DOMESTIC NORMATIVE FRAMEWORKS FOR THE PROTECTION OF HEALTH CARE

HEALTH CARE IN DANGER IT'S A MATTER OF LIFE & DEATH

ICRC

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REPORT OF THE BRUSSELS WORKSHOP
29-31 JANUARY 2014

The Seven Fundamental Principles of the Movement

Proclaimed in Vienna in 1965, the seven Fundamental Principles bond together the National Red Cross and Red Crescent Societies, the International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies. They guarantee the continuity of the International Red Cross and Red Crescent Movement and its humanitarian work.

Humanity
The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality
It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality
In order to continue to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence
The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service
It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity
There can be only one Red Cross or one Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality
The International Red Cross and Red Crescent Movement, in which all Societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

ACRONYMS

IHL – International humanitarian law

IHRL – International human rights law

GC I, II, III and IV – Geneva Convention I, II, III and IV of 1949

AP I and II – Protocols I and II of 1977 Additional to the Geneva Conventions of 1949

AP III – Protocol III Additional to the Geneva Conventions of 1949

ECHR – European Convention on Human Rights of 1950

ICCPR – International Covenant on Civil and Political Rights of 1966

CESCR – United Nations Committee on Economic, Social and Cultural Rights

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Didier Revol/ICRC

1. EXECUTIVE SUMMARY

The present report summarizes the results of the Workshop on Domestic Normative Frameworks for the Protection of Health Care that was held in Brussels from 29 to 31 January 2014, together with the main findings of the background study that was previously conducted by the ICRC Advisory Service on International Humanitarian Law. The workshop was organized jointly by the ICRC, the Belgian Interministerial Commission for Humanitarian Law and the Belgian Red Cross. Participants included civil servants, members of national IHL committees or similar bodies, members of parliament, independent experts and representatives of organizations with expertise in certain issues on the agenda of the workshop.

As part of the experts' consultation process of the Health Care in Danger project, presented in Section 2 of the report, the objective of the Brussels workshop was to identify concrete domestic measures and procedures, in particular legislative and regulatory ones, that could be established by State authorities in order to implement the existing international framework for protection of the provision and access to health care in armed conflict and other emergencies. To this end, participants were encouraged to share national experience and particular expertise with a view to helping identify good practice and possible challenges, as well as drawing up specific recommendations with regard to the implementation of the international rules and standards protecting the provision of health care. In this respect, the focus of the workshop was on implementation of the existing international framework and not on creating new rules or standards.

In preparation for the workshop, the Advisory Service on International Humanitarian Law conducted desk research on existing domestic normative frameworks with regard to the protection of the provision of health care at the national level. A detailed questionnaire was sent to the Advisory Service's regional legal advisers, who collected relevant information on the domestic frameworks of 39 countries from all regions of the world. Based on the information provided by means of the questionnaire, the Advisory Service prepared six Country Studies, which are presented in Annex 1 of the report. The results of the background study, preceded by a summary of the international rules and standards protecting the provision of health care, can be found in Section 4 of the report. The information contained in that section served as a source of reference and basis for discussion for the participants.

The workshop consisted of both plenary sessions and working groups which focused on four topics related to the protection of the provision of health care in armed conflict and other emergencies: (1) the legal protection of the wounded and sick, health-care personnel and facilities and medical transports; (2) the proper use of the distinctive emblems under international law and of other signs used for identifying health-care activities; (3) the protection of medical ethics and confidentiality; and (4) the repression and sanction of violations of the law in connection with health care. In order to facilitate the debate, participants were divided into four working groups, based on their language preferences, to form one French-speaking, one Spanish-speaking and two English-speaking groups. Each group addressed all four topics.

The recommendations presented in Section 4 of the report, along with a summary of the discussions held at the workshop, are the product of a reflection on the extensive discussions and exchanges that took place between all participants during the working group sessions and the plenary sessions that followed them. These recommendations revolve around three major types of measures: legislative measures for the implementation of the existing international legal framework; dissemination and training; and coordination between the stakeholders concerned. Recommendations also include specific measures to effectively repress and sanction all forms of violence against health care. It is worth mentioning that these recommendations were formulated by the ICRC on the basis of the report on the discussions held at the workshop and on the background research, without formal approval or endorsement by the participants.

State authorities are encouraged to refer to these recommendations and engage in reflection on how the measures proposed can help them discharge their obligations in terms of implementation of the international legal framework for protecting the provision of health care and guaranteeing more effective protection of health-care services. Given, however, that not all countries have reached the same level of implementation of their international obligations in their domestic legal framework, it is important that State authorities identify which of those recommendations are relevant in their own contexts and choose appropriate means to implement them. This requires that States take measures to reach a comprehensive understanding of the nature and causes of violence against health care occurring on their territory.

In this perspective, it is hoped that the recommendations set out in this report will serve as a source of guidance and a basis for further development of practical domestic measures to enhance protection for the provision of and access to health care, and of solutions adapted to the specific national or regional context, which is the ultimate purpose for which they have been drafted.

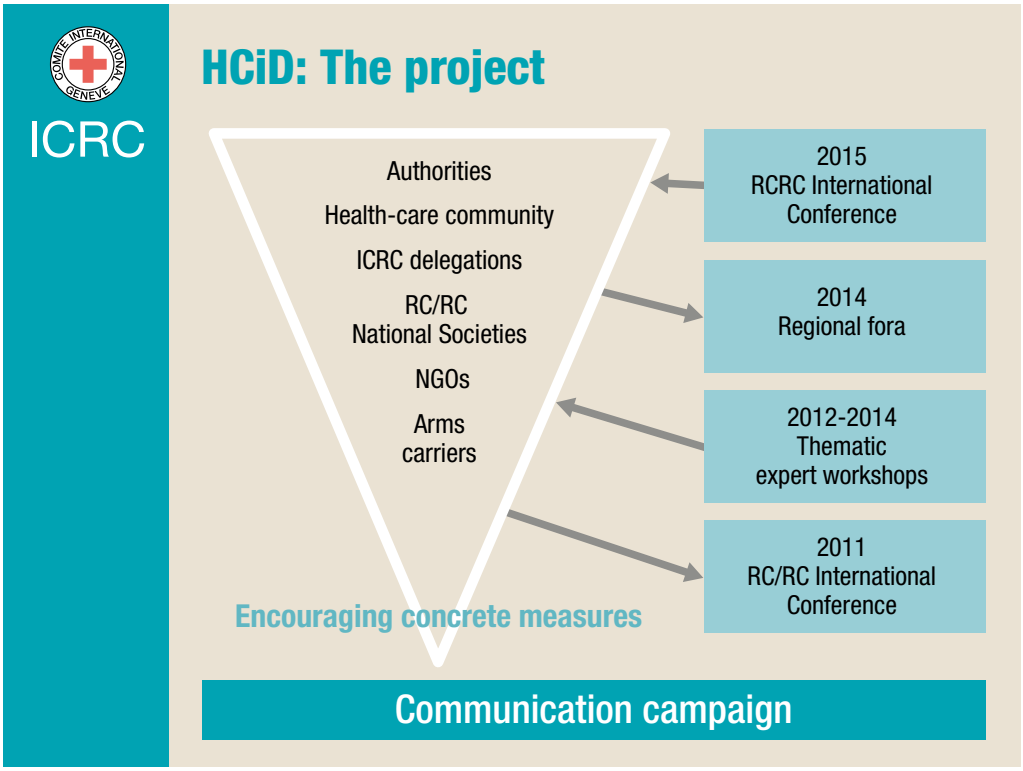
Boris Heger/ICRC

2. THE HEALTH CARE IN DANGER PROJECT

Respect for and protection of the wounded and sick, health-care personnel and facilities and medical transports have been at the heart of the development of international humanitarian law (IHL) since the original Geneva Convention was adopted in 1864. Today, however, various forms of violence continue to disrupt or endanger health care in many parts of the world.

Violence – both actual and threatened – against health-care personnel, facilities and medical transports during armed conflicts and other emergencies is widespread and affects individuals, families and entire communities. It is probably one of the most serious humanitarian issues that we have to address; the potential number of people affected by it and its effects on chronic and acute needs warrant this conclusion.

In November 2011, the 31st International Conference of the Red Cross and Red Crescent[1] asked the ICRC to initiate consultations with experts from States, the International Red Cross and Red Crescent Movement and others in the health-care sector. The aim was, and still is, to make the delivery of health-care services in armed conflicts and other emergencies safer, and to report to the 32nd International Conference in 2015 on the progress made.



1 31st International Conference 2011: Resolution 5 – Health Care in Danger, available at: http://www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm

The Health Care in Danger (HCiD) project, launched in support of this objective, has drawn attention to the sometimes violent acts that impede or prevent health-care delivery. These range from direct attacks on patients, medical staff, health-care facilities and medical transports to denial of access to, forced entry to and looting of health-care facilities. In most cases these are likely to amount to breaches of international law.

The HCiD project brought together National Societies and various external stakeholders such as policy-makers, government health sector personnel, military staff, humanitarian agencies and representatives of academic circles in order to identify concrete measures and recommendations that authorities and/or health-care personnel could implement to ensure better respect and protection for health-care delivery.

All in all, experts from some 100 countries participated in a series of workshops on the following topics between 2012 and 2014:

- The role and responsibility of National Societies in delivering safe health care in armed conflict and other emergencies (two workshops: Norway and Iran)
- The rights and responsibilities of health-care personnel (two workshops: United Kingdom and Egypt)
- Ambulance/pre-hospital services in risk situations (one workshop: Mexico)
- The physical safety of health-care facilities (two workshops: Canada and South Africa)
- The role of civil society and religious leaders in promoting respect for health care (one workshop: Senegal)
- Promoting military operational practice that ensures safe access to and delivery of health care (one workshop: Australia)
- Domestic normative frameworks for the protection of health-care provision (one workshop: Belgium)

DEFINITIONS

As the Health Care in Danger project deals with a number of different situations, the terms used in this publication – for instance, health-care personnel and facilities and medical transports – should be understood more broadly than the terms "medical personnel", "units" and "transports" under international humanitarian law (IHL), which applies during armed conflict. Medical personnel, units and transports fall within the IHL definition when they are "assigned exclusively to medical purposes by a competent authority or party to the conflict." In the context of the Health Care in Danger project, personnel, units or transports can fall within the scope of the definition even if they have not been assigned by a party to a conflict.

Health-care facilities include hospitals, laboratories, clinics, first-aid posts, blood transfusion centres, and the medical and pharmaceutical stores of these facilities.[2]

Health-care personnel include:[3]

- people with professional health-care qualifications, e.g. doctors, nurses, paramedics, physiotherapists, pharmacists;
- people working in hospitals, clinics and first-aid posts, ambulance drivers, hospital administrators, or personnel working in the community in their professional capacity;
- staff and volunteers of the International Red Cross and Red Crescent Movement involved in delivering health care;
- medical personnel of armed forces;
- personnel of health-oriented international and non-governmental organizations;
- first-aiders.

Medical transports include ambulances, medical ships or aircraft – whether civilian or military – and means of transport conveying the wounded and sick, health-care personnel and medical supplies or equipment. The term includes all vehicles used for health-care purposes, even if not assigned exclusively to medical transportation and under the control of a competent authority of a party to a conflict, such as private cars used to transport the wounded and sick to a health-care facility, transport vehicles for medical supplies, and people-carriers transporting medical staff (e.g. for local vaccinations or to work in mobile clinics).

2 ICRC, *Health Care in Danger: Making the Case*, ICRC, Geneva, 2011.
3 ICRC, *Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflict and Other Emergencies*, ICRC, Geneva, 2012.

Mstyslav Chernov/Unframe

3. THE LEGAL FRAMEWORK FOR THE PROTECTION OF HEALTH CARE

3.1 The international legal framework (IHL and IHRL)

This section presents the specific rules of international humanitarian law (IHL) and international human rights law (IHRL)[4] on the protection of the provision of health care in peacetime as well as during armed conflict and other emergencies.

3.1.1. General protection

Under IHRL, States party to the relevant treaties have, in all circumstances (i.e. in peacetime as well as during armed conflict), an obligation to maintain a functioning health-care system. They must maintain access to essential health facilities, goods and services, access to minimum essential food, basic shelter, housing and sanitation, and an adequate supply of safe and potable water, as well as providing essential drugs, while respecting the principles of non-discrimination and equitable access. States must also design and implement public health strategies.[5]

Similar provisions exist in IHL, requiring States to provide food and medical supplies for the population. For example, in an occupied territory, the Occupying Power (with the cooperation of national and local authorities) must, to the fullest extent of the means available, ensure and maintain medical and hospital establishments and services and public health and hygiene, and adopt the prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics.[6]

Although both IHL and IHRL allow States to assume their obligations in accordance with the resources available to them, a lack of resources does not *per se* justify inaction. When resources are extremely limited, States should adopt low-cost programmes that target the most disadvantaged and marginalized members of the population.[7]

4 IHL is a set of rules that seeks, for humanitarian reasons, to limit the effects of armed conflict. It protects persons who are not or are no longer participating in hostilities and restricts the means and methods of warfare. IHL applies in situations of armed conflict, whether international or non-international in character.
IHRL is a set of rules that seeks to protect individuals from arbitrary behaviour by their governments. Human rights are inherent entitlements which belong to every person. In principle, they apply at all times, in peacetime and in situations of armed conflict. However, some human rights treaties permit governments to derogate from certain rights in situations of public emergency.
For more information on similarities and differences between IHL and IHRL, please refer to the ICRC website: http://www.icrc.org/eng/war-and-law/ihl-other-legal-regmies/ihl-human-rights/index.jsp.

5 United Nations Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health, 11 August 2000, http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4. En NB: The General Comments constitute an authoritative interpretation of the obligations of States under human rights treaties. They are, however, not binding as such on States.

6 In full, Art. 56, GC IV, states: "To the fullest extent of the means available to it, 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 preventive measures necessary to combat the spread of contagious diseases and epidemics. Medical personnel of all categories shall be allowed to carry out their duties.
If new hospitals are set up in occupied territory and if the competent organs of the occupied State are not operating there, the occupying authorities shall, if necessary, grant them the recognition provided for in Article 18. In similar circumstances, the occupying authorities shall also grant recognition to hospital personnel and transport vehicles under the provisions of Article 20 and 21.
In adopting measures of health and hygiene and in their implementation, the Occupying Power shall take into consideration the moral and ethical susceptibilities of the population of the occupied territory."

7 CESCR, General Comment No. 3, para. 10; CESCR, An Evaluation of the Obligation to Take Steps to the "Maximum of Available Resources" Under an Optional Protocol to the Covenant, 10 May 2007, http://www2.ohchr.org/english/issues/escr/docs/e_c12_2007_1.pdf, para. 10.

To ensure that access to health care is protected, States must disseminate the content of IHL and IHRL obligations as widely as possible within their territory. This information should be provided in particular for the armed forces and for civil defence and law enforcement officials; it should also be disseminated among health-care personnel and among civilians in general.[8] Dissemination may require the translation of legal texts. States should also provide military commanders and law enforcement officials with legal advisers, with a view to helping them to apply and teach IHL and IHRL.[9]

3.1.2 Specific rules[10]

A) Protection of the wounded and sick, health-care personnel and facilities and medical transports

LEGAL FRAMEWORK[11]

Protection of the wounded and sick

International Humanitarian Law

Common Art. 3, GC I, II, III and IV

Arts 6, 7, 9, 10, 12, 15, 18, 19 and 46, GC I

Arts 6, 7, 9, 10, 12, 18, 21, 28, 30 and 47, GC II

Art. 30, GC III

Arts 16 and 91, GC IV

Arts 10, 11 and 44(8), AP I

Arts 7 and 8, AP II

Rules 109-111, Customary IHL Study

International Human Rights Law

Art. 25, Universal Declaration of Human Rights, 10 December 1948

Art. 2, ECHR

Art. 6(1), ICCPR

Art. 12, ICESCR

Art. 4, ACHR

Art. 4, ACHPR

Basic Principles on the Use of Force and Firearms by Law Enforcement Officials

CESCR, General Comment No. 3

CESCR, General Comment No. 14

CESCR, An Evaluation of the Obligation to Take Steps to the "Maximum of Available Resources" Under an Optional Protocol to the Covenant, UN Doc. E/C.12/2007/1, 10 May 2007

In addition, it is worth mentioning that the international rules and principles of medical ethics[12] governing health-care personnel in the performance of their duties also contain rules that are aimed at protecting the wounded and sick.

8 For more information on dissemination, please refer to the fact sheet prepared by the ICRC's Advisory Service, "The Obligation to Disseminate International Humanitarian Law," http://www.icrc.org/eng/assets/files/other/obligation_to_disseminate.pdf.

9 For more information on legal advisers in armed forces, please refer to the fact sheet prepared by the ICRC's Advisory Service, "Legal advisers in armed forces," http://www.icrc.org/eng/assets/files/other/legal_advisers_ffaa.pdf.

10 This section is based on a document prepared by the ICRC for the 31st International Conference, "Health Care in Danger: Respecting and Protecting Health Care in Armed Conflict and Other Situations of Violence," http://www.rcrcconference.org/docs_upl/en/31IC_Health_Care_in_danger_EN.pdf.

11 For more information about rules concerning penal sanctions for serious violations of the Geneva Conventions and their Additional Protocols committed against the wounded and sick, health-care personnel and medical facilities and transports, please refer to Section 3.1.3.

12 The term "medical ethics" refers to a branch of ethics that deals with moral issues in medical practice. See World Medical Association, Medical Ethics Manual, 2nd ed., 2009, http://www.wma.net/en/30publications/30ethicsmanual/pdf/intro_en.pdf, p. 9.

Protection of health-care personnel

International Humanitarian Law

Arts 24- 27, 28-30 and 32, GC I

Arts 36 and 37, GC II

Art. 20 GC IV

Arts 15 and 16, AP I

Arts 9 and 10, AP II

Rules 25 and 26, Customary IHL Study

International Human Rights Law

ICCPR

ECHR

ACHR

ACHPR

Protection of health-care facilities and medical transports

International Humanitarian Law

Arts 19-23 and 33-37, GC I

Arts 21-35 and 38-40, GC II

Arts 18,19, 21, 22 and 57, GC IV

Arts 12-14 and 21-31, AP I

Art. 11, AP II

Rules 28 and 29, Customary IHL Study

International Human Rights Law

CESCR, General Comment No. 14

– All possible measures must be taken to provide health care for the wounded and sick on a non-discriminatory basis.

Under IHL, all parties to an armed conflict have a 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 without any adverse distinction, irrespective of the party with which a wounded or sick person is associated, and irrespective of his or her race, religion, political opinions or other similar criteria.[13] Distinctions may only be made on purely medical grounds.[14] The qualifying clause "as far as practicable and with the least possible delay" means that this obligation is not absolute, but requires parties to take all possible measures given their resources and given the feasibility of implementing such measures during an armed conflict.[15] However, no-one may be wilfully left without medical assistance.[16]

Under IHRL, States have an obligation to ensure the non-derogable right to life by refraining from deliberately withholding or delaying the provision of health care to individuals under their jurisdiction

13 According to the *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949*, the term "without adverse distinction", mentioned in the four Geneva Conventions and in the Preamble to Additional Protocol I, means that not all distinctions are prohibited but only those designed to prejudice certain persons or categories of person.

14 Common Art. 3(2), GC I-IV; Art. 12, GC I; Art. 12, GC II; Art. 10(2), AP I; Art. 7(2), AP II; Rule 110, J.M. Henckaerts and L. Doswald-Beck, *Customary International Humanitarian Law*, ICRC/Cambridge University Press, 2005 (Customary IHL Study).

15 *Commentary* on Art. 10, AP I, paras 446 and 451.

16 Art. 12(2), GC I and GC II.

in life-threatening circumstances.[17] In addition, the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, a soft-law instrument adopted in 1990 at the 8th United Nations Congress on the Prevention of Crime and the Treatment of Offenders, states that "[w]henever the lawful use of force and firearms is unavoidable, law enforcement officials shall (…) [e]nsure that assistance and medical aid are rendered to any injured or affected persons at the earliest possible moment."[18]

Furthermore, under the right to health, which has been enshrined in a series of human rights instruments and enhanced by national constitutions, States have an obligation to ensure non-discriminatory provision of at least essential health care, including preventive, curative and rehabilitative services.[19] This is a non-derogable but not an absolute obligation, since its implementation is dependent on the resources available.[20] States are nonetheless obliged to make use of the resources that are available and, where those are insufficient, to actively seek resources in the form of cooperation and assistance from the international community.[21] Any other restriction of the right to health must be in accordance with the law, including IHRL, compatible with the nature of this right, required by the pursuit of legitimate aims, and strictly aimed at serving general economic and social welfare. Furthermore, such restrictions must be of limited duration and subject to regular review.[22]

– **All possible measures must be taken to search for, collect and evacuate the wounded and sick in a non-discriminatory manner.**

Under IHL, whenever circumstances permit, but particularly in the immediate aftermath of fighting, all parties to an armed conflict must take all possible measures without delay to search for, collect and evacuate the wounded and sick without any adverse distinction.[23]

Within the scope of the right to health in IHRL, States have a non-derogable obligation to ensure access to "health facilities, goods and services on a non-discriminatory basis,"[24] subject to the availability of resources.[25] While "health facilities, goods and services" must be within safe physical reach of all sections of the population, States have a special obligation to take all possible measures – including searching for, collecting and evacuating the wounded and sick – to provide access to health care for people who are unable to realize that right by the means at their disposal, for reasons beyond their control.[26] Since access to health care is often unavailable to the wounded and sick, because of their physical condition and/or the prevailing violence, fulfilling this obligation entails an active duty to search for, collect and evacuate the wounded and sick.

17 This was recognized by the European Court of Human Rights in *Cyprus* v. *Turkey*, Application No. 25781/94, Judgment, 10 May 2001, paras 219-221. More generally, see also United Nations Human Rights Committee (HRC), General Comment No. 6: The right to life, 30 April 1982, http://www.unhchr.ch/tbs/doc.nsf/0/84ab9690ccd81fc7c12563ed0046fae3, para. 5; M. Nowak, *U.N. Covenant on Civil and Political Rights: CCPR Commentary*, 2nd ed., Kehl-Strasbourg-Arlington: N. P. Engel, 2005 (Nowak CCPR Commentary), pp. 123-124.

18 Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, A/CONF.144/28/Rev.1, 8th United Nations Congress on the Prevention of Crimes and Treatment of Offenders (Basic Principles on the Use of Force), 1990, http://www.unrol.org/doc.aspx?d=2246, p. 2. Moreover, Art. 6 of the Code of Conduct for Law Enforcement Officials states: "Law enforcement officials shall ensure the full protection of the health of persons in their custody and, in particular, shall take immediate action to secure medical attention whenever required." Code of Conduct for Law Enforcement Officials, United Nations General Assembly Resolution 34/169, 17 December 1979, http://www.ohchr.org/EN/ProfessionalInterest/Pages/LawEnforcementOfficials.aspx.

19 CESCR, General Comment No. 3: The nature of States parties' obligations, 14 December 1990, http://www.unhchr.ch/tbs/doc.nsf/0/94bdbaf59b43a424c12563ed0052b664, para. 10; CESCR, General Comment No. 14, para. 43.

20 Art. 2(1), International Covenant on Economic, Social and Cultural Rights, 19 December 1966 (ICESCR).

21 CESCR, General Comment No. 3, para. 10; CESCR, An Evaluation of the Obligation to Take Steps to the "Maximum of Available Resources" Under an Optional Protocol to the Covenant, 10 May 2007, http://www2.ohchr.org/english/issues/escr/docs/e_c12_2007_1.pdf, para. 10.

22 Art. 4, ICESCR; CESCR, General Comment No. 14, paras 28-29.

23 Art. 15(1), GC I; Art. 18, GC II; Art. 8, AP II; Rule 109, Customary IHL Study.

24 CESCR, General Comment No. 14, para. 43.

25 Art. 25, Universal Declaration of Human Rights, 10 December 1948; Art. 12, ICESCR.

26 CESCR, General Comment No. 14, paras 12, 37 and 43.

– **The wounded and sick and health-care personnel must not be attacked, arbitrarily deprived of their lives, or ill-treated. The use of force against health-care personnel is justified only in exceptional circumstances. Health-care facilities and medical transports also may not be attacked and must be spared as far as possible.**

IHL contains basic obligations to respect and protect the wounded and sick in all circumstances. This entails, in particular, not attacking, ill-treating or harming them in any way, or killing them. It also entails sparing them, taking active measures to assist them and making sure that they are respected by third persons.[27]

The specific protection provided by IHL for medical personnel, units and transports are derived from the basic obligations to respect and protect the wounded and sick.[28] Medical personnel, units and transports – military or civilian – pursuing their exclusively humanitarian tasks may also not be attacked or harmed in any way and must be spared during hostilities.[29] Thus, in the conduct of hostilities, not only are attacks deliberately directed against them and indiscriminate attacks that affect them prohibited, on the basis of the obligation to respect and protect, but so, too, are attacks that may be expected to cause excessive harm to medical personnel, units and transports in relation to the direct and concrete military advantage anticipated.[30]

Parties to the conflict are also required to do everything feasible to verify that attacks are not directed against civilians, civilian objects and objects entitled to special protection (as is the case for medical personnel, units and transports), but only against military objectives.[31] When targeting military objectives, they must also take all feasible precautions in the choice of means and methods of attack, with a view to avoiding, or at least minimizing, incidental harm to medical personnel, units and transports.[32]

This requires: choosing means and methods of attack that inflict the fewest incidental injuries on the wounded and the sick and on medical personnel; cancelling attacks when it becomes apparent that they could result in excessive injury or damage[33] or that the objectives are not military in character or enjoy special protection; and giving effective advance warning of attacks that might affect the civilian population. The obligation to spare medical personnel, units and transports in the conduct of hostilities, which is inherent in the obligation to respect and protect those persons and objects, as well as the wounded and sick, also obliges the defending party to take precautionary measures. Parties to the conflict should, as far as possible, ensure that medical units are situated in such a manner that attacks against military objectives do not endanger their safety.[34] They must also, to the greatest extent possible, limit the effects of attacks by removing the wounded and sick and medical personnel, units and transports from the vicinity of military objectives.[35]

The specific protection to which medical personnel, units and transports are entitled may be lost when they commit or are used to commit, outside their humanitarian function, acts harmful to the enemy.[36] Examples of such acts include: sheltering able-bodied combatants, storing arms or ammunition, serving as military observation posts or as a shield for military action,[37] transporting able-bodied troops, arms or munitions, and collecting or conveying military intelligence.[38] However, certain other acts do not result in the loss of specific protection: for example, carrying or using light individual weapons for self-defence or to defend the wounded and sick; the presence of or provision of escort by military

27 Art. 12, GC I; Art. 12, GC II; Art. 16, GC IV; Art. 10, AP I; Art. 7, AP II; *Commentary* on Art. 10, AP I, para. 446. By definition, under IHL the wounded and sick refrain from any act of hostility. See Art. 8(a), AP I.
28 *Commentary* on Art. 12, GC I, p. 134.
29 *Commentary* on Art. 18, GC IV, pp. 147-148; *Commentary* on Art. 10, AP I, p. 146; *Commentary* on Art. 11, AP II, pp. 1433 and 1434.
30 Other persons not exclusively assigned to medical activities by a party to the conflict would also generally benefit, if they are civilians, from protection against direct or indiscriminate attacks and against attacks that may be expected to cause excessive civilian harm in relation to the concrete and direct military advantage anticipated. Art. 51, AP I; Rules 1, 11 and 14, Customary IHL Study.
31 Art. 19, GC I; Arts 22 and 38, GC II; Arts 18 and 22, GC IV; Art. 51, AP I; Rule 1, Customary IHL Study.
32 Art. 57(2)(a)(ii), AP I; Rule 17, Customary IHL Study.
33 Art. 57(2)(a)(i) and 57(2)(b), AP I; Rules 16 and 19, Customary IHL Study.
34 See Art. 19(2), GC I; Art. 18(5), GC IV; Art. 12(4), AP I; Customary IHL Study, p. 96.
35 See Art. 58(a), AP I; Rule 24, Customary IHL Study.
36 Rules 25, 28 and 29, Customary IHL Study; Arts 19(1), 24-26 and 35, GC I; Arts 23 and 36, GC II; Arts 18, 20 and 21, GC IV; Arts 12(1), 15 and 21, AP I; Arts 9 and 11(1), AP II.
37 *Commentary* on Art. 21, GC I, paras 200-201; *Commentary* on Rule 28, Customary IHL Study, p. 97.
38 *Commentary* on Rule 29, Customary IHL Study, p. 102.

personnel; and possessing small arms and ammunition taken from the wounded and sick and not yet handed over to the proper authority.[39]

Under IHRL, States have an obligation not to subject any individuals under their jurisdiction – including the wounded and sick, and health-care personnel – to arbitrary deprivation of life.[40] The use of force against health-care personnel by State security, police or armed forces engaged in law-enforcement operations is justified only where it is absolutely necessary to defend a person from an imminent threat to his or her life or bodily integrity.[41] Generally, neither the wounded and sick nor health-care personnel would pose a threat that would warrant the use of force. If, however, the use of force is warranted, State officials engaged in law-enforcement operations must issue a clear warning of their intent to use firearms, with sufficient time for the warning to be registered – unless doing so would create a risk of serious harm or death to the State official concerned or third persons.[42]

In essence, the obligation to respect the wounded and sick as well as health-care personnel, which implies that they shall not be harmed or ill-treated, prohibits rape and other forms of sexual violence against them. More specifically, rape and other forms of sexual violence are prohibited by IHRL at all times[43] and by IHL in both international and non-international armed conflict.[44] Rape and other forms of sexual violence may also contravene the States' obligation under IHRL not to subject individuals under their jurisdiction to cruel, inhuman or degrading treatment or punishment.

– Access to health-care facilities and medical transports should not be arbitrarily denied or limited.

Under IHL, the obligation to respect medical personnel, units and transports performing their exclusively medical functions also means that the discharge of those functions is not unduly impeded; this implies the requirement that the passage of medical personnel and supplies must not be arbitrarily prevented.[45] Like all other obligations concerning medical personnel, units and transports, this one derives from the fundamental obligations to respect, protect, collect and care for the wounded and sick.[46] For instance, since the obligation to ensure adequate care for the wounded and sick includes handing them over to a medical unit or permitting their transportation to a place where they can be adequately cared for,[47] arbitrary measures impeding their access to health care violate this obligation.

Under IHRL, the non-derogable obligation to respect the right of access to health-care facilities, goods and services on a non-discriminatory basis requires States to abstain from arbitrarily denying or limiting such access to the wounded and sick, for instance as a punitive measure against political opponents.[48] Placing restrictions on the treatment of persons believed to be opposed to a government constitutes arbitrary limitation, since the State would be hard put to it to show that such restrictions were compatible with the essential nature of the right of access to health care.[49] Restrictions on grounds of national security can be invoked only if they serve the economic and social well-being of a State's population.[50] This would not be the case when a part of the population is deprived of urgently-needed health care.

39 Art. 22, GC I; Art. 13, AP I; *Commentary* on Rules 25 and 29, Customary IHL Study, pp. 85 and 102.
40 Art. 6(1), International Covenant on Civil and Political Rights, 16 December 1966 (ICCPR); Art. 2, European Convention on Human Rights, 4 November 1950 (ECHR); Art. 4, American Convention on Human Rights, 22 November 1969 (ACHR); Art. 4, African Charter on Human and Peoples' Rights, 27 June 1981 (ACHPR).
41 Art. 2(2), ECHR; 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; Inter-American Court of Human Rights (IACHR), Las Palmeras case, Judgment, 26 November 2002, Ser. C., No. 96 (2002); Nowak CCPR Commentary, p. 128; Principles 9 and 10, Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, UN Doc. A/CONF.144/28/Rev. 1 (1990) (Basic Principles on the Use of Force).
42 Principles 9 and 10, Basic Principles on the Use of Force.
43 Art. 7, ICCPR; Art. 5, ACHR; Art. 3, ECHR; Art. 24, Convention on the Rights of the Child; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. See also footnote 5.
44 Art. 3 common to the Geneva Conventions; Art. 27, GC IV; Art. 75, AP I; Art. 77(1), AP I; Art. 4(2), AP II; Rule 93, Customary IHL Study.
45 *Commentary* on Art. 12, AP I, p. 166, para. 517.
46 *Commentary* on Art. 12, GC I, p. 134.
47 *Commentary* on Art. 12, GC I, p. 137; *Commentary* on Art. 8, AP II, p. 1415, para. 4655.
48 CESCR, General Comment No. 14, paras 34, 43, 47 and 50.
49 *Ibid*., para. 28.
50 Art. 4, ICESCR; Alston, P. and Quinn, G., "The Nature and Scope of States Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights", Human Rights Quarterly, Vol. 9, No. 2, May 1987, p. 202.

– **The wounded and sick, as well as health-care personnel and facilities and medical transports, must be protected against interference by third persons. Health-care personnel and facilities and medical transports must also be assisted in the performance of their duties.**

Under IHL, parties to a conflict have an obligation to protect the wounded and sick and medical personnel, units and transports. This also means ensuring respect for them by third persons and taking measures to assist medical personnel, units and transports in the performance of their duties. This requires, for instance, removing the wounded and sick from battle sites and sheltering them or ensuring the delivery of medical or other critical supplies by making vehicles available.[51] In particular, the wounded and sick must be protected against ill-treatment and the pillaging of their personal property.[52]

Under IHRL, the obligation of States to ensure individuals' right of access to health-care facilities, goods and services on a non-discriminatory basis also means that States must take positive measures to enable individuals to enjoy their right to health.[53] It also requires States to take appropriate measures to prevent third persons from interfering with medical treatment given to the wounded and sick.[54]

B) The distinctive emblems

LEGAL FRAMEWORK

IHL

Arts 36, 38-44, 53 and 54, GC I

Arts 39, 41 and 43-45, GC II

Arts 18 and 20-22, GC IV

Arts 8, 18, 23, 38 and 85, AP I

Annex 1, AP I

Art. 12, AP II

AP III

Rules 30, 59 and 60, Customary IHL Study

Regulations on the Use of the Emblem of the Red Cross or the Red Crescent by the National Societies

The red cross, red crescent and red crystal are the symbols recognized by international humanitarian law to signal specific protection of distinct categories of medical personnel, units and transports (protective use), as well as to show that persons or objects are linked to the Red Cross and Red Crescent Movement (indicative use). Their use is governed by the Geneva Conventions of 1949, their Additional Protocols I and II of 1977 and Additional Protocol III of 2005, and also by the applicable domestic legislation of the State concerned. These provisions define the individuals and services entitled to use the emblems and the purposes for which they may be employed. The use of the emblems is regulated at all times, during peacetime as well as during times of armed conflict. Any use of the emblems not prescribed by IHL is considered to be improper.

51 *Commentary* on Arts 19, 24 and 35, GC I, pp. 196, 220 and 280; *Commentary* on Arts 12 and 21, AP I, pp. 166 and 250; *Commentary* on Arts 9 and 11, AP II, pp. 1421 and 1433.
52 Art. 15, GC I; Art. 18, GC II; Art. 16, GC IV; Art. 8, AP II; Rule 111, Customary IHL Study.
53 CESCR, General Comment No. 14, para. 37; Principle 5(c), Basic Principles on the Use of Force.
54 See CESCR, General Comment No. 14, paras 33 and 37.

– **The red cross, red crescent and red crystal emblems should be used only to identify protected health-care personnel and facilities and medical transports authorized to display them in armed conflicts or to indicate that persons or objects are linked to the International Red Cross and Red Crescent Movement.**

Generally, the use of the emblems can be authorized to signal specific protection conferred by IHL on the medical services of the armed forces and, in wartime, civilian hospitals. They are also used by National Red Cross or Red Crescent Societies, their International Federation, and the International Committee of the Red Cross.[55] The main rules governing the use of the emblems imply that they may be used only (a) for medical activities; (b) with the authorization of the authorities concerned; and (c) under the control of those authorities.

Responsibility for authorizing the use of the red cross, red crescent or red crystal emblems rests with the State, which must regulate their use in a manner consistent with the terms of the Geneva Conventions and their Additional Protocols. In order to ensure effective control of the use of the emblems, States must adopt internal measures establishing: (a) the identification and definition of the emblem(s) recognized and protected; (b) the national authority with the competence to regulate the use of the emblems; (c) those entities with permission to employ the emblems; and (d) the uses for which permission is authorized.

The protective use of the emblems constitutes the visible sign of protection conferred by IHL on certain categories of persons in armed conflicts, while the indicative use is intended to show that persons or objects are linked to the Movement.[56] When used as a protective device, the emblem must be identifiable from as far away as possible, and may be as large as necessary to ensure recognition.[57] By contrast, when used as an indicative device, the emblem should be comparatively small in size and may not be displayed on armlets or on the roofs of buildings.[58] It bears emphasizing that the emblem as such does not confer protection; it is applicable IHL that confers protection on the wounded and sick and on health-care personnel and facilities and medical transports.

The distinction between protective and indicative use is necessary to avoid any confusion as to who is entitled to use the emblem as a protective device in armed conflicts.[59] Under Article 4 of the Regulations on the Use of the Emblem, National Societies which continue their peacetime activities during an armed conflict should take all measures necessary to ensure that the emblem used as an indicative device is not perceived as conferring the right to protection under international humanitarian law. In particular, National Societies should endeavour, already in peacetime, to display an emblem of relatively small dimensions. However, the Commentary on those Regulations makes it clear that this is in the nature of a recommendation by providing 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".[60] In this regard, the 2009 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 Societies display a

55 The authorized users of the protective emblems are: medical services of armed forces and sufficiently organized armed groups; medical personnel, units and transports of National Societies that have been duly recognized and authorized 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 recognized as such by State authorities and authorized to display the emblem; in occupied territory and in zones of military operation, 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 is taking place or is likely to take place; civilian medical units and transports, as defined under AP I, recognized by the competent authorities and authorized by them to display the emblem; other recognized and authorized voluntary aid societies, subject to the same conditions as those for National 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 Arts 39-44, GC I; Arts 22-23, 26-28, 34-37, 39, 41-44, GC II; Arts 18(1)(4), AP I; Art. 12, AP II; Art. 2, Additional Protocol III (AP III).

56 Art. 44, GC I; Art. 1, Regulations on the Use of the Emblem of the Red Cross or the Red Crescent by the National Societies (Regulations on the Use of the Emblem), last revised in 1991, http://www.icrc.org/eng/resources/documents/misc/57jmbg.htm. The authorized users of the indicative emblem are: National Societies; 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 domestic legislation and that the National Society has expressly authorized such use.
See Art. 44(2) and (4), GC I. The ICRC and the International Federation of Red Cross and Red Crescent Societies may use the emblem for indicative purposes with no restriction. See Art. 44(3), GC I.

57 Arts 39-44, GC I; Art. 18, AP I; Art. 6, Regulations on the Use of the Emblem.

58 Art. 44(2), GC I; Arts 4 and 16, Regulations on the Use of the Emblem.

59 Art. 44(2), GC I.

60 *Commentary* on Art. 4, Regulations on the Use of the Emblem.

large-sized indicative emblem in situations of internal disturbance and tension if (a) it might enhance their medical assistance to victims of violence and (b) it is authorized, or at least not prohibited, by the domestic normative framework.[61] It must be noted that both the ICRC and the International Federation may use the emblem, including as a protective device, at all times without any further restrictions.

In view of the strict conditions regulating the use of the red cross, red crescent and red crystal emblems, and the fact that the emblems may be used only marginally in situations that do not qualify as armed conflict, health-care activities may also be identified by means other than the distinctive emblems.

– All necessary measures must be taken to prevent and repress misuse of the emblems.

In addition to regulating the use of the emblems, States must take all measures necessary to prevent and repress any misuse thereof,[62] including imitations,[63] improper use,[64] and perfidious use.[65] This requires States to enact legislation prohibiting and punishing unauthorized use of the emblems at all times. This legislation must apply to all forms of personal and commercial use and prohibit imitations or designs capable of being mistaken for the red cross, the red crescent or the red crystal. Perfidious use of the emblem during armed conflict – to hide or shelter combatants or military equipment, for example – constitutes a war crime when it results in death or serious injury, and should be repressed as such.

The prevention and repression of emblem misuse is not accomplished solely by the adoption of penal or regulatory measures. A State should also undertake to inform the public and all stakeholders concerned, such as the health-care community, about the proper use of the emblems. It is fundamental that the measures to prevent misuse of the emblems apply also to members of the armed forces. However, this may be established through the processes of the State governing military discipline.

The adoption of domestic measures to ensure respect for the emblems is fundamental to maintaining the impartiality associated with the provision of health care. Consequently, the care and protection of those receiving aid is enhanced. The failure of a State to take the appropriate measures to prevent and repress misuse of the emblems can lead to a decrease in the respect and confidence which they enjoy and to erosion of their protective value, as well as endangering the lives of those legitimately using them. In addition, failure to repress misuses committed in peacetime is likely to open the way to increased misuse of the emblems during armed conflict.

C) Health-care ethics and confidentiality

LEGAL FRAMEWORK

Art. 16, AP I

Art. 10, AP II

Rule 26, Customary IHL Study

World Medical Association (WMA) Regulations in Times of Armed Conflict[66]

61 ICRC, in consultation with the International Federation of Red Cross and Red Crescent Societies and National Societies, *Study on Operational and Commercial and other Non-Operational Issues Involving the Use of the Emblems*, CD/09/7.3.1, October 2009, submitted to the Council of Delegates, Nairobi, Kenya, 23-25 November 2009, http://www.icrc.org/eng/assets/files/other/25-09-09_strategy-for-the-mvt_7-3_emblem_english.pdf, pp. 80-82.

62 Art. 54, GC I; Art. 12, AP II; Art. 6, AP III.

63 The use of a sign that, owing to its shape and/or colour, may be confused with the emblem.

64 This refers to the use of the emblem by people usually authorized to do so, but in a manner inconsistent with IHL provisions governing its use; or to the use of the emblem by entities or persons not entitled to do so (commercial enterprises, pharmacists, private doctors, non-governmental organizations [NGOs], ordinary individuals, etc.); or for purposes that are inconsistent with the Fundamental Principles of the Movement. See Art. 38, AP I.

65 Misuse of the emblem during an armed conflict to invite the confidence of an adversary and lead him to believe that one is protected in order to capture, injure or kill him. See Art. 37, AP I. Wounding or killing an adversary by resorting to perfidy constitutes a war crime in both international and non-international armed conflicts. See Art. 8(2)(b)(xi) and 8(2)(e)(ix) of the Rome Statute of the International Criminal Court, A/CONF.183/9, 17 July 1998 (Rome Statute). See also Art. 85(3)(f), AP I.

66 WMA Regulations in Times of Armed Conflict and Other Situations of Violence.

– **Health-care personnel must not be hindered in the performance of their exclusively medical tasks. They should not be harassed for assisting the wounded and sick or prosecuted for carrying out acts compatible with medical ethics.**[67]

Under IHL, the obligation to respect medical personnel performing their exclusively medical duties also entails an obligation on parties to the conflict not to arbitrarily interfere with their treatment of the wounded and sick.[68] Parties to the conflict may not molest or punish medical personnel for carrying out activities compatible with medical ethics, nor may they compel such personnel to perform activities contrary to medical ethics or to refrain from performing acts required by those ethics.[69] These rules preclude practices such as armed takeovers of hospitals by armed forces or armed groups leading to harassment, intimidation or arrest of health-care personnel.

Such practices are equally prohibited under IHRL, which also imposes the non-derogable obligation to respect the right of the wounded and sick to have non-discriminatory access to health-care facilities and medical goods and services; this obligation requires States to refrain from interfering, directly or indirectly, with the enjoyment of that right.[70]

Furthermore, under the WMA Regulations in Times of Armed Conflict,[71] parties to an armed conflict should not prosecute medical professionals for complying with any of their obligations with regard to medical ethics. Similarly, UN General Assembly Resolution 37/194 of 1982 provides that this rule applies regardless of the person benefiting from those medical activities.

– **Information on patients obtained by health-care personnel in the performance of their duties is confidential and must be not be disclosed to third parties without the patient's consent, except under precise circumstances.**

Health-care personnel have precise ethical duties to observe, such as treating patients in a non-discriminatory manner or acting in the best interests of the patient when providing health care. Protection of the confidentiality of information obtained in connection with the treatment of patients is one of the most important principles of medical ethics.

Under Protocols I and II of 8 June 1977 additional to the Geneva Conventions, unless required to do so by law, such as for the compulsory notification of communicable diseases, persons engaged in medical activities may not be compelled to give information concerning the wounded and sick who are or have been under their care either to their own party or to an adverse party if this information would prove harmful to the patients or their families.[72]

Under IHRL, the right not to be subjected to arbitrary or unlawful interference with their privacy protects persons under the jurisdiction of a State against undue disclosure of medical and other private data to persons outside the relationship between health-care professional and patient.[73] Such disclosure may not take place except where it is explicitly based on national law, and the protection from "arbitrary" interference adds that even interference legitimized by law must be in conformity with the object and purpose of IHRL and reasonable in the particular circumstances of the case.[74]

67 The term "medical ethics" refers to a branch of ethics that deals with moral issues in medical practice. See World Medical Association, *Medical Ethics Manual*, 2nd ed., 2009, http://www.wma.net/en/30publications/30ethicsmanual/pdf/intro_en.pdf, p. 9.
68 *Commentary* on Arts 19, 24 and 35, GC I, pp. 196, 220 and 280; *Commentary* on Arts 12 and 21, AP I, pp. 166 and 250; *Commentary* on Art. 11, AP II, p. 1433.
69 Art. 18(3), GC I; Art. 16(1) and 16(2), AP I; Art. 10(1) and 10(2), AP II.
70 CESCR, General Comment No. 14, paras 33 and 43.
71 WMA Regulations in Times of Armed Conflict and Other Situations of Violence.
72 Art. 16, API and Art.10, APII.
73 Art. 17, ICCPR; Human Rights Committee, General Comment No. 16: The right to respect for privacy, family, home and correspondence, and protection of honour and reputation, 4 August 1988, http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/23378a8724595410c12563ed004aeecd?Opendocument, para. 10.
74 Human Rights Committee, General Comment No. 16, paras 3 and 4.

3.1.3. Sanctions

LEGAL FRAMEWORK

Arts 49-54, GC I

Arts 50-53, GC II

Arts 146-149, GC IV

Art. 85, AP I

Rules 156, 157 and 158, Customary IHL Study

Art. 8(2)(b)(vii), (ix) and (xxiv), and 8(2)(e)(ii) and (iv), Rome Statute

By acceding to IHL treaties, States commit themselves to ensuring compliance with IHL provisions and to taking all measures necessary to prevent and suppress violations of this body of law. Such measures may include penal sanctions as well as military regulations and administrative orders.

– Repressing war crimes[75]

States have further obligations concerning the most serious violations of the Geneva Conventions and Additional Protocol I, referred to as "grave breaches." IHL explicitly requires States to enact legislation to criminalize and punish those responsible for committing grave breaches; and to search for individuals alleged to have committed such crimes, bring them before their own courts or extradite them to another State for prosecution.[76] By means of these provisions, IHL grants all States universal jurisdiction over grave breaches. IHL requires – it does not just permit – all States to prosecute perpetrators of grave breaches, regardless of their nationality, the nationality of the victim or the place where the crime was committed.

Under customary IHL, neither amnesty nor statutory limitations may exempt those responsible for war crimes from being brought to justice.[77] It is important to note that IHL provides for both individual criminal responsibility and command responsibility for war crimes.[78] This means that commanders and other superiors are responsible for war crimes committed pursuant to their orders; they also incur criminal responsibility if they failed to take all necessary and reasonable measures in their power to prevent or punish the commission of war crimes when they "knew, or had reason to know that their subordinates were about to commit or were committing such crimes."[79]

Under the Rome Statute, attacks against hospitals or places where the wounded and the sick are collected and attacks against medical personnel, units and transports may constitute war crimes in both international and non-international armed conflict.[80] Additionally, if committed in the context of an armed conflict, rape and some other forms of sexual violence amount to war crimes and must be repressed accordingly.[81] Rape and other forms of sexual violence may also constitute other international crimes.[82]

75 For more detailed information on the repression of war crimes, please refer to the fact sheet prepared by the ICRC's Advisory Service, "Penal Repression: Punishing War Crimes", http://www.icrc.org/eng/assets/files/other/penal_repression.pdf.
76 Arts 49 and 50, GC I; Arts 50 and 51, GC II; Arts 129 and 130, GC III; Arts 146 and 147, GC IV.
77 Rules 159 and 160, Customary IHL Study.
78 Rule 151, Customary IHL Study, p. 554, "Forms of individual criminal responsibility."
79 Rules 152 and 153, Customary IHL Study. See also Art. 86(2), AP I.
80 See Art. 8(2)(b)(ix) of the Rome Statute: "Intentionally directing attacks against buildings dedicated to religion, education, art, science or charitable purposes, historic monuments, hospitals and places where the sick and wounded are collected, provided they are not military objectives"; Art. 8(2)(b)(xxiv): "Intentionally directing attacks against buildings, material, medical units and transport, and personnel using the distinctive emblems of the Geneva Conventions in conformity with international law"; Art 8(2)(e)(ii): "Intentionally directing attacks against buildings, material, medical units and transport, and personnel using the distinctive emblems of the Geneva Conventions in conformity with international law"; and Art. 8(2)(e)(iv): "Intentionally directing attacks against buildings dedicated to religion, education, art, science or charitable purposes, historic monuments, hospitals and places where the sick and wounded are collected, provided they are not military objectives."
81 See Art. 8(2)(b) (xxii) and 8(2) (e)(vi), Rome Statute.
82 The Rome Statute includes rape and other forms of sexual violence – "when committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack" – in its list of crimes against humanity (see Art. 7(1)(g), Rome Statute). Rape and other forms of sexual violence can also amount to torture when intentionally inflicted, for instance, by a State official in order to obtain confessions from the victim or a third party (e.g. see International Criminal Tribunal for the former Yugoslavia, *The Prosecutor* v. *Delalic et al. ("Celebici")*, 16 November 1998). Sexual violence can even constitute an act of genocide when, for instance, it is a measure imposed to prevent births within a group, through forced sexual mutilation, sterilization, and so on (e.g. see International Criminal Tribunal for Rwanda, *The Prosecutor* v. *Akayesu*, 2 September 1998).

– Ensuring effectiveness of sanctions

To repress war crimes and other violations committed against the effective provision of health care, States must take all measures necessary to ensure that the applicable rules and sanctions are incorporated into their domestic legal system, as well as into the institutional framework for those who are instrumental in the implementation of IHL. The importance of implementation, dissemination, education and training cannot be overstated in this regard.

Sanctions for violating the rules of IHL – whether criminal, disciplinary or administrative in nature – must at all times be accompanied by measures for improving adherence to the rules and respect for them; they should therefore incorporate measures for preventing the recurrence of violations, and should be pragmatic and realistic. Furthermore, sanctions must be certain in nature and implemented without distinction; and they should be applied as quickly as possible after the commission of the violation.[83]

Effective repression of IHL violations also depends on the ability and the experience of national authorities, particularly law enforcement and judicial authorities. Therefore, in implementing IHL provisions in the domestic legal system, repression may be better addressed *inter alia* by ensuring clarity and coherence of applicable provisions and providing training for judges and prosecutors.

– Violations of the right to health

Under IHRL, States have an obligation to take steps towards the progressive and full realization of the right to health for all individuals under their jurisdiction in a non-discriminatory manner, to the maximum of available resources. States are, by definition, responsible for any breach of this obligation.

In its General Comment No. 14, the CESCR makes a distinction between *violation through acts of commission* – which include a "formal repeal or suspension of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health" – and *violations through acts of omission,* which include "failure to enforce the relevant laws." The CESCR makes a further distinction between *violations of the obligation to respect*, *violations of the obligation to protect* and *violations of the obligation to fulfil*.[84]

In the framework of IHRL, any person or group of people whose right to health has been violated should have access to effective judicial or other suitable remedies at both the national and international levels.[85] With regard to the latter, it is worth mentioning the UN Special Rapporteur on the Right to Health,[86] the individual complaints mechanism created under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights[87] and regional bodies, such as the Inter-American Commission on Human Rights, which play an important role in protecting the right to health.

3.2. DOMESTIC LEGAL FRAMEWORKS – RESULTS OF THE BACKGROUND RESEARCH

Between 2012 and 2013, the ICRC Advisory Service on IHL conducted desk research on existing domestic normative frameworks for protecting the provision of health care. A detailed questionnaire was drawn up and sent to the Advisory Service's regional legal advisers, who collected relevant information in 39 countries from all regions of the world.[88] The results of these efforts – the main findings and analysis of the domestic normative frameworks in those 39 countries – are presented in this section of the report.

83 See A.-M. La Rosa, "Sanctions as a means of obtaining greater respect for humanitarian law: A review of their effectiveness." *International Review of the Red Cross*, Vol. 90, No. 870, June 2008.
84 General Comment No. 14, paras 47-52.
85 *Ibid*., para. 59.
86 Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
87 As at 1 September 2014, 15 States were party to this Optional Protocol (which entered into force in 2008).
88 Afghanistan, Argentina, Australia, Belarus, Bosnia and Herzegovina, Belgium, Brazil, Burundi, Cameroon, Chile, China, Colombia, Comoros, Croatia, Democratic Republic of the Congo, Egypt, Hungary, India, Côte d'Ivoire, Kazakhstan, Kenya, Malaysia, Mali, Mexico, Nepal, Nigeria, Niger, Pakistan, Peru, Philippines, Poland, Republic of Korea, Russian Federation, Senegal, Serbia, Spain, South Africa, Thailand and Uganda.

The countries were chosen with a view to reflecting the diversity of legal traditions, regional characteristics and health-care models (unitary vs federal States, private vs public health care, etc.) and the consequences for the provision of health care. On the basis of the responses to the questionnaire, the Advisory Service prepared six country studies, which are presented in Annex 1.

3.2.1 Introduction

All the States analysed have adopted domestic normative frameworks aimed at regulating the health-care systems on their territory. The legal framework varies both in substance and in form from one country to another; some are more detailed than others. Most States consider the right to health as a constitutional right[89] and have adopted legislation on access to health care, regulations for the health-care system and laws or acts for specific situations, such as natural disasters and other emergencies. In the majority of cases, however, normative frameworks do not define the scope of their application, since they do not explicitly refer to situations of armed conflict and other emergencies and thus remain comparatively general.

At present, only a few States have developed legal frameworks designed specifically to address situations of armed conflict and other emergencies.[90] In most contexts, however, protection for the provision of health care[91] is enacted through domestic legislation regulating the use of the distinctive emblems, thus covering only one aspect of the issue, or penal legislation, or, alternatively, provided for through other legal measures and military manuals. Where there are no specific legal frameworks covering armed conflicts and other emergencies, States have made it possible for the authorities to adopt the measures necessary to deal with emergencies when they arise.[92]

3.2.2. The protection of health care in domestic law and practice

Protection of the wounded and sick, health-care personnel and facilities and medical transports

– Protection of the wounded and sick

Various legal frameworks at the national level protect the wounded and sick. Constitutions include the right to health, specific provisions on health care exist, and administrative and criminal law penalize violations of this right.

Health-care systems vary from one State to another, as do conditions of access. Some States have adopted specific frameworks that guarantee access for the wounded and sick to the health-care system without imposing any conditions. Access of this kind is granted because those wounded and sick are regarded as or declared to be victims of a specific situation (an armed conflict or other emergency).

Colombia[93] is an interesting case since the country has had to deal with both an armed conflict – one that has now lasted for over 60 years – and other emergencies. Its health-care system has been adapted to take into account both these situations. A comprehensive system has been put in place to provide health-care services for victims of the armed conflict. As defined in the Victims and Land Restitution

89 Some examples: Argentina, Belarus, Bosnia and Herzegovina, Cameroon, Chile, Colombia, Côte d'Ivoire, Croatia, Egypt, Mexico, Nepal, Niger, Pakistan, Russian Federation, Senegal and Serbia.

90 **Colombia** is the most noteworthy example of a State that has developed normative frameworks specifically for the protection of health-care delivery in armed conflicts and other emergencies. In December 2012, the Ministry of Health issued decision 4481, adopting the Medical Services Manual (see http://www.icrc.org/eng/assets/files/2013/colombia-report--2012-icrc-eng.pdf).
In addition, a 2011 law on reparations for victims and restitution of land includes various provisions on access to health care, as part of the reparations for victims of the armed conflict.
The example of **Afghanistan** is also worth mentioning, where the law on disaster management includes two types of disaster: natural and man-made. As its title suggests, the former has natural causes; the latter is the result of human agency (fires, plane crashes, explosions, conflicts, cyber threats, and so on).
Belgian law recognizes two types of emergency: (i) situations of collective emergency and (ii) demonstrations.

91 For the purposes of this workshop, the term "medical mission" covers the following: (1) health-care facilities and medical transports (e.g. hospitals, clinics, first-aid posts and ambulances); (2) health-care personnel (e.g. personnel working in medical facilities or ambulances, or independent practitioners); (3) Red Cross and Red Crescent staff involved in the delivery of health care, including volunteers; (4) health-oriented NGOs; and (5) military health-care facilities and personnel and military medical transports.

92 For example, in **Belarus**, Art. 63 of the Law on Health Care stipulates that during emergencies, rescuers, personnel from the Ministry of the Interior and other officials must take the measures necessary to provide assistance for persons in need of emergency health care.

93 Please refer to the Country Study on **Colombia** in Annex 1.

Law of 2011, they have the right of free access to health care. This law contains a list of health-care services to which victims of the armed conflict are entitled. Special emphasis is laid on access to abortion services for victims of sexual violence when such cases are covered by the jurisprudence of the Constitutional Court, and on support for the sexual and reproductive rights of women.

In **Peru**, the reparation plan for victims of the violence that took place between 1980 and 2000 includes a health programme that grants them the right of free access to health care. In addition, the Ministry of Health issued a resolution in 2012 containing guidelines for the provision of psychosocial support for the families of missing persons.

Modalities of access to health-care services can vary in times of armed conflict and other emergencies. For example, in **Belgium**, domestic legislation establishes that during emergencies no formality is required to have access to health-care services.

– Protection of health-care personnel

Health-care personnel and health-care activities

In almost every case, domestic normative frameworks provide a definition of the expression "health-care personnel."[94] "Health-care personnel" is defined in the domestic legal frameworks regulating the public health-care system, in particular the provisions relating to different categories of health professionals (e.g. physicians, nurses, dentists). In addition, definitions of "health-care personnel" can be found in laws protecting the red cross, red crescent and red crystal emblems.[95]

The diversity of domestic normative frameworks attests to the many ways in which the term "health-care personnel" is defined in the context of armed conflict and other emergencies.[96] The activities carried out by health-care personnel are also enshrined in various ways in domestic legislation and include, notably, diagnosis, preventive and special care, emergency care and assistance, and transportation and treatment of the wounded and sick.[97]

94 A resolution of the Ministry of Health in **Colombia** adopts the following general definition of "medical personnel": "health-care professionals or persons from other disciplines exercising health-related functions, in the context of armed conflict or other emergencies."
In the **Russian Federation**, "medical personnel" is defined in Federal Law 323-FZ, Art. 2 (cl.13) as follows: "an individual who possesses medical or other education, is working in a medical institution, and his or her job duties include medical activities, or an individual being an individual entrepreneur, directly engaged in medical activities." In the case of disasters, the same personnel will also act as rescuers.

95 For example, in **Belarus** the law on the emblem gives a definition of "medical personnel' in Art. 2: "persons appointed on a permanent or temporary basis for searching, picking up, transporting, diagnosing or treating the wounded and the sick, shipwrecked persons, including rendering of first aid, for preventive measures against diseases, and also for economic, material and technical supplying of medical formations". See http://law.by/main.aspx?guid=3871&p0=H10000382e

96 Domestic law contains numerous definitions of "medical personnel", as do regulations governing medical activities and health services. Definitions of the term in connection with armed conflict can be found in a number of military manuals. See, for example, **Australia**'s Law of Armed Conflict (LOAC) Manual (2006); **Cameroon**'s Instructor's Manual (2006); **Peru**'s IHL Manual (2004); **South Africa**'s Revised Civic Education Manual (2004) or **Spain**'s LOAC Manual (2007). These definitions take into account the IHL definition of the term.

97 In **Côte d'Ivoire**, the term "medical activities" includes preventive care, healing, and special care. In **Burundi**, it includes diagnosis, preventive and special care, training of new personnel, planning and supervision. The law on the emblem in **Belarus** says that health-care personnel can carry out the following activities: searching for, picking up, transporting, diagnosing and treating the wounded and sick and the shipwrecked; providing first aid; disease prevention; and providing logistical support for the operations of medical units. Activities of medical personnel under the regulations of the **Russian** Service for Disaster Management include the following: provision of medical aid during emergencies, emergency care and assistance, ensuring effective response to emergencies, emergency forecasting and rescuer training.
The **Belgian** armed forces provide medical support that includes: (i) caring for the wounded, sick and shipwrecked, civilian and military, including evacuation; (ii) distributing medical supplies; (iii) educating local people in the general principles of preventive medicine and hygiene and making them aware of the health hazards of the environment; (iv) advising local authorities on medical matters such as prevention and, if necessary, providing support; and (iv) participating in the collection and transportation of dead bodies.
States also include the activities carried out by medical personnel in their laws dealing with disasters and other emergencies. For example, the regulations governing the All-**Russian** Service for Disaster Medicine contain the following list of medical activities: (i) provision of medical aid during emergencies; (ii) emergency care and assistance; (iii) ensuring effective response to emergencies; (iv) improving the capabilities of the Service; (v) expertise development and control-of-population emergency (including medical) protection measures; (vi) emergency forecasting; (vii) rescuer training; and (viii) other tasks.
The Medical Services Manual in **Colombia** (see http://www.icrc.org/eng/assets/files/2013/colombia-report--2012-icrc-eng.pdf) defines the following as "medical activities": searching for, collecting and transporting the wounded and the sick, as well as providing first aid, medical diagnoses and physical rehabilitation for them; administration of medical units and transports; prevention of disease including measures such as vaccination programmes; control of water sources; the zoonosis programme; extramural care; and in general, every humanitarian service related to health care.

Exceptional measures have been established in some contexts to provide health care in emergency situations. For example, in **Belgium**, those who are not lawfully qualified to practise medicine may do so under exceptional circumstances: they are entitled to perform certain medical tasks after a disaster or during a war.[98]

An important aspect of the definition of health-care activities is the inclusion of traditional medicine,[99] as many people would rather have access to these types of treatment. That is why different States have adopted legal frameworks that specifically regulate such medical practices.[100]

Respecting and protecting health-care personnel

One of the fundamental aspects of guaranteeing the safe delivery of and access to health care is ensuring respect and protection for health-care personnel and facilities. In most of the contexts analysed, health ministries and health authorities at various levels oversee the management of civilian health-care personnel; defence ministries are in charge of the medical personnel of the armed forces.

Beyond the control exercised over health-care personnel, the adoption of measures to ensure respect and protection for them is crucial for preventing attacks of any kind against them or violent interference with their work. This is especially important in situations where threats are made against health-care personnel and their families. The creation of specific tools and mechanisms for ensuring their safety is one possible solution: for example, hotlines that health-care personnel could use to contact State authorities with requests for evacuation or protection.

In **Afghanistan**, some preventive measures have been adopted to protect the delivery of health care as well as the wounded and sick. The Police Law requires the police to protect public and private health-care facilities and medical transports. Private hospitals are entitled by law to adopt the security measures necessary to guarantee the safety of patients and medical staff. It should be noted that in Afghanistan there are no mechanisms, at present, for monitoring the implementation of these legal obligations.

In **China**, specific measures have been established for protecting Red Cross staff. Those impeding the work of Red Cross personnel on duty during disaster relief and emergency response through violence or threats are subject to the same criminal punishment as those hindering the work of government officials.

– Protection of health-care facilities and medical transports

In almost every case, domestic legislation provides definitions of health-care facilities and medical transports, either in the laws that organize and regulate the health-care system or in those that protect the red cross or red crescent emblem.[101]

Health-care services may be provided by private companies or be part of the public health-care system.[102]

98 Please refer to the Country Study on **Belgium** in Annex 1.

99 Traditional medicine is defined by the World Health Organization (WHO) as "the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness." See WHO website: http://www.who.int/medicines/areas/traditional/definitions/en/.

100 For more information, please refer to WHO, *Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review*, WHO, 2001, http://apps.who.int/medicinedocs/pdf/h2943e/h2943e.pdf.

101 For example, Art. 2 of **Nigeria**'s emblem law defines "medical units" as "stationary or mobile medical institutions and other civil or military units, acting on a permanent or temporary basis in order to search, pick up, transport, diagnose or treat and care for the sick, wounded and shipwrecked, including the provision of the first aid and disease prevention." It defines "medical transports" as "any means of transportation, whether military or civilian, assigned exclusively to quickly transfer people in emergency situations to medical facilities, and this could be air ambulance, helicopters or vehicle ambulances, hospital ships, medical aircraft. These vehicles, ships and aircraft must be exclusively assigned to the conveyance of the sick, medical personnel, medical equipment or medical supplies."

102 Please refer to the Country Study on **Colombia** in Annex 1.

The distinctive emblems

Almost every country under study has adopted domestic legislation protecting the emblem, as envisioned under Article 54 of the First Geneva Convention[103] States that have not adopted a specific law protecting the emblem have included such provisions in their criminal codes[104] or have incorporated appropriate guidelines into their military manuals.[105] Some States, however, are yet to draft any legislation on this matter.[106]

Although most countries have adopted domestic legislation protecting the emblem, the need for effective implementation remains, as well as the need for supplementary domestic measures[107] that provide detailed regulation of use of the emblem.

It is the government that authorizes and controls the use of the emblem. In some contexts, the defence ministry supervises use of the emblem by the medical services of the armed forces, while military or civilian authorities, such as the health ministry, can do so for civilian hospitals and objects.[108] The competence to authorize use of the emblem as a protective device by civilian hospitals and objects can also be delegated to National Societies.[109]

Protected health-care activities can also be identified by means other than the red cross, red crescent and red crystal emblems.[110] This is the case in **Colombia**, which has created and adopted its own means of identification for health-care activities (referred to as medical missions). Since use of the red cross, red crescent and red crystal emblems is subject to very strict conditions and they can be used as protective devices in times of armed conflict only, the use of other distinctive signs has the potential to enhance protection for health-care activities in situations of emergencies that do not reach the threshold of armed conflict and to prevent the risk of emblem misuse as defined by IHL.

Medical ethics and confidentiality

During armed conflict and other emergencies, the protection of patients' personal data and the disclosure of such information are among the most crucial issues in connection with medical ethics and confidentiality. Some States have adopted a policy of complete confidentiality with respect to information contained in medical files and the reporting of certain wounds; but there is no rule in international law that prohibits a State from adopting legislation making it compulsory to provide information – for instance to deal with potential epidemic diseases – and a number of States have done so.[111]

Most States have developed domestic legislation on medical ethics and confidentiality, but without specific reference to armed conflict and other emergencies. In **Spain**, however, the Criminal Code and

103 Art. 54, GC I, states that "[t]he High Contracting Parties shall, if their legislation is not already adequate, take measures necessary for the prevention and repression, at all times, of the abuses referred to under Article 53."
104 See, for example, Côte d'Ivoire, Senegal and Uganda.
105 Please refer to "Military Manuals" under "Practice" in Rule 30, Customary IHL Study, https://www.icrc.org/customary-ihl/eng/docs/v2_rul_rule30.
106 See, for example, Burundi, Côte d'Ivoire, Nepal, Peru, Russian Federation and South Africa. In **Nepal**, the emblem is protected by a decision of the Ministry of Health that is included in the army handbook on the law of armed conflict. There is no legal framework that specifically protects the emblem. In the **Russian Federation**, even though according to the Constitution international treaties are part of the domestic legal system, no specific law protecting the emblem has been adopted and no government agency appointed to oversee its proper use.
107 Please refer to the Country Study on **Mexico** in Annex 1.
108 In **China**, for example, governments at different levels, with the assistance of the National Society, oversee the use of the emblems and deal with misuse. Protective use of the red cross emblem is authorized and monitored by the State Council and the Central Military Committee, and indicative use is authorized and monitored by the Red Cross Society of China.
In **India**, Section 12 of the Geneva Conventions Act – in accordance with the Geneva Conventions – prohibits use of the red cross and other emblems without the approval of the Central Government. As India has not ratified AP III, there is no specific legal protection for the red crystal emblem under domestic legislation. In addition, the Indian Red Cross Society's Rules for State/UT/District Branches, drawn up under Section 5 of the Indian Red Cross Society Act of 1920, contain certain provisions that relate to the emblem and to members' duties to ensure its proper use.
109 For more information on the role that National Societies can play in authorization of use of the emblem for protective purposes, please refer to the ICRC publication *Study on the Use of the Emblems – Operational and Commercial and other Non-operational Issues*, 2001, pp. 60-64. This publication can be consulted online at http://www.icrc.org/eng/resources/documents/publication/p4057.htm.
110 Please refer to the "Legal framework" under Section 3.
111 Rule 26, Customary IHL Study. See, for example, **Philippines** Executive Order 212, para. 276.

the Military Criminal Code contain rules that do refer to medical ethics during armed conflict.[112] By contrast, in **Hungary**, the medical services of the armed forces are not governed by specific regulations on medical ethics or medical confidentiality; the regulations governing civilian health-care services are, according to the Ministry of Defence, applicable to them as well.

In **Belgium**, the Code of Medical Ethics (Section 55) requires doctors to ensure professional secrecy regardless of the circumstances. Section 458 of the Belgian Penal Code condemns any violation of professional secrecy, unless the provider is called upon to testify in a court or before a parliamentary commission of inquiry, or required by law to disclose confidential information that has been entrusted to him. Under **Afghan** law, exceptions to medical confidentiality have been established to preserve public order and security; to assist in preventing the commission of a crime or in arresting perpetrators of crimes; and to prevent the spread of communicable diseases that would affect large numbers of people. In **Russia**, medical confidentiality is established in accordance with Federal Law No.323-FZ (Art. 13); there is also an exhaustive list of situations in which confidential medical information may be disclosed to third parties. This list does not indicate whether such confidentiality is applicable to armed conflict or other emergencies, but it makes reference to certain situations constituting emergencies: (i) threat of epidemic or mass poisoning; and (ii) investigation of accidents at work.

Recent cases in which health-care personnel have been prosecuted for providing health care to members of non-State armed groups appear to be in contradiction to some of the most basic principles of medical ethics. In some cases, which have been the subject of judicial decisions at the national level, domestic courts have found health-care personnel guilty of committing acts of terrorism or rebellion, or of providing support for terrorism by providing health care to members of non-State armed groups. In particular, the case of *De La Cruz-Flores* v. *Peru* has been the subject of a decision by the Inter-American Court of Human Rights.[113]

Sanctions

Various legislative approaches may be envisaged by State authorities to incorporate sanctions for violations of the rules protecting the provision of health care into their domestic legal framework, thus complying with their obligation to effectively repress, suppress and prevent those violations.[114] Sanctions may be criminal, disciplinary or administrative in nature, and combinable according to the seriousness of the violation committed.

In **Kenya**, the Geneva Conventions Act provides for the repression of grave breaches of the Conventions. In addition, Section 8 of the International Crimes Act gives the High Court jurisdiction over war crimes committed in Kenya or elsewhere if either the perpetrator or the victim is a Kenyan citizen or if the perpetrator is currently in the country. The Kenyan Defence Forces Act also provides for disciplinary measures for some of the offences under the Act; these include dismissal from the armed forces, reprimands, fines and prison sentences.[115] Violations of IHL are also subject to disciplinary measures under the military manuals of Belarus and Russia.

112 The Military Criminal Code and the Criminal Code contain rules on medical ethics that are relevant during armed conflict. Art. 76 of the Military Criminal Code prohibits unjustified medical experimentation. Art. 609 adds a prohibition of any medical acts not indicated for the well-being of the patient or not conforming to generally accepted medical rules. Finally, Art. 612(3) makes it mandatory to provide appropriate medical assistance, as well as to inform the patient of his or her condition. These are prohibitions that offer a basic but effective way to ensure medical ethics are upheld in armed conflicts.

113 Inter-American Court of Human Rights, *De La Cruz-Flores* v. *Peru. Merits, Reparations and Costs*. Judgment of November 18, 2004, para. 102. The Court found that the State had violated the principle of legality by taking into account, as elements that gave rise to criminal liability, membership in a terrorist organization and failing to comply with the reporting obligation by applying an article that did not provide a definition for these actions; by not specifying which of the actions set out in Art. 4 of Decree Law No. 25,475 had been committed by the plaintiff in order to be found guilty of the crime; for penalizing a medical activity, which is not only an essential lawful act but also one that a physician is obliged to provide; and for imposing on physicians the obligation to report the possible criminal behavior of their patients, on the basis of information obtained in the exercise of their profession.

114 For more information on domestic approaches to repressing international crimes, please refer to the ICRC publication *Preventing and repressing international crimes: Towards an "integrated" approach based in domestic practice*, report of the Third Universal Meeting of National Committees for the Implementation of International Humanitarian Law, February 2014.

115 For further details see the Country Study on **Kenya** in Annex 1.

In **Serbia**, the Criminal Code covers war crimes committed against the civilian population and the wounded and sick; cruel treatment of the wounded and sick and prisoners of war; and misuse of internationally recognized emblems. As far as administrative sanctions are concerned, health-care facilities can be fined for (i) violating data protection rules and (ii) in epidemics and other disasters, when they do not submit accurate data on the situation to the pertinent State bodies. The law also provides for the fining of people responsible for health-care facilities. Furthermore, the Law on the Use and Protection of the Emblem and the Name of the Red Cross imposes fines for unauthorized use of the red cross emblem.

Similarly, in **Senegal**, misuse of the red cross emblem and other distinctive emblems is criminalized, and according to the Law Relating to the Use and to the Protection of the Red Cross and Red Crescent Emblem, an offender may be sentenced to a fine and/or up to five years of imprisonment. The length of the sentence is doubled if the violation is committed during armed conflict. A number of provisional measures are envisaged in the Senegalese domestic normative framework, including seizure of the objects bearing the distinctive emblem, the person responsible for the violation shouldering whatever expense this entails.

Amnon Gutman/ICRC

4. THE BRUSSELS WORKSHOP: DISCUSSIONS AND RECOMMENDATIONS

4.1 GENERAL REMARKS

The present section of the report contains a summary of the discussions held in the working groups and during the plenary sessions held after each working group session, and reflects to the best possible extent the various points of view expressed by the participants. The recommendations formulated in this section are therefore the product of extensive discussions and exchanges between all participants about good practices and the challenges experienced in their respective countries with regard to protection of the provision of health care in armed conflict and other emergencies.

The participants were divided into four working groups based on their language preferences to form one French-, one Spanish- and two English-speaking groups. Four working group sessions, corresponding to the four main topics previously identified by the ICRC, were held. In preparation for the workshop, all participants received a background document summarizing the rules deriving from the international legal framework protecting the provision of health care, together with the results of the desk research conducted by the Advisory Service on domestic legal frameworks.[116] With a view to facilitating and guiding the debate within the working groups on the most important issues in relation to each theme, the Advisory Service also prepared a further document setting out, for each working group session, precise questions for discussion.

Given that not all countries have reached the same level of implementation in their domestic legislation of the international legal framework regarding the protection of and access to health care, it is important that State authorities identify which of those recommendations are relevant in their own contexts and take appropriate measures to implement them. Identifying which recommendations make sense in a given context also requires that States have a comprehensive understanding of the nature and causes of violence against health care occurring on their territory.

On the other hand, the fact that a State has adopted an extensive legal framework for the protection of health care does not necessarily mean that it has fully complied with its international obligations. Indeed, States that are well advanced in terms of domestic implementation can still face challenges in ensuring respect for the law and effective protection of the provision of and access to health care on their territory. These countries might need to focus, for example, on the dissemination of the rules, on training the stakeholders concerned and potential perpetrators of violence against health care, and on enhancing the effectiveness of their criminal justice and sanctions systems.

116 For more information on the background research, please refer to Section 3.2.

Overall, the recommendations extracted from the discussions revolved around three major types of measures, namely:

- Legislative measures for the implementation of the existing international legal framework;
- Dissemination, education and training;
- Coordination between the stakeholders concerned.

4.2. DISCUSSIONS AND RECOMMENDATIONS

4.2.1. First session: How to make legal protection for the wounded and sick, health-care personnel and facilities and medical transports more effective

Discussion

Situations of armed conflict and other emergencies often render the provision of and access to health-care services and facilities more difficult or hazardous. On the basis of the principle that health-care personnel and facilities and medical transports must be protected against all forms of violence and that the wounded and sick must have access to impartial health-care services[117] in all circumstances, participants discussed various types of domestic measures that could be envisaged to enhance protection of the provision of health care and to guarantee effective and safer access to health care in situations of armed conflict and other emergencies, where it is often most needed.

In the course of this first working group session, some participants expressed reservations with regard to use of the expression "other emergencies," mentioned in Resolution 5 adopted at the 31st International Conference of the Red Cross and Red Crescent, given the fact that it is not clearly defined in international law, and requested that its scope of application be defined by the State concerned, in line with the applicable legal framework. Therefore, these participants were of the view that the HCiD project should focus on enhancing the protection of the provision of health care in situations of armed conflict. By contrast, other participants considered that the HCiD project should also cover the protection of health care in emergency situations that do not reach the threshold of armed conflict.

Participants were asked the following questions:

- Should there be a specific legal framework for protection of the provision of health care in armed conflict and other emergencies, or any specific emergency legislation, or is the existing legal framework also applicable in those situations?
- Does the monitoring of health-care personnel and facilities and medical transports include measures for their protection as well as mechanisms for tracking threats or attacks against them?
  - If so, what are the criteria for recording incidents, based on a contextual analysis of the nature of violent incidents?
  - Who should manage such monitoring mechanisms (State authorities or other stakeholders)?
- What else is needed to develop and implement safety measures at the domestic level to guarantee effective and safer access for the wounded and sick to the health-care system?
- What additional measures need to be put in place to address the health-care needs of victims of sexual violence in armed conflict and other emergencies?
- Are other types of medical treatment (e.g. traditional medicine) included in the notion of medical mission?

117 Impartiality is one of the seven Fundamental Principles of the International Red Cross and Red Crescent Movement and proscribes any discrimination based on nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Recommendations

RECOMMENDATION (1): STATES MUST TAKE APPROPRIATE MEASURES TO IMPLEMENT THEIR INTERNATIONAL OBLIGATIONS WITH REGARD TO THE PROTECTION OF HEALTH CARE IN THEIR DOMESTIC LEGAL FRAMEWORK IN A WAY THAT TAKES INTO ACCOUNT THEIR NATIONAL SPECIFICITIES AND ENSURES EFFECTIVE PROTECTION AND ACCESS TO HEALTH CARE IN ALL CIRCUMSTANCES

When developing their domestic legal framework for the protection of health care, State authorities should consider the advantages and disadvantages of both specific legislation applicable to armed conflict and other emergencies and general legislation applicable in all circumstances.

Participants were invited to reflect on the advantages and disadvantages of developing a specific domestic legal framework applicable to situations of armed conflict and other emergencies,[118] alongside other legislation applicable in peacetime, rather than a general legal framework applicable in all circumstances. While opinions diverged widely among the groups, most participants agreed that a specific legal framework has the advantage of providing clear provisions that require less interpretation and that are better suited to situations of armed conflict and other emergencies. However, this is more likely to be inefficient in practice because of the process of deciding whether a situation amounts to an armed conflict or another emergency, undertaken by State authorities, which is generally subject to political considerations. In fact, a State might be reluctant to classify an existing situation on its territory as an armed conflict, or, to a lesser extent, as an emergency.[119] By contrast, most participants underlined that a general legal framework making no reference to any particular situation and thus applicable in all circumstances offers the advantage of avoiding the issue of the classification of situations by State authorities.

Some participants disagreed on the relevance of developing legislation applicable to other situations of emergency, arguing, notably, that the term was not sufficiently defined by international law. By contrast, other participants considered that enhanced protection for health care was needed in countries dealing with various forms of internal violence or disturbances that do not reach the threshold of armed conflict.

It was generally agreed that in the event that a State chose to adopt a specific domestic framework applicable to armed conflict and other emergencies, whether in the form of a single body of legislation applicable to both situations or in the form of distinct laws, it would be the responsibility of each State to define and circumscribe precisely the expression "other emergency" in its domestic legislation. It was also pointed out that specific legislation would need to be appropriately disseminated to make all relevant stakeholders aware of its existence and to include specific training for health-care personnel.

Implementation of the international legal framework for the protection of health care must take into account the specificities of each domestic legal system (e.g. civil- vs common-law systems) and distribution of jurisdictional competencies (e.g. federal vs. centralized States).

Participants rejected the idea of a universal solution with regard to the question of the specificity of the legal framework for the protection of health care, and underlined the importance of taking into account the characteristics of each State in terms of legal system and distribution of jurisdictional competencies. For example, the distribution of legislative powers between the central authority and federated entities in federal States can affect the ability of State authorities to legislate in matters relating to the protection of health care and also on issues relating to situations of armed conflict or other emergencies. Whether general or specific, it is understood that the domestic legal framework for protection of the provision of health care must reflect international obligations and be comprehensive and coherent.

118 This option includes, in addition to general legislation applicable in peacetime, specific legislation applicable in situations of armed conflict and other emergencies, or specific legislation applicable to armed conflict and further rules applicable to other emergency situations.

119 For example, a situation of armed conflict entails the application of the obligations set forth in the Geneva Conventions and its Additional Protocols (e.g. with regard to the protection of the civilian population or the protection of prisoners of war).

Most importantly, it must be designed in such a way as to ensure the most effective protection for the provision of and access to health care.

RECOMMENDATION (2): STATES SHOULD DEVELOP A BETTER UNDERSTANDING OF THE NATURE OF VIOLENCE AGAINST HEALTH CARE ON THEIR OWN TERRITORY, INCLUDING ALL TYPES OF UNDUE INTERFERENCE WITH THE PROVISION OF HEALTH CARE, IN ORDER TO ELABORATE AN ADEQUATE RESPONSE

Set up a national system for collecting data on the occurrence of violence against health-care personnel and facilities and medical transports as well as against patients, including all types of interference with the provision of health care.

Participants underlined the general lack of information on the nature of violence against health care in their respective countries, with regard notably to its causes, perpetrators and consequences. The establishment of a national data-collection system on the occurrence of all forms of violence against health care (including undue pressure on health-care personnel for violating their ethical duties, such as their obligation to observe medical confidentiality) was thus considered essential in order to have a better understanding of the prevailing situation in a given context and to allow State authorities to develop an adequate follow-up strategy and a practical protection response. The particular points discussed in this regard concerned what should be reported in the context of data collection, who should draw up the report and what national authority or entity should take responsibility for collecting information and managing such a system, as well as how and for what purpose the data should be collected, used and protected.

Generally, participants agreed that this system should be established by State authorities in peacetime as a preventive measure and respond to certain criteria. Notably, a national data-collection system should:

1. **Be guided by clear criteria**, classifying data in context-specific categories (for example, the legislation creating such a system should precisely define what type of information is to be collected and how it is to be organized);
2. **Be managed by State authorities** (e.g. the health and interior ministries and, where such a post exists, an Ombudsman[120]) and involve all stakeholders concerned with the health-care system (medical associations, etc.), coordination between all stakeholders being essential;
3. **Be independent and transparent** with a view to ensuring the reliability of the data collected;
4. **Serve the purposes of analysis only** (not intended to be used in criminal prosecution);
5. **Ensure protection of the use of and access to** the data collected.

In order to prove useful for understanding the nature of violence against health care and contribute to the development of practical measures to address it, the data collected should be carefully organized and analysed according to pre-defined criteria. It was considered essential that the establishment of such a national data-collection system be accompanied by a follow-up strategy and that the concrete operational protection measures developed by State authorities be adapted to each particular context.

Furthermore, there was general acknowledgement that this system should be created and managed by State authorities, some participants suggesting that the health and interior ministries have a crucial role to play in the process. It was deemed important that the collection of information, the analysis mechanism and supervision of the system involve all stakeholders concerned with the provision of health care, coordination between all stakeholders being considered as essential to its effectiveness.

Participants were of the view that the purpose and function of this system should be clearly defined to ensure that it serves the purposes of analysis only and that the use of and access to the data collected

120 In the context of the discussions, the term "Ombudsman" was used to refer to an independent and objective government official who has the duty to hear and investigate complaints by private citizens about other officials or government agencies.

should be adequately protected and regulated, for example by ensuring the confidentiality of the information collected. While some participants suggested that this information could potentially be used in criminal prosecutions, most agreed that the confidentiality of personal data collected would encourage more cooperation between stakeholders and ensure that the information gathered better reflects reality. Appropriate measures should be taken to guarantee independence and transparency of the system.

A national data-collection system could be complemented by an international system for consolidation and comparison of data in order to have a comprehensive understanding of the nature of violence against health care worldwide and foster cooperation between States in developing global coordinated strategies for the protection of health-care personnel and facilities and medical transports.

It was also suggested that national monitoring could be complemented by an international system that would allow for consolidation and comparison of data in order to gain a global understanding of the nature of violence against the delivery of health care worldwide, and hence to foster cooperation between States in order to develop global strategies and coordinated protection responses for health-care personnel and facilities and medical transports.[121]

RECOMMENDATION (3): PREVENTIVE AND SAFETY MEASURES FOR PROTECTING THE PROVISION OF, AND GUARANTEEING SAFER ACCESS TO, HEALTH CARE SHOULD INCLUDE EDUCATION, TRAINING AND DISSEMINATION OF THE EXISTING LEGISLATION

States should take appropriate measures to train the armed and security forces, civil servants, health-care personnel and the population at large about the national legislation protecting the provision of and access to health care (including the right to health).

Many participants emphasized that one of the main obstacles to the effective protection of the delivery of health care in many contexts was not the lack of domestic legislation but rather the fact that persons responsible for observing and applying the rules protecting the provision of and access to health care are often not aware, or fully conscious, of the extent of their obligations or in what circumstances these are applied. It was generally recommended that State authorities take appropriate measures to ensure specific training to explain those rules to members of the armed and security forces (military and police) and, where applicable, to non-State armed groups[122] as well as to civil servants of the national authorities concerned, such as the health, interior and justice ministries.

State authorities should raise awareness of the importance of respecting health-care personnel and facilities and medical transports.

Participants stressed the importance of raising awareness among the armed and security forces, non-State actors and the population at large about the serious consequences of violence against health-care personnel and facilities and medical transports, including undue pressure on health-care personnel to give priority for treatment, not based on medical criteria, to their military or police units or family members, as well as other types of threats to the life and security of health-care personnel. These forms of lack of respect for health-care personnel can occur in all circumstances, including in peacetime, but are more likely to have devastating consequences on the humanitarian situation in conflict zones where health-care personnel who become victims of such threats are forced to flee their workplaces, leaving the local population without health care in times when it is often most needed.

There should be an obligation to rescue or provide assistance to people in need of urgent medical care under domestic law which is applicable and subject to criminal sanctions in all circumstances, including armed conflict and other emergencies.

121 In this context, mention was made of the example of WHO, which was tasked by States at the Sixty-fifth session of the World Health Assembly in 2012 to develop a global methodology on collecting data on violence against the delivery of health care.

122 The term "non-State armed groups" includes militias, private security agents as well as rebel and guerrilla movements that are not part of a State's law enforcement, military or security apparatus.

Many participants agreed that an obligation on all individuals to rescue or provide assistance to people in need of urgent medical care could contribute to enhancing access of the wounded and sick to health-care services in times of armed conflict and other emergencies. This obligation already exists in many countries. In **Colombia**, for example, this obligation derives from a constitutional "duty of social solidarity"[123] and any contravention may lead to imprisonment under the Criminal Code.[124] In **Belgium**, the failure to assist or to obtain assistance for a person in grave danger is punishable under the Belgian Criminal Code (Section 422bis) by imprisonment of eight days to one year and/or by a fine of 50 to 500 euros.[125]

RECOMMENDATION (4): STATES SHOULD TAKE APPROPRIATE MEASURES TO ENHANCE COORDINATION BETWEEN THE DIFFERENT STAKEHOLDERS INVOLVED IN THE PROVISION OF EMERGENCY HEALTH-CARE SERVICES IN ORDER TO ALLOW FOR A BETTER-ORGANIZED AND MORE EFFICIENT EMERGENCY RESPONSE

Domestic legislation should clearly define the respective roles and responsibilities of the different stakeholders acting in the provision of emergency health care.

During discussion of the roles and responsibilities of the different stakeholders providing health-care services in situations of armed conflict and other emergencies, a need for enhancing coordination between those stakeholders in order to provide better-organized and more efficient health care for those affected by armed conflict and other emergencies was identified. One observation was that the respective roles of health-care providers in the provision of emergency health-care services were sometimes not precisely defined in domestic legislation. Therefore, it was deemed very important that State authorities clearly designate, in advance and through laws or regulations, those who are allowed to provide emergency health care in situations of armed conflict and other emergencies, as well as the acts that they are authorized to perform. Domestic legislation should also describe precisely the circumstances in which those provisions come into effect.[126]

The definition of the respective responsibilities of the different stakeholders involved in emergency response can take various forms, depending among other things on the specificities of each State's legal system. In **Peru**, for example, the Disaster Response Law[127] defines the roles of the different stakeholders acting in emergency situations and establishes mechanisms of joint intervention, which coexist with professional associations of health-care professionals and hospitals' own internal regulations, all designed to enhance the channelling of medical assistance in emergency situations.[128]

In **Belgium**, on the other hand, a Royal Decree[129] provides that, when health care is lacking or inadequate in a province, the medical commission shall, on its own initiative or at the request of the provincial governor, request that certain organizations or practitioners set up health-care services or supplement existing ones. In addition, during a war or other calamity, persons who do not qualify as health-care practitioners under national legislation but who have followed special training for that purpose may carry out certain medical procedures, in particular where such procedures are urgently required and not enough accredited practitioners are available. These provisions are complemented by an agreement signed in 2012 between the Federal Public Service in charge of Public Health and the Belgian Red Cross, stating that the latter is responsible for setting up rapid-response services and for providing urgent

123 Art. 95 of the Colombian Constitution: "… The following are duties of each person and each citizen: (…) 2. To strive, in accordance with the principle of social solidarity, to respond with humanitarian actions when faced with situations that endanger the life or health of individuals…"

124 Art. 131 of the Criminal Code (Law 599 of 2000): "Failure to provide assistance/relief: A person who fails, without just cause, to assist a person whose life or health is in grave danger, shall be liable to imprisonment."
Art. 152 of the same law: "Failure to provide humanitarian assistance and relief measures: A person who fails, within and during the armed conflict when so obliged, to adopt assistance and humanitarian relief measures in favour of protected persons shall be liable to imprisonment."

125 See Country Study on Belgium in Annex 1.

126 See Recommendation (1). If these provisions apply to situations of "other emergencies", the term "other emergencies" needs to be properly defined in order to avoid ambiguities in its interpretation, p. 37.

127 "Ley de Respuesta a los Desastres."

128 For more information, please refer to the Country Study on **Peru** in Annex 1.

129 Royal Decree No. 78 of 10 November 1967 on the exercise of health-care professions.

medical care.[130] Moreover, each year, the Federal Public Service of Public Health grants the Belgian Red Cross a subsidy in support of services that contribute to providing urgent medical care and for the organization of psychological assistance in public emergencies and other situations of danger.

State authorities should take appropriate measures to ensure knowledge on the part of the different stakeholders acting in the provision of emergency health care about each other's roles and responsibilities in order to ensure their comprehensive understanding of the organization of emergency response.

Another issue raised was that health-care providers are often unaware of other stakeholders' roles and responsibilities in providing emergency health care, which is likely to create confusion and delays in the provision of health care in situations of armed conflict and other emergencies. While legislation can sometimes be scattered through different laws and regulations, it is essential that State authorities take appropriate measures to ensure that health-care providers have a comprehensive understanding of the organization of emergency response. This could be done by providing special training for all stakeholders likely to intervene in emergency response, including simulation exercises and/or the drafting of handbooks and guidelines to provide tools for their work.

Every State should have a plan of coordination, involving all stakeholders, to organize emergency response and the provision of health-care services in times of armed conflict or other emergencies.

In addition to clearly defining the different stakeholders' roles and responsibilities in the provision of emergency health care, participants identified the need for every country to have a national plan of coordination for emergency response in times of armed conflict and other emergencies, which may include various practical measures to ensure the effective provision of health-care services to those in need.

Many countries already have such a plan. In **Senegal**, a plan for the organization of emergency services, referred to as "Plan ORSEC,"[131] can be launched by State authorities when certain conditions are met.[132] This plan identifies the different State institutions involved in emergency response and provides for the establishment of a coordination mechanism as well as a crisis cell responsible for follow-up on the provision of health-care in such circumstances. This plan is coordinated by the Ministry of Internal Affairs. Senegalese law also provides for requisition of State services in times of danger.

Similarly, in **Sri Lanka**, the National Council for Disaster Management was established by the Disaster Management Act, covering both "natural" disasters and "man-made" disasters such as armed conflict. This council has the authority to designate the stakeholders (including any ministries and other governmental bodies) tasked with implementing either the National Disaster Management Plan or the National Emergency Operation Plan, as the case may be.[133]

In **Argentina**, the Federal System of Emergencies[134] defines a national response to complement the efforts of provincial and municipal governments when their capacities are exceeded.[135] The Commander-in-Chief of the Armed Forces is in charge of coordinating operations when the Ministry of Defence or another State authority authorizes the use of the armed forces, including their medical services.

Domestic legislation should always identify clearly which national authority is in charge of coordinating the provision of emergency health-care services, whether the emergency response is put in place following a pre-established plan of coordination or in application of special prerogatives allowing State authorities to take special measures to ensure the provision of health care in emergency situations.

130 The agreement provides that the Belgian Red Cross is in charge of supplying, setting up and deploying rapid mobile teams to help organize and implement medical, sanitary and psychological assistance in the event of a disaster (medical and sanitary services, logistics, personnel).
131 "Organisation de la Réponse de Sécurité Civile" (ORSEC).
132 Plan ORSEC was adopted by Decree no. 99-172 of 4 March 1999.
133 Art. 21(1) of the Disaster Management Act No.13 of Sri Lanka (2005).
134 "Sistema Federal de Emergencias" (SIFEM).
135 Argentina, National Decree1250/99.

RECOMMENDATION (5): SPECIFIC LEGISLATIVE AND PRACTICAL MEASURES SHOULD BE ADOPTED IN ORDER TO ADEQUATELY ADDRESS THE NEEDS OF VICTIMS OF SEXUAL VIOLENCE IN ARMED CONFLICTS AND OTHER EMERGENCIES

Taking into account that victims of sexual violence, and of rape in particular, need comprehensive emergency health care within 72 hours, to prevent disease as well as to treat injuries, it is important that State authorities take specific measures to adequately address their specific needs.

Health-care personnel should be specifically trained in how to assist victims of sexual violence on the basis of a multidisciplinary approach, including social, psychological and communications training.

Given the specific needs of and the immediate medical attention required by victims of sexual violence, participants underlined the importance of training health-care personnel on how to provide them with adequate medical care and assistance. Such specific training should cover, among other things, the measures to be taken by health-care personnel to prevent the spread of transmissible diseases and to preserve evidence of sexual violence for potential use in criminal proceedings. However, health-care personnel should never use this evidence without the consent of the victims.[136] It was generally agreed that specific training for health-care personnel on how to assist victims of sexual violence should be based on a multidisciplinary approach that covers social, psychological and communications aspects, and include guidance on how to deal with the victims' families and to communicate with judicial authorities in specific cases.

From a broader perspective, information on the services available to the victims of sexual violence should be publicized among the population in general.

The staff of health-care facilities should include at least one properly trained person to assist victims of sexual violence who need immediate assistance.

As forensics experts are not always available and victims of sexual violence need immediate attention, health-care facilities should ensure the continuous presence of at least one health-care professional properly trained to provide such victims with the medical care they require.

National legislation should address the specific consequences of sexual violence for women, such as pregnancy.

It also has to be taken into account that sexual violence has specific consequences for women, given that pregnancy may be a result. Hence, the question of abortion would need to be further examined and addressed.

Beyond immediate medical care and other health-care services that should be provided for the victims, appropriate legislation should be adopted for sanctioning the perpetrators (for additional information on sanctions, see Section 4.2.4.).

136 For more information on medical confidentiality, please refer to Section 4.2.3.

RECOMMENDATION (6): WHEN APPROPRIATE, TRADITIONAL MEDICINE SHOULD BE INCLUDED IN THE SPHERE OF PROTECTED HEALTH-CARE ACTIVITIES AND MEASURES SHOULD BE TAKEN TO FACILITATE ACCESS TO THIS TYPE OF MEDICINE BY THE POPULATION AT LARGE

Some countries, such as Chile and Nepal, already include traditional medicine in the sphere of protected health-care activities.

Nepal, for example, has developed a domestic normative framework for Ayurvedic medicine. According to the World Health Organization, "[t]he policy of the Government, based on five-year plans, involves a system of integrated health services in which both allopathic and Ayurvedic medicine are practised. Ayurvedic clinics are considered to be part of the basic health services, and there is a section responsible for Ayurvedic medicine in the Office of the Director General of Health Services. The programmes for health services included in the Fifth Five-Year Plan make provision for four Ayurvedic hospitals, one in each of the four development regions. The Ayurvedic Governmental Pharmaceutical Unit works to provide inexpensive medicaments."[137]

4.2.2. Second session: How to legally improve proper use of the distinctive emblems, whose use is regulated under international law, and of other signs used for identifying health-care activities

Discussion

The distinctive emblems established by the Geneva Conventions and their Additional Protocols – to visibly manifest the specific protection of duly authorized persons and objects[138] providing medical care and assistance to persons affected by armed conflict and to identify persons or objects linked with the International Red Cross and Red Crescent Movement – have become a symbol of impartial humanitarian assistance and care for those who suffer. In the context of this workshop, the use of the red cross, red crescent and red crystal emblems as protective and indicative devices by health-care personnel and facilities and medical transports was therefore approached as a fundamental aspect of protecting the provision of and access to health care in times of armed conflict and other emergencies. While many States have regulated the use of the distinctive emblems through the adoption of appropriate domestic legislation, consistent with their obligations under the Geneva Conventions and their Additional Protocols, participants stressed the need in certain contexts for more effective implementation through the adoption of further appropriate domestic regulations. Such regulations should address the following issues: identification and definition of the distinctive emblems; designation of the national authority competent to regulate the use of the distinctive emblems; designation of the entities allowed to use the emblems; and identification of the uses for which permission is requested.[139]

Participants also voiced concern about what they perceived as erosion of respect for the distinctive emblems in recent armed conflicts. Some observed that, in modern warfare, protected health-care personnel and facilities and medical transports are targeted by armed groups not only by mistake or because of distrust, but for the precise purpose of attacking and destroying anything providing health care for the enemy and the civilian population, thus blatantly ignoring the impartiality associated with medical assistance and care. Therefore, the adoption of appropriate measures to reinforce the prestige and meaning of the distinctive emblems was identified as a priority by most participants.

137 For more information, please refer to WHO, *Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review*, WHO, 2001, http://apps.who.int/medicinedocs/pdf/h2943e/h2943e.pdf.
138 For more information on the authorized users of the emblem, please refer to Section 3.1.2 - B.
139 For more information, please refer to the fact sheet prepared by the ICRC's Advisory Service, "The Protection of the Red Cross, Red Crescent and Red Crystal Emblems".

It also emerged clearly from the discussions that the use of emblems other than those protected under the Geneva Conventions and their Additional Protocols to identify health-care activities in certain countries could not be ignored. As a consequence, reflection about appropriate measures to enhance the protection of health-care personnel and facilities and medical transports could not be limited to the red cross, red crescent and red crystal emblems alone. For example, the Star of Life is known throughout the world as a symbol of emergency medical services, while the white cross against a green background is a widely used symbol for first aid. Some countries have also created their own emblem to identify health-care activities on their territory, such as the Colombian emblem for the medical mission.[140] Participants observed that in certain contexts, such as in Colombia, the creation and adoption of a sign other than the red cross, red crescent or red crystal could enhance the protection of health-care activities and respect for the emblems protected under the Geneva Conventions and their Additional Protocols by reducing their abusive or unauthorized use.

Participants were asked the following questions:

- How is use of the emblem authorized and regulated?
- What kind of mechanisms should be developed at the national level for monitoring the use of the emblems?
- Is there a need to adopt additional means of identification – for example, additional emblems?
- Colombia has created and developed, through domestic legislation, its own emblem for the medical mission (for situations of armed conflict as well as for other emergencies). Have such other means of identification been adopted in domestic legislation elsewhere? Should this practice be developed more generally? If the answer is yes, how can confusion with the red cross, red crescent or red crystal emblem be avoided?

Recommendations

RECOMMENDATION (7): ENSURE MORE EFFECTIVE DOMESTIC IMPLEMENTATION AND DISSEMINATION OF THE LEGISLATION REGULATING THE INDICATIVE AND PROTECTIVE USE OF THE RED CROSS, RED CRESCENT AND RED CRYSTAL EMBLEMS

When implementing international law protecting the use of the red cross, red crescent and red crystal emblems at the domestic level, States should adopt specific legislation with a view to reinforcing the prestige and meaning of the emblems.

Participants expressed their sense of lack of respect for the distinctive emblems in certain contexts and sometimes complete indifference towards health-care activities identified by the red cross, red crescent and red crystal emblem in situations of armed conflict. Therefore, they felt that there was a need to reaffirm the prestige and meaning of the distinctive emblems as the visible sign of the protection conferred by IHL to certain health-care personnel, facilities and medical transports that provide the wounded and sick with impartial health care. Many participants embraced the view that specific legislation on the use of the emblem, as opposed to general legislation (referring to the inclusion of specific provisions on the use of the emblems in a law of a more general nature), presented the advantage and potential of reaffirming the importance of the emblem and increasing awareness of this issue. Again, the specificities of each country's legal system have to be taken into account.[141] It must be noted that the adoption of legislation for the prevention and repression of misuse of the emblems is an obligation under the Geneva Conventions.[142]

140 For more information on the Colombian emblem for the medical mission, please refer to the box on page 49.

141 For an example of a specific law and model provisions on the use and protection of the distinctive emblems, please refer to the ICRC's *"Model law concerning the use and protection of the emblem of the red cross or red crescent,"* 31 August 1996, Article, *International Review of the Red Cross*, No. 313. The text of this model law can be consulted online at http://www.icrc.org/eng/resources/documents/misc/57jn8k.htm

142 Art. 54, GC I.

Domestic legislation should, already in peacetime, identify the entities permitted to use the red cross, red crescent or red crystal emblems and designate the national authority competent to regulate their use.

With a view to reducing abusive and unauthorized use of the emblems observed in certain contexts, participants recognized the need for more clarity about the authorized users of the red cross, red crescent or red crystal emblems, especially with regard to their use for protective purposes in times of armed conflict.[143] While the use of the emblems by the medical services of the armed forces must be regulated by the competent military authority,[144] most likely the defence ministry, there is more flexibility as to which State authority may authorize their use by civilian hospitals[145] and by medical units and transports.[146] Domestic legislation must therefore designate the national authority competent to authorize and control the use of the emblems by civilian health-care personnel, facilities and transports, a role that could be undertaken by the health ministry or even by the National Society, where it is so empowered by law.

Domestic legislation should also identify the entities having permission to use the emblems for indicative purposes,[147] such as National Societies.

States should take appropriate preventive measures to promote and enhance knowledge about the proper use of the red cross, red crescent or red crystal emblems among the population at large and ensure training of the armed forces in order to prevent misuse of the emblems.

Participants highlighted the importance of promoting knowledge among the population at large about the meaning of the red cross, red crescent or red crystal emblem and about the importance of respecting health-care personnel and facilities and medical transports as well as the wounded and sick in their charge. They stressed that this should be done in times of peace as a preventive measure. State armed forces and, when applicable, non-State armed groups, should receive specific training in proper use of the emblems in times of armed conflict and other emergencies.

This recommendation is intended to implement the obligation of States to disseminate IHL rules, including those protecting the emblems, as widely as possible, in their respective countries, in peacetime as well as during armed conflict, so that they may become known to the armed forces and to the civilian population.[148]

National Societies can play a significant role in assisting the authorities of their respective countries in disseminating the regulations concerning use of the emblems. That is the case in many countries such as **Belgium**, where the National Society's Statutes impose on the Belgian Red Cross a duty to spread knowledge of the Fundamental Principles of the International Red Cross and Red Crescent Movement and IHL,[149] and **Serbia**, where the Law on the Red Cross imposes on the Society the duty to ensure respect for IHL and to work for the prevention of abuses and the education of citizens about IHL-related topics.[150]

143 "As a protective device, the emblem is the visible sign of the special protection under IHL (mainly the GCs and their APs) for certain categories of persons, units and transports (in particular medical personnel, facilities and means of transport). In such circumstances, to ensure maximum visibility, the emblem must be large in comparison with the person or object displaying it and nothing must be added to either the emblem or the white ground. Displaying the emblem in certain places, such as on armlets or painted on the roofs of buildings, is always considered protective use" (extract from the ICRC publication *Study on the Use of the Emblems – Operational and commercial and other non-operational issues*, 2011, p.25).

144 Art. 39, GC I, and its *Commentary*, p.308.

145 Art. 18, para. 3, GC IV.

146 Art. 18(4), AP I.

147 "As an indicative device, the emblem signifies the link between the person or object displaying it and the Movement. In this case, the emblem must be relatively small in comparison with the person or object displaying it" (extract from the ICRC publication Study on the Use of the Emblems – Operational and commercial and other non-operational issues, 2011, p. 25).

148 Art. 47, GC I; Art. 48, GC II; Art. 127, GC III; Art. 144, GC IV; Art. 83, AP I; Art. 19, AP II; Art. 7, AP III; Rules 142 and 143, Customary IHL Study. For more information on dissemination, please refer to Section 4.

149 Statutes of the Belgian Red Cross, amended on 13 October 2003, Art. 4.

150 Law on the Red Cross of Serbia (2005), Art. 2.

The auxiliary role of National Societies in the humanitarian field

National Societies have an important role in guaranteeing the safe delivery of health care and safe access to it during armed conflict and other emergencies. This role was reaffirmed by Resolution 5 of the 31st International Conference of the Red Cross and Red Crescent, which "…call[ed] upon National Societies, the ICRC and the International Federation to continue supporting and strengthening the capacity of local health-care facilities and personnel around the world and to continue providing training and instruction for health-care staff and volunteers by developing appropriate tools on the rights and obligations of health-care personnel and on protection for and the safety of health-care delivery."[151]

More specifically, National Societies can play a significant role in dissemination and training relating to the regulations concerning the use of the emblems. The Statutes of the International Red Cross and Red Crescent Movement provide that the National Red Cross and Red Crescent Societies shall "disseminate and assist their governments in disseminating international humanitarian law" and, more specifically, shall "cooperate with their governments to ensure respect for international humanitarian law and to protect the distinctive emblems recognized by the Geneva Conventions and their Additional Protocols."[152]

National Societies serve as auxiliaries to public authorities in the humanitarian field.[153] In accordance with this role and to fulfil their mandates, National Societies have signed various agreements at the national level enabling them to organize the provision of health care in their countries.[154]

RECOMMENDATION (8): REINFORCE MEASURES OF CONTROL OF THE USE OF THE RED CROSS, RED CRESCENT AND RED CRYSTAL EMBLEMS AS WELL AS REPRESSION MECHANISMS FOR MISUSE OF THE EMBLEMS

Measures repressing unauthorized or abusive use of the emblem should include not only criminal sanctions but also administrative and disciplinary measures, and misuse of the emblems such as imitation and improper use must be severely repressed. Perfidious use of the emblems constitutes a war crime and must be repressed as such.

Given its serious consequences in humanitarian terms, participants highlighted that abusive and unauthorized use of the emblem was not adequately sanctioned in most States, and that repression mechanisms should include criminal sanctions as well as administrative and disciplinary measures applicable in all circumstances.[155] In particular, it was thought that dissuasive disciplinary measures, along with criminal sanctions, should be imposed on members of the armed forces using the distinctive emblems for purposes other than those authorized by the Geneva Conventions and their Additional Protocols, such as using vehicles of the medical services or medical facilities marked with the emblem to carry or hide weapons or soldiers. In **Belgium**, for example, misuse of the distinctive emblems is punishable by imprisonment and/or by the payment of a fine, the punishment being more severe when the misuse occurs in times of armed conflict.[156] In **Serbia**, misuse of the distinctive emblem is punishable by

151 31st International Conference of the Red Cross and Red Crescent, 2011 – Resolution 5, Health Care in Danger: Respecting and Protecting Health Care, 31IC/11/R5, para. 8.
152 Statutes of the International Red Cross and Red Crescent Movement, adopted by the Twenty-fifth International Conference of the Red Cross in Geneva in 1986 and amended in 1995 and 2006. Statutes of the International Red Cross and Red Crescent Movement, 1986, Section II, Art. 3.2.3.
153 Being auxiliaries to State public services goes beyond the auxiliary role established in Art. 26, GC I.
154 For example, the Belgian Red Cross signed an agreement in 2012 with the Public Federal Service for Public Health, the purpose of which was to develop and implement means of providing urgent medical assistance. For more information, please refer to the Country Study on Belgium in Annex 1.
155 For more information on sanctions, please refer to Section 4.2.4.
156 The Belgian Law of 4 July 1956 protecting Red Cross designations, signs and emblems (as amended by the law of 22 November 2013) provides: "Art. 1 – Without prejudice to other criminal provisions, anyone who, in violation of international conventions, uses any of the designations 'red cross', 'Geneva cross', 'red crescent', 'red lion and sun', 'third Protocol emblem', 'red crystal', or any corresponding signs or emblems shall be punished by imprisonment of eight days to three years and by a fine of 26 to 3,000 francs, or by either one or the other. The same penalty shall apply to anyone who uses a designation, sign or emblem likely to be confused with the aforesaid designations, signs or emblems.
Art. 2 – Wherever committed in wartime, the offences described in Art. 1 shall be punished by imprisonment of fifteen days to five years and by a fine of 50 to 5,000 francs, or by either one or the other."

imprisonment of up to three years, and by a minimum of six months and a maximum of five years when committed in a situation of armed conflict.[157]

National monitoring should be put in place for tracking and repressing misuse of the emblem.

Participants highlighted the need to track emblem misuse and to create or strengthen monitoring mechanisms for controlling use of the emblems. This responsibility could be undertaken by military authorities, as in the case of **Belgium,** for protective use of the emblem. The health ministry could also play an important role in monitoring use of the emblems by civilian hospitals and other medical facilities and transports and by health-care personnel.

States should take appropriate measures to encourage reporting of emblem misuse to the appropriate State authorities and make such cases public.

Denunciations of emblem misuse were perceived as crucial for preserving the protective value of the emblems and ensuring respect for them by potential perpetrators of violence against health care. Therefore, some participants insisted on the importance of publicizing the results of reports of violations of legislation or regulations concerning the distinctive emblems in order to add to their deterrent effect.

RECOMMENDATION (9): THE USE OF SIGNS OTHER THAN THE RED CROSS, RED CRESCENT OR RED CRYSTAL EMBLEMS TO IDENTIFY HEALTH-CARE ACTIVITIES NEEDS TO BE FURTHER EXAMINED, CONSIDERING EACH SPECIFIC CONTEXT AND WHETHER THE USE OF SUCH SIGNS WOULD ENHANCE PROTECTION OF HEALTH CARE

Bearing in mind the need to avoid a proliferation of emblems, the creation and/or use of signs other than the red cross, red crescent or red crystal emblems to identify health-care activities should respond to the necessity of enhanced protection of the provision of health care in a specific context.

While the provision of health care and access to health-care services for the wounded and the sick must be respected and protected from attacks and other violent interference in all circumstances, health-care personnel, facilities and medical transports do suffer violent incidents also in situations not reaching the threshold of armed conflict. Since in most cases the red cross, red crescent or red crystal emblems may be used as a protective device only in times of armed conflict,[158] it was understood that the discussion on the signs used to identify protected health-care activities had to be broadened to include existing signs, or signs yet to be created, other than those protected under the Geneva Conventions and their Additional Protocols. Therefore, it was understood that the discussion did not aim to create new emblems to replace or add to the existing ones, but rather to evaluate how the use of emblems other than the red cross, red crescent or red crystal to identify protected health-care activities in all circumstances, including those not reaching the threshold of armed conflict, could contribute to enhanced protection of the provision of health care in armed conflict and other emergencies.

While the potential use of signs other than the red cross, red crescent or red crystal was contemplated mostly in the perspective of identifying protected health-care activities in situations not reaching the threshold of armed conflict, it was stressed that State authorities could authorize their use in armed conflict when it is believed that this would enhance protection of health-care personnel and facilities and medical transports (e.g. in situations where the belligerent perceived a confusion between civilian and military health-care personnel or where there is an increasing number of cases of misuse of the

157 Criminal Code of the Republic of Serbia (as amended in 2012), Art. 385.

158 Although the medical services of the armed forces, and National Societies whose assignment to medical duties in armed conflict has already been decided, may use the protective emblem also in situations short of armed conflict when doing so with the consent of the competent domestic authorities. The ICRC and the International Federation may use the emblem as a protective device at all times without any further restrictions. (For more information, please refer to Section 3.1.2 – B).
In this regard, the 2009 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 Societies display a large-sized indicative emblem in situations of internal disturbance and tension if (a) it might enhance their medical assistance for victims of violence and (b) it is authorized, or at least not prohibited, by the domestic normative framework. It must be noted that both the ICRC and the International Federation may use the emblem, including as a protective device, at all times without any further restrictions.

red cross, red crescent or red crystal by the belligerents). In all cases, however, participants pointed out that signs other than those protected under IHL should not be used at the expense of the prestige and meaning of the distinctive emblems.

Although generally reluctant to agree to the creation of new signs to identify health-care activities, most participants acknowledged that the use of signs other than the red cross, red crescent or red crystal emblems could contribute to preventing abusive or unauthorized use of the emblems in situations of armed conflict or other emergencies in certain contexts, for example in asymmetric conflicts. However, participants came to the conclusion that the use or creation of additional signs should respond to a real need in relation to a specific context and be expected to contribute to enhancing the protection of the provision of health care, as in the case of **Colombia**, which created a supplementary emblem for the medical mission.[159]

If signs other than the red cross, red crescent or red crystal emblems are to be used to identify health-care activities, they must be established and regulated by State authorities and a clear distinction should be made from the distinctive emblems whose use is regulated under international law in order to avoid confusion.

Participants emphasized that to be effective and avoid creating confusion, the distinctive signs should not be too numerous in the same country, and that the proliferation of new signs should be avoided to the fullest extent possible. Participants clearly agreed that the competence for creating and authorizing the use of signs other than the red cross, red crescent or red crystal emblems should lie with State authorities and that the creation and use of signs other than those protected under IHL by health-care providers on their territory should be regulated by domestic legislation. Such legislation should clearly identify and define the sign chosen, the entities permitted to use it, the uses for which it is authorized and the national authority competent to regulate its use. In **Colombia**, for example, use of the emblem for the medical mission is subject to authorization by the Ministry of Health and Social Protection.

The adoption of an additional emblem to identify health-care activities must be accompanied by wide dissemination and education about its purpose and use.

Considering the previous remarks, participants felt that when State authorities choose to adopt signs other than the red cross, red crescent or red crystal emblems to identify health-care activities, they must also have a concrete plan for disseminating and enhancing knowledge of all stakeholders concerned and of the population at large about the purpose and the conditions for use of this additional sign, clearly marking the differences between the latter and the emblems conferring specific protection under IHL. It was also noted that special attention should be given to ensuring respect for impartiality on the part of users of additional distinctive signs, for example by adopting guidelines with regard to their roles and responsibilities.

The potential use of new technologies for identifying health-care providers (e.g. GPS, bar codes) and other means of identifying health-care facilities and medical transports (e.g. reflective colours) should be further explored.

Some participants suggested that, in particular when contemplating the creation of additional signs to identify protected health-care activities, State authorities alternatively consider other means of enhancing respect for the red cross, red crescent or red crystal emblems. The potential use of new technologies such as GPS and bar codes to locate and identify health-care providers, as well as other ways of identifying medical facilities and vehicles, such as reflective colours, were mentioned.

159 For more information on the Colombian emblem for the medical mission, please refer to the box on page 49.

The Colombian emblem for the medical mission as a response to specific circumstances

The Colombian sign of protection for the medical mission was created in 2002, partly in response to numerous violent incidents against health-care activities in particular circumstances, and to the proliferation of emblems used in the context of internal disturbances which did not reach the threshold of armed conflict under IHL. The emblem's purpose is to ensure respect and protection for the medical mission in armed conflict and in other emergencies.[160] It aims to strengthen the guarantees that health care will be provided for the most vulnerable in situations of armed conflict, natural disasters or other emergencies; it also aims to guarantee, protect and facilitate the provision of health care by civilian health-care personnel and civilian private or public health-care facilities and medical transports at large.[161]

Some well-known symbols

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

The sign for Médecins Sans Frontières

The Star of Life, known throughout the world as a symbol of emergency medical services

The emblems of the International Red Cross and Red Crescent Movement

International Federation of Red Cross and Red Crescent Societies

The International Federation of Red Cross and Red Crescent Societies

COMITE INTERNATIONAL GENEVE

ICRC

The International Committee of the Red Cross

A widely used symbol for first aid

PROTECCION CIVIL

The *Asociación Nacional de Proteccion Civil* is one of the main providers of pre-hospital services in Mexico and other Latin American countries, as well as in other parts of the world. It also plays an important role in disaster response. In Mexico it has a mandate to coordinate all activities related to disaster response.

160 Please refer to the Country Study on Colombia in Annex 1.
161 Colombia, Ministry of Health, Resolutions 1020/2002 and 441/2012. For more details please refer to the Country Study on Colombia in Annex 1.

4.2.3. Third session: How to provide legal protection for medical ethics and confidentiality during armed conflict and other emergencies

Discussion

Medical ethics was approached as an essential component in the protection of the provision of and access to health care. Discussions in the working groups revolved around the principles of medical ethics, the ethical duties of health-care personnel, the rights of the patients, the protection of medical confidentiality and other sensitive issues, such as disclosure of a patient's personal and health-care-related information and the solution to ethical dilemmas. Participants also shared with their counterparts their respective countries' regulations on the protection of and exceptions to medical confidentiality, and expressed their views on specific exceptions in domestic legislation regarding the disclosure of information during armed conflict and other emergencies.

Participants agreed that the ethical duties of health-care personnel, such as the obligation to treat the wounded and sick humanely, to provide them with impartial care, understood as without adverse discrimination, and to refrain from taking part in any act of hostility or posing an immediate threat to the lives or physical integrity of others,[162] remain the same in peacetime as in times of armed conflict and other emergencies.[163] Participants also highlighted the importance for health-care personnel to carry out their duties without interference of any kind and to focus solely on their duty to provide health care for those in need. They also expressed concern about some countries where physicians have been prosecuted for the sole act of providing health care for members of non-State armed groups or political opponents, as was recently the case in **Colombia,** observing that such laws are not only likely to deter health-care personnel from providing health care for the population in times of armed conflict and other emergencies, but may also prevent the wounded and sick from accessing health-care facilities and services.[164]

The protection of medical confidentiality, understood as the confidential nature of a patient's medical information and personal data obtained by health-care personnel in the course of their duties, was a major topic of discussion. Approached not only as a privilege and ethical duty of health-care personnel but also as a right of the patient, medical confidentiality was identified as a universal and abiding principle of medical ethics and a general rule in the delivery of health-care services. Participants emphasized that medical confidentiality must be adequately protected under domestic legislation and that exceptions authorizing the disclosure of patients' medical information and personal data to the authorities, when applicable, must be exceptional in nature and strictly limited to cases defined in domestic legislation, considering that exceptions to medical confidentiality are likely to restrict access to health-care services for the wounded and sick. Participants expressed particular concern about the effect of legislation in some countries requiring health-care personnel to report certain types of events, such as gunshot wounds, to the authorities, fearing that this might prevent the wounded and sick from accessing health-care facilities and seeking the medical care that they need for fear of criminal prosecution.

162 These duties are enacted in the WMA Regulations in Times of Armed Conflict and Other Situations of Violence, as well as in the 2012 ICRC publication Health Care in Danger: *The responsibilities of health-care personnel working in armed conflict and other emergencies*.

163 Although some participants pointed out certain differences in the application of ethical duties in times of emergency: for example, in **Brazil**, the law offers the possibility for a doctor to deny health care to a patient when it goes against his conscience, except in times of emergency.

164 Similar observations were made by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report to the United Nations General Assembly, 68th Session, 9 August 2013, p. 7: "States may enact laws that impose a duty on health-care workers to report persons who may have committed a crime. However, some States have enacted laws and policies restricting or criminalizing provision of medical care to people opposing the State, such as political protestors and non-State armed groups. Laws criminalizing support for terrorists or others opposing the State may also be inappropriately applied to the provision of medical care. Consequently, doctors and other health-care workers have been arrested, charged and sentenced for acting within their professional duty of ensuring medical impartiality. Such laws may deter health-care workers from providing services in conflict situations due to fear of prosecution, thus creating a chilling effect on health-care providers."

With a view to helping health-care personnel deal with ethical dilemmas, particularly under stressful circumstances such as armed conflict or other emergencies, participants strongly suggested that they receive specific training in medical ethics.

In summary, the discussions gave rise to three major recommendations touching upon domestic legislation on ethical duties, the protection of medical confidentiality and exceptions to that rule, and specific training for health-care personnel in resolving ethical dilemmas.

Participants were asked the following questions:

- How are the roles and responsibilities of the various stakeholders involved in emergency response defined in domestic legislation?
- Given that most countries do not specify the scope of the applicable legislation, would the principles governing the protection of medical confidentiality in peacetime also be applicable in armed conflict and other emergencies?
- Does/should existing national legislation on medical ethics and confidentiality include specific exceptions for the disclosure of information during armed conflict and other emergencies?
- How should health-care personnel weigh their professional ethical duties concerning confidentiality against legal obligations requiring the disclosure of certain kinds of information that they may come across while carrying out their exclusively medical duties during armed conflict and other emergencies?

The World Medical Association and the promotion of universal principles of medical ethics

The World Medical Association (WMA) is an international organization of physicians with 106 national medical associations as members. Founded in 1947 and based in Ferney-Voltaire, France, the WMA seeks to ensure the independence of physicians and to promote the highest standards of ethical behaviour and care by physicians at all times. In pursuit of this objective, the WMA has adopted several declarations, resolutions and global policy statements providing ethical guidance for physicians, national medical associations and governments on a range of ethical issues including medical professionalism, the rights of the patient, care of wounded and sick in times of armed conflict, research on human subjects and public health. Furthermore, the WMA serves as a clearing house of information resources on ethics for its members, and cooperates with academic institutions and global organizations concerned with ethical matters, as well as individual experts in the field of medical ethics.

- The **Declaration of Geneva** (1948, revised in 2006), like the **International Code of Medical Ethics** (1949, revised in 2006), enshrines the obligation of the physician to act in the best interests of the patient's health and to provide health care in a fully independent, impartial and non-discriminatory manner and to respect the right of the patient to confidentiality.
- The **Declaration of Lisbon** (1985) on the rights of the patient specifically enshrines the right to medical confidentiality.
- The **Manual of Medical Ethics** (2005) explains the principal features of medical ethics and provides guidance for physicians in applying them to relations with patients, society and colleagues.
- The **WMA Regulations in Times of Armed Conflict and Other Situations of Violence** (1956) provide a code of conduct with regard to the duties that physicians must observe in those circumstances.

On 26 June 2013, a **memorandum of understanding** was signed between the WMA and the **ICRC** to join forces in a worldwide effort to combat violence against patients and health-care workers.[165]

165 Professional codes of ethics also exist for other health-care professionals, including nurses, pharmacists, etc.

Recommendations

RECOMMENDATION (10): ENSURE CLARITY AND COHERENCE OF DOMESTIC LEGISLATION CONCERNING ETHICAL DUTIES APPLYING TO HEALTH-CARE PERSONNEL

The rights and responsibilities of health-care personnel should be clearly defined in domestic legislation, for example in laws regulating access to health-care professions or in codes of ethics adopted by professional associations.

In most countries, health-care personnel perform their duties under the surveillance and control of professional associations, which are generally empowered by law to regulate their access to the profession and their professional practice, including sanctioning them in case of misconduct. Ethical duties applicable to them are thus most often enacted in specific laws creating those medical associations or in codes of ethics manuals adopted by those professional associations and defining their roles and responsibilities. Participants stressed that a clear definition of the rights and responsibilities of health-care personnel by their professional associations, including their ethical duties, was an essential step in ensuring effective protection of medical ethics and confidentiality.

To this end, it was considered useful by participants to reaffirm – on the international level – the universally recognized principles of medical ethics, which should be consistent across all domestic regulations and applicable in all circumstances.

There are different ways of incorporating a definition of the rights and responsibilities of health-care personnel in domestic legislation. **Colombia**, for example, has adopted a specific manual applicable to its medical mission.

Colombia – The Manual of the Medical Mission[166]

In 2012, the **Ministry of Health and Social Protection** adopted the Manual for the Medical Mission through Resolution 4481, which was the result of a joint effort on the part of the ICRC delegation in Bogotá, in particular the Health Department, the Colombian Red Cross, the Ministry of the Interior, Justice and Law and other governmental institutions. **The Manual aims to strengthen respect and protection for the medical mission and is applicable to both situations of armed conflict and "other situations of violence"**. It sets out, among other things:

- The rights and responsibilities of health-care personnel
- The acts that constitute violations affecting the medical mission
- The establishment and use of the emblem of the medical mission
- Recommendations for the safety of health-care personnel
- Forms for requesting authorization to use the emblem, requesting an identity card and reporting violations or incidents related to the medical mission.

The Manual also includes the WMA regulations relating to armed conflict.

States should ensure coherence and consistency of other domestic legislation applying to health-care personnel, including criminal laws, with their ethical duties, and adequately protect the independence and impartiality of health care.

It is one thing to enact legislation protecting medical ethics, but another to ensure its effectiveness in practice. To this end, States should guarantee the coherence and consistency of other domestic legislation dealing with the rights and responsibilities of health-care personnel. In particular, States must not criminalize the provision of health care for certain persons, such as members of opposing parties

166 Manual de la Misión Medica, Ministerio de Salud y Protección Social, February 2013.

in a conflict, members of non-State armed groups or irregular migrants, as this is in contradiction to health-care personnel's obligation and ethical duty to provide impartial care for the wounded and sick without any adverse distinction. Such criminalization also violates the obligation of health-care personnel to provide the wounded and sick with medical care on a non-discriminatory basis according to IHL and IHRL.

Participants stressed that, as universal principles of medical ethics, independence and impartiality of health care should be adequately protected by domestic legislation, State authorities should take appropriate measures to ensure that health-care personnel can exercise their profession without undue pressure to give unwarranted priority for treatment (not based on medical criteria) to certain persons or fear of facing criminal prosecution for providing certain persons with impartial care when acting in conformity with their ethical duties.

The **WMA Regulations in Times of Armed Conflict**[167] were adopted by the 10th World Medical Assembly in 1956. Last revised in 2012, they set out general guidelines as well as a code of conduct to be observed by physicians working in all circumstances. Reiterating that medical ethics are identical in times of armed conflict and in peacetime, the Code of Conduct enacts that physicians must, **in all circumstances:**

- not take part in any act of hostility;
- provide effective and impartial care to the wounded and sick (without reference to any ground of unfair discrimination, including whether they are the "enemy");
- encourage authorities to recognize their obligations under international humanitarian law and other pertinent bodies of international law with respect to protection of health-care personnel and infrastructure in armed conflict and other situations of violence;
- be aware of the legal obligations to report to authorities the outbreak of any notifiable disease or trauma.

RECOMMENDATION (11): REAFFIRM THE NECESSITY TO PROTECT MEDICAL CONFIDENTIALITY AS AN ABIDING PRINCIPLE OF HEALTH-CARE ETHICS IN ALL CIRCUMSTANCES (IN PEACETIME AS WELL AS IN ARMED CONFLICT AND OTHER EMERGENCIES); EXCEPTIONS TO MEDICAL CONFIDENTIALITY MUST BE LIMITED AND STRICTLY CIRCUMSCRIBED IN DOMESTIC LEGISLATION

Approach medical confidentiality as a right of the patient rather than a simple privilege and ethical duty of health-care personnel.

Bearing in mind that the protection of medical confidentiality serves both the interests of the wounded and sick and of health-care personnel, participants stated that it should be approached in domestic legislation not only as a privilege and ethical duty of health-care personnel, but also as a right of the patient. This implies that medical confidentiality should also be defined and protected under domestic legislation dealing with the rights of the patient. For more coherence of the domestic legal framework and enhanced protection, it was also suggested that, where possible, the rights of patients and the protection of health-care personnel be combined in the same legislation.

The **Belgian** regulations on the rights of the patient[168] is an example of the inclusion of medical ethics in legislation dealing with other rights of the patient, such as patient consent, protection of privacy and the right to information and to access medical records.

167 WMA Regulations in Times of Armed Conflict and Other Situations of Violence.
168 Law of 22 August 2002 on the rights of the patient (Belgium).

Exceptions to medical confidentiality may vary from one State to another and be context-specific, but they should in any event be limited and strictly defined and circumscribed in domestic legislation for all circumstances.

While recognizing the universal nature of medical confidentiality as an abiding principle of medical ethics, participants generally agreed that some exceptions, such as requiring health-care personnel to report certain health-related information to the authorities, are inevitable. Exceptions may be made, for example, for security or public health purposes, but they must be limited and strictly defined and circumscribed in domestic legislation.[169] It was felt that while exceptions are specific to each particular context, the guiding principle is to reach an appropriate balance between the rights of the individual and the interest of public health and security. Domestic legislation should define exceptions in precise terms and clearly identify the circumstances in which they apply, avoiding vague and general wording that could open the door to a broad interpretation by judges or executives ruling on requests for ordinances of disclosure, and lead to abuses. Also, while international instruments are clear as to the obligation to report the outbreak of communicable diseases or trauma that may constitute an "international" danger to public health (e.g. a cholera epidemic), it was recommended that the notion of international danger to public health in domestic legislation be circumscribed so as to avoid an unduly broad interpretation of obligations on State authorities to disclose certain health-related information.

Furthermore, given the diversity of cases that may arise, and to avoid defining all exceptions to medical confidentiality in domestic legislation, some participants also suggested that regulatory authorities be granted the competence to assess the balance between the rights of the individual and the interest of public health and security on the basis of general guiding principles, which should be defined in domestic legislation in a way that avoids general wording. In short, exceptions should not be subject to discretion to the extent where there would be the potential to render the principle of medical confidentiality essentially meaningless.

Participants generally agreed that exceptions to medical confidentiality should include denunciation to State authorities of visible signs of violence against minors or persons who are not in a position to give informed consent, which medical personnel have observed on patients while performing their duties. This should constitute a duty, and not only an option, for health-care personnel. However, before making a denunciation, health-care personnel should take into account the interests of the patient, for example the risks of reprisals against the victim by the community or the family, which can be more significant in certain contexts, and use their judgement and discretion in this regard.

However, when a patient who is a victim of violence is an adult and is able to give informed consent, health-care personnel should abide by their obligation of medical confidentiality and limit themselves to giving information on how to seek help when such services exist (e.g. organizations providing psychological support or legal advice for victims of violence; women's shelters).

Most participants agreed that medical confidentiality should be protected in all circumstances and that there should be no specific exceptions applicable in times of armed conflict and other emergencies. Many domestic frameworks, like those in **Belgium**, **Mexico**, **Cuba**, **Colombia** and **Venezuela**, do not distinguish between peacetime and times of armed conflict or other emergencies. **Spain**, on the other hand, has specific legislation regulating medical confidentiality in times of armed conflict.

Moreover, at the international level, the WMA Regulations in Times of Armed Conflict[170] state that physicians should, to the greatest degree possible, denounce acts of torture or cruel, inhuman or degrading treatment that they are made aware of, where possible with the consent of the patient, or without explicit consent when the victim is deemed unable to express him/herself freely.

169 It is worth noting that IHL provides that persons engaged in medical activities may not, unless required to do so by law, be compelled to give information concerning the wounded and sick who are or have been under their care. Please refer to Art. 16, AP I and Art. 10, AP II.

170 WMA Regulations in Times of Armed Conflict and Other Situations of Violence.

When under a legal duty to disclose patient information protected under medical confidentiality, health-care personnel should take all necessary precautions in order to protect patients' other personal and health-care-related information and only disclose the information strictly required.

When legally required to disclose medical information concerning a patient, for example under a judicial ordinance, health-care personnel should not lose sight of their obligation of confidentiality towards the patient and should disclose only the information strictly required. In any case, the testimony of health-care personnel before a tribunal should be limited to their sphere of competence, that is, describing the wounds they have observed on the patient.

Other legal obligations to disclose medical information, such as mandatory reporting of certain diseases for public health purposes or reporting of certain types of wounds (e.g. gunshot wounds) should be complied with by health-care personnel in a way that ensures confidentiality of the patient's medical information and personal data to the greatest extent possible. For example, the obligation to report certain diseases in order to prevent pandemics should not require health-care personnel to disclose the name of the patient. In **Colombia**, gunshot wounds are reported to the authorities in such a way as not to reveal the origins of the wounds.

Disclosure by health-care personnel of patients' personal and health-care-related information without their consent, where there is no legal obligation to do so, should constitute a violation of professional duty under their code of ethics and be subject to administrative or disciplinary measures.

Participants agreed that health-care personnel who accidently or intentionally disclose patient information to third parties, without patient consent and without being under a legal obligation to do so, should be sanctioned by their professional associations. Some domestic regulations, as in **Belgium**, go even further by making the violation of medical confidentiality (referred to as "professional confidentiality") punishable under the criminal code by imprisonment of eight days to six months and a fine of 100 to 500 euros.[171] Disclosure of confidential medical information also constitutes a criminal offence under Art. 221 of the **Nigerian** Penal Code and is punishable by imprisonment of two months to a year and by a fine of 10,000 to 200,000 nairas.[172]

RECOMMENDATION (12): ENSURE PROPER TRAINING FOR HEALTH-CARE PERSONNEL TO APPLY AND RESPECT THEIR ETHICAL DUTIES, PARTICULARLY FOR RESOLVING DILEMMAS WHEN CONFRONTED WITH LEGAL OBLIGATIONS TO DISCLOSE PATIENTS' PERSONAL AND HEALTH-CARE-RELATED INFORMATION

Health-care personnel should be given special training for resolving dilemmas when legal obligations to disclose patient information conflict with their ethical duties, both in peacetime and in armed conflict or other emergencies, for example by means of simulation exercises.

Health-care personnel are sometimes confronted with external pressures to disclose patient information, including those deriving from domestic legal obligations, which conflict with their ethical duty of medical confidentiality. These types of dilemmas can occur at all times, but in stressful circumstances such as armed conflict or other emergencies, health-care staff members are more likely to be overwhelmed and have less time to think about the proper conduct to adopt in conformity with their ethical duties. In order to help health-care personnel react to those pressures in a way that ensures the protection of patient information, participants strongly recommended that they receive comprehensive training. Such training should include not only sound knowledge of their ethical duties, but also practical guidance on applying those duties to real-case situations and should be part of their vocational training.

171 Art. 458 of the Criminal Code prohibits any violation of such confidentiality except where the practitioner is called upon to testify in a court of law or before a parliamentary commission of inquiry, or where the practitioner is under a legal obligation to disclose the information to which he is privy.

172 Art. 221 of the Nigerian Penal Code of 2003 (as amended in 2008).

State authorities and national associations of health-care personnel are also encouraged to provide guidance to their members through publications such as practical guidelines or handbooks, as has been done in **Colombia** through the Manual of the Medical Mission[173] and in **Côte d'Ivoire** through the White Paper on the Rights and Responsibilities of Physicians Towards Acts of Violence in Times of Crisis and Armed Conflict.[174] In this regard, they can refer to works such as the reference document for the Health Care in Danger project, on the responsibilities of health-care personnel working in situations of armed conflict and other emergencies,[175] an ICRC publication intended to help health-care personnel adapt their working methods to the exigencies of armed conflict and other emergencies. It was also suggested that simulation training be provided in order to support health-care personnel in developing their responses in those particular situations.

Law enforcement officials (police, prosecutors) should be properly trained in the ethical duties of health-care personnel.

To complement the training of health-care personnel, participants emphasized that law enforcement officials, such as police and prosecutors should be provided with proper information about ethical duties of health-care personnel and about the importance of respecting medical confidentiality in all circumstances. It was strongly suggested that, as a preventive measure, health-care personnel maintain a dialogue with law enforcement officials on the challenges posed by armed conflict and other emergencies in relation to their ethical duties, and in particular to the obligation to preserve the confidentiality of the information obtained on patients in the performance of their duties. In order to have a positive impact on the interaction between health-care personnel and law enforcement officials in times of armed conflict and other emergencies, this dialogue should take place in peacetime.

Appropriate measures should be taken to manage health-care personnel's interactions with the media, particularly in emergency situations, in order to better protect medical confidentiality. The media should also be made aware of the ethical duties of health-care personnel, and respect for medical confidentiality should be enshrined in their code of ethics.

Interaction with the media, especially in stressful conditions such as armed conflict or other emergencies, was highlighted by many participants as presenting potential risks for medical confidentiality. Participants suggested that specific regulations or guidelines be adopted in this regard by professional associations to guide health-care personnel's conduct in such situations. A practical measure suggested by participants was to designate one health-care staff member in each working team as a focal point for all interactions with the media, while other health-care staff members should be prohibited from interacting with them. In addition, specific measures to enhance the knowledge of the media about the ethical duties of health-care personnel should be taken by State authorities or associations of media professionals such as journalists, and respect for the obligation of health-care personnel to preserve medical confidentiality should be enshrined in the code of ethics of media associations as an ethical duty. Guidelines for interactions of health-care personnel with the media should also be included in preventive coordination plans for the organization of emergency response.

173 For more information on the Colombian Manual of the Medical Mission, please refer to the box on p. 52.
174 For more information on Côte d'Ivoire's White Paper on the Rights and Responsibilities of Physicians Towards Acts of Violence in Times of Crisis and Armed Conflict, please refer to the box on p. 57.
175 For more information on the ICRC's Health Care in Danger reference publication on the responsibilities of health-care personnel working in armed conflict and other emergencies, please refer to the box on p. 57.

The responsibilities of health-care personnel working in armed conflicts and other emergencies is an ICRC publication intended to help health-care personnel adapt their working methods to the exigencies of armed conflict and other emergencies.[176] While it does not seek to provide precise or final answers to the various ethical dilemmas that health-care personnel can face in such circumstances, this publication is aimed at providing such personnel with guidance and prompting reflection on issues related to their ethical obligations.

The publication gives practical advice on a number of subjects, including:

- The rights and responsibilities of health-care personnel in armed conflict and other emergencies and the sources of these responsibilities deriving from international humanitarian law, human rights law and medical ethics
- Standards of practice
- Gathering data and witnessing violations of IHL
- Handling medical records and disclosing medical information
- Dealing with the media.

It can be downloaded or ordered at:
http://www.icrc.org/eng/assets/files/publications/icrc-icrc-002-4104.pdf

Côte d'Ivoire – A White Paper on the Rights and Responsibilities of Physicians towards Acts of Violence in Times of Crisis and Armed Conflict [177]

In 2013, the Ordre National des Médecins de Côte d'Ivoire (Medical Association of Côte d'Ivoire) adopted a "livre blanc" (white paper) summarizing health-care personnel's roles and responsibilities when facing acts of violence in situations of crisis or armed conflict. The paper is the result of a joint study carried out by the ICRC and the Medical Association. The first part of the paper addresses acts of violence occurring during the exercise of the profession of physician in peacetime, while the second part deals with acts of violence committed in periods of crisis and armed conflict. Building on the role of the health-care community itself in creating an environment conducive to respect for medical ethics and in enhancing the security of the provision of health care, this paper aims to contribute to the preparation and training of health-care personnel to act appropriately in situations of insecurity, considering that such personnel must respect the principles of medical ethics in all circumstances.

The paper includes a WMA Statement on Violence in the Health Sector by Patients and Those Close to Them, the WMA Regulations in Times of Armed Conflict and Other Situations of Violence as well as the WMA International Code of Medical Ethics. **It also contains** testimonies from physicians who have been victims of acts of violence in the performance of their duties in peacetime as well as in armed conflict.

176 ICRC, *Health Care in Danger: The responsibilities of health-care personnel working in armed conflict and other emergencies*, ICRC, August 2012.
177 "Droits et devoirs des médecins face à des actes de violence en période de crise et de conflits armés," Ordre National des Médecins de Côte d'Ivoire, 1st edition, 2014.

4.2.4. Fourth session: How to effectively repress and sanction violations of the rules protecting the provision of health care

Discussion

Any consideration of the development of domestic legal frameworks for the protection of the provision of health care should not underestimate the importance for State authorities to take appropriate measures to repress violations of the rules protecting the provision of health care and to sanction the perpetrators. Major topics discussed during the workshop include the nature of sanctions, the scope and means of their application, the specificity of sanctions and the types of conduct that should be sanctioned. The discussion also touched upon the measures to be taken in order to enhance the effectiveness of sanctions and to ensure that they play their preventive role. Sanctions were therefore analysed not only with regard to their deterrent function in ensuring punishment and accountability of perpetrators, but also with regard to their preventive function in avoiding repetition of violence against the delivery of health care. Different avenues for improving adherence to the rules protecting the provision of health care were explored.

While discussing various means of sanctioning violations of the rules protecting the provision of health care, participants carefully considered the advantages and disadvantages of the different types of sanctions available in their respective domestic legislation (criminal, administrative and disciplinary). Generally, participants insisted on the importance of punishing more severely certain categories of perpetrators by imposing disciplinary sanctions on members of the armed forces, civil servants and health-care personnel found guilty of violations of the rules protecting the provision of health care. It was also felt that deliberate attacks against the provision of health care should be sanctioned severely and considered an aggravating factor in the determination of the sanction to be imposed on a perpetrator.

The debate also highlighted the need for domestic legislation to go further than the Geneva Conventions, both in terms of situations covered and conduct criminalized. As mentioned in the previous section, States party to the Geneva Conventions and their Additional Protocols must prevent and suppress acts contravening those instruments and have further obligations with regard to certain serious violations of IHL committed in international armed conflicts, termed as "grave breaches," which they must criminalize in their domestic legislation and whose perpetrators they must search for and try. Since a significant part of the violence committed against the delivery of health care in modern armed conflicts does not necessarily amount to war crimes, and considering that such violence can also occur in situations that do not reach the threshold of armed conflict, participants believed that the incorporation of war crimes and other international crimes in domestic legislation was not sufficient to effectively repress crimes committed against the provision of health care. Therefore, participants concluded that all types of undue interference with the provision of health care must be repressed and sanctioned by domestic legislation, regardless of the circumstances in which they are committed.

Deficiency of the judicial system and failure to respect judicial guarantees were identified as obstacles to the effectiveness of sanctions in certain contexts, and participants emphasized the need for State authorities to find suitable ways, taking into account the resources available, of enforcing domestic legislation protecting the provision of health care and preventing the recurrence of violence against the provision of health care.

Participants were asked the following questions:

- What types of sanction should be envisaged in the domestic normative framework to repress violations committed against health-care personnel and infrastructure and medical transports?
- How broad should they be to provide effective protection of the provision of health care in situations of armed conflict and other emergencies?
- What are the advantages and disadvantages of the different types of sanction?

Recommendations

Recommendation (13): THE DIFFERENT TYPES OF SANCTIONS (CRIMINAL, ADMINISTRATIVE, DISCIPLINARY) AVAILABLE IN DOMESTIC LAW TO PUNISH VIOLATIONS OF THE RULES PROTECTING THE PROVISION OF HEALTH CARE SHOULD BE SUBJECT TO A GRADUATED APPROACH AND COMBINABLE ACCORDING TO THE GRAVITY OF THE VIOLATION COMMITTED

In addition to criminal sanctions, perpetrators of violations of the rules protecting health care should be subject to administrative and disciplinary sanctions according to their titles or functions, and these sanctions must be combinable.

The discussion on the types of sanctions that should be envisaged in domestic law to repress violations committed against the provision of health care revealed the importance of adopting, in parallel with or complementary to criminal sanctions, administrative and disciplinary sanctions applying to certain categories of perpetrators, depending on their function or status. For example, it was observed that civil servants, health-care personnel and members of the armed forces who – in the course of their duties – are found to commit violations against health-care personnel and facilities and medical transports, or against the wounded and sick should be subject to specific disciplinary measures, including but not limited to the payment of a fine, demotion or suspension from their functions or, for more serious violations, expulsion from their professional associations or from the army.

Participants stated that such sanctions, in the cases in which they can apply, often prove to have a stronger deterrent effect on perpetrators than criminal sanctions, especially because of their immediate effect and consequences. In addition, the perspective of being judged by a community of peers adds to the effectiveness of disciplinary sanctions on members of the armed forces or professional associations. Criminal sanctions, by contrast, can take years to take effect owing to observance of strict and sometimes complex judicial proceedings and guarantees and to a higher burden of proof. Participants added that in certain countries where the judicial system is corrupt or inefficient, criminal sanctions can have even less of a deterrent effect.

At the same time, the importance of criminal sanctions as the basis of repression and in ensuring perpetrators' criminal responsibility cannot be underestimated. Participants noted that despite taking more time to conclude, civil criminal trials are more open and transparent processes than military procedures and have the advantage of offering a basis for extradition, where applicable and appropriate. In addition, their public nature and the fact that they are sometimes subject to media attention reinforces the deterrent effect of criminal sanctions on the population at large.

The applicable sanction(s) for the given violation will thus depend on the status of the perpetrator, and participants stressed that criminal, administrative and disciplinary sanctions must be combinable. As an example, in **Belgium**, misuse of the emblem is subject to criminal sanctions under the Law of 4 July 1956 protecting Red Cross designations, signs and emblems, but when committed by the armed forces it is also subject to disciplinary measures, since it could be considered as a violation of an obligation incumbent on military personnel under legislation or regulations applicable to the armed forces.[178]

Criminal, administrative and disciplinary sanctions provided for in domestic legislation should be graduated to ensure that the penalty is proportionate to the seriousness of the violation committed, taking into account aggravating and mitigating circumstances. Deliberate attacks against the delivery of health care should be considered as an aggravating factor.

Violations of the rules protecting the provision of health care can take various forms and some, of course, can have more serious consequences than others. To ensure adequate sanctioning of the perpetrators, participants made it clear that sanctions, including those a criminal, administrative and disciplinary

178 Law of 14 January 1975 setting out the disciplinary code applicable to the armed forces.

nature, must be subject to a graduated approach, depending on the seriousness of the offence committed. This can be measured, among other factors, by the consequences of the offence or by the circumstances in which it was committed. It was also noted that domestic legislation should allow judges to appreciate both mitigating and aggravating circumstances in order to determine the appropriate level of sanction to be imposed on a perpetrator. Therefore, it was argued that attacks deliberately targeting the provision of health care should be sanctioned more severely than attacks resulting, for instance, from a failure to take all precautionary measures to avoid harming health-care personnel and facilities and medical transports. This can be done either by creating a specific crime in the domestic legislation or, when prosecuting individuals under the general criminal legislation (for instance, general provisions of the domestic criminal code), by considering the deliberate character of the violation committed against the provision of health care as an aggravating factor.

Violence against health care that amounts to a grave breach of the Geneva Conventions must be repressed as such in application of the relevant regime. Where it does not yet exist, such a regime needs to be established in domestic law and must cover both individual and command responsibility.

States have specific obligations with regard to the repression of grave breaches of the Geneva Conventions. States party to the Geneva Conventions and Additional Protocol I must search for and prosecute persons accused of having committed or having ordered the commission of grave breaches, or extradite them for trial in another State. Therefore they must, among other measures, enact national legislation prohibiting and punishing grave breaches,[179] either by adopting a separate law or by amending existing laws.[180] Discussions also highlighted the importance of sanctioning direct responsibility as well as command responsibility for failure to act.[181]

RECOMMENDATION (14): DOMESTIC LEGISLATION SHOULD GO FURTHER THAN THE GENEVA CONVENTIONS IN TERMS OF CRIMINAL REPRESSION, WITH REGARD TO BOTH SITUATIONS COVERED AND CONDUCT CRIMINALIZED

Domestic legislation should sanction all kinds of undue interference with the provision of health care in armed conflict, including threats against health-care personnel and other undue obstacles to the provision of health-care services.

Participants insisted on the fact that threats against health-care personnel and other types of interference with the provision of health care should be taken as seriously as attacks and should consequently be criminalized and sanctioned in domestic legislation. As previously mentioned, States are expressly required to enact legislation necessary to provide effective penal sanctions to punish persons committing or ordering the commission of "grave breaches," which are defined in precise and limited terms and correspond to the most serious violations of the Geneva Conventions. However, as threats against health care, in particular, appear to account for a significant part of the violence committed against health-care activities[182] and can have consequences for the provision of health care just as serious as attacks causing physical injuries or material damage in armed conflict, the need to punish such acts as well as all other types of interference with the provision of health care was considered essential for the effective repression of violence against the delivery of health care. Therefore, it was deemed necessary that domestic legislation cover attacks and other types of interference with the provision of health care that are not covered by the Geneva Conventions.

179 For more information on the repression of grave breaches, please refer to the fact sheet prepared by the ICRC's Advisory Service, "Penal Repression: Punishing War Crimes."

180 For more information on the different ways of incorporating war crimes and other international crimes in domestic law, please refer to the fact sheet prepared by the ICRC's Advisory Service, "Methods of incorporating punishment into criminal law" and, incidentally, to "Preventing and repressing international crimes: Towards an 'integrated' approach based on domestic practice" – Report of the Third Universal Meeting of National Committees for the Implementation of International Humanitarian Law – Volume 1, Section 5, "Incorporation of international humanitarian law (repressive aspects) into domestic legislation," pp. 29-41.

181 See Rules 151-153, Customary IHL Study. For more information, please refer to the fact sheet prepared by the ICRC's Advisory Service, "Command responsibility and failure to act."

182 See ICRC report on "Violent incidents affecting the delivery of health care – January 2012 to December 2013," 2014, p. 5.

Domestic legislation should also sanction all kinds of undue interference with the provision of health care in situations that fall short of armed conflict.

While the Geneva Conventions and their Additional Protocols strictly apply to situations of armed conflict, their implementation in domestic law is not sufficient to repress many of the acts of violence committed against the provision of health care in various contexts. Therefore many participants considered that domestic legislation needed to go further and apply not only to armed conflict but also to other emergencies.[183]

Before adopting specific legislation to criminalize certain violations of the rules protecting the provision of health care, States should assess whether they are already covered by their own general criminal legislation, and special attention should be given to preserving the coherence of the normative framework as well the predictability of sanctions.

The debate on the scope of application and situations covered by domestic legislation led to discussion on the specificity of sanctions with regard to the repression of violence against the delivery of health care. In other words, participants discussed whether domestic legislation should provide for specific sanctions for certain acts of violence against the provision of health care, or if general criminal legislation should apply to those acts, considering deliberate attacks against the provision of health care as an aggravating factor. Although there was no common conclusion on this point, partly owing to the diversity of domestic legal systems, participants agreed on the importance of preserving the coherence of the domestic legal framework and of avoiding scattering the legislation in too many legal frameworks. Some participants suggested that measures to improve implementation of the existing domestic legal framework and sanctions mechanisms be contemplated in priority over the adoption of specific legislation, while others considered that the adoption of specific sanctions to repress crimes committed against the delivery of health care was desirable, provided it is broad enough to cover a variety of factual incidents. The discussion revealed that many countries, like **Brazil**, **Chile** and **Peru**, do not have specific legislation to sanction violence against health care, which are covered by general criminal legislation.

RECOMMENDATION (15): STATE AUTHORITIES SHOULD TAKE APPROPRIATE MEASURES TO ENSURE THAT SANCTIONS ARE EFFECTIVELY APPLIED AND THAT THEY PLAY THEIR PREVENTIVE ROLE

Ensure enhanced knowledge of the population at large and especially of potential perpetrators about sanctions applicable to violations of the rules protecting the provision of health care.

It was understood that in addition to punishing the perpetrators for their unlawful behaviour, sanctions should have a deterrent effect and be aimed at preventing violations. Therefore, one of the principal measures highlighted by participants to improve adherence to the rules protecting the provision of health care was to ensure that the population at large, and especially potential perpetrators, were aware of the sanctions applicable to violations of the rules protecting the provision of health care. Information about the different types of sanctions and their modalities of application should be communicated to all those who are instrumental in, or directly concerned with, the application of rules protecting the provision of health care, namely, State armed forces, State security forces, health-care personnel, civil servants, and, when applicable and feasible, non-State armed groups. Knowledge about sanctions should be included in military or professional training as well as in military manuals or guidelines prepared for the attention of members of the armed forces, health-care personnel or civil servants, when such manuals or guidelines exist. Furthermore, it was deemed important to make sanctions and condemnations public in order to inform the population at large about the consequences of unlawful acts against the provision of health care.

183 As mentioned in Section 4.2.1., the expression "other emergencies" is to be defined by each State in its domestic legislation.

Strengthen the existing institutional framework to oversee compliance with the norms, for example by allowing administrative authorities or specialized supervisory bodies to report unlawful acts to the State authorities competent to conduct investigations or to impose sanctions.

Participants emphasized that State authorities should take adequate measures to monitor compliance with the rules protecting health care, for example, the correct use of the emblem and other signs used to identify protected health-care personnel, facilities, and medical transports as well as the use of medical transports and facilities. One of the measures suggested was to endow administrative authorities or specialized supervisory bodies with investigative powers and the ability to report unlawful acts to State authorities competent to conduct investigations or to impose sanctions, thereby helping to ensure that violations are reported to the appropriate bodies and that perpetrators are effectively sanctioned. Such bodies should have the authority to receive external information on unlawful behaviour observed against the provision of health care and to report the alleged violations to the appropriate State authorities. However, special care should be taken to avoid overlapping competences with other national bodies that already have the authority to monitor compliance with the rules by certain categories of persons, such as professional associations, according to their titles and functions, as well as those competent to carry out investigations into criminal or administrative offences.[184]

It was also deemed important to encourage reporting of violations of the rules protecting health care by making the complaints procedure safe and accessible to victims.

Ensure the integrity and independence of the judicial system and respect for judicial guarantees in relation to criminal procedures (e.g. fair trial, right to defence, presumption of innocence) as well as the transparency of administrative authorities empowered to sanction perpetrators of violations of the rules protecting the provision of health care.

Participants observed that the effectiveness of criminal sanctions also relies on their implementation, which, in turn, is intrinsically linked to the conformity of the judicial system with the main legal principles and judicial guarantees of criminal justice. States have specific obligations in terms of minimum legal safeguards applicable to persons accused of serious violations of any of the four Geneva Conventions or of Additional Protocol I.[185] In this respect, depriving protected persons of a fair and regular trial amounts to a grave breach under the Third and Fourth Geneva Conventions.[186] With regard to violations committed in connection with non-international armed conflicts, Article 3 common to the four Geneva Conventions "prohibits executions in violation of judicial guarantees which are recognized as indispensable," and, more specifically, sentencing or executions without previous judgement pronounced by a regularly constituted court.[187] Many of these guarantees and procedural safeguards are already part of the domestic law of States party to the Geneva Conventions, whether in their codes of criminal procedure, rules of evidence and/or in their Constitutions, and roughly correspond to those offered by instruments of human rights law.[188] For example, it was clear to participants that the right of the accused to be judged by an independent and impartial court and without undue delay, the right of defence and the presumption of innocence are minimum judicial safeguards that should be guaranteed in the course of criminal proceedings at all times. It is understood that administrative authorities with sanctioning competences must also observe minimal procedural guarantees, such as equal and fair treatment.

184 Please refer to Section 3.1.2 - C.
185 Art. 49, GC I; Art. 50, GC II; Art. 129, GC III; Art. 146, GC IV. Furthermore, Art. 75 of AP I contains a list of guarantees afforded to persons under these treaties and to persons accused of war crimes.
186 Art. 130, GC III; Art. 147, GC IV.
187 Furthermore, AP II stipulates, with regard to offences committed in connection with a non-international armed conflict, that no sentence may be passed and no penalty executed in the absence of a conviction previously pronounced by a court offering the essential guarantees of independence and impartiality. In addition, it spells out the procedural safeguards that must be respected (Art. 6).
188 Universal Declaration of Human Rights (Arts. 9-11) and the International Covenant on Civil and Political Rights (Art. 14).

States should do everything feasible, considering the resources at their disposal, to enhance their capacity to enforce existing sanctions provided by law.

Participants observed that the main challenge which many States face in implementing their international legal obligations has less to do with incorporating them into their domestic legal framework than with effective application of the rules and generating respect for them. In other words, the main issue in enhancing effective protection for the provision of health care on their territory for States struggling with armed conflict or other situations of emergency – and particularly developing States with fewer resources at their disposal and many other priorities on their agenda – is proper enforcement of existing sanctions. Lack of resources and of political will were identified as common obstacles to effective implementation of the rules in many contexts. However, in accordance with their obligations under international law, States should do everything feasible to have the capacity to enforce the sanctions provided by law. Concerning implementation of IHL, States are encouraged to adopt a pragmatic and realistic approach, which consists in seeking ways of preventing crimes from being committed, bearing in mind the resources available.[189]

189 For more information, please refer to the fact sheet prepared by the ICRC's Advisory Service, "Elements to render sanctions more effective," 2008.

Héctor Gonzáles de Cunco/ICRC

5. CONCLUDING REMARKS

The Brussels Workshop was based on a number of *findings* and *assumptions* that were generally endorsed by the participants. These findings and assumptions merit recapitulation in the conclusions of this report.

1) Violence against patients and health-care personnel, facilities, and medical transports is a humanitarian issue with far-reaching consequences. While it is clear that this violence can take many different forms, further evidence of the extent of the problem is still needed on all levels – national, regional and international. National authorities are encouraged to contribute to the evidence base on the problem of violence against the delivery of health care by putting in place mechanisms – where they do not already exist – for collecting information on violent incidents against health-care personnel, facilities and medical transports so as to devise strategies on how to address this problem.
2) Health-care personnel are both witnesses to and victims of very serious threats. These are threats to which they have to react, either by changing their work patterns or sometimes even by leaving their work. Although such threats do not always directly affect the physical integrity of the health-care personnel, they can result in depriving an entire population of health-care services.
3) Direct attacks and violent incidents are not the only threat to the delivery of health care. A rhetoric that challenges the basic humanitarian consensus, anchored in the Geneva Conventions, that the wounded and sick must receive adequate and timely treatment in an impartial manner, has emerged in the discourse of some political and military leaders. The idea that health care should be directed as a priority to some segments of the population over others, or that by taking up arms people can legitimately be deprived of health care, goes not only against IHL, but also against a fundamental ethical duty of all health-care professionals.
4) Even in armed violence, in the middle of a war or during a violent upheaval, it should still be possible to ensure that the wounded and sick get timely access to health care. There is, of course, no single solution for improving the safe delivery of health care.
5) Many actors, taking many different measures, are needed to achieve a change. If authorities, military, police, lawyers, the international community and the health-care workers themselves took a certain number of practical measures, the lives of thousands of people in many countries around the world could be spared.
6) Violence against health-care facilities and personnel – in all its forms – is not only morally questionable, it is *prohibited by international law*. Primary responsibility for ensuring that the law is obeyed lies with States and with combatants. In addition, national legislators and courts must fulfil their responsibility for ensuring that domestic legislation recognizes the criminal responsibility of anyone who violates IHL and relevant IHRL, and for actually enforcing such legislation. Other State authorities, including administrative authorities, may play a useful complementary role in imposing sanctions other than criminal ones for violations of IHL and/or other relevant international legal norms.
7) Offenders must be held *accountable* and, in the most serious cases, should face individual criminal responsibility.
8) On the basis of field activities and extensive expert consultations, the ICRC has come to the conclusion that – if properly implemented – *existing* international rules could adequately ensure the provision of health care. What is crucially needed is a determined effort to implement the rules effectively. This effort requires strong domestic frameworks.

The Brussels Workshop was entirely focused on the elaboration of such domestic normative frameworks. Thanks to the very active involvement of all participants, who displayed a very rich palette of different but complementary areas of expertise, significant results have been achieved.

The Workshop did not only offer the opportunity to discuss and clarify a number of sometimes controversial legal and practical issues; it also allowed for the identification of very concrete recommendations that should really improve the protection of health-care professionals and the provision of health care in exceptional situations.

The ICRC is convinced that these recommendations could make a difference. It invites State authorities and other actors concerned to consider them and to engage in reflection on how to implement them in their respective areas of competence.

The ICRC, of course, remains ready to assist all actors concerned in this difficult task.

Didier Revol/ICRC

ANNEXES

ANNEX 1. COUNTRY STUDIES

BELARUS

1. The health-care system in Belarus

According to Article 45 of the Constitution of the Republic of Belarus (RB), "[n]ationals of the Republic of Belarus are guaranteed the right to health care, including free medical treatment in State health-care institutions. The State ensures the availability of medical services accessible to all nationals." Moreover, Article 3 of the Law on Health Care of 1993[190] sets out a number of general principles in regard to the health-care policy, including the following relating to access to the health-care system:

- accessibility of medical care and pharmacological support
- priority for the development of first-aid care
- priority for medical care in favour of minors, pregnant women, disabled persons and veterans.

According to Article 63 of the Law on Health Care, in case of emergencies, relief workers, Ministry of Interior personnel and other officials shall take necessary measures to provide assistance for persons in need. All legal persons and individuals are bound to assist health-care personnel during the provision of medical aid. Health-care personnel are entitled to use any transport vehicle available in the area, regardless of whose property it is, in order to reach the persons whose lives are in danger or transport those persons to the nearest medical station; any person who denies health-care personnel the use of a vehicle for that purpose is subject to liability.

Emergency relief forces were established under the Enactment on the State System of Prevention and Relief of Emergencies of 2000.[191] These forces comprise health-care and medical divisions responsible for providing health care for people affected by emergencies. Combined with Article 63 of the Law on Health Care, this means that the provision of health care for the population in its entirety is guaranteed.

The legal framework regulating the conditions of access to, as well as importation and distribution of, humanitarian aid and assistance and providing protection for the wounded and sick in situations of armed conflict and other emergencies mainly consists of the following acts:

- Constitution of the RB
- Law of the RB No. 2435-XII dated 18.06.1993 "On Health Care" (Law on Health Care)
- Law of the RB No. 382-Z dated 12.05.2000 "On the Use and Protection of the Red Cross and Red Crescent Emblems" (Law on the Emblem)
- Law of the RB No. 437-3 dated 24.10.2000 "On the Belarus Red Cross Society" ("BRCS")[192] (Law on the BRCS)
- Enactment of the Council of Ministers of Belarus No. 495 dated 10.04.2001 "On the State System of Prevention and Relief of Emergencies"
- Various local acts (city districts, oblast levels, etc.).

190 Law of the RB No. 2435-XII, dated 18.06.1993, "On Health Care".
191 Enactment of the Council of Ministers of Belarus No. 495 dated 10.04.2001 "On the State System of Prevention and Relief of Emergencies."
192 The BRCS is also responsible for organizing the import of humanitarian aid.

Pursuant to clause 20 of Enactment No.495, the Ministry of Health Care is responsible, at top level, for surveillance and control of emergency aid.

The Law on the Emblem and the Law on the BRCS allow humanitarian organizations to provide care for the wounded and sick in Belarus.

2. The protection of health-care personnel

The Law on the Emblem, the Law on Emergency Rescue Service and the Rescuer's Status[193] and the Law on Health Care provide protection for health-care personnel in situations of armed conflict and other emergencies.

Article 2 of the Law on the Emblem defines health-care personnel as "persons permanently or temporarily responsible for seeking, collecting, transporting, diagnosing or treating the sick and wounded and the shipwrecked, including the provision of the first aid, disease prevention, as well as logistic support and day-to-day operations of medical units." The Ministry of Health Care is in charge of the authorization and control of health-care personnel.

Health-care personnel bearing the red cross emblems are subject to protection under the Geneva Conventions and Protocols I and II (Art. 8 of the Law on the Emblem). The respective emblem established by Article 7 of the Law on BRCS (a red cross in the centre of a white circle with two red sidelines, bearing the inscription BRCS in English and Belorussian) may be, inter alia, worn by health-care personnel. This regulation also corresponds to Article 11 of the Law on the Emblem concerning the use of the red cross by the BRCS.

Activities carried out by aid societies, indicated by Articles 9 to 12 of the Law on the Belarus Aid Society, are numerous and generally correspond to the humanitarian mission. They include:
- implementing IHL during armed conflicts;
- assisting the sick and the wounded during armed conflicts and emergencies;
- acting as an "information bureau" during armed conflicts;
- collecting information on the missing;
- organizing the import of humanitarian aid;
- promoting IHL during peacetime.

3. Protection of medical units and transports

The Law on the Emblem and the Law on the BRCS provide legal protection for medical units and transports in situations of armed conflict and other emergencies.

Article 2 of the Law on the Emblem defines "medical transportation" as "aerial, ground, marine, or river military and civil transportation vehicles, used permanently or temporarily, only for the transportation of the sick and the wounded, the shipwrecked, health-care personnel, medical property, and for other medical purposes, and being under control of a party to an armed conflict."

The same article defines "medical units" as "stationary or mobile medical institutions and other civil or military units, acting on a permanent or temporary basis in order to search for, collect, transport, diagnose or treat the sick, the wounded and the shipwrecked, including the provision of first aid and disease prevention."

Civil and military medical and transport units are under the respective responsibility of the Ministry of Health Care and the Ministry of Defence.

Like health-care personnel, medical units and transports bearing the red cross emblem are subject to protection under the Geneva Conventions and Additional Protocols I and II (Art. 8 of the Law on the Emblem).

193 Law of the RB No. 39-3, dated 22.06.2001,"On Emergency Rescue Service and the Rescuer's Status."

The Laws on the Emblem and the BRCS do not specifically provide for loss of protection of health-care personnel or medical units and transports in situations of armed conflict. However, since Article 18 of the Law on the Emblem prohibits the undue use of the emblem, it can be deduced that such undue use could lead to loss of the protection it provides.

4. Protection of the wounded and sick

In situations of emergency, the Republican Special Purpose Detachment of the EMERCOM RB is responsible for assisting and treating the sick and the wounded. It operates in accordance with the Enactment of the Council of Ministers of RB No. 179, dated 15.05.1991. Such an obligation is also provided for in Article 63 of the Law on Health Care.

5. Protection of the distinctive emblems

The Law on the Emblem grants protection to the emblems protected under the Geneva Conventions and their Additional Protocols, and its basic provisions regarding the correct use of the distinctive emblems correspond to the ICRC Model Law on the Emblems.

Article 19 of the Law on the Emblem gives the BRCS responsibility for controlling the use of the distinctive emblems, along with the competent public authorities (without naming them).

6. Medical ethics and confidentiality

The Law on Health Care of 1993 refers to medical ethics. Article 63 of that law provides an exhaustive list of exceptions to medical secrecy, but these exceptions do not directly relate to armed conflicts. In other emergencies, the law enforcement bodies are entitled to request disclosure of the patient's medical details.

7. Repression

Belarus law provides for criminal sanctions, notably for crimes against peace and humanity and war crimes, as well as for violations of customary IHL. Violations of the Military Service Manual are subject to disciplinary liability, which requires servicemen "to be aware of and observe the international rules of conduct of the military effort."

BELGIUM

(French original prepared by the Belgian Interministerial Commission for Humanitarian Law)

1. The health-care system in Belgium

Under Belgian law, good-quality health care is a universal right. In an emergency, medical care must be provided unconditionally.

Royal Decree No. 78 of 10 November 1967 on the exercise of health-care professions provides that, wherever health care is lacking or inadequate, a medical commission shall, on its own initiative or at the request of the provincial governor, request that certain organizations or practitioners set up health-care services or supplement existing ones. In addition, persons who do not qualify as health-care practitioners under national legislation may carry out certain medical procedures, in particular where, during a war or other calamity, such procedures are urgently required and not enough accredited practitioners are available.[194]

194 Art. 50 of Royal Decree 78 authorizes the King to decide which medical procedures may be carried out by persons who are not legally qualified to do so but who have received special training to that end.

The obligation to protect medical personnel in armed conflict is laid down in the Geneva Conventions and their Additional Protocols. These legal instruments apply directly in Belgium.

2. Protection for medical personnel

Royal Decree No. 78 regulates the exercise of health-care professions in Belgium.[195] The country's Federal Public Service (FPS) in charge of public health is responsible for overseeing all such professions and approving accreditation for health-care practitioners, thereby confirming that their qualifications meet the criteria required to obtain the professional title in question. Doctors serving under the armed forces are affiliated with the Order of Doctors and answer to the relevant military authorities.

An agreement between the Belgian Red Cross and the FPS, signed on 19 December 2012, regulates the organization and setting-up of rapid-response services providing urgent medical care. Under the agreement, the Belgian Red Cross is in charge of supplying, setting up and deploying rapid mobile teams to help organize and implement medical, sanitary and psychosocial assistance in the event of a disaster (medical and sanitary services, logistics, personnel).

Moreover, by royal decree, the FPS grants the Belgian Red Cross an annual subsidy in support of services that contribute to providing urgent medical care[196] and for the organization of psychosocial assistance[197] in public emergencies and other situations of danger.

3. Protection for the wounded and the sick

Belgium's legal framework protecting the wounded and the sick consists of:
- legislation on the rights of patients;
- human rights treaties, including the 1950 European Convention for the Protection of Human Rights and Fundamental Freedoms;
- the Belgian Criminal Code (failure to assist a person in danger);[198]
- the provisions of the Geneva Conventions protecting the wounded and the sick.

This protection is backed up by penalties and disciplinary measures, as outlined in Section 5 below.

4. Protection for the emblem

The law of 4 July 1956 protecting Red Cross designations, signs and emblems[199] sets out the right to use the emblem in conformity with the Geneva Conventions and their Additional Protocols, establishes penalties for peacetime and wartime violations of international treaties governing the use of the designations "red cross," "Geneva cross," "red crescent," "red lion and sun" or of any corresponding sign or emblem. The law does not specify who is responsible for enforcing the rules protecting the emblems and designations, or for making them known.

Nonetheless, in practice and in peacetime, the Belgian Red Cross helps the authorities to prevent and punish any misuse of the emblem, while publicizing the provisions laid down in the 1956 law and in the 1949 Geneva Conventions and their Additional Protocols concerning such misuse (appropriation by unauthorized persons, imitation).

195 e.g. doctor, pharmacist, kinesiologist, nurse, midwife, first responder, ambulance technician, paramedic.
196 "Arrêté royal du 17 décembre 2012, octroyant un subside à la Croix-Rouge de Belgique pour l'année 2012 pour l'appui aux services qui participent à la mise en œuvre de l'aide médicale urgente lors des situations d'urgence collective et de manifestations à risque," *Moniteur belge*, 21 January 2013.
197 "Arrêté royal du 17 décembre 2012, octroyant un subside à la Croix-Rouge de Belgique pour l'année 2012 pour l'organisation d'un service d'intervention psychosociale urgente pour des situations d'urgence collective et des manifestations à risque et fixant les conditions d'octroi à ce subside," *Moniteur belge*, 21 January 2013.
198 "Anyone who fails to assist or to obtain assistance for a person in grave danger, and who has either witnessed the circumstances or been told about them by someone requesting assistance, shall be punished by imprisonment of eight days to one year and a fine of 50 to 500 euros or by either one or the other. This may be considered as an offence, however, only if the person whose assistance was requested could have intervened without serious risk to himself or to anyone else. Where the person did not directly witness the situation, he may not be found guilty if the circumstances in which he was asked to intervene were such as to shed doubt on the existence of a danger or a risk." (ICRC translation)
199 "Loi du 4 juillet 1956, relative à la protection des dénominations, signes et emblèmes de la Croix-Rouge," *Moniteur belge*, 11 July 1956.

The role played by the Belgian Red Cross in this regard derives from the National Society's statutes,[200] under which, in its capacity as an auxiliary to the public authorities in the humanitarian sphere, the Belgian Red Cross has a duty to spread knowledge of the Fundamental Principles of the International Red Cross and Red Crescent Movement and the basic tenets of international humanitarian law.[201] This duty is enshrined in the Statutes of the International Red Cross and Red Crescent Movement,[202] which provide that the National Red Cross and Red Crescent Societies shall "disseminate and assist their governments in disseminating international humanitarian law" and shall "cooperate with their governments to ensure respect for international humanitarian law and to protect the distinctive emblems recognized by the Geneva Conventions and their Additional Protocols."[203]

The military authorities are in charge of monitoring and ensuring respect for the protective use of the emblem, and the armed forces' medical services are currently drafting a directive on this use.

5. Penalties

Book II, Title I*bis*, of the Belgian Criminal Code sets out penalties for serious violations of international humanitarian law. The crime of genocide, crimes against humanity and war crimes are dealt with in 136*bis* to 136*quater*, respectively, of the Code.

The relevant provisions are as follows:

- Art. 136*quater*, para. 1.15°, protecting medical buildings, materials, units and means of transport and of personnel using, in conformity with international law, the distinctive signs provided for under international humanitarian law;[204]
- Art. 136*quater*, para. 1.17°, protecting humanitarian and peace-keeping missions, in conformity with the Charter of the United Nations;[205]
- Art. 136*quater*, para. 1.18°, on acts or omissions that may adversely affect the health and mental or physical integrity of persons entitled to protection under international humanitarian law;[206]
- Art. 136*quater*, para. 1.19°, prohibiting physical mutilation, medical or scientific experiments, or the removal of tissue or organs for transplantation;[207]
- Art. 136*quater*, para. 1.21°, protecting places where the sick and the wounded are gathered;[208]
- Art. 136*quater*, para. 1.29°, on use of the protective signs recognized by international humanitarian law;[209]
- Art. 136*quater*, para. 1.35°, prohibiting the launch of attacks on certain buildings, including hospitals, as long as those buildings cannot be considered as military objectives.[210]

200 Statuts de la Croix-Rouge de Belgique, révisés le 13 octobre 2003; arrêté du gouvernement de la Communauté française portant approbation des statuts de la Croix-Rouge de Belgique, 4 décembre 2003 (Statutes of the Belgian Red Cross, amended on 13 October 2003: Decree issued by the government of the French Community approving the Statutes of the Belgian Red Cross, 4 December 2003), *Moniteur belge*, 22 April 2004; Arrêté du gouvernement flamand portant approbation des statuts modifiés de la Croix-Rouge de Belgique, 2 avril 2004 (Decree issued by the government of the Flemish Community approving the amended Statutes of the Belgian Red Cross, 2 April 2004), *Moniteur belge*, 1 July 2004; Arrêté du gouvernement de la Communauté germanophone portant approbation des nouveaux statuts de la Croix-Rouge de Belgique, 4 juin 2004 (Decree issued by the government of the German-speaking Community approving the new Statutes of the Belgian Red Cross, 4 June 2004), *Moniteur belge*, 20 August 2004.

201 Statutes of the Belgian Red Cross, amended on 13 October 2003, Art. 4.

202 Statutes of the International Red Cross and Red Crescent Movement adopted by the Twenty-fifth International Conference of the Red Cross in Geneva in 1986, and amended in 1995 and 2006.

203 Statutes of the International Red Cross and Red Crescent Movement, 1986, Section II, Art. 3.2.3.

204 Criminal Code, Art. 136*quater*, para. 1.15°, prohibiting: "the launching of a deliberate attack against medical buildings, materials, units and means of transport, and against personnel using, in conformity with international law, the distinctive signs provided for by international humanitarian law" (ICRC translation).

205 Criminal Code, Art. 136*quater*, para. 1.17°, prohibiting: "the launching of a deliberate attack against personnel, installations, materials, units or vehicles used within the framework of a humanitarian or peace-keeping mission, in conformity with the Charter of the United Nations, provided they are entitled to the protection afforded by the international law of armed conflict to civilians and civilian objects" (ICRC translation).

206 Criminal Code, Art. 136*quater*, para. 1.18°, prohibiting: "acts or omissions without legal justification that may adversely affect the health and mental or physical integrity of any persons entitled to protection under international humanitarian law, in particular medical procedures that are unwarranted by the state of health of the persons in question or that contravene the general rules governing the medical profession" (ICRC translation).

207 Criminal Code, Art. 136*quater*, para. 1.19°, prohibiting: "acts that consist in performing, on persons referred to in para. 1.18° and even with their consent (unless justified by the conditions provided for in said para.), physical mutilation, scientific experiments or the removal of tissue or organs for transplantation other than the donation of blood for transfusion or of skin for grafting, provided the donation is voluntary, agreed and intended for therapeutic purposes only" (ICRC translation).

208 Criminal Code, Art. 136*quater*, para. 1.21°, prohibiting: "the launching of a deliberate attack on places where the wounded and the sick are gathered, provided these places cannot be considered as military objectives."

209 "Criminal Code, Art. 136*quater*, para. 1.29°, prohibiting: "the perfidious use of the distinctive sign of the red cross or red crescent or of any other protective signs recognized under international humanitarian law wherever such use results in death or serious injury".

210 Criminal Code, Art. 136quater, para. 1.35°, prohibiting "the launching of a deliberate attack against buildings used for religious, artistic, scientific or charitable purposes, or against historic buildings or hospitals, provided that these buildings cannot be considered as military objectives."

Furthermore, the Act of 4 July 1956[211] protecting designations, signs and emblems of the Red Cross provides for the punishment of any misuse, in peacetime or in wartime, of the designations "red cross," "Geneva cross," "red crescent and red lion and sun," or of any corresponding signs or emblems. Within the framework of the procedure launched by Belgium to ratify Protocol III additional to the Geneva Conventions, legislative steps have been taken to amend the 1956 law with a view to adding the emblem enshrined in Protocol III, namely the "red crystal," to the list of protected designations, signs and emblems.

The Act of 14 January 1975 setting out the disciplinary code applicable to the armed forces provides that any violation thereof may entail disciplinary measures. Likewise, violations of the Geneva Conventions or their Additional Protocols may entail disciplinary measures.

Apart from the general rules protecting civilians in armed conflict, several offences listed as war crimes in Art. 136*quater*[212] of the Belgian Criminal Code refer to protection for medical personnel and objects.

6. Medical ethics and confidentiality

Under the code of medical ethics, all practitioners must respect doctor-patient confidentiality in all circumstances. Article 458 of the Criminal Code prohibits any violation of such confidentiality except where the practitioner is called upon to testify in a court of law or before a parliamentary commission of inquiry, or where the practitioner is under a legal obligation to disclose the information to which he is privy.[213]

Various directives issued by the World Medical Association have been incorporated into federal law, however, confirming that priority must be given to access to health care in all circumstances.

COLOMBIA

The situation of violence in Colombia has been characterized by the existence of an armed conflict that has lasted for more than 60 years and other forms of violence affecting, among other things, safe access to and delivery of health care. Over the last 15 years, normative frameworks have been developed at the national level in order to enhance respect for the medical mission.

1. The health system in Colombia

Health has been elevated to the status of a constitutional right[214] which covers two essential aspects: (i) health care and environmental sanitation are declared to be public services; and (ii) the right of

211 Law of 4 July 1956:
"Art. 1 – Without prejudice to other criminal provisions, anyone who, in violation of international conventions, uses any of the designations "red cross," "Geneva cross," "red crescent," "red lion and sun" or any corresponding signs or emblems shall be punished by imprisonment of eight days to three years and by a fine of 26 to 3,000 francs, or by either one or the other. The same penalty shall apply to anyone who uses a designation, sign or emblem likely to be confused with the aforesaid designations, signs or emblems.
Art. 2 – Wherever committed in wartime, the offences described in Art. 1 shall be punished by imprisonment of 15 days to five years and by a fine of 50 to 5,000 francs or by either one or the other."

212 Criminal Code, Art. 136*quater*, para. 1: "The following are considered as crimes under international law and are punishable in conformity with the provisions laid down herein: the crimes set out in the Geneva Conventions of 12 August 1949 and Additional Protocols I and II of 8 June 1977; those set out in the laws and customs of war as defined in Art. 2 of the aforesaid Geneva Conventions, in Art. 1 of Additional Protocols I and II, and in Art. 8.2(f) of the Statute of the International Criminal Court, as enumerated hereinafter, wherever those crimes undermine, either by commission or omission, the protection afforded to persons and objects by said Conventions, Protocols, and laws and customs, without prejudice to the criminal provisions applicable to offences committed by negligence:
1° intentional homicide;
2° (…)".

213 "Doctors, surgeons, health officials, pharmacists, midwives and all other parties who, owing to their profession or for any other reason, are privy to confidential information and who disclose such information in circumstances other than when called upon to testify in a court of law (or before a parliamentary commission of inquiry) or when under a legal obligation to do so, shall be punished by imprisonment of six days to six months and a fine of 100 to 500 francs."

214 Art. 49 of the Colombian Constitution: "Public health and environmental protection are public services for which the State is responsible. All individuals are guaranteed access to services that promote, protect, and rehabilitate public health. It is the responsibility of the State to organize, direct, and regulate the delivery of health services and of environmental protection to the population in accordance with the principles of efficiency, universality, and cooperation, and to establish policies for the provision of health services by private entities and to exercise supervision and control over them. In the area of public health, the State will establish the jurisdiction of the nation, territorial entities, and individuals, and determine the shares of their responsibilities within the limits and under the conditions determined by law. Public health services will be organized in a decentralized manner, in accordance with levels of responsibility and with the participation of the community. The law will determine the limits within which basic care for all the people will be free of charge and mandatory.
Every person has the obligation to attend to the integral care of his/her health and that of his/her community."

every individual to access promotion, protection and recovery of health services is guaranteed. Therefore, the public policy of the State seeks to achieve *universal coverage* to ensure access to health care by guaranteeing that the entire population has access to a Mandatory Plan of Health (Plan Obligatorio de Salud – POS). In addition, there is a constitutional duty of social solidarity which embodies the principle of social solidarity by creating an obligation for every citizen "to respond with humanitarian actions when faced with situations that endanger the life or health of individuals".[215]

Colombia's health-care system has been adapted over the years, taking into account the characteristics of the armed conflict and other situations of violence. Different rules, norms and procedures have been adopted at national level in order to enhance protection of the medical mission.

2. Protection of the wounded and sick, medical units and transports [216]

In Colombia, victims of the armed conflict and other situations of violence have the right to receive health care through two systems. First through the Solidarity Fund of the Social Security System, which offers the possibility for health-care institutions to charge to the Fund the expenses of assistance to victims. Second, through the Victims and Land Restitution Law of 2011[217] which includes a list of health services to which victims of the armed conflict are entitled (hospitalization, drugs, transportation, treatments for HIV and sexually trasmitted diseases in cases where the person is a victim of sexual violence, medical fees, medical and surgical material, osteosynthesis, orthotics and prosthetics, support services and abortion services if the abortion falls within the cases allowed by the jurisprudence of the Constitutional Court and assistance for the sexual and reproductive rights of women victims).[218] It is important to take into account that the Constitutional Court recently recognized that internally displaced victims of emerging armed groups are also entitled to be considered as beneficiaries of attention, assistance and integral reparation obligations established by the Law.[219]

In addition to the above-mentioned forms of reparation, protection of the wounded and sick, medical personnel, units and transports has been established at national level through (i) criminal repression, and (ii) the development of other normative frameworks.

(i) Criminal repression

The Criminal Code includes a list of crimes against persons and objects protected by international humanitarian law. In relation to the protection of the wounded and sick, medical personnel, units and transports, it is worth mentioning the following crimes:

- Murder and other crimes committed against protected persons[220]
- Destruction of property and health facilities
- Obstruction of health and humanitarian tasks
- Failure to adopt relief and humanitarian assistance measures.

215 Art. 95 of the Colombian Constitution: "To be Colombian is an honour for every member of the national community of Colombia. Everyone has the duty to respect and dignify this honour. The exercise of liberties and rights recognized in this Constitution implies responsibilities. Every person has the duty to respect and obey the Constitution and the laws. The following are duties of each person and each citizen:
1. To respect others' rights and not abuse one's own; 2. To strive, in accordance with the principle of social solidarity, to respond with humanitarian actions when faced with situations that endanger the life or health of individuals; 3. To respect and support the legitimately constituted democratic authorities in their efforts to maintain national independence and integrity; 4. To defend and foster human rights as a basis of peaceful coexistence; 5. To participate in the country's political, civic, and community life; 6. To strive toward the achievement and maintenance of peace; 7. To cooperate for the sound operation of the administration of justice; 8. To protect the country's cultural and natural resources and watch over the conservation of a healthy environment; 9. To contribute to the financing of State expenditures and investments in accordance with the principles of justice and equity."

216 Under the health-care system, hospitals and other health institutions operate in general as private, lucrative or non-profit-making companies. It is worth mentioning that today the health-care system tends towards the "privatization" of health institutions. Public hospitals and other health institutions depend on the municipalities (generally of the first level) and on the departments (of the second and third level). They can operate as State or private companies.

217 Law 1448 of 2011: Victims and Land Restitution Law.

218 Constitutional Court of Colombia, case C-355 of 2006. Magistrados Ponentes Jaime Araújo Rentería y Clara Inés Vargas Hernández. In this case, the Constitutional Court decided to exclude abortion from the Criminal Code in three cases: (i) when the pregnancy constitutes a danger for the life or health of the woman, certified by a doctor; (ii) when there is a malformation of the foetus which makes its life non-viable and this condition is certified by a doctor; and (iii) when the pregnancy is the result of a behaviour, duly reported, which constitutes intercourse or a sexual act without consent, is abusive or is the result of artificial insemination or the transfer of fertilized ovules without consent, or is the result of incest.

219 Constitutional Court of Colombia, Decision 119 of 2013. (Corte Constitucional, Sala especial de Seguimiento a la Sentencia T-025 de 2004 y sus autos de cumplimiento. Auto 119 de 2013. Magistrado Ponente Luis Ernesto Vargas Silva).

220 Art. 135 of the Criminal Code (Law 599 of 2000) establishes a list of persons who are protected under IHL. Medical personnel are explicitly mentioned.

By the same token, the Criminal Code considers as crimes failure to provide assistance and relief and failure to provide humanitarian assistance and relief measures in the context of armed conflict.[221]

(ii) Other normative frameworks

As stated before, over recent years normative frameworks to protect safe access to and delivery of health care have been adopted at the national level.[222] Among these, it is worth mentioning:

- Law 875 of 2004, which regulates the use of the red cross/red crescent emblem and other emblems protected by the Geneva Conventions and the Additional Protocols;
- Decree 138 of 2005, which regulates different articles of the Law of 2004 and established new provisions regarding the protective use of the emblem by medical personnel, units and transports of the armed forces and by civilian medical personnel;
- Resolution 4481 of 2012 of the Ministry of Health, which adopted the new Manual of the Medical Mission (see below).

3. Medical ethics

Medical ethics and confidentiality have been of particular concern in Colombia, with respect to the armed conflict and the provision of health care to other weapons bearers. There have been some cases of medical personnel who have been prosecuted for having provided health care to members of armed groups.[223]

As far as the normative framework is concerned, the code of medical ethics provides that "the doctor will abide by the laws in force in the country and the recommendations of the World Medical Association".[224] This implies that the regulations of the World Medical Association for situations of armed conflict and other situations of violence are incorporated into the national legal system. In addition, the code of ethics makes specific reference to armed conflicts by providing that "[t]he doctor shall not favour, condone or participate in the practice of torture or other cruel, inhuman or degrading procedures, whatever the offense attributed to the accused or convicted victim is, whatever the motives or beliefs in all situations, armed conflict and civil struggle."[225]

4. Conclusion

Even if there has been an important improvement at the national level regarding the adoption of normative frameworks for the protection of the wounded and sick and the medical mission, some problems relating to the lack of access of the civilian population to health services and medicines remain a reality. Thus, there is a need to continue work on the implementation and enforcement of existing normative frameworks.

The Manual of the Medical Mission as an example of good practice

The Resolution of 2012 superseded Resolution 1020 of 2002 and adopted the Manual of the Medical Mission.

The resolution is the result of a joint enterprise between the ICRC Delegation in Bogotá, in particular the health department, the Colombian Red Cross, the Ministry of Health and Social Protection and other governmental institutions.

221 Art. 131 of the Criminal Code (Law 599 of 2000): "Failure to provide assistance/relief: A person, who fails, without just cause, to assist a person whose life or health is in grave danger, shall be liable to imprisonment."
Art. 152 of the Criminal Code (Law 599 of 2000): "Failure to provide humanitarian assistance and relief measures: A person who fails, within and during the armed conflict when so obliged, to adopt assistance and humanitarian relief measures in favour of protected persons shall be liable to imprisonment."

222 In addition to the normative frameworks mentioned in this part, the following rules have been adopted in order to ensure and guarantee the provision of health care in cases of terrorist events: (i) Decree 1283 of 1996, which regulates the functioning of the Solidarity and Guarantee Fund of the Social Security System; (ii) Decree 3990 of 2007, which establishes conditions for the insurance of risks arising from corporal damage caused by transit accidents, catastrophes and terrorist events; and (iii) Decree 2973 of 2010, which establishes the criteria for providing physical and mental rehabilitation services for victims of political violence.

223 In these cases, national tribunals considered that medical personnel who provided health care for members of armed groups incurred responsibility for the crime of rebellion and sedition for providing them with medical assistance and support.

224 Code of Medical Ethics, Law 23 of 1981.

225 Code of medical Ethics, Law 23 of 1981.

The goal of the Manual is to adopt and implement a system aimed at respecting and protecting the medical mission in Colombia. It is worth mentioning that the Manual is applicable both for situations of armed conflict and for other situations of violence.

The Manual deals with different issues related to health care. Specifically, it gives practical guidance on:

a. The rights and responsibilities of medical personnel and health institutions

It is worth mentioning that the Manual makes reference to the rights of the personnel involved in the medical mission. In this sense, they have the right:

- to be respected and protected;
- not to be attacked;
- to have access to and provide health care;
- to have necessary means to provide health care;
- not to be sanctioned or prosecuted for the exercise of medical activities;
- not to be forced to act contrary to the principles of medical ethics;
- to respect medical secrecy;
- to be able to identify themselves.

b. Violations committed against the medical mission

The Manual refers to the Geneva Conventions, Additional Protocols I and II and the rules of customary international humanitarian law. In this regard, the Manual defines violation of the medical mission as "behaviour which affects the components and activities of the Medical Mission or its direct beneficiaries (patients and communities), which are related to situations of public order, by disrespecting one or more of the responsibilities and rights mentioned in the legal basis and the cases which have been evaluated".[226]

The Manual includes violations against life and health, infrastructure, medical activities and medical secrecy. In addition, it includes a list of acts which amount to perfidy.

c. The emblem of the medical mission

This section of the Manual provides specific guidance on the protection, characteristics, supervision, authorization and cancellation of the use of the emblem of the medical mission. It is worth mentioning that the medical mission in Colombia has its own distinctive emblem:

d. Recommendations for the safety of medical personnel, units and transports

This part of the Manual can be considered as the most operational part, since it includes a series of obligations for medical personnel and also requires that these obligations be translated at the institutional level in order to ensure effective implementation. The Manual seeks to clarify the notions of threat, risk and vulnerability[227] so that an assessment can be made that would help to identify which measures should be adopted in a particular case.

226 Manual of the Medical Mission, p. 18.

227 These definitions were taken from the Hospital Disaster Planning Course of the Pan American Health Organization (available only in Spanish):
Threat: External factor of risk, represented by the potential occurrence of an event of natural origin, generated by human activity, or the combination of both which can occur in a specific place and which has a specific duration and intensity.
Risk: The probability of social, environmental and economic damages in a specific community, within a period of time, in relation to the threat and vulnerability.
Vulnerability: Internal risk factor of a person, object or system which has been exposed to a threat and which has an inherent predisposition to be damaged. (ICRC Translation).

Finally, it is worth mentioning that the Manual includes instructions on recording violations of IHL and incidents[228] against the medical mission in Colombia.

KENYA

1. The health-care system in Kenya

The right to health-care services and emergency medical treatment is enshrined in the Kenyan Constitution.[229] There is currently no system to facilitate access to the safe delivery of health care in armed conflict and other emergencies. At the moment, everything is managed at the policy level.[230] However, it is important to consider the measures that have been adopted to avoid or deal with what happened during violent situations that took place in the previous years and that affected health care.

The lack of a proper system to ensure health care in armed conflict and other emergencies was particularly evident during the 2007/2008 post-election violence (PEV). The provision of health care was very poorly coordinated during this period and many internally displaced persons (IDPs) completely lacked access to health-care services.[231] Following the PEV, the government created two policy documents: the *National Policy for Disaster Management in Kenya* and the *National Disaster Response Plan*. These documents outline the principles for effective disaster preparedness and management and contain guidelines on how to coordinate the response to various types of emergencies, including the mobilization of resources. For the purpose of coordination, the policy documents established the National Disaster Management Agency (NADIMA).[232] This is a semi-autonomous body with representatives from various ministries and civil society groups and organizations at both national and county level. The disaster-response activities of NADIMA are the responsibility of the National Disaster Operations Centre (NDOC).[233] This is a reporting centre for emergencies and conflicts that operates on a 24-hour, seven-days-a-week basis.[234]

In order to be prepared for violent situations, ad hoc sectorial committees took it upon themselves to conduct sector-specific planning. For instance, the health sector created a *Contingency Plan for the March 2013 General Elections.*

As for the way forward, the Kenya Health Policy 2012-2030 refers to "instituting emergency preparedness and response mechanisms at all levels of the health system" in order "to ensure adequate response to [the] health effects of disasters and emergencies."[235] Instituting a proper system to facilitate access to the safe delivery of health care in armed conflict and other emergencies therefore appears to be on the Government's radar.

2. Protection of medical personnel, units and transports

In Kenya medical personnel depend on the Ministry of Health, which has overall responsibility for the authorization and control of health-care personnel but has delegated practical responsibility to various

228 The Manual defines such incidents as "any action or omission which, directly or indirectly, impedes, delays or limits access to services and is not considered as an IHL violation." Manual of the Medical Mission, p. 13.
229 Constitution of Kenya, 2010, Art. 43(1) and (2).
230 Interview with representative from the Ministry of Health, Nairobi, 1 March 2013.
231 The Kenyan Section of the International Commission of Jurists and Kenya Human Rights Commission, *Elusive Justice: A Status Report on Victims of 2007-2008 Post-Election Violence in Kenya*, ICJ Kenya and KHRC, 2012, p. 29, Health Rights Advocacy Forum, *Report on the Effects of 2007 Post Election Violence on Health Workers and the Preparedness of the Health Care System in Kenya*, Assessment Report, HERAF, 2008, p. 23, http://www.heraf.or.ke/heraf-reports/page-1.html.
232 Ministry of State for Special Programmes, *National Policy for Disaster Management in Kenya*, MSSP, March 2009, p. 37.
233 National Policy for Disaster Management in Kenya (note 27), p. 39.
234 Ministry of State for Special Programmes and Ministry of Provincial Administration and Internal Security, *National Disaster Response Plan*, MSSP and MOPAIS, 2009, para. 41.
235 Ministry of Medical Services and Ministry of Public Health and Sanitation (today's Ministry of Health), *Kenya Health Policy 2012-2030,* 2012, p. 21, http:// www.healthresearchweb.org/files/KenyaHealthpolicyfinalversion.pdf.

statutory bodies.[236] In addition, each hospital has its own Hospital Administration Board that regulates the workers of the hospital.

In situations of armed conflict, legal protection of health-care personnel is provided for under the Geneva Conventions Act and the International Crimes Act. In other emergencies the protection of health-care personnel falls under general domestic law.[237]

A major weakness of the legal protection of health-care personnel in Kenya is lack of specificity. The Geneva Conventions Act and the International Crimes Act both provide that health-care personnel should be protected, but neither stipulate which authority or body is in charge of ensuring that this happens. The protection is further undermined by the lack of a definition under Kenyan law of the term "medical personnel".

After consultations and interviews with medical personnel and experts in Kenya, three topics on which work needs to be done were identified: (a) access to work; (b) safety in the workplace; and (c) special status of health-care personnel. A series of measures which could be adopted in order to guarantee the protection of health-care personnel were mentioned. The majority of these measures reflect that the main concern is related to the security of medical personnel.

a. Access to work

This area concerns the journey to and from the health-care facility.[238] The following measures were suggested:

- Creation of identification (ID cards) for health-care personnel
- Improvement of security protection by the police by establishing an obligation to escort health-care personnel during situations of violence to protect them from attacks on the road
- Adoption of measures in order to guarantee evacuation of health-care personnel from situations where security can no longer be guaranteed.[239]

b. Safety in the workplace

This makes reference to the environment and the workplace of medical personnel. The following measures were suggested:

- Access to adequate resources
- Adoption of legal provisions for the protection of medical personnel while at work
- Adoption of additional security measures during emergencies and conflict situations

236 "During the PEV, multiple instances of ethnic-related violence and threats against health-care personnel were reported. The violent mob made no distinction between medical personnel and ordinary civilians when evicting people from their homes and burning their houses to the ground. This caused many health care personnel to become IDPs, 246 in the Rift Valley region of Kenya alone. In addition, doctors and nurses belonging to "the wrong tribe" were attacked and threatened while at work, both by their colleagues and by patients. As a result of both real and perceived threats a record number of transferral requests were made in early 2008. It is believed that endowing health care personnel with a special and neutral status under law and then educating the population about this status would help prevent this happening in the future. Of course this also requires that health care personnel always act neutral, but it is imagined that the disciplinary powers of the various medical regulatory bodies can be used to ensure this." Presidential Circular No. 1 of 2008: Organisation of the Government of the Republic of Kenya (Office of the President, 2008).

237 The Geneva Conventions Act incorporates some elements of the Geneva Conventions into Kenyan law. In particular, Section 3 of the Act criminalizes grave breaches of the Geneva Conventions, as defined in Art. 50 of Geneva Convention I, Art. 51 of Geneva Convention II, Art. 130 of Geneva Convention III and Art. 147 of Geneva Convention IV. Acts considered to constitute grave breaches under the Conventions include wilful killing, torture, inhumane treatment, and causing great suffering or serious bodily or mental injury to protected persons. Persons protected under the Geneva Conventions include medical personnel and hospital staff. As such, anyone who commits any of the aforementioned acts against health-care personnel is guilty of an offence under Section 3 of the Geneva Conventions Act. The International Crimes Act domesticates parts of the Rome Statute. Section 6(1)(c) of the Act criminalizes "war crimes," the definition of which is the same as under Art. 8(2) of the Rome Statute. Intentionally directing attacks against personnel involved in humanitarian assistance or using the distinctive emblems of the Geneva Conventions are some of the acts which constitute war crimes under the Rome Statute. As such, these acts are also prohibited under Kenyan law by virtue of the International Crimes Act.
The Kenyan Penal Code criminalizes acts such as murder, manslaughter, assault, threats to life and the causing of grievous harm. These acts are prohibited in general and at all times, including during emergencies. Health-care personnel as such are not singled out as worthy of any type of special protection under the Penal Code.
Numerous provisions under IHL relating to the protection of health-care personnel are included in the *Law of Armed Conflict* manual, a training manual for the Kenyan Defence Forces (KDF). The medical personnel of the KDF are, furthermore, allowed to carry small, light weapons for their own personal protection.

238 One major hurdle faced by the health-care system during the 2007-08 PEV was that medical personnel were unable to get to work. This was partly due to the lack of public transport. While private health-care facilities arranged transport for their staff, no such arrangements were made for staff at public facilities; they had to use their own cars. Even then, travelling to and from work was made difficult by the frequent roadblocks put up along the main roads.

239 For example, in the volatile north-eastern part of Kenya there have been instances where medical personnel working for NGOs were evacuated by their respective organizations but the public health-care personnel were left to their own devices.

- Adoption of procedures in order to determine how ambulance personnel should act while performing their duties[240] (through the establishment of a reporting procedure).

c. Special status for health-care personnel

This area concerns the status of health-care personnel under Kenyan law and its impact on their work. In this sense, the adoption of a special legal status that strengthens the neutrality of health personnel is required.

3. Medical units and transports

In situations of armed conflict, legal protection of medical units and transports is provided for under the Geneva Conventions Act and the International Crimes Act. In other emergencies the protection of medical units and transports falls under general domestic law.[241]

The protection of medical units and transports is undermined by the lack of legal definitions for "medical units" and "medical transports" in the Geneva Conventions Act and the International Crimes Act. Without such definitions, it is unclear which precise buildings and vehicles are entitled to protection under the two Acts. The definition of medical units and transports under international law is found in Additional Protocol I, which Kenya has ratified.[242] Article 2(6) of the Kenyan Constitution provides that "[a]ny treaty or convention ratified by Kenya shall form part of the law of Kenya". In essence, this means that the definition of medical units and transports in Additional Protocol I forms part of Kenyan law. For the purpose of clarity and consistency, this definition should be inserted into the Geneva Conventions Act and the International Crimes Act.

A particular weakness in the protection of medical transports is the fact that Kenya lacks a legal regime regulating the use of ambulances. Medical transports are unregulated and therefore not accorded any special legal recognition to distinguish them from regular vehicles. In this sense, the following measures should be adopted:

- Adoption and implementation of a law on ambulances
- Adoption of security measures which will guarantee the protection of medical units and transports by the police and other government institutions.[243]

4. Protection of the wounded and sick

In situations of armed conflict, legal protection of the wounded and sick is provided for under the Geneva Conventions Act and the International Crimes Act. In other emergencies, the protection of the

240 Ambulance personnel are taught to ask the police for assistance when responding to a call from a particularly dangerous neighbourhood or when, for example, there is a mob after a football match. However, the police have no legal obligation to comply with this request. This is therefore an area of potential legal reform. In addition, the legal obligation of ambulance personnel to save lives is unclear. As a result, one interviewee reported that there have been instances when ambulance personnel have been taken to the police station for questioning following the death of someone they tried to assist. To rectify this, there should be established procedures in law for ambulance personnel regarding how they are required to act in various circumstances.

241 The Geneva Conventions Act, Section 3, criminalizes grave breaches of the Geneva Conventions. This includes extensive destruction of property protected under the Conventions. Property protected in this manner includes medical units, medical transports and hospitals. As such, causing extensive destruction to medical units and transports during an armed conflict is an offence under Section 3 of the Geneva Conventions Act. The International Crimes Act, Section 6(1)(c), criminalizes the war crimes stipulated in Art. 8(2) of the Rome Statute. One such war crime is attacks on medical units and transports involved in humanitarian disasters or using the red cross or red crescent emblems. Attacks on medical units and transports during an armed conflict are therefore prohibited by virtue of Section 6(1)(c) of the International Crimes Act. The Kenyan Penal Code criminalizes acts such as arson, malicious injury to property and sabotage of property. Property includes both movable and immovable items. The Traffic Act prohibits the throwing of objects at vehicles or persons therein or otherwise impeding the progress of a vehicle in a way that may cause injury or damage to the vehicle. In both the Penal Code and the Traffic Act these actions are prohibited in general and no distinction is made between regular buildings or vehicles and those hosting medical units. Numerous provisions under IHL relating to the protection of medical units and transports are included in the *Law of Armed Conflict* manual. In addition, the Kenya Defence Forces Act prohibits members of the KDF from destroying public and non-public property, which presumably includes medical units.

242 See Art. 8(e)-(g), AP I.

243 The Security of Government Buildings Unit of the Administration Police, located under the Ministry of Provincial Administration and Internal Security, is mandated to protect Government buildings and installations. At the moment, the Unit is mainly concerned with the protection of Government office buildings, but it was suggested that it be specifically charged with also protecting hospitals in situations when extra security is required.

wounded and sick falls under general domestic law.[244] In addition to this protection, it is worth mentioning that the *National Policy for Disaster Management* contains a Code of Conduct declaring that "the right to receive assistance during disasters is a fundamental humanitarian principle which should be enjoyed by all citizens of Kenya."[245]

In interviews with relevant stakeholders, the main problem appeared to be access to health care. The consensus seemed to be that in order to improve the legal protection of the wounded and sick in such situations one must ensure that health-care professionals have access to them.

- Adoption of a special nation-wide system[246] in order to facilitate access of the wounded and sick. This could include rules or procedures which provide that all hospitals, both private and public, are required to accept and treat any wounded or sick person seeking treatment in such situations.[247]
- Sanction those responsible for obstructing access to health care for the wounded and sick.

5. The distinctive emblems

The use of the emblems is protected under the National Flag, Emblems and Names Act of 1963. Legal Notice No. 487 of 1991 inserted the Red Cross and Red Crescent into Part 1, Schedule 1 of the Act, thereby according the emblems the same protection as the National Flag of Kenya. This protection is detailed in Section 3(1) of the Act and consists in prohibition of the use of the emblems by any company or profession and in any designs or on any product unless specifically authorized by the Minister.

Section 6(1)(c) of the International Crimes Act criminalizes the war crimes set out in the Rome Statute. One such crime is the improper use "of the distinctive emblems of the Geneva Conventions" in times of international armed conflict.[248] The Red Cross and Red Crescent are both mentioned in the Geneva Conventions and are thus protected by the International Crimes Act.

The National Flag, Emblems and Names Act prohibits the use of the red cross and red crescent emblems by any company or profession and in any designs or on any product, unless specifically authorized by the Minister.[249] The Act does not afford any protection for the red crystal emblem.

However, the legal protection of the distinctive emblems in Kenya is not detailed enough. The following measures should be adopted:

- Current legislation should stipulate that the emblems may be used in accordance with the Geneva Conventions.
- The sanctions for unauthorized use of the emblems should be revised.

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244 Section 3 of the Geneva Conventions Act criminalizes grave breaches of the Geneva Conventions. Killing, torturing, treating inhumanely or seriously injuring people protected under the Conventions are all acts that constitute a grave breach. People protected under the Conventions include the wounded and sick. As such, committing any of the acts mentioned against a person who is wounded or sick is a grave breach of the Geneva Conventions and a criminal offence by virtue of Section 3 of the Geneva Conventions Act.
The International Crimes Act, Section 6(1)(c), domesticates the war crimes defined in Art. 8(2) of the Rome Statute. One such crime is the inhuman and cruel treatment of a person and, although not explicitly stated, this includes the wounded and sick. Accordingly, cruel and inhuman treatment of the wounded and sick is an offence under the International Crimes Act.
The Kenyan Penal Code criminalizes acts such as murder, manslaughter, causing grievous harm and assault as well as threats to life. These acts are prohibited against people in general, in both peacetime and situations of emergency. In addition, the Constitution provides that "[e]very person has the right to the highest attainable standard of health," which includes a general right to health-care services. It also holds that "a person shall not be denied emergency medical treatment," adding further protection for the wounded and sick in emergency situations.
Numerous provisions under IHL relating to protection for the wounded and sick are included in the Law of Armed Conflict manual. The manual also provides for physical protection of the wounded and sick since military medical personnel looking after them are permitted to carry small arms for their defence. The military's treatment of the wounded and sick is also regulated through the Kenya Defence Forces Act, which specifically prohibits members of the military from pillaging wounded persons. The Act also provides for punishment of KDF members who, outside Kenya, commit "any wrongful act" in relation to members of the civilian population. The term "wrongful act" is defined as "an act contrary to law, regulation, lawful order or custom" and would, if committed in Kenya, presumably fall under the Penal Code. The Kenya Defence Forces Act also includes the offence of disgraceful conduct "of a cruel, indecent or unnatural kind".

245 A disaster in this context is defined as "a serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental loses which exceed the ability of the affected community/society to cope using its own resources." Arguably, this would include all levels of a conflict as well as other emergency situations. However, as this is a policy document, it carries no legal force.

246 Interview with a Lecturer of Surgery at Moi Teaching and Referral Hospital, Nairobi, 28 February 2013.

247 Interview with a Lecturer of Surgery at Moi Teaching and Referral Hospital, Nairobi, 28 February 2013. At present, apart from the vague right to emergency medical care provided for in the Constitution, hospitals have no legal obligation to receive the wounded and sick. Many privately-owned hospitals are reluctant to take on charity cases and will instead send these to the nearest public facility which, in an emergency situation, is likely to be overcrowded.

248 Rome Statute, Art. 8(2)(b)(vii).

249 National Flag, Emblems and Names Act, 1963, Section 3.

6. National repression

Kenya's national legislation provides criminal, disciplinary and administrative sanctions relating to the protection of medical personnel, units and transports, the wounded and sick and the emblem.

a. Criminal sanctions

The Geneva Conventions Act, Section 3, provides for the repression of grave breaches of the Geneva Conventions, whether committed in Kenya or elsewhere. According to this provision, a person, whether a Kenyan citizen or not, found guilty of wilfully killing another person protected under the Geneva Conventions is liable to life imprisonment. A person found guilty of any other grave breach of the Conventions is liable to imprisonment for a maximum of 14 years.

The International Crimes Act, Section 8, gives jurisdiction to the High Court for war crimes committed in Kenya or elsewhere if either the perpetrator or the victim is a Kenyan citizen or if the perpetrator is currently in the country. When the basis of the offence is killing with intent, the offence is treated as murder and the perpetrator charged accordingly. The punishment for murder in Kenya is death, unless the person convicted is pregnant.[250] When killing with intent is not the basis of the offence, the maximum punishment provided for is imprisonment for life.

The Penal Code provides repressive measures for the offences contained therein. The punishment for murder is death, unless the offender is pregnant. The maximum sentence for manslaughter and grievous harm is life imprisonment, while the offence of assault attracts up to five years' imprisonment.[251] The maximum punishment for arson and destruction of property is imprisonment for life.[252]

The Kenya Defence Forces Act outlines repressive measures for the offences covered by the Act. These only apply to members of the KDF or civilians who travel with the forces and have consented, in writing, to be bound by the Act.[253] A court martial has jurisdiction over all of the offences under the Act.[254] The various punishments are mostly stipulated in the form of a maximum number of years' imprisonment, followed by the phrase "or any lesser punishment provided for under this Act". For example, destruction of property attracts a maximum of seven years' imprisonment or any lesser punishment, while the punishment for disgraceful conduct of a cruel, indecent or unnatural kind is a maximum of 10 years' imprisonment or any lesser punishment.[255] Murder attracts the death sentence, but the sentence may not be carried out before the President has approved of the court martial's ruling.[256]

The court martial is considered subordinate to the superior courts in Kenya, namely the High Court, Court of Appeal and Supreme Court (in increasing order of rank).[257] Appeals from a court martial can therefore be lodged with the High Court and, thereafter, if applicable, the other superior courts.[258] The Military Director of Prosecution may also appeal to the High Court against an acquittal by a court martial.

b. Disciplinary sanctions

The Kenya Defence Forces Act provides for disciplinary measures for some of the offences under the Act. In the case of an offence that does not attract a prison sentence, the accused can choose whether to have the charges heard by a court martial or summarily. The punishments that may be imposed at a summary hearing include dismissal from the forces, reprimand and fines.[259]

c. Administrative sanctions

Under Article 22(1) of the Constitution, individuals have the right to bring a legal complaint if their constitutional rights have been violated. The proceedings may be brought by the victim, somebody

250 Kenyan Penal Code, 1930, sections 204 and 211.
251 Kenyan Penal Code, 1930, sections 205, 234 and 250.
252 Kenyan Penal Code, 1930, sections 235, 332 and 339.
253 Kenya Defence Forces Act, 2012, sections 4 and 5.
254 Kenya Defence Forces Act, 2012, section 162.
255 Kenya Defence Forces Act, 2012, sections 87(2) and 120.
256 Kenya Defence Forces Act, 2012, section 184.
257 Constitution of Kenya, 2010, Arts 162(1) and 169(1)(c).
258 Kenya Defence Forces Act, 2012, section 186.
259 Kenya Defence Forces Act, 2012, sections 155 and 156.

acting on his or her behalf, or somebody acting in the public interest.[260] In response to such an action the High Court may issue a declaration of rights, an injunction, a conservatory order or an order for compensation.[261] However, the Constitutional rights relating to health care are extremely vague and lack precise criteria for accessing emergency medical care. The Constitution also fails to stipulate what exactly constitutes "health care services". It is therefore extremely difficult to hold the Government accountable for any failings regarding the right to health care, and any type of judicial decision on the matter will be very difficult to come by.

7. Medical ethics and confidentiality

Some of the statutory medical regulatory bodies in Kenya have developed codes of conduct for the professionals they control. These codes make reference to medical ethics. Health-care professionals are legally required to adhere to the code of the regulatory body under which they are registered. Failure to do so is a ground for disciplinary action, including de-registration.[262]

The *Code of Professional Conduct and Discipline* applies to doctors, dentists and clinical officers.[263] It contains the World Medical Association Declaration of Geneva[264] and the International Code of Medical Ethics.[265] The Nursing Council of Kenya's *Code of Ethics and Conduct for Nurses in Kenya* applies to all nurses in Kenya.[266] The Pharmacy and Poisons Board has not developed a code of conduct; a code of ethics has instead been published by the Pharmaceutical Society of Kenya. Military health-care personnel are required to adhere to the code of conduct of the regulatory body of the medical profession to which they belong.[267]

MEXICO

1. The health-care system in Mexico

Health has been established as a constitutional right.[268] The National Health System aims to provide health services[269] for the entire population. Health services provided in public health facilities are based on the principles of universality, free access according to social and economic conditions[270] and non-discrimination.[271]

In Mexico, the provision of health services is a concurrent competence between the Federal and local states. Thus, medical activity is subject to:

1. The Law on Health;
2. The Regulatory Law of Article 5 of the Constitution (Professions Act);
3. The basis of coordination between health and education authorities;
4. State laws on these matters.

The National Health Information System is an interesting tool, developed by the Federation, which aims to determine the criteria necessary to obtain, integrate, organize, process and analyse information relating to health (population, coverage, resources available, threats to health and evaluation of the National Health System's performance).[272]

260 Constitution of Kenya, 2010, Art. 22(2).
261 Constitution of Kenya, 2010, Art. 23(3).
262 See Nurses Act, 1983, section 18A(1)(f) and Clinical Officers (Training, Registration and Licensing) Act, 1989, section 15(1).
263 Medical Practitioners and Dentists Board, *The Code of Professional Conduct and Discipline*, 6th ed., MPD Board, 2012.
264 WMA Declaration of Geneva, adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948. Available at: http://www.wma.net/en/30publications/10policies/g1/.
265 WMA International Code of Medical Ethics, adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949. Available at: http://www.wma.net/en/30publications/10policies/c8/.
266 Nursing Council of Kenya, *Code of Ethics and Conduct for Nurses in Kenya* (2nd ed., NCK 2012).
267 Armed Forces Code of Conduct and Ethics, Part III: General Code of Conduct and Ethics, section 9(d).
268 Mexican Constitution (Constitución Política de los Estados Mexicanos), Art. 4.
269 Health services are defined as "all actions performed on behalf of an individual and a society in general, intended to protect, promote and restore the health of the individual and the community. These services include health care, public health and welfare." These services also include promotion, prevention, diagnosis, treatment, rehabilitation, and medical and pharmaceutical hospital services.
270 Law on Health (Ley General de Salud), Art. 35.
271 Law on Health (Ley General de Salud), Art. 77bis 1 and 77bis 36.
272 National Health Information System (Sistema Nacional de Información en Salud).

Mexican domestic regulation for situations of armed conflict is scattered and not abundant.[273] The regulation on medical personnel, units and transports does not make reference to any special regime. The only emergency context in Mexico that has been regulated is civil protection during disaster situations.[274] The Civil Protection Act defines disaster as the "result of the occurrence of one or more severe and/or extreme disruptive agents, concatenated or not, which come from natural or human activity that, when occurring at a determined place and time, cause damage whose magnitude exceeds the response capacity of the affected community".[275] Among the various disruptive agents, there are two interesting categories: *anthropogenic phenomenon and socio-organizational phenomenon.* The first is defined as a disturbing agent produced by human activity and the second as a disturbing agent generated by human error or deliberate acts in the context of large concentrations or mass population movements such as demonstrations of social unrest, massive concentrations of population, terrorism, sabotage, vandalism, air, sea or land accidents and interruption or impairment of basic services and strategic infrastructure.[276]

During any emergency situation, it is mandatory to give priority to the protection of life, health and safety of people. If the occurrence of a disruptive agent is imminent and represents a threat to life and integrity, the Ministry of Interior may issue an emergency declaration to provide urgent and necessary support. The approval of the declaration should not take more than five days and the assistance should start the day after the authorization has been issued.

Mexico is one of the few examples of States in which protection of the medical mission is enacted through national legislation on the protection of the emblem.[277]

2. Protection of the wounded and sick, medical personnel, units and transports

Victims of emergency situations or accidents have the right to receive health care immediately and to be transferred to the nearest health facilities. There is a legal obligation for public and private health-care facilities and for the Public Attorney to guarantee access, attention to and transfer of patients.[278]

As far as protection of the medical mission is concerned, the Law on the Protection of the Emblem provides the following definition of the medical mission:

The totality of persons, units, transports, equipment, materials and activities, transitory or permanent, fixed or mobile, destined exclusively and necessary for the administration, operation and provision of health-care services in the areas of prevention and promotion, care and rehabilitation of people.[279]

The Law on the Protection of the Emblem includes a chapter on the establishment of control measures and sanctions. However, the Law imposes administrative sanctions only on any person who uses the red cross emblem, distinctive signs, the name "Red Cross" or any imitation that can lead to confusion with the emblem protected by the Law. Finally, it is important to stress that the Law does not establish specific protection for the medical mission since it does not sanction any attack against it.

The Law on the Protection of the Emblem only refers to the inviolability of the medical mission during an armed conflict. Therefore, protection of the emblem in emergency situations is less specific.

The regulations of the Law on Health define "facility for medical care" as "any public, social or private, fixed or mobile facility, whatever its designation, which provides medical care services (outpatient or inpatient), with the exception of medical offices."[280]

273 Mexico has not ratified AP II.
274 Law on Civil Protection (Ley General de Protección Civil).
275 Art. 2-VXI of the Law on Civil Protection.
276 See Art. 2, Sections XX and XXVII.
277 Law on Use and Protection of the Name and Emblem of the Red Cross (Ley para el Uso y Protección del Emblema de la Cruz Roja).
278 Law on Health (Ley General de Salud), Art. 56.
279 Law on the Use and Protection of the Name and Emblem of the Red Cross (Ley para el Uso y Protección de la Denominación y del Emblema de la Cruz Roja), Art. 3-XII. Original in Spanish: "Misión Médica: Comprende el conjunto de personas, unidades, medios de transporte, equipos, materiales y actividades, transitorios o permanentes, fijos o móviles, de destinación exclusiva y necesarios para la administración, el funcionamiento y la prestación de servicios médico-asistenciales, en las áreas de prevención y promoción, atención y rehabilitación a las personas."
280 Regulation of the Law on Health Care, Art. 7-III. Medical offices are also regulated under the Regulation of the Law on Health Care (Arts 56 and 58).

3. Criminal repression

Federal regulations cover the following crimes:

- Violation of the duties of humanity[281]
- Crimes committed against civil servants (for those cases where the medical mission is attached to a public institution)[282]
- Enforced disappearances[283]
- Threats[284]
- Injuries[285]
- Homicide[286]
- Abandonment of people[287]
- Illegal deprivation of liberty[288]
- Extortion.[289]

From this list of crimes, only the first (violation of the duties of humanity) makes reference to acts that can occur during an armed conflict by stating that those who violate the duties of humanity in relation to prisoners and hostages of war, the wounded, or blood transfusion centres will be subject to a penalty of imprisonment of three to six years, except in special cases provided for in military laws.[290]

The Code of Military Justice punishes those who, in the absence of extreme demands of war operations, attack hospitals, ambulances, or charitable shelters that are marked with their established signs or whose nature can be recognized from far away. The penalty is imprisonment for 12 years.[291]

4. Protection of the emblem

Mexico has a law regarding the use and protection of the red cross emblem. However, the regulations of this law are still being drafted.

The law defines the emblem according to the First Geneva Convention and establishes the two types of uses recognized in the Convention: indicative and protective.[292] It also establishes who is entitled to use the emblem, the means of making it visible as well as the rules governing its authorization by the Secretary of National Defence.

The Secretary of National Defence is in charge of authorizing the use of the red cross emblem. Once authorization has been granted, medical and religious personnel of the armed forces, the Mexican Red Cross, aid societies, civilian hospitals and hospital ships, transportation and medical zones are entitled to use the emblem.

Administrative sanctions, such as fines, are imposed for unauthorized use of the emblem and of any imitation that may give rise to confusion.

The Law on Health makes reference to education on respect for and the importance of medical personnel and their activities, with emphasis on respect for and protection of the medical mission.

281 Federal Criminal Code, Art. 149.
282 Federal Criminal Code. Art. 189.
283 Federal Criminal Code, Art. 215-A to 215-D.
284 Federal Criminal Code, Art. 282.
285 Federal Criminal Code, Arts 288-301.
286 Federal Criminal Code, Arts 302-308 and 310-325.
287 Federal Criminal Code, Art. 335.
288 Federal Criminal Code, Art. 364.
289 Federal Criminal Code, Art. 390.
290 Federal Criminal Code, Art.149. Original in Spanish: "Al que violare los deberes de humanidad en los prisioneros y rehenes de guerra, en los heridos, o en los hospitales de sangre, se le aplicará por ese sólo hecho: prisión de tres a seis años, salvo lo dispuesto, para los casos especiales, en las leyes militares."
291 Code of Military Justice, Art. 209. Original in Spanish: "Se castigará con la pena de doce años de prisión al que, sin exigencia extrema de las operaciones de la guerra, incendie edificios, devaste sementeras, saquee pueblos o caseríos, ataque hospitales, ambulancias o asilos de beneficencia dados a conocer por los signos establecidos, o cuyo carácter pueda distinguirse a lo lejos de cualquier modo, o destruya bibliotecas, museos, archivos, acueductos u obras notables de arte; así como vías de comunicación."
292 Protective emblem: use of the emblem is granted to persons, objects, units, transports and medical material that carry out activities within an armed conflict.
Indicative emblem: persons and objects that are related to one or various components of the International Movement.

5. Medical ethics and confidentiality: A system of absolute confidentiality

The Federal Code of Criminal Procedure establishes that persons such as health professionals or civil servants who are bound by medical confidentiality may not be compelled to testify on any information received, known or in their possession.[293] More specifically, surgeons or specialists cannot testify as to the health of their patients.[294] Public attorneys and judges have the obligation to reject the admission of any communication that violates the duty of confidentiality.

Medical records should always be handled with discretion and confidentiality, according to scientific and ethical principles. They may be disclosed to third parties only after judicial, administrative or health authorities, or the National Medical Arbitration Commission or a State arbitration commission have issued an order.

Federal courts (in civil matters) have determined that professional confidentiality is linked to the right to privacy. Persons bound by the duty of medical confidentiality cannot disclose information made accessible to them in the exercise of their profession. Thus, they are not obliged to testify.

NEPAL

1. The health-care system in Nepal

Article 16 (2) of the 2007 Interim Constitution of Nepal guarantees as a fundamental right of every citizen the right to basic health services. It further provides that basic health services shall be delivered free of charge by the State, a right which is complemented directly or indirectly by a number of legislations.[295] Under the Ministry of Health and Population, the Department of Health Services is responsible for the administration of public health services, which comprise notably central, regional, sub-regional and district hospitals, primary health-care and health centres, medical stores, health posts and clinics. These institutions can be accessed by anyone without formalities and most of them provide health services free of charge. Private and NGO-operated hospitals, nursing homes and medical colleges are also accessible to anyone, but they charge higher fees.

The Natural Calamity (Relief) Act of 1982 allows humanitarian organizations to provide care for the wounded and sick with prior permission of the Government (except for representatives of the Nepal Red Cross Society and the Nepal Scouts, who are ex-officio members of the Central Natural Calamity Relief Committee). Under the Natural Calamity (Relief) Act, aid societies may be allowed to carry out activities such as evacuating people or goods and commodities from disaster zones to safe areas, and saving land, houses, factories, temples, shrines, religious places and other significant objects and places from destruction, or taking other necessary safety measures for protecting the lives of individuals as well as personal property.

Article 144(6) of the Interim Constitution provides that in situations of armed conflict or other emergencies the President may, on the recommendation of the Government of Nepal (Council of Ministers), "issue such orders as are necessary to meet the exigencies". Orders so issued shall be operative with force of law as long as the state of emergency is effective.

Nepal has developed a national legal framework for Ayuverdic medicine. According to the World Health Organization (WHO), "the policy of the Government, based on five-year plans, involves a system of integrated health services in which both allopathic and Ayurvedic medicine is practised. Ayurvedic clinics are considered to be part of the basic health services, and there is a section responsible for

293 Federal Code of Criminal Procedures, Art. 243bis-IV.
294 Federal Code of Criminal Procedures, Art. 243bis-V.
295 Chapter on Treatment of the General Code (Muluki Ain), 1964; Smallpox Control Act, 1964; Infectious Disease Act, 1964; Nepal Medical Council Act, 1964; Drug Act, 1978; Nepal Ayurvedic Council Act, 1988; Nepal Health Research Council Law, 1991; Breast Milk Substitutes (Marketing Control) Act, 1992; B.P. Koirala Health Sciences Institute Act, 1992; B.P. Koirala Memorial Cancer Hospital Act, 1997; Nepal Health Services Act, 1997; Nepal Health Professionals Council Act, 1997; Nepal Nursing Council Act, 1997; Human Organ Transplantation (Regulation and Prohibition) Act; 1998; Sahid Gangalal National Heart Center Act, 2001; Nepal Pharmacy Council Act, 2001; National Academy of Medical Sciences Act, 2007; Patan Health Sciences Academy Act, 2008; and, last but not the least, the Security of Health Professionals and Health Institutions Act, 2010 and the rules and regulations framed under these Acts.

Ayurvedic medicine in the Office of the Director General of Health Services. The programmes for health services included in the Fifth Five-Year Plan make provision for four Ayurvedic hospitals, one in each of the four development regions. The Ayurvedic Governmental Pharmaceutical Unit works to provide inexpensive medicaments".[296]

2. Protection of health-care personnel

Health professionals in Nepal are protected in situations of emergency by the Health Professionals and Health Institutions Protection Act of 2010. While domestic legislation does not explicitly envisage special protection for health workers during armed conflict or other emergencies, health workers can request such protection under the Health Professionals and Health Institutions Protection Act. Security of employment is, however, well protected by relevant service laws, for example by the Nepal Health Services Act of 1997.

A number of laws define those who qualify as health-care personnel. For example, the Nepal Medical Council and Nursing Council provide for qualifying examinations under the Medical Council Act of 1964 and the Nursing Council Act of 1996 for doctors and nurses, respectively. Similarly, the Ayurveda Medical Council Act of 1987, the Nepal Health Professionals Council Act of 1997 and the Nepal Pharmacy Council Act of 2000 provide for establishing respective Councils for qualifying and regulating the professions concerned. Those respective councils, constituted under the Nepal Medical Council Act of 1964, the Nursing Council Act of 1996, the Ayurveda Medical Council Act of 1987, the Nepal Health Professionals Council Act of 1997 and the Nepal Pharmacy Council Act of 2000, are responsible for authorization and control of their professional activities. In the public sector, the Ministry of Health and Population is in charge of the authorization and control of health-care personnel working under the Nepal Health Services Act of 1997. They are appointed by the Ministry of Health and Population upon recommendation of the Public Service Commission.

Health-care personnel carry out treatment, diagnosis, disease prevention and any other activities relating to health. "Health professional" refers to any person who has obtained minimum qualification, permission or licence and who is registered under the respective council for his profession and is involved in the health-care sector. A chapter of the General Code of 1964 on Medical Treatment provides general guidelines on who can carry out what kind of medical treatment. It also protects the rights of health professionals and makes them accountable for any negligence or recklessness. Article 12(3)(f) of the Interim Constitution protects the freedom to practise any profession and engage in any occupation as fundamental rights of the citizens of Nepal. Article 32 of the Interim Constitution ensures remedy for violations of this right.

Section 3 of the Security of Health Workers and Health Organizations Act, 2010, provides generally, without referring specifically to situations of armed conflict or other emergencies, that no-one shall do or cause to be done any of the following acts:

(a) Besieging, manhandling or subjecting to degrading treatment any health worker on the issue of medical treatment;
(b) Destroying, or setting fire to, any health facility or committing any similar act.

Section 4 of the Act provides that if any person commits or attempts to commit any act against a health worker or any health facility in contravention of Section 3, that health worker or health organization may make a request to the local administration for security.

Nepalese law does not provide that health-care professionals should lose their protection merely for carrying out their professional duties during armed conflict or other emergencies. However, it was said that during internal armed conflict, the governmental Security Forces verbally warned the local Miteri Hospital not to provide services to members of the (then) Maoist rebellion group in future, and, according to media reports, health professionals working in the government service were warned not to make medicines and other medical equipment available to them. Nonetheless, there are no cases at the

296 WHO, *Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review,* WHO, 2001, p. 148.

national level where health-care professionals have been investigated for providing health care to the other party in situations of armed conflict or other emergencies.

In order to improve protection of health-care workers during conflict, the law should explicitly recognize the neutral and humanitarian character of health professions and require that they be respected and protected in all circumstances in the course of their duties. Prior to amendment of domestic law, awareness should be spread via the media that health professionals have legal protection and the population should be informed of good practices in other countries in this area.

3. Protection of medical units and transports

From a Nepalese administrative point of view, in order to be qualified as "medical unit," the said unit should have obtained legal authority with a structure, professionally qualified medical personnel and equipment as well as a specified targeted service area. Senior medical professionals are generally in charge of the authorization and control of medical units. During emergencies and natural disaster situations they carry out their functions under the leadership and control of the Ministry of Home Affairs.

The organizational structure of the medical units of the Nepal Army, Armed Police and Nepal Police is approved by the Council of Ministers. In situations of disaster and other emergency situations, the Ministry of Health and Population can constitute medical units and deploy health personnel from the Nepal Health Service under the overall leading role of the Ministry of Home Affairs. When necessary, the Nepal Army, Armed Police and Nepal Police may also set up an ad hoc medical unit.

Medical transports are not the object of any specifically organized system and there are no specific rules or guidelines that qualify as such. No specific authority is prescribed for medical transport. However, the Nepal Army, the Nepal Police, the Ministry of Health and the Nepal Red Cross Society may carry out such functions during disaster-related emergencies.

Regarding respect for and protection of medical units and transports, while not specifically defined by law, it can be stated that "to respect" medical units and transports means not to impede them in the performance of their mandate or functions and "to protect" them means to provide effective remedy in case of disturbance or violations. No provision exists relating to loss of protection for medical units and transports.

4. Protection of the wounded and sick

The Nepal Army Handbook on Law of Armed Conflict, which provides reference guidelines for the Nepal Army, states that persons who are "hors de combat" and those who do not take a direct part in hostilities are entitled to respect for their lives and their moral and physical integrity. They shall in all circumstances be protected and treated humanely without any adverse distinction. It is forbidden to kill or injure an enemy who surrenders or who is "hors de combat". Captured combatants and civilians are entitled to respect for their lives, dignity, personal rights and convictions and must be protected against all acts of violence and reprisals. They have a right to correspond with their families and to receive relief.

The Nepal Army Handbook on Law of Armed conflict also creates the obligation to search for, collect and evacuate the sick, the wounded and the dead without any distinction or prejudice. The wounded and sick must receive, to the fullest extent possible, the medical care required by their condition, priority of treatment being determined by medical reasons alone, and they must be protected from ill-treatment or pillage of their personal property. The Natural Calamity (Relief) Act envisages the requirement of special assistance for the wounded and sick but does not specify what type.

The Nepal Army Handbook on Law of Armed Conflict states that these provisions are applicable to the members of the Nepal Army. Even though its provisions are soft law, this handbook only offers guidelines and there is no specific legislation that defines who has an obligation to treat and protect the wounded and sick in situations of armed conflict and other emergencies. Generally speaking, human rights law prohibits torture, inhuman degrading treatment and punishment. The Interim Constitution protects

human dignity, abolishes the death penalty and prohibits physical and mental torture, and the Torture Compensation Act of 1996 ensures compensation for victims. However, enactment of national legislation for the implementation of the Geneva Conventions is required to improve legal protection of the wounded and sick. The latest development is that the Supreme Court of Nepal has issued orders to the Government to submit bills to the Parliament for such implementation.

5. Protection of the distinctive emblems

An executive decision of the Ministry of Health and Population prohibits the perfidious use and misuse of the distinctive emblem recognized by the Geneva Conventions and provides for the imposition of fines and other disciplinary sanctions. The Nepal Army Handbook on Law of Armed Conflict may also be used for disciplinary measures. However, binding legislation relating to protection of the correct use of the distinctive emblems is yet to be enacted. Domestic law does not specify who is in charge of control and use of the distinctive emblems, but the Ministry of Defence and the Ministry of Health and Population are both concerned with protection of the emblem.

6. Medical ethics and confidentiality

According to Section 7A(1) and (2) of the Medical Council Act of 1964, the Medical Council has responsibility for taking action against medical practitioners who violate the ethics of their profession and cancelling their registration or licence as prescribed by law. Rule 22 of the Medical Council Rules of 1967 prescribes a detailed code of conduct and ethics for medical practitioners. In particular, it provides that medical practitioners shall not disclose to anyone the confidential information provided by a patient during a course of treatment, except by order of the tribunal.

ANNEX 2. LIST OF PARTICIPANTS

Expert Workshop on Health Care in Danger: Domestic Normative Frameworks, 29-31 January 2014				
Country	**Last Name**	**First Name**	**Position**	**Employer**
Argentina	Sandri Fuentes	Annabella	Asesora Jurídica	Ministerio de Defensa de Argentina
Australia	Quinn	Todd	Legal Adviser	Australian Embassy to the Netherlands
Australia	Skillen	Geoff	Chair, IHL Committee	Australian Red Cross
Brazil	Freitas de Oliveira	Eduardo	Segundo Secretário	Ministerio das Relações Exteriores
Canada	MacGregor	Bruce	Assistant Deputy JAG Operations	Canadian Armed Forces
Chile	Ferrada-Walker	Luis Valentin	Asesor en Derecho Internacional	Ministerio de Defensa Nacional de Chile
Colombia	Caicedo Trujillo	Adriana	Asesora Jurídica	ICRC – Colombia
Côte d'Ivoire	Ako	Yapi Eloi	Sous-directeur de la législation	Ministère de la Justice de la Côte d'Ivoire
Cuba	Casares Benites	Dennis	Primer Secretario	Ministerio de Relaciones Exteriores de la República de Cuba
Dem. Rep. of the Congo	Balanda	Gérard Mikuin Leliel	Professeur et avocat	Université de Kinshasa et Université protestante au Congo
Egypt	Shokry	Dina	Prof. of Forensic Medicine and Toxicology	Faculty of medicine – Cairo University
Iran	Hosseini	Amir Hossein	Deputy Director	Ministry of Foreign Affairs of Iran
Iran	Mohammadi Araghi	Mohammad Shahabeddin	Secretary	Iranian Red Crescent
Kenya	Njau-Kimani	Maryann	Head, Department of Justice	Office of the Attorney General & Department of Justice
Lesotho	Ketsi	Tseliso	Legal Officer	Ministry of Defence of Lesotho
Liberia	Coleman	Peter	Chairman	Liberian Senate
Nepal	Sharma	Bhesh Raj	Secretary	Ministry of Law, Justice, Constituent Assembly and Parliamentary Affairs
Niger	Ibrahim	Amadou Lamine	Directeur de la législation et du contentieux	Ministère de la santé publique du Niger
Norway	Aasland	Kjetil	Minister Counsellor	Permanent Norwegian Mission in Geneva
Norway	Harlem	Mads	Head of Policy and international law	Norwegian Red Cross
Peru	Percy Rudy	Montes Rueda	Director General	Ministerio de Salud

Expert Workshop on Health Care in Danger: Domestic Normative Frameworks, 29-31 January 2014				
Country	**Last Name**	**First Name**	**Position**	**Employer**
Russia	Kholikov	Ivan	Chief International Cooperation Branch of Main Military Medical Directorate	Ministry of Defence of the Russian Federation
Senegal	Ndiaye	Papa Moussé	Directeur de l'Ecole militaire de Santé de Dakar	Ministère des Forces Armées Sénégalaises
Serbia	Caric	Slavoljub	Head of Department for International Legal Affairs	Ministry of Foreign Affairs of Serbia
Sri Lanka	Ahamed	Riyasa Ahamed	Chief Legal Officer	Ministry of Health and member of National IHL Committee
Sweden	Rudvall	Samuel	Legal Adviser	Ministry of Defence of Sweden
Venezuela	Flores Alvarado	Leomagno	Diputado principal	Asamblea Nacional de Venezuela
ICMM	Neirinckx	Pierre	Deputy Secretary General	International Committee of Military Medicine
ICN	Benton	David	Chief Executive Officer	International Council of Nurses
ISMLLW	De Coninck	Luc	Management Assistant	International Society for Military Law and the Law of War
ISMLLW	Van Der Veken	Ludwig	Secrétaire général	International Society for Military Law and the Law of War
JH University	Footer	Katherine	Research Associate	Bloomberg School of Public Health, Johns Hopkins University
WHO	Coninx	Rudi	Coordinator Policy, Practice & Evaluation Unit	World Health Organization
WHO	Maes	Sophie	Programme Officer	World Health Organization
WMA	Deau	Xavier	Président-élu	World Medical Association
WMA	Colegrave-Juge	Marie	International and EU Affairs Manager	World Medical Association
Belgium	De Cock	Christian	Head of International Law Section	Belgian Ministry of Defence
	Dive	Gérard	Head of the Unit for International Humanitarian Law	Service Public Fédéral (Ministère) de la Justice – Belgique
	Genot	Guy	Directeur Général, Secrétaire de la CIDH	Belgian Ministry of Foreign Affairs
	Gijs	Geert	Head of Service, Crisis Management	Federal Public Service Health, Food Chain Safety and Environment
	Goes	Benjamin	Conseiller, membre de la CIDH	SPF Chancellerie du Premier Ministre
	Goldman	Alexis	Conseiller juridique, membre de la CIDH	Belgian Ministry of Foreign Affairs
	Janssens	Alix	Stagiaire	SPF Affaires étrangères

Expert Workshop on Health Care in Danger: Domestic Normative Frameworks, 29-31 January 2014				
Country	**Last Name**	**First Name**	**Position**	**Employer**
	Masschelein	Liesbet	Attaché, membre de la CIDH	SPF Chancellerie du Premier Ministre
	Reypens	Pascale	Membre de la CIDH	SPF Intérieur
	Van Oost	Nadine	Assistante	SPF Affaires étrangères
	Vandermeersch	Damien	President	Belgian Interministerial Commission for International Humanitarian Law
Belgian Red Cross	Joris	Christ'l	National Vice-President	
	Croufer	Edouard	National Vice-President	
	Braibant	Thomas	IHL Intern	
	Casier	Frédéric	Legal Adviser in IHL	
	De Greve	Laura	Legal Adviser	
	Hoste	Tuur	General Secretary	
European Commission	Georgieva	Kristalina	Commissioner	Commission européenne – Direction Générale ECHO
	Lemasson	Antoine	Deputy Head of Unit	Commission européenne – Direction Générale ECHO
	Lensu	Maria	Policy Officer	Commission européenne – Direction Générale ECHO
	Sharrock	David	Spokesman for Commissioner Georgieva	Commission européenne – Direction Générale ECHO
ICRC	Maurer	Peter	President	
	Bellon	François	Head of Delegation	ICRC Brussels
	Apraxine	Pierre	Chef adjoint de Délégation	ICRC Brussels
	Bouvier	Antoine	Legal Adviser	ICRC, Advisory Service on IHL
	Breitegger	Alexander	Legal Adviser	ICRC, Legal Division
	Catin	Céline	Assistant to the Head of Delegation	ICRC Brussels
	de Jong	Laura	Legal Assistant	ICRC Brussels
	Eshaya-Chauvin	Bruce	Medical Adviser HCiD	ICRC, Office of the Director of Operations
	Gentile	Pierre	Head of Project HCiD	ICRC, Office of the Director of Operations

Expert Workshop on Health Care in Danger: Domestic Normative Frameworks, 29-31 January 2014				
Country	**Last Name**	**First Name**	**Position**	**Employer**
	Girard	Geneviève	HCiD Adviser	ICRC, Advisory Service on IHL
	Kolanowski	Stéphane	Senior Legal Adviser	ICRC Brussels
	Lair	Sophie	Stagiaire en communication	ICRC Brussels
	Lorge	Anne-Catherine	Administratrice	ICRC Brussels
	Miltcheva	Olga	Marketing officer, HCiD Campaign Coordinator	ICRC, Social Marketing Unit
	Pellandini	Cristina	Head of Unit	ICRC, Advisory Service on IHL
	Sénéchaud	François	Head of Division	ICRC, Implementation and Promotion of the Law
	Vanden Driessche	Thomas	Communication Officer	ICRC Brussels
Interpreters	Bovet	Maria Teresa		
	Butticker	François		
	Gimenez	Maria Reyes		
	Lauwers	Nadine		
	Shahidi Chubin	Nanaz		
	Van Simaeys	Paul		

ANNEX 3. PROGRAMME OF THE WORKSHOP

Health Care in Danger Project

"Domestic Normative Frameworks for the Protection of the Provision of Health Care"

Experts' Workshop for National IHL Committees and Civil Servants

Brussels
29-31 January 2014
Programme

Wednesday 29 January	
08:45 – 09:15	**Registration of participants**
09:15 – 10:45	**Introductory session** Introductory statements by **Mr Didier Reynders**, Deputy Prime Minister and Minister of Foreign Affairs; **Mr Peter Maurer**, ICRC President; and **Mrs Christ'l Joris**, Vice-President of the Belgian Red Cross Address by **Mrs Kristalina Georgieva**, EU Commissioner for International Cooperation, Humanitarian Aid and Crisis Response Presentation of the HCiD project **Mr Pierre Gentile**, Head of Project, ICRC Presentation of the Workshop (objectives, format and methodology) **Mr Antoine Bouvier**, Legal Adviser, ICRC
10:45 – 11:15	**Coffee break**
11:15 – 12:15	**Presentation of country studies** **Belgium:** Mr Geert Gijs **Colombia:** Mrs Adriana Caicedo Trujillo **Kenya:** Mrs Maryann Njau-Kimani **Nepal:** Mr Bresh Raj Sharma
12:15 – 13:15	**Lunch break**
13:15 – 13:30	**Introduction to the first session:** How to make legal protection of the wounded and sick, health-care personnel, facilities and medical transports more effective Introductory remarks by **Mr Alexander Breitegger**, Legal Adviser, ICRC Session objective: – To provide an overview of the protection of the wounded and sick, medical personnel, units and transports under national legislation and to open the debate on how to make this protection more effective Reference documents: – Background document – ICRC Advisory Service Fact Sheet: "Respecting and Protecting Health Care in Armed Conflicts and in Situations Not Covered by International Humanitarian Law"
13:30 – 15:15	**Working groups** Session objective: – The participants will be divided into four groups. Each group will start the discussion on how to make the protection of the wounded and sick, medical personnel, units and transports more effective by answering the following questions: (questions to be defined in a separate document)
15:15 – 15:45	**Coffee break**

15:45 – 16:15	**Plenary meeting:** Presentation of the results from the working groups of the first session
16:15 – 16:30	**Introduction to the second session:** How to legally improve the correct use of the distinctive emblems under the Geneva Conventions and their Additional Protocols and of other distinctive signs used by the medical mission Introductory remarks by **Mr Antoine Bouvier**, Legal Adviser, ICRC Session objective: – To provide an overview of the protection of the distinctive emblems under national legislation and to open the debate on how to make this protection more effective Reference documents: – Background document – ICRC Advisory Service Fact Sheet: "Respecting and Protecting Health Care in Armed Conflicts and in Situations Not Covered by International Humanitarian Law"
16:30 – 18:00	**Working groups** Session objective: – The participants will be divided into four groups. Each group will start the discussion on how to make the protection of the distinctive emblems and other signs more effective by answering the following questions: (questions to be defined in a separate document)
18:45	**Dinner/cocktail**

Thursday 30 January

09:00 – 10:00	**Plenary meeting:** Presentation of the results from the working groups of the second session
10:00 – 10:30	**Introduction to the third session:** How to legally protect medical ethics and confidentiality in situations of armed conflict and other emergencies? Introductory remarks by **Dr Xavier Deau**, President-elect, World Medical Association Session objective: – To provide an overview of medical ethics and confidentiality during armed conflict and other emergencies
10:30 – 11:00	**Coffee break**
11:00 – 12:30	**Working groups** Session objective: – The participants will be divided into four groups. Each group will start the discussion about medical ethics and confidentiality during armed conflict and other emergencies by answering the following questions: (questions to be defined in a separate document)
12:30 – 13:30	**Lunch break**
13:30 – 14:15	**Plenary meeting:** Presentation of the results from the working groups of the third session
14:15 – 14:30	**Introduction to the fourth session:** How to effectively repress and sanction violations of the law in connection with health care Introductory remarks by **Mrs Cristina Pellandini**, Head of the Advisory Service on IHL, ICRC Session objective: – To provide an overview of criminal repression and sanctions for violations against the wounded and sick, medical personnel, units and transports Reference documents: – Background document – ICRC Advisory Service Fact Sheet: "Respecting and Protecting Health Care in Armed Conflicts and in Situations Not Covered by International Humanitarian Law"
14:30 – 16:00	**Working groups** Session objective: – The participants will be divided into four groups. Each group will start the discussion about repression and sanction of violations committed during armed conflict and other emergencies by answering the following questions: (questions to be defined in a separate document)
16:00 – 16:30	**Coffee break**
16:30 – 17:30	**Plenary meeting:** Presentation of the results from the working groups of the fourth session

Friday 31 January	
9:00 – 9:45	Presentation of conclusions and recommendations by the **co-Chairs**
9:45 – 10:30	Discussion on conclusions and recommendations
10:30 – 11:00	**Coffee break**
11:00 – 11:45	Discussion on the type of "tool" recommended by the experts
11:45 – 12:15	Follow-up of the Workshop by **Mr Pierre Gentile**, Head of Project
12:15 – 12:45	Concluding remarks by the **co-Chairs**

Chairmanship of the workshop

The workshop will be co-chaired by

Mr François Sénéchaud, Head of Division for the Integration and Promotion of the Law, ICRC

Mr Benjamin Goes, Counsellor to the Chancellery of the Prime Minister and President of the working groups on the Protection of Cultural Property and on Communication, Belgian Interministerial Commission for Humanitarian Law

The working groups will be chaired by:

Mr Pierre Gentile for the French-speaking group

Mrs Cristina Pellandini for the Spanish-speaking group

Mr Alexander Breitegger for the first English-speaking group

Mr Stéphane Kolanowski, Legal Adviser, ICRC delegation to Brussels, for the second English-speaking group

MISSION

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.

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