that military medical personnel and objects do not commit (or are not used to commit), outside of their humanitarian function, acts harmful to the enemy, and that wounded and sick combatants refrain from any act of hostility.<sup>8</sup>

7 'In the ICRC's view, any assessment of the expected incidental harm under the rule of proportionality must take into account possible deaths or injuries among all the medical personnel, including military medical personnel, as well as combatants who are *hors de combat*. This stems from the central obligation to respect and protect these persons': 14th Bruges colloquium, 17 and 18 October 2013, keynote address by Ms. Christine Beerli, ICRC vice-president, available at: [www.icrc.org/eng/resources/documents/statement/2013/10-18-protected-person-bruges.htm](http://www.icrc.org/eng/resources/documents/statement/2013/10-18-protected-person-bruges.htm) (last visited 3 April 2014). See also the article by Alexander Breitegger in this issue of the *Review*.

8 For medical persons and objects, see Art. 21 of GC I, Art. 13 of AP I, Art. 11 of AP II, and Rules 25, 28 and 29 of the ICRC Customary Law Study, above note 2. For the wounded and sick, see the definition under Art. 8(a) of AP I.

## The principles of proportionality and precautions

The principles of proportionality and precautions are mainly outlined in Articles 51, 57, and 58 of AP I, which reflect customary international humanitarian law (IHL) in international and non-international armed conflicts on most, if not all of these aspects.

The principles of proportionality and precautions do not forbid all incidental harm to persons and objects protected against direct attack. However, they do impose limits on such harm. The principle of proportionality forbids attacks that may be expected to cause incidental civilian casualties, and damage to civilian objects, which would be excessive in relation to the concrete and direct military advantage anticipated.<sup>9</sup> The principle of precautions requires the parties to the conflict to take constant care in the conduct of military operations to spare the civilian population and civilian objects; a number of specific rules are derived from this principle that are designed to avoid or at least minimise incidental casualties and damage when carrying out an attack.<sup>10</sup> The parties to the conflict must also take all feasible precautions to protect the civilian population and civilian objects under their control against the effects of attacks.<sup>11</sup>

Among the rules stemming from the principle of precautions, the obligations to take all feasible precautions to verify that the target is a military objective, and to cancel or suspend an attack if it becomes apparent that this is not the case, expressly include the obligation to verify that the objective to be attacked is not subject to *special protection*. This is a verification that goes beyond the check that the targets are neither civilians nor civilian objects.<sup>12</sup> Military medical personnel and objects, as well as wounded and sick combatants, are obviously all subject to such special protection.

Conversely, all other rules stemming from the principle of precautions,<sup>13</sup> as well as the principle of proportionality,<sup>14</sup> mention only the expected incidental

9 Art. 51(4) of AP I; Rule 14 of the ICRC Customary Law Study, above note 2.

10 Art. 57 of AP I; Rules 15–21 of the ICRC Customary Law Study, above note 2.

11 Art. 58 of AP I; Rules 22–24 of the ICRC Customary Law Study, above note 2.

12 'Article 57 – Precautions in attack

[...]

2. With respect to attacks, the following precautions shall be taken:

(a) those who plan or decide upon an attack shall:

(i) do everything feasible to verify that the objectives to be attacked are neither civilians nor civilian objects *and are not subject to special protection* but are military objectives within the meaning of paragraph 2 of Article 52 and that it is not prohibited by the provisions of this Protocol to attack them;

[...]

(b) an attack shall be cancelled or suspended if it becomes apparent that the objective is not a military one *or is subject to special protection*' (emphasis added).

13 Arts. 57(1) and 57(5) of AP I speak of 'the civilian population, civilians and civilian objects'; Art. 57(2)(a)(ii) of 'loss of civilian life, injury to civilians and damage to civilian objects'; Art. 57(2)(c) of 'the civilian population'; Arts. 57(3) and 57(4) of 'civilian lives and civilian objects'; and Art. 58 of 'the civilian population, individual civilians and civilian objects'.

14 Arts. 51(5)(b), 57(2)(a)(iii), and (57)(2)(b), second sentence, of AP I all speak of 'loss of civilian life, injury to civilians, damage to civilian objects, or a combination thereof'.



civilian casualties and damage to civilian objects. On that basis, one could claim that these rules do not cover protected persons and objects other than civilians and civilian objects. It will be shown that a closer reading of the law does not support this conclusion.

## **Military medical objects are civilian objects under the rules governing the conduct of hostilities**

Military hospitals and other places for collecting sick and wounded combatants were already protected under the early expression of the principle of precautions found in the 1907 Hague Regulations – which have been considered to reflect customary IHL<sup>15</sup> – as it covered them without distinction based on their military or civilian character: ‘In sieges and bombardments all necessary steps must be taken to spare, as far as possible, . . . hospitals, and places where the sick and wounded are collected, provided they are not being used at the time for military purposes.’<sup>16</sup>

Under contemporary IHL, the matter can be put to rest easily for military medical transports and units, and more generally for all military medical objects (including blood bank reserves, medicines, or other purely medical supplies or equipment even outside of a medical unit). Insofar as objects are concerned, treaty and customary IHL defines military objectives as follows:

military objectives are limited to those objects which by their nature, location, purpose or use make an effective contribution to military action and whose total or partial destruction, capture or neutralization, in the circumstances ruling at the time, offers a definite military advantage.<sup>17</sup>

By requiring that the object makes an effective contribution to military action, and that the military advantage be definite, this definition excludes notably objects that only make an indirect contribution or advantages that are only hypothetical or speculative.<sup>18</sup> It was carefully crafted to avoid an overly broad understanding of the notion of military objective that would undermine the principle of distinction.

15 Report of the Secretary-General Pursuant to Paragraph 2 of Security Council Resolution 808 (1993), S/25704, 3 May 1993, para. 41. International Criminal Tribunal for the former Yugoslavia (ICTY), *The Prosecutor v. Duško Tadić*, Case No. IT-94-1, Decision on the Defence Motion for Interlocutory Appeal on Jurisdiction, 2 October 1995, para. 87.

16 Convention (IV) respecting the Laws and Customs of War on Land and its annex: Regulations concerning the Laws and Customs of War on Land, The Hague, 18 October 1907 (entered into force 26 January 1910), Regulations, Art. 27(1). The same provision is found in the 1923 Hague Rules on Air Warfare, Art. XXV; see ‘General Report of the Commission of Jurists at the Hague’, in *The American Journal of International Law*, Vol. 17, No. 4, Supplement: Official Documents, October 1923, pp. 242–260.

17 Art. 52(2) of AP I; Rule 8 of the ICRC Customary Law Study, above note 2.

18 Knut Doermann, ‘Obligations of international humanitarian law’, in *Military and Strategic Affairs*, Vol. 4, No. 2, September 2012, pp. 11–23, p. 15; Michael Bothe, Karl Josef Partsch and Waldemar A. Solf, *New Rules for Victims of Armed Conflicts*, Martinus Nijhoff Publishers, The Hague, 1982, p. 326; Marco Sassòli and Lindsey Cameron, ‘The protection of civilian objects: current state of the law and issues de lege ferenda’, in Natalino Ronzitti and Gabriella Venturini (eds), *The Law of Air Warfare: Contemporary Issues*, Eleven International, The Hague, 2006, pp. 35–74, p. 48.

Despite the fact that they form part of the military, at least as long as they are not used outside of their humanitarian function to commit acts harmful to the enemy,<sup>19</sup> military medical objects do not make an effective contribution to military action and their destruction cannot be considered to offer a definite military advantage. As they do not fulfil either of the two cumulative conditions set by the definition of military objective, they do not constitute military objectives. Henderson's assertion that military medical units *prima facie* would meet the test for a military objective is thus not supported by a closer reading of the definition of military objective under IHL.<sup>20</sup>

Civilian objects are defined in Article 52(1) of AP I and customary IHL<sup>21</sup> as *all* objects which are not military objectives as defined in Article 52(2) of AP I. Whatever the usual or colloquial meaning of the terms, military medical transports, units, and other military medical objects are therefore 'civilian objects' under the law governing the conduct of hostilities.<sup>22</sup> This conclusion is reinforced by the ICRC Commentary on the 1973 Draft Additional Protocols.<sup>23</sup> As long as they do not fulfil the definition of military objectives, military medical objects are thus covered by all the protections afforded to civilian objects under the rules governing the conduct of hostilities. This includes the obligation to take into consideration the expected incidental damage to military medical transports, units, or other military medical objects in proportionality assessments, and the obligation to take all feasible precautions to avoid or at least minimise incidental damage to such objects. It has to be noted that this conclusion also stems from the provisions affording special protection to medical objects, as will be developed below for persons.

19 'To be used, outside of their humanitarian function, to commit acts harmful to the enemy', is the standard leading to the loss of the special protection afforded to medical objects because of their function (subject to other safeguards such as the obligation to issue a warning); cf. Art. 21 of GC I and Art. 13 of AP I; Rules 28–29 of the ICRC Customary Law Study, above note 2.

20 Henderson, above note 5, p. 195. Henderson also develops a somewhat circular reasoning according to which medical objects were granted special protection because they were military objectives in the first place, which proves they are not entitled to the general protection granted to civilian objects. This would arguably mean that civilian medical units – or any other specially protected object (or person) – should also be considered a military objective because otherwise they would not need the special protection. In the view of this author, this argument is therefore also not convincing.

21 Rule 9 of the ICRC Customary Law Study, above note 2.

22 Rule 22(a) of the *Manual on International Law applicable to Air and Missile Warfare*, HPCR, Bern, 2009 (hereafter *HPCR Air and Missile Warfare Manual*) specifically excludes medical transports from military vehicles when giving examples of military objectives by nature. Dinstein gives the same argument with regard to POW camps: see Yoram Dinstein, *The Conduct of Hostilities under the Law of International Armed Conflict*, 2<sup>nd</sup> ed., Cambridge University Press, Cambridge, 2010, para. 305.

23 The ICRC Commentary on the 1973 Draft Additional Protocols makes it clear when talking about paragraphs that included notably the draft proportionality rules (draft Arts. 50(1)(a) and (b), which became Arts. 57(2)(a)(i) and (iii) and 57(2)(b) of AP I): 'All these various factors with their probable or possible effects on protected civilians and civilian objects must therefore be borne in mind when planning, deciding (sub-paragraph (a)) and launching (sub-paragraph (b)) the attack'. A footnote attached to the words 'civilian objects' clarifies: 'Not only within the meaning of Art. 47 (2) [which listed 'objects designed for civilian use ... and all objects which are not military objectives'], but any object protected under existing treaty law or customary international law (civilian and *military hospitals*, cultural objects, hospital and safety zones, etc.)' ICRC, *Draft Additional Protocols to the Geneva Conventions of August 12, 1949, Commentary*, Geneva, 1973, p. 65, fn. 32 (emphasis added).

## Military medical personnel and wounded and sick combatants must be included in the notion of ‘incidental casualties’

Article 50(1) of AP I defines civilians as follows:

A civilian is any person who does not belong to one of the categories of persons referred to in Article 4 A (1), (2), (3) and (6) of the Third Convention and in Article 43.

Article 43 of AP I defines the armed force of a party to a conflict. Thus, put otherwise, civilians are persons who are not members of state armed forces,<sup>24</sup> or (for non-international armed conflicts) of an organised armed group of a non-state party to a conflict.<sup>25</sup> Henderson’s and Bartels’ positions excluding medical personnel and wounded and sick combatants from the relevant ‘incidental casualties’ evaluation under the principle of proportionality is based on the definition of civilians as expressed in Article 50 of AP I.<sup>26</sup>

The argument developed above for objects cannot simply be mirrored for persons. It is nevertheless submitted that military medical personnel and wounded and sick combatants must be included in the notion of ‘incidental casualties’ for the purposes of applying the principles of proportionality and precautions. This stems from the interpretation of the specific rules protecting medical personnel and the wounded and sick, as well as of the rules governing the conduct of hostilities.

### Persons cannot be less protected than objects

It would make no sense that military medical *objects* would be protected by the principles of proportionality and precautions while military medical *personnel* would not. Beyond setting little store on the value of human life compared to objects, this would go against the fundamental rationale of the special protection, which is the same for both military medical personnel and objects – namely, to grant them this protection on account of their function of ensuring medical care and attention to the wounded and sick.

### The special protection is more stringent than the rules protecting the civilian population

The specific rules protecting medical personnel, transports, and units are in some aspects more stringent than the rules protecting the civilian population.<sup>27</sup> Protective

24 Rule 5 of the ICRC Customary Law Study, above note 2. Participants in a *levee en masse* are also not civilians: see Art. 4(A)(6) of the Geneva Convention relative to the Treatment of Prisoners of War of 12 August 1949, 75 UNTS 135 (entered into force 21 October 1950).

25 For the concept of civilian in non-international armed conflict, see ICRC, *Interpretive Guidance on the Notion of Direct Participation in Hostilities under International Humanitarian Law*, 2009, pp. 27ff.

26 I. Henderson, above note 5, p. 206; R. Bartels, above note 6, p. 304.

27 For example, the special protection afforded to medical personnel, transports, and units, whether military or civilian, will cease only after due warning has been given (Art. 21 of GC I, Art. 19 of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field

emblems have been established to display this special protection, precisely to ensure that these personnel, transports, and units are protected against the danger of hostilities. Besides being counterintuitive, it is thus contrary to the system of the special protection to claim that specially protected persons are less protected than those afforded general protection for being civilians.

### The obligation to ‘respect and protect’ medical personnel and the wounded and sick encompasses the obligation to avoid their incidental killing or injury

Fundamentally, the obligation to avoid or at least minimise the incidental killing or injury of medical personnel and the wounded and sick, as well as the prohibition of causing excessive incidental harm to them, stems directly from the obligation to ‘respect and protect’ them.

Contrary to the prohibition on direct attacks against medical units or combatants *hors de combat*,<sup>28</sup> the prohibition on direct attacks against *military medical personnel* is nowhere expressly stated. It is however undisputed and stems directly from the broader obligation to respect and protect medical personnel. There is no apparent reason why the obligation stemming from this broader protection would be limited to the prohibition on direct attacks and not extend to all the rules on the conduct of hostilities. In that regard, it is telling that the very same words, to ‘respect and protect’, are used in the basic rule protecting civilians against the danger of hostilities<sup>29</sup> and in the rules protecting the wounded and sick and medical personnel, civilian and military alike.<sup>30</sup> With regard to wounded and sick soldiers, the ICRC Commentary on the First Geneva Convention, which came out 20 years before the adoption of AP I, already clarified that:

The word ‘respect’ . . . means . . . ‘to spare, not to attack’ . . . whereas ‘protect’ . . . means ‘to come to someone’s defence, to lend help and support’ . . . . The introduction of these words made it unlawful for an enemy to attack, kill, illtreat or in any way harm a fallen and unarmed soldier, while it at the same time

of 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950) (hereafter GC IV), Art. 13 of AP I, and Art. 11 of AP II), whereas no warning is required before directing an attack against a civilian (other than civilians entitled to special protection such as civilian medical personnel) who takes a direct part in hostilities.

28 See Art. 19(1) of GC I, Art. 12(1) of AP I, and Art. 11(1) of AP II for medical units, and Art. 41 of AP I for persons *hors de combat*. The rules on the protection of the medical mission neither expressly prohibit direct attacks on civilian medical personnel (see Art. 20 of GC IV and Art. 9 of AP II), though they enjoy the protection of the general prohibition of directing attacks against civilians.

29 See Art. 48 of AP I, which opens Part IV of the First Additional Protocol, in which all three principles of distinction, proportionality, and precautions are developed.

30 For the wounded and sick, see Art. 12 of GC I, Art. 10 of AP I, and Art. 7 of AP II. For medical personnel, see Art. 24 of GC I, Art. 20 of GC IV, Art. 15 of AP I, and Art. 9 of AP II; Rule 27 of the ICRC Customary Law Study, above note 2. The ICRC Commentary on Art. 48 of AP I (above note 1, para. 1872) makes the link between the words used in Arts. 10 and 48 of AP I.

imposed upon the enemy an obligation to come to his aid and give him such care as his condition required.<sup>31</sup>

This understanding was equally valid for the obligation to respect and protect military medical personnel<sup>32</sup> and was confirmed after the adoption of AP I.<sup>33</sup> Bugnion explains that ‘protection is a duty to act. It requires the belligerents to take all precautions in attack and defense so as to avoid exposing wounded and sick military personnel gratuitously to danger.’<sup>34</sup>

In the context of civilian hospitals, the ICRC Commentary on the 1949 First Geneva Convention already emphasised that the special protection was meant to extend to incidental damages:

The prohibition must therefore be regarded as wider in its significance [than the prohibition of attacks deliberately directed against hospitals]; . . . the belligerents are under a general obligation to do everything possible to spare hospitals. . . . When attacking such [military] objectives, the attacking force is bound . . . to take special precautions to spare hospitals as far as is humanly possible. . . . The general obligation to spare hospitals requires . . . that the two belligerents should take precautions to ensure that hospitals should suffer as little as possible from the attacks and from hostilities in general.<sup>35</sup>

According to Parks, ‘[t]he provisions [Article 19 GC I and 18 GC IV] are important in their recognition of the *shared* responsibility for limiting collateral damage or, put another way, for not placing the responsibility for limiting collateral damage or injury exclusively on an attacker’.<sup>36</sup> This implies that an attacker also has the

31 Jean Pictet (ed.), *Commentary on the Geneva Conventions of 12 August 1949*, Vol. 1: *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, Geneva, 1952, pp. 134–135, on Art. 12 of GC I.

32 *Ibid.*, p. 220, on Art. 12 of GC I. The ICRC Commentary on Art. 19 of GC I again refers to it with regard to military medical units: *ibid.*, p. 196.

33 ICRC Commentary on Art. 10(1) of AP I (above note 1), para. 446: “‘Respect’ means “to spare, not to attack”, while “protect” means “to come to someone’s defence, to lend help and support”. Thus it is prohibited to attack the wounded, sick or shipwrecked, to kill them, maltreat them or injure them in any way, and there is also an obligation to come to their rescue.’ The understanding of the terms ‘respect and protect’ as explained in the Commentaries to GC I and AP I could imply a stronger protection than the prohibition of excessive incidental harm, as they state that it is prohibited to harm, kill or injure them ‘in any way’. On the face of it, this could be said to prohibit *any* incidental harm to these specially protected persons.

34 François Bugnion, *The International Committee of the Red Cross and the Protection of War Victims*, ICRC, Geneva, Macmillan, Oxford, 2003, pp. 471ff.

35 Jean Pictet (ed.), *Commentary on the Geneva Conventions of 12 August 1949*, Vol. IV, *Geneva Convention relative to the Protection of Civilian Persons in Time of War*, ICRC, Geneva, 1958, pp. 147–148, on Art. 18. Here again, Henderson’s argument that ‘nothing in the drafting history of article 19 of GC I . . . indicates that “respected and protected” extends so far as to mean that collateral damage to military medical units must be considered when determining the proportionality of an attack on a nearby military objective’ is unconvincing, even if it would have been made for persons rather than objects (I. Henderson, above note 5, p. 196). In 1949, the proportionality rule had not yet emerged in such clarity as it did in Art. 51 of AP I, so few conclusions can be drawn about it from the drafting history of the Geneva Conventions on proportionality specifically, but the drafting history makes clear that the obligation to respect and protect must be understood broadly.

36 W. Hays Parks, ‘Air war and the law of war’, in *The Air Force Law Review*, Vol. 32, No. 1, 1990, p. 57.

responsibility to limit incidental damage to military hospitals. Though the Commentary and Parks discuss the protection of hospitals, they are relevant here because they shed light on the meaning of the obligation ‘to respect and protect’ in provisions dealing with the special protection of the delivery of medical care and attention.<sup>37</sup>

Similarly, when analysing the scope of the special protection granted to medical units under Article 12 of AP I, the two leading commentaries on the Additional Protocols not only assert that medical units must be included in the relevant incidental damages under the principles of proportionality and precautions; they also express the understanding that this protection extends to persons enjoying the special protection. The ICRC Commentary on AP I confirms that even in the face of violations by the enemy, ‘[a]lthough not explicitly mentioned, these precautions [the precautionary measures provided for in Article 57 (Precautions in attack)] should also be taken with regard to *the wounded and sick*, and consequently the medical units where they are being cared for.’<sup>38</sup> The commentary by Bothe, Partsch and Solf states that:

The first sentence of para. 4 [of Art. 12] is a corollary of Art. 51, para. 7. *Protected* objects and *persons* may not be used to “shield” military targets. . . . Article 12, para. 4 and Art. 19 of the First Convention show that, with respect to collateral damage, the rules which protect the civilian population against such damage constitute also, at least in principle, an adequate solution concerning the same problem as it arises in relation to medical units. Thus, the principle of proportionality applies in this case as well.<sup>39</sup>

Again, this sheds light on the extent of the special protection.

The special protection is granted without distinction with regard to the military or civilian status of the persons entitled to it

The fundamental purpose of the law governing the protection of medical personnel and the wounded and sick codified in the First Additional Protocol is to afford protection *without distinction* with regard to the civilian or military status of these protected persons. The ICRC Commentary on AP I emphasises this point in relation to the wounded and sick: ‘the Protocol covers all wounded, sick and shipwrecked persons, with no distinction between military and civilian persons.’<sup>40</sup> As civilian

37 Such as Art. 10 of AP I and Art. 7 of AP II for wounded and sick, and Art. 24 of GC I and Art. 9 of AP II for medical personnel.

38 ICRC Commentary on Art. 12 of AP I (above note 1), para. 540 (emphasis added).

39 M. Bothe, K. J. Partsch and W. A. Solf, above note 18, p. 118f (emphasis added). The next paragraph confirms that this refers to the principle as stated in Arts. 51(5)(b) and 57(2)(a)(iii) of AP I: ‘In applying the proportionality test to the protection of medical units against collateral damage, everything depends on the concrete situation. The yardstick of proportionality is the concrete and direct military advantage anticipated’ (p. 119).

40 ICRC Commentary on Art. 10 of AP I (above note 1), para. 444. See in particular Arts. 8, 10(1), and 12(1) of AP I, as well as Art. 15 of AP I, which extends to civilians the protection already afforded to military medical personnel by Art. 24 of GC I. The Commentary’s introduction on Part II of AP I states:

medical personnel and wounded and sick civilians are undoubtedly protected by the principles of proportionality and precautions, it would be contrary to this fundamental purpose to exclude military medical personnel or wounded and sick combatants from the protection afforded by these principles.

In view of their object and purpose, the rules governing the conduct of hostilities must take into account incidental harm to persons protected against direct attack without distinction with regard to their military or civilian status

The obligation to afford the same protection to all medical personnel and wounded and sick, whether civilian or military, stems also directly from the rules governing the conduct of hostilities when interpreted in the light of their object and purpose. The rules governing the conduct of hostilities, and in particular the principle of proportionality, aim at finding an appropriate balance between the principles of military necessity and humanity.<sup>41</sup> Civilian and military wounded and sick are entitled to the same care. Both the law and medical ethics impose upon civilian and military medical personnel the same obligation to treat civilian and military wounded and sick, friend or foe, alike. None of them are among the targets considered lawful to weaken the military forces of the enemy, and military medical personnel do not have the right to participate directly in hostilities.<sup>42</sup> They can therefore be said to have the same ‘value’ – or lack thereof – in terms of the principles of military necessity and humanity. To exclude military medical personnel, or wounded and sick combatants, from the protection afforded by the principles of proportionality and precautions would thus introduce in the rules governing the conduct of hostilities a distinction that would be arbitrary in view of their object and purpose – namely, to find an appropriate balance between military necessity and humanity.<sup>43</sup>

‘Finally, let us summarize the points which seem to reflect the essence of the contribution of Part II of Protocol I to the Geneva Conventions:

[...]

2) recognized civilian medical personnel, as well as civilian medical units, will henceforth receive the same protection as that formerly reserved for military medical personnel and units’.

- 41 See Michael N. Schmitt, ‘Military necessity and humanity in international humanitarian law: preserving the delicate balance’, in *Virginia Journal of International Law*, Vol. 50, No. 4, 2010, pp. 795–839, p. 798. On the principle of proportionality as a specific expression of these two principles, see M. Bothe, K. J. Partsch and W. A. Solf, above note 18, p. 309; M. Sassòli and L. Cameron, above note 18, p. 63; W. J. Fenrick, ‘The rule of proportionality and Protocol I in conventional warfare’, in *Military Law Review*, Vol. 98, 1982, p. 125; United Kingdom, *The Joint Service Manual of the Law of Armed Conflict*, JSP 383, 2004, paras. 2.6.2 and 5.33.2.
- 42 Art. 43(2) of AP I. Wounded or sick combatants who directly participate in hostilities are excluded from the definition of wounded and sick under Art. 8(a) of AP I, which requires that they refrain from any act of hostility.
- 43 Though referring to the prohibition of direct attack against an enemy *hors de combat* under Art. 41 of AP I, the ICRC Commentary on AP I recalls that ‘[i]t is a fundamental principle of the law of war that those who do not participate in the hostilities shall not be attacked. In this respect harmless civilians and soldiers “hors de combat” are a priori on the same footing’ (above note 1, para. 1605, emphasis added).



When discussing the protection of persons *hors de combat*, which appears in Part III of AP I on means and methods of warfare, Bothe, Partsch and Solf consider that the principle of proportionality also covers these individuals as they assert that ‘any anticipated collateral casualties of *hors de combat* persons should not be excessive in relation to the military advantage anticipated.’<sup>44</sup>

Finally – and quite to the contrary of Henderson – Bothe, Partsch and Solf use the principle of proportionality to assert the legality of attacks causing collateral damage to medical units: ‘An obvious example that medical units cannot be exempted by law from suffering collateral damage is the existence of sickbays on men of war. If it were inadmissible to subject medical units to collateral damage, no attempt to sink a warship with a sickbay aboard would be permissible.’<sup>45</sup> While this concerns medical units, it is relevant here because it sheds light on the interaction between the rules governing the conduct of hostilities and the special protection.

### Using any protected persons as human shields is a war crime

Finally, the Rome Statute provision on the war crime of using human shields supports the conclusion that all persons protected against direct attack are also protected under the principle of proportionality. Article 8(2)(b)(xxiii) of the Rome Statute lists civilians or other protected persons as those whose presence it is forbidden to use to render certain points, areas, or military forces immune from military operations. It has been recalled in that framework that ‘the presence of protected persons would in the vast majority of cases only influence the proportionality test as defined in Articles 51(5)(b) and 57(2)(a)(iii).’<sup>46</sup> Protected persons other than civilians influence the proportionality test – and thus shield – only insofar as they are included in the relevant expected incidental casualties under that rule. The unqualified inclusion of ‘other protected persons’ in Article 8(2)(b)(xxiii) of the Rome Statute thus confirms that military medical persons and wounded and sick combatants are to be included for the purpose of applying the principle of proportionality.

All these elements demonstrate that, when interpreted in their context and in light of their object and purpose, the specific rules protecting medical personnel and the wounded and sick, as well as the rules governing the conduct of hostilities, must be understood as protecting military medical personnel and wounded and sick combatants against incidental loss of life and injury for the purposes of applying the principles of proportionality and precautions.

44 M. Bothe, K. J. Partsch and W. A. Solf, above note 18, p. 221.

45 *Ibid.*, p. 119

46 Knut Doermann, *Elements of War Crimes under the Rome Statute of the International Criminal Court*, Cambridge University Press, Cambridge, 2002, p. 345.

## Military manuals

Military manuals, which constitute verbal state practice,<sup>47</sup> support the inclusion of protected persons and objects other than civilians and civilian objects among the relevant incidental casualties and damage under the principles of proportionality and precautions. While unsurprisingly many military manuals simply reproduce the wording of the relevant AP I articles, a number of military manuals give definitions that include protected persons and objects other than civilians or civilian objects in the notion of ‘incidental casualties and damages’,<sup>48</sup> or expressly refer to non-combatants or to protected persons and objects when discussing the principles of proportionality,<sup>49</sup> precautions in

47 ICRC Customary Law Study, above note 2 p. xxxviii. On state practice relevance, see Vienna Convention on the Law of Treaties, 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980), Art. 31(3)(b).

48 Australia: *Law of Armed Conflict*, Australian Defence Doctrine Publication 06.4, Australian Defence Headquarters, 11 May 2006, does not limit its definition of collateral damage to civilians or civilian objects in its Glossary (though it does in para. 5.2). United States: *Joint Targeting*, Joint Publication 3-60 (3 January 2013) defines collateral damage as ‘[u]nintentional or incidental injury or damage to *persons or objects that would not be lawful military targets* in the circumstances ruling at the time’ (p. GL – 4 Terms and definitions), a definition which includes protected persons and objects other than civilians and civilian objects, and informs the entire publication when the term ‘collateral damage’ is used in an unqualified manner. *JP 3-60* also emphasises that ‘[t]he United States of America places a high value on preserving civilian and noncombatant lives and property and seeks to accomplish its mission through the discriminate application of forces with minimal collateral damage’ (p. III – 1; all emphasis added). The definition of collateral damage given in *JP 3-60* is included in the *Department of Defense Dictionary of Military and Associated Terms*, Joint Publication 1-02 (As Amended Through 15 March 2014). Though now rescinded, the US Air Force pamphlet *Commander’s Handbook on the Law of Armed Conflict*, 1980, generally defined civilians as follows: ‘Civilians, in this pamphlet, are all persons other than those who are subject to direct attack under paragraphs 2–6 through 2–8’ (paras. 3-1); paras. 2–7 of the pamphlet excluded military medical personnel and the sick and wounded from those subject to direct attack. So for the pamphlet, through a definition more akin to Art. 52 than Art. 50 of AP I, military medical personnel and wounded and sick combatants directly fell under the definition of civilians despite the usual meaning of that term (see above for the discussion of Art. 52 of AP I).

49 Australia: *Law of Armed Conflict*, above note 48, includes non-combatants other than civilians when setting out the principle of proportionality (para. 2.8). Canada: *The Law of Armed Conflict at the Operational and Tactical Levels*, Office of the Judge Advocate General, 13 August 2001, para. 204.5: ‘In deciding whether the principle of proportionality is being respected, the standard of measurement is the anticipated contribution to the military purpose of an attack or operation considered as a whole. The anticipated military advantage must be balanced against other consequences of the action, such as the adverse effect upon civilians or civilian objects. It involves weighing the interests arising from the success of the operation on the one hand, against the possible harmful effects upon *protected persons and objects* on the other.’ New Zealand: *Interim Law of Armed Conflict Manual*, DM 112, New Zealand Defence Force, Headquarters, Directorate of Legal Services, Wellington, November 1992, para. 207: ‘The principle of proportionality establishes a link between the concepts of military necessity and humanity. This means that the commander is not allowed to cause damage to *non-combatants* which is disproportionate to military need . . . It involves weighing the interests arising from the success of the operation on the one hand, against the possible harmful effects upon *protected persons and objects* on the other.’ Philippines: *Air Power Manual*, Philippine Air Force, Headquarters, Office of Special Studies, May 2000, paras. 1–6.4: ‘However, LOAC should not serve as an obstacle in the conduct of operations. In fact, the law recognizes the belief that the destruction of vital targets, especially if it shortens the conflict, has its long term humane effects. The chief unifying principle always applies – that the importance of the military mission (military necessity) determines, as a matter of balanced judgment (proportionality), the extent of permissible collateral or incidental injury to [an] *otherwise protected person or object*.’ United States: *No-Strike and the Collateral Damage Estimation Methodology*, CJCSI 3160.01, 13 February 2009, Glossary, GL-4: ‘*Collateral damage*. Unintentional or incidental injury or damage to *persons or objects that would not be lawful*

attack in general,<sup>50</sup> precautions in the choice of means and methods of warfare,<sup>51</sup> the obligation to issue effective advance warnings,<sup>52</sup> or precautions against the effects of attacks.<sup>53</sup>

## The preparatory work of the First Additional Protocol

During the 1974–1977 Diplomatic Conference that adopted AP I, most of the draft articles and declarations on the principles of proportionality and precautions mentioned only civilians and civilian objects. However, while Articles 46(3)(b) and 50 of the 1973 Draft Additional Protocol submitted to the Diplomatic Conference (which became Articles 51(5)(b) and 57 of AP I respectively) only referred to civilians and civilian objects, the ICRC Commentary on the 1973 Draft Additional Protocols uses the terms ‘civilians’ and ‘protected persons’ almost interchangeably with regard to these articles. The 1973 Commentary indeed explains that ‘[t]he first sentence [of draft Article 50] lays down the general rule governing the behaviour of combatants with regard to the risks which military operations, and especially attacks, involve for *protected persons and objects*.’ It later states that ‘[p]roportionality covers the accidental effects of attacks on *protected persons and objects*, as the word “incidental” indicates.’ And finally: ‘Within the scope of this Chapter [what became AP I Chapter IV on Precautionary measures containing Articles 57 and 58 of AP I], precautionary measures are meant to strengthen the protection of *all persons and objects protected*.’<sup>54</sup>

*military targets* in the circumstances ruling at the time. Such damage is not unlawful so long as it is not excessive in light of the overall military advantage anticipated from the attack’ (all emphasis added; New Zealand and Philippines Manuals as quoted in the practice related to Rules 14 and 15 of the ICRC Customary Law Study, above note 2).

- 50 Australia: *Law of Armed Conflict*, above note 48, extends the precautions in attacks to protected persons, places, and objects other than civilians and civilian objects (para. 5.53). Hungary: *A Hadijog, Jegyzet a Katonai, Főiskolák Hallgatói Részére*, Magyar Honvédség Szolnoki Repülőtisztí Főiskola, 1992, p. 45: ‘All possible measures must be taken to spare civilian persons and objects [and] *specifically protected persons and objects*’ (emphasis added; Hungary Manual as quoted in the practice related to Rule 15 of the ICRC Customary Law Study, above note 2).
- 51 United Kingdom: *The Joint Service Manual of the Law of Armed Conflict*, JSP 383, 2004, para. 5.32.5: ‘In considering the means or methods of attack to be used, a commander should have regard to the following factors: . . . f. factors affecting incidental loss or damage, such as the proximity of civilians or civilian objects in the vicinity of the target or *other protected objects or zones*’ (emphasis added).
- 52 Australia: *Operations Law for RAAF Commanders*, AAP 1003, Royal Australian Air Force, para. 10.4: ‘When circumstances permit, advance warning should be given of attacks that might endanger *non-combatants*’ (emphasis added).
- 53 United States: *Commander’s Handbook on the Law of Naval Operations*, NWP 1-14M, July 2007, pt. 8.3.2, p. 8-3: ‘A party to an armed conflict has an affirmative duty to remove civilians under its control (*as well as the wounded, sick, shipwrecked, and prisoners of war*) from the vicinity of objects of likely enemy attack.’ While this appears in the *Commander’s Handbook* Chapter 8 on the law of targeting, it might be a reference to the precautionary obligations under the specific rules on medical units (Art. 19(2) of GC I and Art. 12(4) of AP I).
- 54 ICRC Commentary on the 1973 Draft Additional Protocols, above note 23, pp. 65–66 (all emphasis added). In respect to draft Art. 51 on what became precautions against the effects of attacks (Art. 58 of AP I), which again spoke only of the civilian population, individual civilians, and civilian objects, the ICRC 1973 Commentary states ‘[t]hat Party [attacked or liable to be attacked] can contribute to the safeguard of *protected persons and objects* in its power’, *ibid.*, p. 67 (emphasis added).

The ICRC Commentary on the 1973 Draft Additional Protocols therefore shows that the rules under discussion on proportionality and precautions were understood as covering *all* protected persons through the word ‘civilians’. This understanding also appears in the ICRC representative’s statements when introducing draft Articles 46 and 50 to the Diplomatic Conference Third Committee.<sup>55</sup> Insofar as this understanding might have to some extent informed the Diplomatic Conference debates with regard to the principles of proportionality and precautions, it could arguably be considered as the intended meaning of the term ‘civilians’ in these provisions.<sup>56</sup>

In view of this broad understanding of the scope of application of the principles of proportionality and precautions at the time of their drafting – despite the fact that the draft articles expressly mentioned only civilians and civilian objects – one should not overemphasise the importance of the fact that Articles 51 and 57 of AP I, like the draft articles, expressly mention only civilians and civilian objects in the principle of proportionality and some rules on precautions.<sup>57</sup>

## Conclusion

To consider expected incidental casualties of protected persons other than civilians as being included among the persons whose incidental loss of life or injury is relevant for the purpose of applying the principles of proportionality and precautions could be seen as broader than a literal reading of Articles 51 and 57 of AP I would suggest. It is however submitted that any other conclusion would be unreasonable in view of the context and in light of the object and purpose of the Protocol.<sup>58</sup> As shown above, this conclusion stems from the interpretation of the specific rules protecting medical personnel and objects and the wounded and sick, and of the rules governing the conduct of hostilities. In particular, it stems from the

55 Diplomatic Conference, Official Records, CDDH/III/SR.5, Vol. XIV, p. 35, para. 10, and CDDH/III/SR.21, Vol. XIV, p. 181, para. 3.

56 1969 Vienna Convention on the Law of Treaties, above note 47, Arts. 31(4) and 32.

57 Cf. above notes 12–14 and accompanying text. With regard to the obligation to verify that the objective is a lawful target, Art. 50 of the 1973 Draft Additional Protocol spoke of ensuring that the objectives to be attacked are duly identified as ‘military objectives’. No indication was found in the Official Records of the Diplomatic Conference as to why this was changed to ‘verify that the objectives to be attacked are *neither civilians nor civilian objects and are not subject to special protection*’ (Art. 57(2)(a)(i) of AP I, emphasis added), or why the other rules stemming from the principles of precautions and proportionality should have a less protective scope. Henderson draws an additional argument from the fact that Art. 56(1) (second sentence) of AP I expressly protects works and installations containing dangerous forces against collateral damage. This would show that ‘there are no grounds for presuming that the drafters of AP I intended protection from attack necessarily to always include protection from collateral damage. Rather, each class of object must be assessed separately’ (above note 5, p. 196). However, this argument fails to note that Art. 56 of AP I introduces a prohibition on *any* attack expected to release dangerous forces, not only those in which the incidental casualties and damages are expected to be excessive. The absence of such a provision for other specially protected objects only means that they are not afforded the stronger protection of Art. 56(1) of AP I, not that they should be excluded from the ‘normal’ protection against incidental damage under the principles of proportionality and precautions.

58 1969 Vienna Convention on the Law of Treaties, above note 47, Art. 31(1).

interpretation of the obligation ‘to respect and protect’ as the overarching obligation of the special protection afforded to all medical personnel and the wounded and sick. It finds some support in the preparatory work of AP I and in the leading Commentaries to AP I. Beyond AP I, it is submitted that the interpretation of customary law leads to the same conclusion.<sup>59</sup> Finally, support for this conclusion can be found in a number of states’ military manuals.

In light of the above, the protection against incidental harm granted to civilians and civilian objects by the principles of proportionality and precautions must actually be understood as extending to other persons and objects protected against direct attack.

Beyond civilians and civilian objects (which include notably military medical transports, units, and other military medical objects as long as they do not fall under the definition of military objective), all feasible precautions must be taken to avoid, or at least minimise, incidental casualties of other protected persons such as military medical personnel or wounded or sick combatants. If such incidental casualties are expected to be excessive compared to the direct and concrete military advantage – alone, or in combination with the expected civilian casualties and damage to civilian objects, if any – they render the attack unlawful by virtue of the principle of proportionality.

59 The paragraph on ‘Definitions’ in the *San Remo Manual on International Law Applicable to Armed Conflicts at Sea* states that ‘collateral casualties or collateral damage means the loss of life of, or injury to civilians or other protected persons, and damage to or the destruction of the natural environment or objects that are not in themselves military objectives’: see Louise Doswald-Beck (ed.), *San Remo Manual on International Law Applicable to Armed Conflicts at Sea*, International Institute of Humanitarian Law, Cambridge University Press, Cambridge, 1995, p. 9, para. 13(c); see also ‘Explanation’, p. 87, para. 13.9. The *HPCR Air and Missile Warfare Manual*, above note 22, includes ‘other protected objects’ beside ‘civilian objects’ in its definition of collateral damage in Rule 1(l), and ‘other protected persons and objects’ in its Rules 33 and 43 which concern precautions in the choice between several military objectives and precautions against the effects of attacks respectively. Specifically with regard to persons: in its Final Report to the Prosecutor, the Committee Established to Review the NATO Bombing Campaign Against the Federal Republic of Yugoslavia mentioned ‘injury to non-combatants’ (and not ‘injury to civilians’) when speaking of incidental harm under the principle of proportionality (paras. 49 and 50); Schmitt does not distinguish between civilian and military medical personnel or those *hors de combat* on board medical aircraft when recalling that they have to be taken into consideration during proportionality calculation and when assessing feasible precautions (Michael N. Schmitt, ‘Targeting in operational law’, in Terry D. Gill and Dieter Fleck (eds), *The Handbook of the International Law of Military Operations*, Oxford University Press, Oxford, 2010, pp. 244–275, para. 18.19(1); cf. also para. 16.08(1)). More generally, when discussing the application of the principle of proportionality to medical units (though underlining the ‘permissive’ aspect of an attack which would cause non-excessive incidental damages), Bothe, Partsch and Solf state that ‘[t]he principle of proportionality is a general principle of the law of armed conflict which has found its expression in such provisions as the prohibition of “unnecessary” suffering (Article 23(c) of the Hague Convention no IV of 1907). It is not restricted to the question of the protection of the civilian population for which it has now been codified by Part IV of Protocol I’ (M. Bothe, K. J. Partsch and W. A. Solf, above note 18, p. 119). For Bartels, see above note 6.

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