



SAFEGUARDING THE PROVISION OF HEALTH CARE

OPERATIONAL PRACTICES AND RELEVANT
INTERNATIONAL HUMANITARIAN LAW
CONCERNING ARMED GROUPS

**HEALTH CARE MATTER
IN OF LIFE
DANGER & DEATH**



ICRC



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CONTENTS

1. FOREWORD	7
2. THE HEALTH CARE IN DANGER PROJECT	9
3. KEY TERMS	11
4. EXECUTIVE SUMMARY	15
5. METHODOLOGY	17
5.1. UNDERSTANDING THE ISSUES AT STAKE AND IDENTIFYING SOLUTIONS	17
5.2. FACTORS INFLUENCING ARMED GROUPS' BEHAVIOUR TOWARDS THE PROVISION OF HEALTH CARE	18
6. SAFEGUARDING THE PROVISION OF HEALTH CARE: INTERNATIONAL LEGAL OBLIGATIONS	21
6.1. INTERNATIONAL LEGAL FRAMEWORK	21
6.2. INTERNATIONAL LEGAL OBLIGATIONS	22
6.3. RESPECTING OBLIGATIONS CONCERNING THE PROVISION OF HEALTH CARE: VIEWS FROM ARMED GROUPS	24
7. SAFEGUARDING THE PROVISION OF HEALTH CARE: PRACTICAL MEASURES	27
7.1. INTEGRATING OBLIGATIONS UNDER IHL	27
7.1.1. <i>Doctrine</i>	28
7.1.2. <i>Education</i>	28
7.1.3. <i>Training</i>	29
7.1.4. <i>Sanctions</i>	29
7.2. RESPECT FOR HEALTH-CARE PERSONNEL	30
7.2.1. <i>Humanitarian problems</i>	30
7.2.2. <i>Case studies</i>	31
7.2.2.1. <i>Case study 1: Ensuring health-care personnel have access to civilians</i>	31
7.2.2.2. <i>Case study 2: Respecting and ensuring the safety of health-care personnel</i>	33
7.2.2.3. <i>Case study 3: Understanding and respecting the principles underlying health-care ethics</i>	34
7.3. RESPECT FOR HEALTH-CARE FACILITIES	35
7.3.1. <i>Humanitarian problems</i>	35
7.3.2. <i>Case studies</i>	36
7.3.2.1. <i>Case study 4: Respecting health-care facilities and ensuring access to medical supplies</i>	36
7.3.2.2. <i>Case study 5: Mapping the location of health-care facilities</i>	37
7.3.2.3. <i>Case study 6: Taking precautions when planning and conducting military operations</i>	38
7.4. RESPECT FOR THE WOUNDED AND SICK AND FOR MEDICAL VEHICLES	39
7.4.1. <i>Humanitarian problems</i>	39
7.4.2. <i>Case studies</i>	40
7.4.2.1. <i>Case study 7: Respecting wounded adversaries</i>	40

7.4.2.2. <i>Case study 8: Collecting and caring for the wounded</i>	41
7.4.2.3. <i>Case Study 9: Ensuring the safe and speedy passage of medical vehicles at checkpoints</i>	42
7.4.2.4. <i>Case Study 10: Respecting the protective emblems</i>	44
8. CONCLUDING REMARKS	47
ANNEXES	49
ANNEX 1: MODEL UNILATERAL DECLARATION	49
ANNEX 2: PATTERNS AND IMPACT OF VIOLENCE ATTRIBUTED TO ARMED GROUPS	52
ANNEX 3: ETHICAL PRINCIPLES OF HEALTH CARE	56
ANNEX 4: RELEVANT EXCERPTS FROM ARMED GROUPS' DOCTRINE	58
ANNEX 5: PROTECTIVE EMBLEM	60
ANNEX 6: CITED IHL RULES PERTAINING TO THE PROVISION OF HEALTH CARE	61
ANNEX 7: HEALTH CARE IN DANGER PROJECT REFERENCES	66



1. FOREWORD

By Dominik Stillhart, Director of Operations, International Committee of the Red Cross

“Respect for health care is part of our education, culture and belief.”

This idea, expressed by many of the armed groups consulted in the context of this study, is a powerful illustration of the universal nature of the principle of respect for health care. Efficient health care is essential for both civilians and combatants in conflict situations.

In fact, providing care to the wounded and sick without adverse distinction is a fundamental component of the principle of humanity. A natural corollary of that principle is the need to respect and protect those who provide care impartially and in the best interest of the patients.

Health care is in danger

Despite abundant evidence that the above principles have been endorsed by people waging wars since time immemorial, health care is nevertheless the target of repeated and widespread violence. And these days, much of it takes place in non-international armed conflicts, i.e. fighting between states and armed groups or between such groups. Health-care personnel are regularly threatened, wounded or killed; health-care facilities are looted and destroyed; and the wounded and sick go without care and, as a result, experience unnecessary suffering or even die.

The knock-on effects of this violence are devastating, as entire communities and regions are deprived of the health-care services they need.

The International Committee of the Red Cross (ICRC), determined to improve this situation, began the Health Care in Danger (HCiD) project in 2011 under the auspices of the Red Cross and Red Crescent Movement. Since then, we have consulted a wide range of individuals and organizations keen to develop practical recommendations aimed at improving the effective and impartial delivery of health care during armed conflict and other emergencies.

A participative process

In view of the prominent role of armed groups in contemporary conflicts, we quickly recognized the need to bring them into the consultative process. Over the last two years, we interviewed members of more than 30 armed groups engaged in non-international armed conflicts around the world. Very diverse in nature, the groups nevertheless raised many similar points regarding the safe delivery of health care. Participants took an open and constructive approach to the consultation process, and this led to a greater understanding of the phenomenon of violence against health care and helped identify practical measures to address it.

The consultative process and the resulting measures are presented in this report, which also highlights armed groups' health-care-related obligations under IHL.

Working together towards a shared vision

We wish to express our gratitude to all those who contributed in some way to this report. Thanks to them, we are able to make progress towards the shared vision of a world in which all the wounded and sick in non-international armed conflicts are properly attended to and all health-care personnel are able to perform their humanitarian duty without fearing for their safety.



2. THE HEALTH CARE IN DANGER PROJECT

The Health Care in Danger (HCiD) project is an initiative of the Red Cross and Red Crescent Movement. It is designed to respond to the growing humanitarian concern over violence affecting the delivery of, and access to, health care, in violation of IHL and other applicable bodies of law on the protection of health-care personnel, patients, facilities and transports. The project officially began in 2011 and is led by the ICRC.

The ICRC's study on violence undermining the provision of health care in 16 countries, conducted between July 2008 and December 2010, was the first of its kind to highlight a wide range of concerns. In 2012, the ICRC began collecting cases in more than 20 countries or regions where it has operations,¹ and it has published periodic reports on violent incidents against health care.² The latest report analyses incidents documented from January 2012 to December 2014 in 11 countries affected by armed conflicts and other emergencies. The findings confirm that violence against health care is a serious humanitarian concern with devastating short- and long-term consequences:

- Patients are killed, wounded, beaten and/or arrested.
- Health-care personnel are threatened, physically assaulted and subject to arrest and coercion (such as being forced to provide treatment).
- Incidents against health care most often take place against, inside or within the perimeter of health-care facilities, and these facilities are often subject to attack, armed entry, takeover and/or looting.
- Obstructions and attacks against medical vehicles take place on the way to and from health-care facilities, at checkpoints and in public spaces.

Since 2012, through the HCiD project, the ICRC has held consultations with key stakeholders for the purpose of formulating practical measures to improve the security and delivery of impartial and efficient health care.³ This report concerns the consultations held with armed groups, and it is the last theme-based publication of the HCiD project. Engaging with armed groups was deemed important because they are beneficiaries of health care and, at times, provide health-care services themselves. It was also considered essential because armed groups are critical when it comes to respecting and ensuring safe access to health care. Among the 2,140 incidents affecting health care identified by the ICRC in eight countries where a non-international armed conflict was taking place,⁴ 548 (26%) were attributed to armed groups.⁵ A publication addressing issues faced by state armed forces was released in 2014.

¹ Initially, 22 countries and regions were addressed; over the years, some of the countries or regions taken into consideration changed.

² See Annex 7 for a list of HCiD project reports and publications.

³ The HCiD project has organized expert consultations and workshops on nine themes so far: Rights and responsibilities of health-care personnel in armed conflict and other emergencies; The role and responsibility of National Red Cross and Red Crescent Societies in delivering safe health care in armed conflict and other emergencies; The role of civil society and religious leaders in promoting respect for health care; Ambulances and pre-hospital services in risk situations; Promoting military operational practice that ensures safe access to and delivery of health care; Ethical principles of health care in times of armed conflict and other emergencies; The security of health-care facilities; Domestic normative frameworks for the protection of the provision of health care.

⁴ It was decided to base statistics related to armed groups on eight of the countries monitored by the ICRC. In these eight countries, armed groups are active and involved in situations of non-international armed conflict.

⁵ See Annex 2: Patterns and impact of violence attributed to armed groups.



3. KEY TERMS⁶

Armed groups, as understood in this publication, are organized armed actors whose conduct is not attributable to a state party to a conflict, and that are involved in an armed conflict as parties to it. Private military and security companies (PMSCs) are not considered armed groups. There is no legally agreed definition of an armed group.

The wounded and sick are all persons requiring medical care, regardless of whether they took part in the fighting, provided that they refrain from any hostile act. The wounded and sick include pregnant women and new-born babies.⁷

Health-care facilities include hospitals, laboratories, clinics, first-aid posts, blood transfusion centres, and the medical and pharmaceutical stores of those facilities.⁸ This term includes but goes beyond the different categories of “medical units” specifically protected under IHL and entitled to use the red cross, red crescent or red crystal emblem for protective purposes.⁹

Health-care personnel

This term includes but goes beyond the various categories of “medical personnel” that are specifically protected under IHL and entitled to use the red cross, red crescent or red crystal emblem for protective purposes.¹⁰

This term includes:

- Individuals with professional health-care qualifications, e.g. doctors, nurses, paramedics, physiotherapists and pharmacists.
- Individuals working in hospitals, clinics and first-aid posts, ambulance drivers, hospital administrators and 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.
- The medical personnel of armed forces.
- The medical personnel of armed groups.
- The personnel of health-oriented international and non-governmental organizations.
- First-aid providers.¹¹

⁶ Where a given definition goes beyond what is stated in a specific treaty, it should not be interpreted as extending that definition in law. More broadly, nothing in this document is meant to extend any definitions or obligations under IHL or any other body of law.

⁷ See Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Additional Protocol I), 8 June 1977 (AP I), Art. 8 (a); Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Additional Protocol II), 8 June 1977 (AP II), commentary on Art. 7, pp. 1408-1409, paras. 4637-4639.

⁸ ICRC, *Health Care in Danger: Making the Case*, ICRC, Geneva, 2011.

⁹ A description of the emblems is provided in Annex 5.

¹⁰ AP II, Art. 9.

¹¹ ICRC, *Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflict and Other Emergencies*, ICRC, Geneva, 2012. It should also be noted that IHL recognizes the assistance provided by civilians to parties to the conflict in collecting and caring for the wounded and sick. See AP II, Art. 18 (1); and AP II, commentary on Art. 18, p. 1478, paras. 4874-4876.

Health-care ethics¹² is the branch of ethics that deals with moral issues in the practice of health care. The principles for ethical decision-making in the field of health care include:

- Being impartial.
- Maintaining confidentiality.
- Respecting the patient's dignity.
- Acting in the patient's best interest.
- Avoiding inflicting harm on patients.
- Treating individuals and groups fairly.¹³

Medical vehicles¹⁴ include ambulances, medical ships or aircraft, whether civilian or military, and generally any means of transport, including private means of transport, conveying the wounded and sick, health-care personnel and medical supplies or equipment. The term includes, but goes beyond the various categories of "medical transports" that are specifically protected under IHL and that are entitled to use the red cross, red crescent or red crystal emblem for protective purposes.

An **ambulance**, for the purposes of this publication, is a locally available means of transport that carries wounded and acutely sick people as safely as possible to a place where their condition can be stabilized and they can receive the emergency care they need. Transportation may be either from the site of an emergency to a health-care facility or between two health-care facilities.

¹² Adapted from the WMA Medical Ethics Manual, World Medical Association, 2005, pp. 6-9.

¹³ A list of ethical principles on health care was developed in the context of the HCID project. It is presented in Annex 3.

¹⁴ AP II, Art. 11 (1); AP II, commentary on Art. 11, p. 1433, paras. 4711-4712.



4. EXECUTIVE SUMMARY

This report is intended for armed groups involved in non-international armed conflicts. Because these groups differ greatly, the recommendations presented in this report are not meant to be “one size fits all” and do not apply equally to all armed groups. Rather, an effort should be made to contextualize and adapt the recommendations to the environment and capacities of the individual armed groups. Ultimately, the behaviour of armed groups towards health care depends on a number of identified factors: the extent of territorial control, the availability and accessibility of health-care services, the level of organization, the level of command and control within the groups and the tactics adopted by the groups and their opponents.

As parties to non-international armed conflicts, armed groups have obligations under IHL to ensure both safe access to health care for those in need and the ability of health-care personnel to provide health care. First, armed groups must not engage in any action or behaviour that would prevent the delivery of health care. Second, armed groups must take the necessary measures to ensure safe access to, and the safe delivery of, health care.

The vast majority of armed groups consulted agree with the need to respect and protect health care. Some have acted on this commitment by integrating their obligations towards health care in their doctrine, education, training and sanctions. Some examples are included in this report. In addition, the armed groups that were consulted identified and discussed situations they experienced or witnessed that could jeopardize the safe delivery of health care. This report is organized around case studies that are based on these situations and that highlight the relevant principles:

1. Ensuring health-care personnel have access to civilians;
2. Respecting and ensuring the safety of health-care personnel;
3. Understanding and respecting the principles underlying health-care ethics;
4. Respecting health-care facilities and ensuring access to medical supplies;
5. Mapping the location of health-care facilities;
6. Taking precautions when planning and conducting military operations;
7. Respecting wounded adversaries;
8. Collecting and caring for the wounded;
9. Ensuring the safe and speedy passage of medical vehicles at checkpoints;
10. Respecting the protective emblems.

The armed groups consulted shared practices and measures that can be adopted to ensure compliance with the aforementioned principles. Their main aims: to foster an environment conducive to the delivery of, and access to, health care for all the wounded and sick; to prevent the occurrence or repetition of abuses against health care; to ensure the safety and facilitate the work of health-care personnel, health-care facilities and medical vehicles; and to develop the armed groups’ own ability to provide emergency health care.

The ICRC complemented the discussion of these ten situations with the IHL rules relevant in each case and ensured that the practical measures proposed were consistent with the legal framework.



5. METHODOLOGY

5.1. UNDERSTANDING THE ISSUES AT STAKE AND IDENTIFYING SOLUTIONS

Within the framework of the HcID project, the ICRC carried out consultations with armed groups in order to better understand their views regarding the safe delivery of, and access to, health care. Between April 2013 and October 2014, 36 armed groups from ten countries on four continents agreed to participate in this consultation process. The groups were diverse in terms of size, organizational structure, strategic objectives and extent of territorial control. The consultations took the form of individual or group interviews with members of armed groups who held political, military or health-related positions. This participatory approach was designed to provide insight into armed groups' behaviour with regard to respect for and access to health care. It also made it possible to identify practical measures that armed groups can take to address some of the issues they may face vis-à-vis respect for and access to health care.

The consultations focused on two dimensions. The first was the armed groups' own access to health care, and the second was the armed groups' views regarding:

- Respect for health-care personnel.
- Respect for health-care facilities.
- Respect for the wounded and for the vehicles used to evacuate them.

ARMED GROUPS CONSULTED



Complementing the consultation process, documents pertaining to 73 armed groups from different regions of the world were examined. These include both internal documents (such as codes of conduct or manuals) and public documents (such as declarations or agreements).¹⁵ Examining how armed groups addressed health care internally helped paint a more comprehensive picture of the armed groups' understanding of and involvement with the issue.

An expert meeting of academics, health-care practitioners and representatives of non-governmental and international organizations was held in June 2014 in Geneva. It provided an opportunity to test the findings of the ICRC's study.

This publication is the outcome of the process described above. It is meant first and foremost for armed groups. It is a practical tool that provides them and other relevant audiences with information on key IHL obligations and practical measures to safeguard the provision of health care. The practical measures were inspired mainly by the armed groups' own practices and suggestions.

5.2. FACTORS INFLUENCING ARMED GROUPS' BEHAVIOUR TOWARDS THE PROVISION OF HEALTH CARE

Armed groups and the situations in which they operate are highly diverse. Consequently, the practical measures suggested in this publication may need to be contextualized to fit the reality of each individual armed group. The main factors determining the armed groups' behaviour, which were identified during the consultation process, are:

Armed groups' extent of territorial control

Control of populated areas shapes how and the extent to which armed groups interact with the local population and with health-care personnel. It also affects the armed groups' ability to ensure the safe delivery of health-care services.

Existing health-care services and characteristics of the environment

The state of existing health-care services combined with the geographical environment (urban or rural), the security situation and the availability of roads and means of transport all have an effect on the ability of people living in territories controlled by armed groups, and the armed groups themselves, to access health care.

Organizational capacity of an armed group

Armed groups with a high level of organizational capacity are more likely to develop internal health-care services. In turn, their ability to deliver internal health-care services influences how they interact with civilians and health-care personnel.

Level of command and control of an armed group

The level of command and control exercised by armed groups shapes their ability to comply with their legal obligations, including those pertaining to respect for and the protection of health care. In particular, in order for the armed group's health units to be allowed to use the distinctive emblem, the groups need to demonstrate a certain degree of organization in general and be capable of applying the rules of IHL. There must also be a competent authority responsible for monitoring the use of the emblem.

¹⁵ Apart from some confidential documents shared by armed groups, most documents came from three sources: Oliver Bangarter, "Internal Control: Codes of Conduct within Insurgent Armed Groups," *Small Arms Survey*, Graduate Institute of International and Development Studies, Geneva, 2012; Geneva Call's database "Their Words," available at: <http://theirwords.org/pages/home>; and the internet (e.g. the armed groups' own websites).

Armed groups' tactics and their opponents' behaviour

Armed groups' behaviour towards the safe delivery of health care depends in part on the range of tactics at their disposal and the behaviour of their adversaries. These factors affect the armed groups' behaviour but do not create any "exceptional circumstances" that might be used to justify disregarding the legal norms relating to respect for and the protection of health care.



6. SAFEGUARDING THE PROVISION OF HEALTH CARE: INTERNATIONAL LEGAL OBLIGATIONS

6.1. INTERNATIONAL LEGAL FRAMEWORK

Non-international armed conflicts (NIACs) are protracted armed confrontations between government armed forces and one or more armed groups, or between such groups. In order to be considered a NIAC, a given confrontation must meet two conditions: it must reach a minimum level of intensity, and the parties involved must show a minimum degree of organization.

International humanitarian law (IHL) is grounded in the universal fundamental principle of humanity, which demands respect for human dignity in all circumstances.¹⁶ It constitutes a set of rules that seek, 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. It is also known as the law of war or the law of armed conflict. It applies only in situations of armed conflict and regulates the behaviour of parties involved. IHL is based on two major sources: international treaties and customary international law.¹⁷ While armed groups cannot be party to international treaties, IHL rules applicable during NIACs are binding on both states and armed groups involved in such conflicts.

IHL applicable in NIACs is contained in:

- Treaty law:
 - Article 3 common to the four Geneva Conventions.¹⁸ It applies to all situations of NIAC;
 - Additional Protocol II to the Geneva Conventions.¹⁹ It applies only to armed conflicts “which take place in the territory of a High Contracting Party between its armed forces and dissident armed forces or other organized armed groups which, under responsible command, exercise such control over a part of its territory as to enable them to carry out sustained and concerted military operations and to implement this Protocol.”²⁰
- Customary international law. Customary international humanitarian law applies to all types of non-international armed conflicts, regardless of whether they are covered by common Article 3 or Additional Protocol II, and, as far as the issue of protection of the wounded and sick and the delivery of health care is concerned, essentially imposes on armed groups party to the conflict obligations similar to those contained in Additional Protocol II.²¹

¹⁶ ICRC, *Health Care in Danger: The Responsibilities of Health-Care Personnel working in Armed Conflicts and Other Emergencies*, 2012, available at: <https://www.icrc.org/eng/resources/documents/publication/p4104.htm>.

¹⁷ While international treaties are written agreements by which states establish certain rules, customary international law consists of rules that derive from “general practice accepted as law.” ICJ Statute, Art. 38(1)(b).

¹⁸ Article 3 common to the four Geneva Conventions.

¹⁹ AP II.

²⁰ AP II, Art. 1(1).

²¹ Jean-Marie Henckaerts and Louise Doswald-Beck, *Customary International Humanitarian Law: Volume 1: Rules*, ICRC, Geneva/Cambridge University Press, Cambridge, 2005, Rules 25, 26, 28-30 on pp. 79-88 and 91-104.

International human rights law (IHRL) shares with IHL the common goal of preserving people's dignity and humanity; it applies in both peacetime and times of armed conflict. IHRL generally constitutes a complementary legal regime to IHL in situations of armed conflict and, especially with regard to the right to life and the right to health, for the issue of the provision of health care. However, it is controversial whether IHRL legally binds armed groups. There is nevertheless a tendency to recognise *de facto* human rights responsibilities where a group, usually by virtue of stable control of territory, has the ability to act like a state authority.²² That said, this report only considers the rules of IHL that legally bind armed groups party to a NIAC. Some of these rules are common to both IHL and IHRL.

6.2. INTERNATIONAL LEGAL OBLIGATIONS²³

In situations of NIAC, armed groups party to the conflict have obligations under IHL in relation to the delivery of health care. These obligations exclusively reflect a humanitarian concern, and their application "shall not affect the legal status of the Parties to the conflict."²⁴

The wounded and sick shall be respected and protected in all circumstances.²⁵

- The obligation to respect the wounded and sick implies refraining from certain conduct, such as attacking, ill-treating or harming them in any way.²⁶
- The obligation to protect means taking measures, wherever possible, to ensure that the wounded and sick are effectively respected by others, for instance that they are not mistreated, robbed of their belongings or harmed.²⁷

The wounded and sick shall be treated humanely in all circumstances and shall be collected and cared for.²⁸

- In all circumstances, the wounded and sick shall be treated humanely, just like any other person who does not participate or no longer participates directly in hostilities.²⁹ In particular, they must never be robbed, murdered, tortured, executed or subject to a sentence delivered without respecting fundamental guarantees of a fair trial.³⁰ Violations of these prohibitions are so serious that they constitute war crimes.³¹
- Whenever the security situation permits, and particularly after an engagement, all possible measures must be taken, without delay, to search for and collect the wounded and sick.³²
- In all circumstances, medical care must be provided to the wounded and sick without adverse distinction (that is, distinction on any but medical grounds), to the "fullest extent practicable,"³³ i.e. as well as possible in the light of available personnel and equipment, and with the least possible delay given the circumstances, including considerations of military necessity.³⁴
- Taking all possible measures to collect the wounded and sick and to provide them with medical care includes permitting impartial humanitarian organizations and civilians to assist with collecting and caring for the wounded and sick. For this purpose, humanitarian organizations and civilians may offer their assistance. Authorities cannot arbitrarily refuse such an offer when there are urgent needs of the wounded and sick to be met.³⁵

²² ICRC, "International Humanitarian Law and the Challenges of Contemporary Armed Conflicts," October 2011, available at: <https://www.icrc.org/eng/resources/documents/report/31-international-conference-ihl-challenges-report-2011-10-31.htm> (last visited 3 December 2014).

²³ The armed groups' legal obligations are presented and explained in each case study. The complete list of relevant IHL obligations is provided in Annex 6. Nothing in this study or its recommendations is meant to imply a legal status for the armed groups.

²⁴ Common Article 3.

²⁵ AP II, Art. 7(1). The phrase "in all circumstances" includes the stipulation that the obligations in question are not subject to any reciprocity, i.e. violations committed by a group's adversary do not entitle the group to commit any in return.

²⁶ AP II, commentary on Art. 7, p. 1408, para. 4635.

²⁷ *Ibid.*; AP II, Art. 8; Customary IHL Study, Rule 111.

²⁸ Common Article 3.

²⁹ Common Article 3(1); AP II, Art. 4; AP II, Art. 7(2).

³⁰ Common Article 3(1); AP II, Art. 4(2)(a)(b)(e)(g).

³¹ Customary IHL Study, Rule 156, pp. 590-592; ICC Statute, Art. 8(2)(c); ICC Statute, Art. 8(2)(e)(v).

³² AP II, Art. 8; Customary IHL Study, Rule 109.

³³ AP II, Art. 7(2); AP II, Art. 8; Customary IHL Study, Rules 110, 111.

³⁴ AP II, commentary on Art. 7, p. 1410, para. 4645.

³⁵ AP II, Art. 18(1); AP II, commentary on Art. 18, p. 1478, para. 4876; Customary IHL Study, commentary on Rule 109, p. 398.

Medical personnel, facilities and transports must be respected and protected in all circumstances. They will, however, lose their protection if they commit or are used to commit hostile acts, outside of their humanitarian function.³⁶

IHL contains specific obligations relative to persons and objects involved in providing medical care to the wounded and sick.

- The obligation to respect means that the persons and objects in question must not be attacked or harmed in any way. It also means that their work must not be interfered with, for example by preventing the passage of medical supplies, and the ability to give continued care to the wounded and sick in their charge must not be hindered.³⁷
- The obligation to protect means that measures must be taken to facilitate their work, where necessary, and to provide help, if needed, for example by facilitating the passage of medical supplies; it also means ensuring that they are respected by others, including taking possible measures to ensure they are not mistreated or endangered, such as by looting.³⁸
- The specific protection outlined above applies to both civilian and military medical personnel, facilities and transports, and this may also include medical personnel and objects of armed groups party to the conflict. Persons and objects falling within those categories are also entitled to use the distinctive emblem of the red cross, red crescent or red crystal for protective purposes. This specific protection, however, will be lost wherever medical personnel commit, or medical facilities or transports are used to commit, hostile acts, outside their humanitarian function.³⁹ While there is not a generally agreed legal definition of “hostile acts, outside of their humanitarian function,” the basic understanding is that medical personnel, facilities and transports should not become involved, in any way, in the military operations of a party to the conflict. Some examples where this would be the case include:
 - shooting at an adversary in combat, i.e. for purposes other than individual self-defence;
 - using medical facilities to shelter healthy fighters;
 - using medical facilities to store arms and ammunition (apart from small arms and ammunition temporarily found there that were taken from military wounded and sick and that could not yet be handed over to the competent authorities);
 - using medical facilities as a military observation post or as a command and control centre;
 - using medical facilities to shield military action;
 - using medical transports to transport healthy fighters, arms or munitions or to collect and convey information of military value.⁴⁰
- Certain acts, however, are generally not understood as constituting “hostile acts, outside their humanitarian function”:
 - carrying light individual weapons (i.e. weapons that can be carried and operated easily by one person) strictly for defending either oneself or the wounded and sick in one’s charge from unlawful violence directed against them from, for example, looters;
 - being escorted or guarded by military personnel or fighters, who are also only permitted to carry light individual weapons strictly for defensive purposes, as outlined in the previous point (thus the obligation to protect, insofar as it concerns coming to the help of medical personnel in case of need, does not exclude resorting in exceptional circumstances to “armed protection” by military personnel or fighters acting as armed escorts or guards);

³⁶ AP II, Art. 9(1); AP II, Art. 11; Customary IHL Study, Rules 25, 28, 29.

³⁷ AP II, commentary on Art. 9, p. 1421, para. 4673-4674; AP II, commentary on Art. 11, p. 1433, para. 4714. Commentaries on other provisions, although not formally applicable to the situations considered in this publication, nevertheless provide useful further interpretative guidance on the meaning of the obligations to respect and protect. See Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 12 August 1949 (GC I), commentary on Art. 19, p. 196; Convention (IV) relative to the Protection of Civilian Persons in Time of War, 12 August 1949 (GC IV), commentary on Art. 18, pp. 147-148; AP I, commentary on Art. 12, p. 166, paras. 517-518.

³⁸ AP II, commentary on Art. 11, p. 1433, para. 4714; see also GC I, commentary on Art. 19, p. 196; AP I, commentary on Art. 12, p. 166, paras. 517-518.

³⁹ AP II, Art. 11(2); Customary IHL Study, Rules 25, 28, 29.

⁴⁰ Commentaries on provisions, although applicable to international armed conflicts, contain the same conditions on the loss of protection of medical facilities and thus provide useful interpretative guidance in this respect. See GC I, commentary on Art. 19, pp. 200-201; GC IV, commentary on Art. 19, p. 154; AP I, commentary on Art. 13, p. 175, par. 551. In addition, see Customary IHL Study, commentaries on Rules 25, 28 and 29, pp. 85, 97, 102, for the loss of protection of medical personnel, facilities and vehicles under customary IHL, including in non-international armed conflicts.

- being in possession of small arms and ammunition taken from the wounded and sick and not yet handed over to the competent authority;
- fighters being present in a medical facility for solely medical reasons.⁴¹
- Where a hostile act, outside of the humanitarian function, is committed, a warning must still be issued setting, whenever appropriate, a time-limit to comply with such a warning. The loss of specific protection becomes effective when this warning goes unheeded.⁴² However, even in the event that medical personnel or objects have lost their specific protection and have become a lawful target, the wounded and sick, and medical personnel who are not involved in the commission of a hostile act, are still protected under the principles of proportionality and precaution and may not be directly attacked.⁴³

In addition to the specific protection of medical personnel, facilities and transports that are entitled to use the distinctive emblem for protective purposes, no one may be punished for performing medical activities compatible with medical ethics, and persons professionally engaged in medical activities must not be compelled to act contrary to, or to refrain from acting in accordance with, medical ethics.⁴⁴

Moreover, where persons and objects exclusively dedicated to ensuring medical care are civilian, they are protected as civilians and civilian objects. Accordingly, they benefit from the general protection of civilians and civilian objects in accordance with the rules on the conduct of hostilities, which include the principles of distinction, proportionality and precaution.⁴⁵

6.3. RESPECTING OBLIGATIONS CONCERNING THE PROVISION OF HEALTH CARE: VIEWS FROM ARMED GROUPS

Without necessarily possessing detailed knowledge of specific IHL rules on the provision of health care, most members of armed groups consulted by the ICRC were familiar and agreed with the spirit and content of these IHL rules. They explained that these principles were enshrined in their education, culture, religion or traditional rules of warfare. Several interviewees also expressly stated their appreciation of and respect for the values of humanity and impartiality, which are essential in the provision of health care.

When asked about their understanding of the meaning of and rationale for respecting health-care personnel, health-care facilities, the wounded and sick and medical vehicles, the armed groups consulted provided an array of reasons for their commitment to these principles. Excerpts and summaries are presented below. However, it is worth noting that while the views expressed in this section reflect the interviewees' perception of the essence and value of IHL principles, there might be gaps between these views and the effective implementation of IHL rules. The practical measures in Section 7 aim at identifying these gaps and providing solutions to fill them.

“It would be wrong from a humanitarian as well as a political perspective not to respect health-care personnel.”⁴⁶

Most members of the armed groups consulted considered respect for health-care personnel a fundamental condition so as to ensure the delivery of health care to the local people and to the groups' own fighters. Numerous armed groups also praised health-care personnel's courage and commitment in working in unsafe conditions and caring for the wounded and sick at their own risk.

⁴¹ These examples are expressly provided for in IHL treaty provisions formally applicable in international armed conflict which may help in the interpretation of scenarios not giving rise to a loss of specific protection also in non-international armed conflicts. See GC I, Art. 22; GC IV, Art. 19; AP I, Art. 13(2); AP II, commentary on Art. 11, p. 1435, para. 4723. See also Customary IHL Study, commentaries on Rules 25, 28, 29, pp. 85-86, 97, 102 (also applicable to non-international armed conflicts).

⁴² AP II, Art. 11(2); Customary IHL Study, commentary on Rules 25, 28, 29, pp. 85, 97, 102.

⁴³ AP I, commentary on Art. 12, p. 171, par. 540. Although not formally applicable to the situations covered in the present publication, it nevertheless gives interpretative guidance in this regard.

⁴⁴ AP II, Art. 10(1) and (2); Customary IHL Study, Rule 26.

⁴⁵ Customary IHL Study, Rules 1-21.

⁴⁶ Quote from an armed group member interviewed by the ICRC.

“Health care facilities are sanctuaries.”⁴⁷

The majority of armed group members consulted did not make a distinction between health-care facilities based on affiliation but rather considered all health-care facilities to be neutral entities deserving respect. The status of health-care facilities was often compared to that of schools and religious sites. Also, for armed groups in control of territory, respect and support for health-care facilities were described as part of their responsibility to act in the interests of the local population.

“Killing the wounded! What type of victory is this? Lack of respect triggers hatred.”⁴⁸

Interviewees’ respect for wounded adversaries and for ambulances was attributed to honour and the expectation of positive reciprocity. Some armed group members explained that it was “better to wound than to kill” because once a combatant was injured, his comrades would withdraw from the fighting to attend to him. Respecting the wounded was also identified as a beneficial factor in peace negotiations.

However, past and present incidents affecting health care together with declarations from certain armed groups indicate that all armed groups do not share and abide by all IHL principles safeguarding the provision of health care. One source of this contrast is differing interpretations of the concept of “protected objects and persons.” A minority of interviewees explained that their perception and treatment of the wounded was not uniform but rather depended on the way the wounded had behaved in battle and whether they had committed “crimes.” Also, a few armed group members did not adhere to the principle concerning the protection of military ambulances. It was, however, not the principle *in itself* that was rejected. The rejection was circumstantial and derived from a lack of trust between the parties and an asymmetry of means. Both issues will be discussed in Section 7, which addresses practical measures.

⁴⁷ Quote from an armed group member interviewed by the ICRC.

⁴⁸ Quote from an armed group member interviewed by the ICRC.



7. SAFEGUARDING THE PROVISION OF HEALTH CARE: PRACTICAL MEASURES

This section tackles three dimensions of the safe delivery of health care:

- Respect for health-care personnel.
- Respect for health-care facilities.
- Respect for the wounded and sick and medical vehicles.

The discussion of each dimension follows a uniform structure:

- An overview of the humanitarian problem and its consequences.
- Specific situations with a high risk of abuse.
- Key laws.
- Practical measures.

The practical measures are examples of actions that can be taken to respond to common issues affecting the safe delivery of health care. These practical measures were developed in large part on the basis of practices and suggestions shared by armed groups. As such they represent neither the general practice of armed groups nor an exhaustive list of measures that can be adopted. The practical measures identified in this document serve the overall purpose, consistent with the aim of the HClD project, of making access to health-care services safer for persons in need and enhancing the security of the provision of health care.

Some of these measures are already required for armed groups as parties to NIACs under existing IHL and therefore must be implemented by armed groups. They are not a substitute for existing IHL obligations of armed groups but contribute to the fulfilment of such obligations.

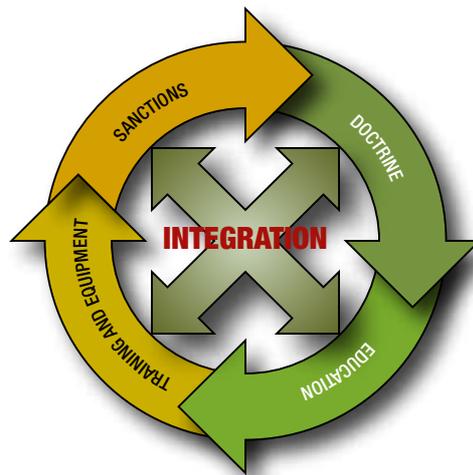
Armed groups shared other measures that go beyond what is required by law. They are also reproduced here. With regard to the latter, armed groups are encouraged to contextualize and implement the measures proposed.

Complementing the practical measures specific to the case studies, this section starts by presenting general mechanisms that armed groups can adopt in their efforts to comply with their legal obligations.

7.1. INTEGRATING OBLIGATIONS UNDER IHL

The “integration process” is how the ICRC, based on its experience with armed actors, defines the process of transposing IHL rules into concrete mechanisms or measures to ensure compliance and then adopting the means required to achieve this end.⁴⁹ Integration is a continuous process. It must address doctrine, education, training and equipment issues and be backed up by an effective system of sanctions. The figure below illustrates the connections between the four elements of the integration process.

⁴⁹ ICRC, *Integrating the Law*, 2007, available at: <https://www.icrc.org/eng/resources/documents/publication/p0900.htm>.



The four elements of the integration process are described below. Observations are made on how each element was reflected in armed groups' documents and addressed during the consultations. Recommendations pertaining to each element are also provided.

7.1.1. Doctrine⁵⁰

Observations

Only one-third of the armed groups' documents studied made reference to respect for health care.⁵¹ The most common reference pertained to respect for the wounded and sick. Respect for health-care personnel and facilities was rarely mentioned. The armed groups consulted clarified that the absence of any reference to respecting health care in their documents should not be seen as signalling an absence of respect. Using the example of respect for health-care facilities, an interviewee explained, "Absolute respect for health structures was a basic principle of the organization, as was respect for civilians and religious sites. However, it was not specified as such in any internal rules."⁵²

RECOMMENDATIONS: IHL PROVISIONS MUST BE INCORPORATED INTO THE ARMED GROUPS' DOCTRINE IN ORDER TO PROVIDE GUIDANCE ON LAWFUL BEHAVIOUR AND THE CONSEQUENCES OF UNLAWFUL BEHAVIOUR (THE APPLICATION OF SANCTIONS). CONSEQUENTLY, EVEN THOUGH PRINCIPLES CALLING FOR RESPECT FOR AND THE PROTECTION OF HEALTH CARE ARE COMMONLY KNOWN AND ACCEPTED, IT IS RECOMMENDED THAT THEY BE INCORPORATED INTO REVISED DOCTRINE.

7.1.2. Education⁵³

Observations

Numerous armed groups have developed a formal education process. Different practices were shared by the armed groups consulted. One armed group explained that each new recruit is provided with the group's documents and given eight days to read them before being tested on their content. Six months later, a review takes place during which the recruits' level of knowledge of internal rules is assessed. Some groups have special units that, at regular intervals, speak to all members of the group about key

⁵⁰ The term "doctrine" refers to all standard principles that guide the action of armed actors at the strategic, operational and tactical levels, independently of the forms these principles may take. It therefore encompasses all directives, policies, procedures, codes of conduct and reference manuals – or their equivalents – on which armed actors are educated and trained, giving them a common vocabulary and shaping the decision-making process, tactics and behaviour in operations.

⁵¹ Examples of armed groups' doctrine making reference to health care are presented in Annex 4.

⁵² Quote from an armed group member interviewed by the ICRC.

⁵³ Education refers to providing armed actors with theoretical knowledge. Nevertheless, knowledge of the relevant law alone is not sufficient. It is paramount to operationalize theoretical knowledge with practical measures, means and mechanisms for compliance with the law, as set by revised doctrine.

principles, including IHL. In other groups, the commander is responsible for ensuring that his or her troops are aware of the internal rules.

RECOMMENDATIONS: THE MEANS AND MECHANISMS FOR COMPLYING WITH THE LAW MUST BECOME AN INTEGRAL PART OF ALL MATTERS TAUGHT, WHENEVER NECESSARY AND RELEVANT. ARMED GROUPS SHOULD MAKE SURE THAT IHL RULES RELATED TO RESPECT FOR AND THE PROTECTION OF HEALTH CARE, INCLUDING THOSE CONTAINED IN THE GROUPS' DOCTRINE, ARE KNOWN BY THEIR MEMBERS.

7.1.3. Training⁵⁴

Observations

Most organized armed groups have created training units at the core level. Although the integration of IHL rules into operational training (such as conduct of hostilities training) was not addressed in depth during the consultations, most armed groups consulted mentioned that they had developed mechanisms to train their members in providing health care. The training took different forms, from first-aid to war-surgery courses, depending on the level and needs of the participants. Some armed groups also call on neutral external bodies to provide training on IHL principles, operational procedures and health care for their members.

RECOMMENDATIONS: TRAINING MUST INCLUDE IHL COMPONENTS IN A REALISTIC WAY. ARMED GROUPS CAN TAKE A NUMBER OF MEASURES TO RAISE AWARENESS ON THE NEED TO CARE FOR THE WOUNDED AND SICK; TRAINING THEIR MEMBERS TO ALLOW THE RAPID PASSAGE OF VEHICLES TRANSPORTING PATIENTS AND PROVIDING HEALTH CARE ARE AMONG THEM. IT IS ALSO RECOMMENDED THAT THE GROUPS INCORPORATE SPECIFIC IHL RULES CONCERNING RESPECT FOR AND THE PROTECTION OF HEALTH CARE DURING THE CONDUCT OF HOSTILITIES INTO THE TRAINING OF ARMED GROUP MEMBERS.

7.1.4. Sanctions⁵⁵

Observations

Many of the armed groups consulted noted that they possessed a list of sanctions together with mechanisms for applying them, such as a criminal code. In general, it was explained that abuses committed by ground troops were usually dealt with by a local commander, whereas serious offences were referred to higher levels of command or special bodies in charge of deciding on the applicable sanctions. The armed groups consulted also asserted that it was the commander's responsibility to sanction his or her troops in response to violations. In addition, some of the armed groups explained that, depending on their gravity, some acts in violation of IHL or their criminal code pertaining to respect for the wounded and sick or health-care personnel and facilities were subject to the stiffest sanctions.

⁵⁴ Training consists in providing armed actors with practical experience in how to perform their functions. It includes taking measures for armed actors to acquire skills and experience for compliance with IHL, i.e. inclusion of all specially protected persons and objects as realistically as possible in the training. Such a training environment provides armed actors with the opportunity to train their personnel in the implementation of the measures, means and mechanisms for compliance with the law, as provided by doctrine. Through repeated practice during training, armed actors should acquire the correct reflexes (such as for effectively identifying military objectives, and selecting the proportionate course of action and relevant precautions), which should thus become second nature.

⁵⁵ Sanctions play a key preventive role. Experience shows that the more widely known and visible they are and the more predictable their application, the more dissuasive they will be. They also make it possible to effectively punish those who have failed to obey the law. They therefore represent a means of enforcing orders and discipline and showing that the whole chain of command is firm in defending its fundamental values.

RECOMMENDATIONS: ARMED GROUPS MUST TAKE MEASURES, INCLUDING SANCTIONS, IN ORDER TO PUNISH MEMBERS FOUND RESPONSIBLE FOR ABUSES AGAINST THE WOUNDED AND SICK AND/OR THE PROVISION OF HEALTH CARE. SANCTIONS MUST BE WIDELY KNOWN, VISIBLE, PREDICTABLE AND EFFECTIVE (WHICH INCLUDES BEING APPLIED RAPIDLY). THEY MUST BE APPROPRIATE AND PROPORTIONAL AND BE RESPECTFUL OF THE INDIVIDUALS' FUNDAMENTAL RIGHTS.

Adding to the “integration process,” the armed groups consulted mentioned three additional measures they take in order to increase their members’ compliance with their internal rules.

Public Declarations⁵⁶

Communicating the armed group’s intention to abide by IHL and other relevant norms through a public declaration was seen as a valuable way to create a conducive environment. It was also deemed useful to reinforce the armed groups’ investment in doctrine, education, training and sanctions by making their own members, as well as adversaries and the local population, more aware of the group’s commitments.

After-Action Review

Carrying out after-action reviews involves debriefing on and analysing an operation. The armed groups consulted found that after-action reviews were useful in identifying needed improvements in the groups’ operational methods.

Standard Operating Procedures

Standard Operating Procedures (SOPs) are a set of instructions detailing actions to be undertaken in specific situations. Preparing and applying SOPs were considered an effective way of ensuring appropriate and uniform behaviour in difficult situations during the conduct of operations.

7.2. RESPECT FOR HEALTH-CARE PERSONNEL

7.2.1. Humanitarian problems

Despite their medical duty to provide care, health-care personnel are often denied access to the wounded and sick. The health-care personnel’s safety and protection are also often not respected. They are frequently deprived of their liberty, put into life-threatening situations and threatened and pressured when carrying out their work.

According to the information collected by the ICRC, health-care personnel are often denied access to civilians living in territory controlled by armed groups. The armed groups consulted acknowledged having security concerns when health-care personnel entered areas under their control, especially if the personnel were affiliated with or assigned by their adversaries. In particular, they described the fear that health-care personnel could access and communicate sensitive information to the groups’ adversaries for military purposes. Denial of access to health-care services takes a heavy toll on civilians.

⁵⁶ A model declaration expressing an armed group’s commitment and intention to abide by IHL is provided in Annex 1.

Some interviewees also described how they witnessed civilians being left without access to health care when health-care personnel assigned to a health-care facility or unit went to treat the wounded and sick in the armed groups' camps. In some cases, the health-care personnel were kept at the camp by the armed groups to provide such care. In such situations, it was explained that when measures necessary to ensure their protection were not put in place, some health-care personnel were exposed to life-threatening situations or even lost their life.

Health-care personnel are regularly the object of pressure and threats as a means to influence who they treat first or to prevent them from registering patients. The armed groups consulted believed such behaviour was due to a lack of knowledge or understanding of health-care ethics, a lack of knowledge of health-care personnel's obligations under national law and the absence of proper rules and discipline within the armed group. The regular presence and inappropriate behaviour of fighters in health-care facilities also pose direct security risks for health-care personnel and patients.

Pressure, threats, interference with their work, and violence affects the ability of health-care personnel to deliver health care. In a number of areas, health-care personnel are no longer able to work. As a consequence, patients do not receive appropriate treatment in due time. This can have many long-term health consequences and often significantly increases conflict-induced mortality.

Humanitarian problems related to health-care personnel will be addressed in the following section from three specific angles: health-care personnel's access to civilians, respect for and the safety of health-care personnel, and an understanding of health-care ethics.

7.2.2. Case studies

7.2.2.1. Case study 1: Ensuring health-care personnel have access to civilians

In a remote region, health services were provided by a limited number of health-care facilities supplemented by government-run mobile clinics. When an armed group took control of the region, the mobile services came to a halt. The armed group mistrusted the government health-care personnel, while the health-care personnel themselves were afraid to enter the region controlled by the group. Reduced access to health care came as an additional burden for civilians who were already suffering from the consequences of the conflict. Some of the wounded and sick were left unattended. A solution to resume the delivery of health care had to be found.

The IHL rules applicable in this type of situation are:

The obligations to respect and protect medical personnel, facilities and vehicles.

These obligations mean that access to health care must not be unduly impeded, and ongoing treatment for the wounded and sick together with health care for the civilian population must not be prevented. Also, measures must be taken to assist medical personnel in their work.⁵⁷

⁵⁷ For the relevant legal sources and the commentaries on relevant provisions which help in interpreting legal obligations, relative to this scenario and all subsequent ones in this section, see Section 6.2.

SOME PRACTICAL MEASURES TO ADOPT IN SUCH SITUATIONS

Establish contact with health-care personnel, for example by:

- Making arrangements directly with the health-care personnel. Arrangements can be oral or take the form of a letter of understanding. This type of arrangement would contain:⁵⁸
 - i) *The relevant principles and ground rules such as the rules of IHL, the principles underpinning health-care ethics, principles of good faith, etc.*
 - ii) *The responsibilities of armed groups and health-care personnel*
 - **Responsibilities of the armed group:** respecting and protecting health-care personnel and facilities, facilitating the health-care personnel's work, and not interfering in the health-care personnel's work;
 - **Responsibility of health-care personnel:** ensuring all their actions are guided by health-care ethics and complying with the rights and responsibilities of health-care personnel.
 - iii) *The operational process*
 - **Interaction** for preparing and implementing health-care activities (e.g. time frame for notification, required documentation);
 - **Designating mechanisms and bodies for problem-solving.**
 - iv) *The respective responsibilities of the armed group and health-care personnel to communicate their arrangement to all those who should respect it or benefit from it.*

Ensure the safety of patients and health-care personnel, for example by:

- Taking relevant measures to ensure that patients, health-care personnel and facilities are protected from security- and environment-related threats (e.g. hostilities, explosive remnants of war, criminality, natural disasters and accidents).
- Establishing and communicating contingency plans to ensure health-care personnel, patients and facilities are protected (e.g. identifying evacuation routes and places where shelter can be found, making plans to evacuate and transfer the wounded and sick and ensure continued treatment) in the event of changing circumstances or unforeseen events.

Facilitate the work of health-care personnel, for example by:

- Establishing fast-track procedures for identifying, checking and clearing health-care personnel and supplies at checkpoints.
- Allowing direct channels of communication between health-care personnel and relevant individuals within communities and, whenever necessary and feasible, providing access to equipment necessary for such communications.
- Ensuring that the facilities and equipment necessary for health-care personnel to carry out their work are not used by the armed group for other purposes.

A success factor of arrangements between armed groups and health-care personnel is the recognition and/or support of such pragmatic arrangements by the state party to the conflict. The arrangement should not, under any circumstances, be interpreted as signalling or demonstrating the health-care personnel's allegiance to an armed group.

⁵⁸ Armed groups have made such arrangements, often with a consortium of humanitarian organizations. Such an arrangement can cover a wide range of provisions detailing all the elements necessary for the safe delivery of health care. They have also been used to secure a clear commitment from the parties to uphold IHL and to respect the agreed procedures.

7.2.2.2. Case study 2: Respecting and ensuring the safety of health-care personnel

When several members of an armed group suddenly fell seriously ill, the group's own health-care personnel were not able to help them because they lacked experience in treating illnesses. Some other members of the group went to the health-care facility and asked the doctor to go to the camp to treat the sick. The doctor refused to leave his post because he was the only health-care professional assigned to the facility. The civilian population would be left without any access to medical attention if he left his position.

In such situations, health-care personnel risk being forcibly taken to provide health care to the armed group members. Taking health-care personnel to an armed group's camp can jeopardize their life and safety.

The IHL rules applicable in this type of situation are:

The obligation to respect medical personnel.

The obligation to respect means that the work of medical personnel must not be interfered with, and the ability to give continued care to the wounded and sick in their charge must not be hampered.⁵⁹

The obligation to protect medical personnel and the obligation to take all feasible precautions against the effects of attacks under the general rules on the conduct of hostilities designed to protect civilians not directly participating in hostilities.

The obligation to protect medical personnel and to ensure that they are respected by others means that health-care personnel must not be kept longer than necessary and against their will, as this would put their life at risk.

The obligation to take all feasible precautions against the effects of attacks under the general rules on the conduct of hostilities means that civilians may not be kept longer than necessary among fighters so as to not unduly expose them to the risk of being incidentally harmed in the event of attacks against the fighters by their adversaries.

SOME PRACTICAL MEASURES TO ADOPT IN ORDER TO PREVENT THE RISK OF ABUSE⁶⁰

Devise internal regulations and mechanisms, for example by:

- Preparing an internal document defining the circumstances and conditions under which it is permissible to call on the services of health-care personnel not affiliated with the armed group and in a manner that is consistent with the obligations to respect and protect such personnel.

Establish contact with health-care personnel, for example by:

- Identifying health-care personnel who can be contacted in times of need and avoiding those health-care personnel who are not supposed to provide care outside their duty station.
- Defining the terms of interaction with health-care personnel who can be contacted in times of need.
- Establishing channels of communications with these health-care personnel.

⁵⁹ For the relevant legal sources and the commentaries on relevant provisions which help in interpreting legal obligations, relative to this scenario and all subsequent ones in this section, see Section 6.2.

⁶⁰ Health-care personnel must not be requested to leave their post if it would result in leaving civilians unattended. For example, health-care personnel assigned to mobile health-care units and primary health-care centres must not be distracted from their mandate or task, which is to provide health care to civilians.

SOME PRACTICAL MEASURES TO ADOPT IF HEALTH-CARE PERSONNEL COME TO ATTEND TO THE WOUNDED AND SICK

Ensure the safety of health-care personnel, for example by:

- Minimizing the likelihood that external health-care personnel will become aware of sensitive information, such as by setting up a location outside of the camp for treating the wounded and sick.
- Stopping operations for such time as to allow the safe passage of health-care personnel.
- Identifying roads for safe passage and, if necessary, areas where shelter can be found.

Facilitate the work of health-care personnel, for example by:

- Organizing the safe passage of health-care personnel and medical evacuations.
- Whenever feasible and medically advised, assembling all people in need of medical care in one area to allow the health-care personnel to more efficiently attend to them all.
- Assembling all medical material the health-care personnel will need in the health-care facility or at the treatment site.
- Preparing all the information on patients (i.e. their medical file) ahead of the health-care personnel's arrival.

Health-care personnel must not be punished for fulfilling their medical duty under IHL and in accordance with health-care ethics. Armed groups should bear in mind that in some countries, health-care personnel might face domestic legal action for providing health care to the groups' members. In addition, armed groups that request the services of health-care personnel must always consider how this may affect civilians' access to health care.

7.2.2.3. Case study 3: Understanding and respecting the principles underlying health-care ethics

When a fighter was injured in hostilities taking place in a town, his fellow fighters took him to a nearby hospital. The hospital was full of people waiting to receive medical attention. The fighters were very concerned because the wounded fighter was unconscious and he was the only one able to operate a particular piece of military equipment. They wanted this person to be treated first.

In such situations, there is a risk that health-care personnel will be pressured or threatened as a way of influencing the order in which they treat patients.

The IHL rules applicable in this type of situation are:

The obligation that impartial medical care be provided to the wounded and sick and the obligation that health-care personnel must not be compelled to act contrary to medical ethics.

The obligation to provide impartial medical care means that differences in treatment, such as giving priority to one patient over another, are only justifiable on medical grounds.

The obligation not to compel health-care personnel to act contrary to medical ethics means that health-care personnel must not be compelled to give a particular person priority unless deemed necessary in view of that person's state of health.⁶¹

SOME PRACTICAL MEASURES TO ADOPT IN ORDER TO PREVENT THE RISK OF ABUSE

Devise internal regulations and mechanisms, for example by:

- Instructing the group in health-care ethics and the obligations of health-care personnel under international and national law.

⁶¹ For the relevant legal sources and the commentaries on relevant provisions which help in interpreting legal obligations, relative to this scenario and all subsequent ones in this section, see Section 6.2.

- Ensuring that the group's own health-care personnel act in accordance with health-care ethics.
- Instructing the group in the detrimental effects on health-care personnel and patients of carrying arms in health-care facilities.

Establish contact with health-care personnel, for example by:

- Establishing a mechanism through which health-care personnel can address complaints concerning respect for health-care ethics by members of the armed group.
- Guaranteeing that health-care personnel who submit complaints and grievances will not face any negative repercussions.

Limit the presence of fighters within health-care facilities, for example by:

- Establishing contact with health-care personnel who can medically evacuate and accompany the wounded and sick to health-care facilities.
- Creating medical services within armed groups or training some members in evacuating the wounded and sick and delivering them to health-care facilities.
- Establishing clear instructions that define the circumstances under which fighters can enter and remain in health-care facilities.

Ensure the safety of health-care personnel and facilitate the work of health-care personnel, for example by:

- Respecting the medical decisions made by health-care personnel and forbidding members of the armed group from pressuring health-care personnel.
- Instructing fighters to follow the regulations of health-care facilities in terms of armed entry. For instance:
 - respect “no-weapon” policies;
 - if the health-care facility is in a region under the armed group's control, the group could put in place its own system for leaving and guarding weapons at the entrance.

7.3. RESPECT FOR HEALTH-CARE FACILITIES

7.3.1. Humanitarian problems

Despite their protected status in situations of armed conflict, health-care facilities are often looted, damaged, destroyed or used for military purposes.

Data gathered by the ICRC identified the looting of health-care facilities as an all-too-common occurrence. Medical supplies and medicines have repeatedly been taken from health-care facilities located in or near combat areas. Some of the armed groups that were consulted explained that, in some cases, they were taken in order to use them for wounded fighters. Yet such actions prevent health-care facilities from functioning properly. Because these acts are often committed by fighters who have just been involved in hostilities, they often involve violence against health-care personnel working in the facility. Such incidents take a heavy physical and psychological toll on health-care personnel. It is not rare to see health-care personnel giving up their work.

Moreover, damage to or the destruction of health-care facilities occurs when the facilities have not been properly identified and/or adequate precautions in the choice of the means and methods of warfare have not been taken, according to several military commanders who were interviewed. For example, health-care facilities were destroyed after one of the parties placed military positions on their premises, jeopardizing their protection under IHL. While direct attacks on health-care facilities might be legitimate once the facilities have lost their protection, in some instances the result has been disproportionate incidental harm to the civilians and patients inside.

In addition to their immediate effect of depriving people of access to health care, these acts may have long-term consequences. Indeed, resupplying, fixing or rebuilding health-care facilities is often challenging in times of peace and becomes extremely complex, if not impossible, in situations of armed conflict.

Humanitarian problems related to health-care facilities will be addressed in the following section from three specific angles: accessing health-care supplies, mapping health-care facilities and taking precautions when planning and conducting military operations.

7.3.2. Case studies

7.3.2.1. Case study 4: Respecting health-care facilities and ensuring access to medical supplies

An armed group unexpectedly encountered a group of adversaries, and an armed confrontation ensued. The fighting left several armed group members with gunshot wounds requiring urgent treatment. The health-care personnel accompanying the group did not have enough material to provide care. Some group members made their way to the nearest health-care facility to get the necessary supplies.

This type of situation presents a high risk that the health-care facility will be looted.

The IHL rules applicable in this type of situation are:

The obligation to respect medical facilities and the prohibition of pillage, the latter being a war crime.

This means that health-care facilities must never be pillaged, i.e. medical supplies can never be unlawfully and forcibly taken against the health-care personnel's will for use by an individual or a group.⁶²

SOME PRACTICAL MEASURES TO ADOPT IN ORDER TO PREVENT THE RISK OF ABUSE

Establish a network of contacts to ensure the availability of medical supplies, for example by:

- Developing contact with different sources of health-care materials to ensure that the necessary supplies are available and secure.
- Whenever possible, concluding special arrangements to ensure the availability of medical supplies that would serve the civilian population in the territory of the armed group and the fighters.
- Entering into communication with humanitarian organizations that could provide basic medical supplies needed for emergency care.

Ensure, to the fullest extent possible, that those in need of urgent or life-saving medical care receive it, for example by:

- Devoting part of the budget to the purchase of medical supplies at the armed group's central and unit levels.
- Providing the armed group's health-care personnel operating close to front lines or the armed group's fighters who have first aid and/or medical knowledge with emergency medical kits to treat the injured (e.g. medicine, bandages and supplies to stitch wounds).
- Providing "emergency cash" to health-care personnel or other armed group members who have health-care responsibilities and who accompany combat units, so they can buy supplies if necessary.
- Encouraging familiarity with natural remedies (e.g. locally available plants) that can be used to treat the wounded and sick.

⁶² For the relevant legal sources and the commentaries on relevant provisions which help in interpreting legal obligations, relative to this scenario and all subsequent ones in this section, see Section 6.2.

SOME PRACTICAL MEASURES TO ADOPT IF GOING TO A HEALTH-CARE FACILITY TO PROCURE SUPPLIES IS UNAVOIDABLE

Facilitate the work carried out in health-care facilities, for example by:

- Ensuring that armed group members entering health-care facilities to obtain supplies:
 - abide by the rules and regulations of the health-care facilities (e.g. no weapons in the facility);
 - are aware of national laws governing health-care personnel (e.g. the requirement to see a patient prior to providing medication) and take measures to prevent putting health-care personnel in danger;
 - only buy enough medication to meet the need for which they entered the health-care facility;
 - refrain from threatening or attacking health-care personnel.

7.3.2.2. Case study 5: Mapping the location of health-care facilities

In a region where hostilities have been taking place for years between two armed groups, the civilian population only had access to limited health-care services. Public health-care services had stopped before the conflict broke out, and only a few health-care facilities run by non-governmental organizations remained. An organization opened a health-care centre on premises that were previously empty. It identified the premises by placing a flag with its logo on the roof. The parties did not map the location of health-care facilities in the region. During a military operation, the health-care centre was seriously damaged.

The IHL rules applicable in this type of situation are:

The obligation to respect and protect medical personnel, facilities and transports, and the general rules on the conduct of hostilities, including the principles of distinction, proportionality and precaution.

The obligation to respect and protect medical personnel, facilities and transports means that efforts must be made to spare medical facilities when engaging in attacks.

The general rules on the conduct of hostilities mean that at all times a distinction must be made between civilians and fighters and between civilian objects and military objectives. Moreover, attacks must not be launched on military objectives if such attacks may be expected to cause excessive incidental civilian harm or harm to specifically protected medical personnel or objects in relation to the concrete and direct military advantage anticipated. All feasible precautions must be taken to verify that targets are military objectives (rather than civilians or civilian objects or specifically protected medical personnel or objects), and attacks must not be launched or must be cancelled or suspended where the attack may be expected to cause excessive incidental civilian harm or harm to specifically protected medical personnel or objects in relation to the concrete and direct military advantage anticipated.⁶³

SOME PRACTICAL MEASURES TO ADOPT IN ORDER TO PREVENT SUCH SITUATIONS

Establish contact with entities providing health care, for example by:

- Appointing a focal point within the group (i.e. a health-care coordinator) to maintain contact with external health-care personnel. This would contribute to the group's up-to-date knowledge about health-care organizations and facilities active in the region.
- Ensuring that health-care personnel active in the region and the civilian population know the focal point.

⁶³ For the relevant legal sources and the commentaries on relevant provisions which help in interpreting legal obligations, relative to this scenario and all subsequent ones in this section, see Section 6.2.

Ensure the safety of and facilitate the work carried out in health-care facilities, for example by:

- Teaching the armed group members about the recognized protective emblems (red cross, red crescent and red crystal).
- Making sure that the mapping of health-care organizations and facilities is regularly updated and shared throughout the group and that their emblems or symbols are known and respected.
- Referring to the above information when planning and conducting military operations.

7.3.2.3. Case study 6: Taking precautions when planning and conducting military operations

An armed group learned that the adversary had taken over a health-care facility for military purposes by setting up its headquarters on its premises. The armed group was determined to have the adversary leave the health-care facility. The health-care facility was still operating and patients were still being treated.

In this type of situation, there is a high risk that the health-care facility will be damaged or destroyed and that patients and health-care personnel will be affected as a result of a lack of precaution in the planning and conduct of military operations.

The IHL rules applicable in this type of situation are:

The rule that the protection of medical facilities is not lost unless they are used for committing hostile acts, outside their humanitarian function.

The obligation to respect and protect the wounded and sick and medical personnel.

The principles of proportionality and precaution in attack under the general rules on the conduct of hostilities.

This means that the principle of protection from direct attack remains intact unless medical facilities are used to commit hostile acts outside their humanitarian function. Protection only ceases after due warning has been given with a reasonable time limit and after the warning has remained unheeded. Taking over a health-care facility for the purpose of launching military operations from it amounts to a hostile act. However, even where a hostile act has been committed from within a health-care facility, the principles of proportionality and precaution must be respected for the benefit of the wounded and sick, medical personnel and civilians in general. An attack on a medical facility that has lost its protection must therefore not be launched if the attack may be expected to cause excessive incidental civilian harm or harm to specifically protected medical personnel or objects in relation to the concrete and direct military advantage anticipated.⁶⁴

SOME PRACTICAL MEASURES TO ADOPT IN ORDER TO PREVENT THE RISK OF ABUSE**Devise internal regulations and mechanisms, for example by:**

- Deciding that health-care facilities will not be used for military purposes.
- Dissociating access to health care from military tactics.
- Establishing a decision-making process for attacking a health-care facility that might have lost its protection under IHL.
- Establishing the reason (military or not) for the presence of adversaries within a health-care facility before considering military action against the facility.
- Suspending the military operation as soon as it appears that the harm to civilians and civilian objects is at risk of becoming, or has become, excessive in relation to the concrete and direct military advantage anticipated.

⁶⁴ For the relevant legal sources and the commentaries on relevant provisions which help in interpreting legal obligations, relative to this scenario and all subsequent ones in this section, see Section 6.2.

Ensure the safety of and facilitate the work carried out in health-care facilities, for example by:

- Attempting to resolve the issue without the use of force:
 - conduct direct negotiations with the commander of the adversary under a flag of truce, if practicable, to have the adversary leave the health-care facility;
 - if desired, seek the help of a neutral intermediary to negotiate the withdrawal of the adversary from the health-care facility.
- Establishing that the attack is directed at a military objective and is militarily necessary.
- Before proceeding with an attack:
 - gathering the necessary intelligence on the health-care facility's occupants. It is necessary, in particular, to identify the number of fighters and civilians in it, determine how to distinguish them and identify the type of weapons present in the facility;
 - carrying out the proportionality assessment (i.e. the balance between military advantage gained from a successful attack and the potential incidental risk to protected persons or objects);
 - issuing appropriate warnings to the adversary;
 - issuing appropriate warnings to the civilian population so that they, along with wounded and sick fighters and health-care personnel, can leave the health-care facility and so that patients can be evacuated;
 - leave enough time between the warning and launching the attack to allow civilians, wounded and sick fighters and health-care personnel to leave the health-care facility and patients to be evacuated;
 - provide civilians, wounded and sick fighters and health-care personnel with information on where they can take safe shelter;
 - continue to respect and protect civilians, wounded and sick fighters and health-care personnel, even those who do not heed the warning to leave the health-care facility.
- Taking appropriate precautions to prevent incidental harm to civilians, wounded and sick fighters, health-care personnel and the health-care facility when carrying out military actions that target or are in the vicinity of a health-care facility.

7.4. RESPECT FOR THE WOUNDED AND SICK AND FOR MEDICAL VEHICLES**7.4.1. Humanitarian problems**

In situations of armed conflict, the wounded and sick are not always respected and provided with the health-care treatment they need. Medical vehicles have been unduly delayed at checkpoints or the object of direct attack.

Despite being under-reported and hard to document,⁶⁵ wounded fighters are sometimes killed in the aftermath of hostilities. While the armed groups consulted stated that respect for wounded and sick adversaries was a norm in their doctrine, some acknowledged that summary executions sometimes occurred when the wounded person was an individual known to have committed crimes or to have behaved treacherously on the battlefield. Impulses deriving from revenge or hatred, heightened after a fight, also sometimes led to such killings. A lack of sanctions in response to abuses was also seen as contributing to an environment conducive to such killings.

In addition, when heavy fighting results in a high number of wounded on all sides, some of the wounded may not be provided with adequate health care. Many interviewees explained that they lacked the supplies, suitable means of transportation and personnel required to provide health care to all who needed it. It was reported that, in such situations, distinctions based on affiliation were sometimes made and the group's own wounded were provided treatment first. At times, armed groups were prevented from providing health care to all the wounded because of security constraints. When health care is provided in a discriminatory manner, wounded adversaries suffer unnecessarily or die.

⁶⁵ This statement is based on commanders consulted who acknowledged that monitoring the fate of wounded adversaries while they are still on the battlefield is extremely difficult.

Vehicles transporting patients are often refused access or delayed at checkpoints. Furthermore, in cases where the patient being transported is taken prisoner, proper treatment is not always provided. Such situations often result from a lack of clear procedures and a lack of training for those guarding the checkpoints.

Civilian and military vehicles transporting the wounded and sick are sometimes the object of direct attack. In some countries and regions, the armed groups consulted explained that the misuse of the emblem distinguishing vehicles assigned to the medical transport of the wounded and sick has undermined trust between the parties and led to direct attacks against those vehicles.

Failure to respect medical vehicles and provide adequate health care to all the wounded on the battlefield leads to unnecessary suffering. It may also cause the wounded and sick to experience deteriorating health or permanent health effects, or, ultimately, to die.

Humanitarian problems related to the respect for the wounded and sick and medical vehicles will be addressed in the following section from four specific angles: respecting wounded adversaries, collecting and caring for the wounded, ensuring the safe and speedy passage of medical vehicles at checkpoints and respecting the protective emblems.

7.4.2. Case studies

7.4.2.1. Case study 7: Respecting wounded adversaries

Armed confrontations resulted in heavy casualties on both sides. In the final push to gain control of an adversary's position, armed-group members came across the opposing commander and his deputy, both injured to the point that they were unable to fight. As the armed group approached the injured adversaries to capture them, their emotions were running high and thoughts of revenge were in the air.

In this type of situation, there is a high risk that the wounded will be mistreated or summarily executed.

The IHL rules applicable in this type of situation are:

The obligation to respect the wounded and sick, including those of the adversary, the obligation to treat the wounded and sick humanely in all circumstances, and the obligation to care for the wounded and sick.

This means that the wounded must not be murdered or executed without respecting fundamental guarantees of a fair trial. These acts amount to war crimes.

The obligation to respect the wounded and sick does not preclude arresting a wounded or sick adversary. The obligation to care means that the treatment required by the wounded or sick person's medical condition must be provided to the fullest extent practicable and with the least possible delay, including during the period of detention.⁶⁶

SOME PRACTICAL MEASURES TO ADOPT IN ORDER TO PREVENT THE RISK OF ABUSE

Devise internal regulations and mechanisms, for example by:

- Establishing that respect for the wounded and sick is absolute and that they must be respected and taken care of irrespective of their affiliation to a party to a conflict and independently of their acts on the battlefield.

⁶⁶ For the relevant legal sources and the commentaries on relevant provisions which help in interpreting legal obligations, relative to this scenario and all subsequent ones in this section, see Section 6.2.

- Dedicating training modules to the treatment of the wounded and sick by incorporating the routine disarming and arrest of the wounded and sick in military training courses.
- Using pre-operation orders to remind fighters of their expected behaviour towards wounded adversaries and to specifically forbid acts of revenge and summary executions.
- Assigning commanders the task of identifying and acting on situations likely to breed strong emotions and feelings of revenge.
- Excluding fighters who are in a highly emotional state from specific operations.
- Establishing a climate that is intolerant of abuses in all circumstances.

Create a conducive environment, for example by:

- Making sure the group's policy towards the wounded and sick is known and understood by the adversaries to enhance the likelihood of positive reciprocity.

Ensure the safety and facilitate the treatment of the wounded and sick, for example by:

- Establishing and maintaining registers on the adversary's wounded, sick, captured and dead. Such registers can specify the type, extent and speed of treatment provided to adversary fighters who are *hors de combat*.
- Promptly transmitting all data up the chain of command.
- Instructing fighters to deliver wounded and sick adversaries as soon as possible to health-care personnel or, in their absence, to those responsible for dealing with captured adversaries.
- Making sure that the group's own health-care personnel are given access to all the wounded and sick without delay.

7.4.2.2. Case study 8: Collecting and caring for the wounded

Armed clashes between two armed groups left numerous fighters from both sides wounded. One armed group had to retreat rapidly and could not collect its injured fighters. The armed group that had just gained control of the territory had limited health-care resources at its disposal. Suspecting that a counter-attack was imminent, time to collect and care for all the wounded was scarce.

In this type of situation, there is a high risk that the wounded will not benefit from adequate and impartial health care.

The IHL rules applicable in this type of situation are:

The obligations to search for, collect and evacuate the wounded and sick, and the obligation to provide medical care to them.

The obligation to provide medical care means that all possible measures are taken to provide medical care and attention to all the wounded without adverse distinction to the fullest extent practicable and with the least possible delay. The obligation to search for, collect and evacuate the wounded and sick means that whenever circumstances permit, and particularly after a confrontation, each party to the conflict must, without delay, take all possible measures to search for, collect and evacuate the wounded and sick without adverse distinction.

Taking all possible measures in this context means also permitting assistance from impartial humanitarian organizations and civilians in collecting, evacuating and caring for the wounded and sick. Such offers must not be arbitrarily refused, and the personnel of such organizations and the civilians must be respected and protected.⁶⁷

⁶⁷ For the relevant legal sources and the commentaries on relevant provisions which help in interpreting legal obligations, relative to this scenario and all subsequent ones in this section, see Section 6.2.

SOME PRACTICAL MEASURES TO ADOPT IN ORDER TO PREVENT THE RISK OF ABUSE

Create a conducive environment, for example by:

- Devising policies and procedures to establish local truces with the adversary in order to search for, remove and evacuate the wounded and sick.
- Establishing communication channels with neutral health-care personnel such as the ICRC.
- Ensuring that the group's health-care personnel abide by health-care ethics.

Ensure the safety and facilitate the treatment of the wounded and sick, for example by:

- Making sure all first-aiders and the group's health-care personnel extend help, to the fullest extent possible, to all the wounded and sick and prioritize by medical need.
- Planning for and transporting first-aid material necessary for emergency care.
- In the event that care cannot be provided on-site, being prepared to carry out evacuations to a place where safe shelter can be found and health care provided, and organizing the follow-up treatment;
- Providing training on how to evacuate the wounded and sick.
- If evacuating them is not possible, ensuring that the wounded and sick are left with the means of survival such as sufficient water and possibly medicine.
- If adequate care cannot be provided, informing neutral health-care personnel, for example those of the ICRC and National Societies, of the need to care for the injured; and identifying and establishing contact with such health-care personnel before the need arises and informing the group on ways to communicate with them (e.g. phone numbers).
- If adequate care cannot be provided, informing the local population of the need to care for the wounded and sick.
- Making clear to the fighters that all those searching for, collecting and caring for the wounded and sick such as medical personnel belonging to parties to the conflict, humanitarian organizations and other health-care personnel and civilians providing assistance are protected and must not be the object of attack. Ambulances and any other vehicles used to evacuate the wounded and sick are also protected and must not be attacked.
- Sparing fighters who have temporarily ceased to take part in hostilities in order to collect and/or care for the wounded or sick.

7.4.2.3. Case Study 9: Ensuring the safe and speedy passage of medical vehicles at checkpoints

An armed group manning a checkpoint in a city stopped a private vehicle transporting a wounded fighter from an opposing armed group. The wounded fighter was bleeding heavily. After a lengthy wait, the armed group searched the vehicle and found weapons hidden under blankets. The men manning the checkpoint immobilized the vehicle, contacted their commander and waited for orders.

In this type of situation, there is a high risk that the patient's access to health care will be delayed, jeopardizing proper treatment and the chance of survival.

The IHL rule applicable in this type of situation is:

The obligation that the wounded and sick must receive medical care, with the least possible delay.

This means that access by the wounded and sick to medical care must not be arbitrarily limited or denied. However, the extent of the obligation to ensure medical care “to the fullest extent practicable, and with the least possible delay” also provides leeway to fighters manning a checkpoint to adopt legitimate security measures, including ensuring that vehicles used for evacuating the wounded and sick are not also used for committing hostile acts, such as transporting arms or ammunition. It is a matter for the fighters manning the checkpoints to determine whether a wounded fighter is refraining from committing hostile acts and thus enjoys the status of being wounded and sick, and whether or not a vehicle has become a military objective due to the fact that weapons are found in it.⁶⁸

SOME PRACTICAL MEASURES TO ADOPT IN ORDER TO PREVENT THE RISK OF ABUSE

Ensure the safety and facilitate the movement of medical vehicles, for example by:

- Establishing fast-track lanes or procedures to expedite the passage of medical vehicles at checkpoints.
- Ensuring that any procedure strikes a balance between security requirements and the necessity for patients to access health-care facilities as quickly as possible. Procedures can include:
 - *identification procedures*: the use of the vehicle, rather than the formal identification of the vehicle, should be the decisive factor in determining whether the vehicle qualifies as a medical vehicle;
 - *security measures to*:
 - verify the identity of passengers;
 - search the vehicle and its occupants;
 - retain the driver or occupant (under the appropriate procedure), if that person needs to be captured.
- Ensuring that proper and uninterrupted medical care is provided whenever wounded or sick adversaries are arrested.
- Prohibiting the removal of equipment and supplies necessary for survival (e.g. water, medicine) from medical vehicles.
- In the event that the wounded or sick being transported need to be captured, ensuring that:
 - they receive appropriate treatment;
 - their treatment is not interrupted;
 - if it is not possible to provide appropriate medical treatment on the spot, the patient is accompanied to the nearest health-care facility where the patient can receive treatment and later be arrested.
- Informing the nearest health-care facility of the patient’s impending arrival.
- Facilitating the safe and unhindered transport of the patient by:
 - informing the driver of the best road/route to take;
 - providing advance warning to other checkpoints of the arrival of the transport.
- When in control of territory and in possession of health-care capacity, providing care to the wounded or sick.

⁶⁸ For the relevant legal sources and the commentaries on relevant provisions which help in interpreting legal obligations, relative to this scenario and all subsequent ones in this section, see Section 6.2.

7.4.2.4. Case Study 10: Respecting the protective emblems

All parties to a conflict frequently misused the distinctive emblem in order to transport supplies and fighters. Trust in the emblem was completely undermined. One of the armed groups decided to attack military vehicles, including those displaying the emblem. While waiting to carry out an ambush, an armed group saw a military medical unit approach displaying the red cross. The armed group attacked the medical unit. The group discovered after the attack that the unit had been carrying only health-care personnel and wounded and sick civilians and fighters.

The IHL rules applicable in this type of situation are:

The obligation to respect and protect military medical vehicles, the conditions determining the loss of protection, and the obligation not to use the distinctive emblem improperly.

The obligation to respect and protect military medical vehicles means that they must not be attacked. Military medical vehicles are not military objectives. If they have been used to commit hostile acts such as sheltering able-bodied combatants, storing arms and ammunition, or other hostile acts outside their humanitarian function, this protection can be lost, but only after due warning has been given and has gone unheeded after a reasonable amount of time. Using medical vehicles (including those displaying a distinctive emblem such as the red cross, red crescent or red crystal) with the intention of deceiving the adversary in order to launch an attack that kills or injures amounts to treacherous (perfidious) killing or wounding. This is a war crime.⁶⁹

SOME PRACTICAL MEASURES TO ADOPT IN ORDER TO PREVENT THE RISK OF ABUSE

Devise internal regulations and mechanisms, for example by:

- Ensuring that the members of the armed group are able to recognize the emblems used by different organisations (e.g. firefighters, civilian protection, red cross, red crescent, red crystal), and that they respect them.
- Defining the group's practice, consistent with IHL requirements, in using symbols and emblems to identify medical vehicles or personnel.
- Instructing the group that precedents of misuse do not justify violence against medical vehicles nor does misuse automatically transform the object or person into a military target.
- Establishing that the protection of medical vehicles, including those belonging to parties to the conflict, only ceases if they are used to commit hostile acts, outside of their humanitarian function, and only after a warning has been given and remains unheeded.

Create a conducive environment, for example by:

- Ensuring that, within the group, the emblem is only used by those entitled to use it and under the prescribed conditions.

Ensure the safety and facilitate the movement of medical vehicles, for example by:

- Providing clear and detailed instructions on how to react in the case of misuse of the emblem (e.g. warnings to the adversary).
- Documenting instances of potential misuse of the emblem by any party by:
 - investigating the instance of misuse;
 - documenting the instance of misuse;
 - taking pictures or videos of the misuse;
 - sending information on the case of misuse to a neutral intermediary.

⁶⁹ For the relevant legal sources and the commentaries on relevant provisions which help in interpreting legal obligations, relative to this scenario and all subsequent ones in this section, see Section 6.2.



8. CONCLUDING REMARKS

This publication is the first step in a participative process, in which the ICRC collected and recorded insights and practices discussed by armed groups.

The next, crucial step in this process is for armed groups to contextualize and adopt the practical measures presented in this document in order to strengthen their ability to respect and protect health care.

In non-international armed conflicts, armed groups do not operate in a vacuum. Other actors, such as health-care personnel, impartial humanitarian organizations and state authorities, also contribute to building an environment conducive to the safe and impartial delivery of health care. Still, armed groups have an essential role to play in promoting the principles of respect for and the protection of health care, both within their own group and when interacting with other armed groups.

To carry on with and further the process of improving the safe delivery of health care, three additional recommendations for armed groups were identified:

- *Clearly separating military tactics from the provision of health care.* The decision whether or not to grant access to health care to adversaries or civilians living in areas under the armed group's control too often takes into account military considerations. Armed groups must identify if this is the case within their practice and, if so, take remedial action.
- *Systematically developing the armed groups' own capacity to provide at least emergency health care.* This necessity responds to the obligation of armed groups to care for the wounded and sick. The armed groups consulted in the context of this project noted that abuses committed against health-care personnel and facilities were often linked to a lack of preparedness and a lack of capacity to provide care to their wounded fighters.
- *Strictly distinguishing between the armed groups' own health-care personnel and those members dedicated to combat functions.* For practical and trust-related reasons, most of the armed groups consulted acknowledged that they did not make this distinction that is enshrined in IHL. Medical personnel affiliated with a party to the conflict are however only entitled to protection and allowed to display the distinctive emblem if they are exclusively assigned to carry out their humanitarian duty. By ensuring that their health-care personnel are entitled to this type of protection and by respecting the adversary's health-care personnel, armed groups can set a positive example and enhance the safe delivery of health care.



ANNEXES

ANNEX 1: MODEL UNILATERAL DECLARATION

Armed groups have legal obligations under international humanitarian law (IHL) to protect the wounded and sick together with health-care personnel, facilities and transports in armed conflicts. To express their commitment to abide by their obligations, they may choose to issue a unilateral declaration. Unilateral declarations are also useful for informing group members of the rules they need to follow.

Unilateral declarations have been made by a variety of armed groups in recent decades. They can be communicated orally or in written form (e.g. in newspapers, or on the group's website or Facebook page).

The International Committee of the Red Cross (ICRC) stands ready to provide guidance and support to armed groups interested in developing a unilateral declaration. The text below represents a model and starting point.

Unilateral declarations are exclusively humanitarian in character. They do not affect the legal status of the armed groups concerned, nor do they undermine or replace their legal obligations.

UNILATERAL DECLARATION ON THE RESPECT AND PROTECTION OF THE WOUNDED AND SICK AND ON ACCESS TO HEALTH CARE

We acknowledge the need for all wounded and sick persons, i.e. those who require health care and refrain from any act of hostility, to have access to health care, and we are deeply concerned about the devastating impact of hindering such access.

We recognize that the provision of health care must be guided by the principles of humanity and impartiality.

We are convinced that we can play an important and positive role in improving the safe delivery of, and access to, health care and are resolved to do so.

We recognize that this declaration is no substitute for existing legal rules, including Article 3 common to the Geneva Conventions, customary international humanitarian law and, where applicable, Additional Protocol II to the Geneva Conventions.

In view of the above:

1. We hereby commit to the following general principles:

- a. respecting and protecting the wounded and sick, and actively supporting and facilitating their access to health care;
- b. respecting and protecting health-care personnel, facilities and medical transports, whether civilian or military, regardless of their affiliation;
- c. respecting the impartial, humanitarian character of health care;

- d. ensuring that health-care personnel, facilities and medical transports remain exclusively engaged in medical tasks;
- e. refraining from denying or disrupting health care as a military tactic;
- f. respecting the distinctive emblems of the red cross, red crescent and red crystal, and not using the distinctive emblems improperly;
- g. disseminating IHL and the terms of this declaration and ensuring that our members abide by them;
- h. abiding by our obligations and commitments regardless of the behaviour of the adversary.

2. We commit to respecting and protecting the wounded and sick. This includes:

- a. not attacking, harming or killing the wounded and sick;
- b. treating the wounded and sick humanely in all circumstances, even if they have engaged in prior military operations on behalf of any party to the conflict;
- c. searching for, collecting and caring for the wounded and sick without delay and without distinction, to the fullest extent practicable, whenever the security situation permits;
- d. allowing civilians and impartial humanitarian organizations to assist in this task;
- e. not preventing medical care, in particular medical supplies, from reaching the wounded and sick;
- f. taking all feasible measures to ensure that the wounded and sick are respected by others.

3. We commit to respecting and protecting medical transports. This includes:

- a. not attacking medical transports, even if they are not identified as such;
- b. allowing and facilitating the medical evacuation of the wounded and sick, including across front lines, to a location where they can receive adequate care;
- c. allowing unimpeded and fast passage to all vehicles dedicated to health care, even if they are not identified as such;
- d. not using medical transports for military purposes, such as transporting healthy fighters and weapons;
- e. taking all feasible measures to ensure that vehicles used for health care are respected by others.

4. We commit to respecting and protecting health-care facilities. This includes:

- a. not attacking health-care facilities exclusively performing medical functions, even if they are not identified as such;
- b. not attacking infrastructure essential for health-care delivery as long as it is not used for military purposes;
- c. not using health-care facilities for military purposes, such as establishing military posts or storing arms and ammunition;
- d. taking all feasible precautions, while planning and conducting military operations, to avoid incidentally damaging or destroying health-care facilities;
- e. taking all feasible precautions to spare health-care facilities from the effects of attack, including avoiding military operations near such facilities;
- f. not interfering with the work carried out in health-care facilities, a commitment that includes not taking supplies or material from health-care facilities and refraining from armed entry that disrupts the functioning of health-care facilities;
- g. facilitating the work carried out in health-care facilities.

5. We commit to respecting and protecting health-care personnel. This includes:

- a. not attacking, threatening or pressuring any health-care personnel providing impartial health care, even if they are not identified as such;
- b. respecting health-care personnel's obligation to treat all wounded and sick, without distinction on any grounds other than medical ones, including the wounded and sick associated with the adversary;
- c. not interfering with the work of health-care personnel;
- d. providing health-care personnel with all possible assistance in the accomplishment of their medical tasks;

- e. being aware of and promoting the ethical principles of health care and the obligations of health-care personnel under international and national law, and not punishing health-care personnel acting in accordance with their obligations;
- f. not compelling health-care personnel to carry out acts contrary to the ethical principles of health care;
- g. ensuring that our health-care personnel abide by the terms of this declaration and the ethical principles of health care.

6. We commit to informing the members of our group of the terms of this declaration and of IHL and ensuring they respect them. This includes:

- a. integrating the rules contained in this declaration in our doctrine, education and training;
- b. ensuring these rules are clearly translated into orders and directives;
- c. setting up an internal system to monitor compliance with this declaration and with the corresponding rules of IHL;
- d. applying sanctions, which are respectful of the individual's fundamental rights, to anyone in the group who does not abide by the rules contained in this declaration, and taking concrete measures to repair the damage done;
- e. widely and publicly disseminating the terms of this declaration, including, to the extent possible, to supporters of the group and to people living on any territory that may be controlled by the group.

ANNEX 2: PATTERNS AND IMPACT OF VIOLENCE ATTRIBUTED TO ARMED GROUPS

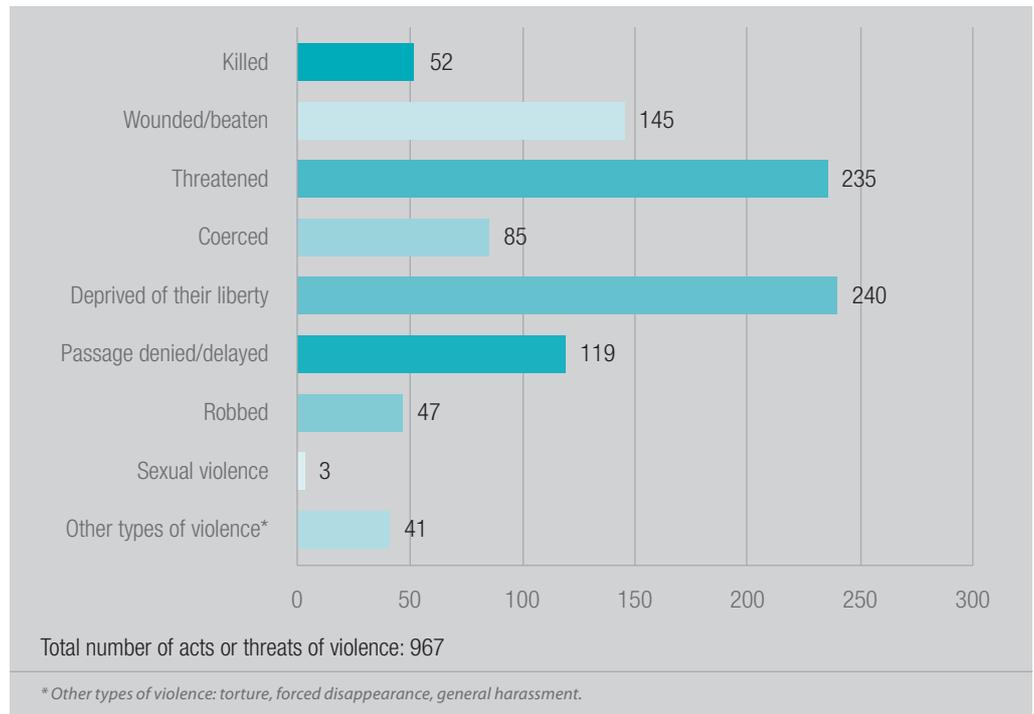
The ICRC has collected information about violent incidents against health care in more than twenty countries and regions through its field teams since January 2012.⁷⁰ The following analysis is based on 2,140 incidents documented from January 2012 to December 2014 in eight of those places where a non-international armed conflict was taking place. The choice of the countries included in this analysis was based on two criteria: a) ICRC field teams operating in the country have sent regular reports during the three years of collection, and b) they used at least three different sources, judged to be of reliable quality, to collect the information. However, it is important to underscore that the data presented below are not exhaustive and are only used to highlight the main trends of abuses affecting the delivery of health care as identified on the basis of the information that was collected.

Due to the focus of this publication, the analysis that follows present findings only on incidents attributed to armed groups that were explicitly recognized as such by the source of information. Out of the 2,140 incidents collected by the ICRC, 548 of them (26%) were attributed to armed groups.

1. Violence attributed to armed groups affecting people

The 548 incidents allegedly perpetrated by armed groups affected a total of 835 people, including health-care personnel, drivers of medical vehicles, the wounded and sick, bystanders and relatives of patients.⁷¹ Health-care personnel (502 victims) and patients (124 victims) were the most frequent victims of incidents.

Figure 1. Types of violence affecting people

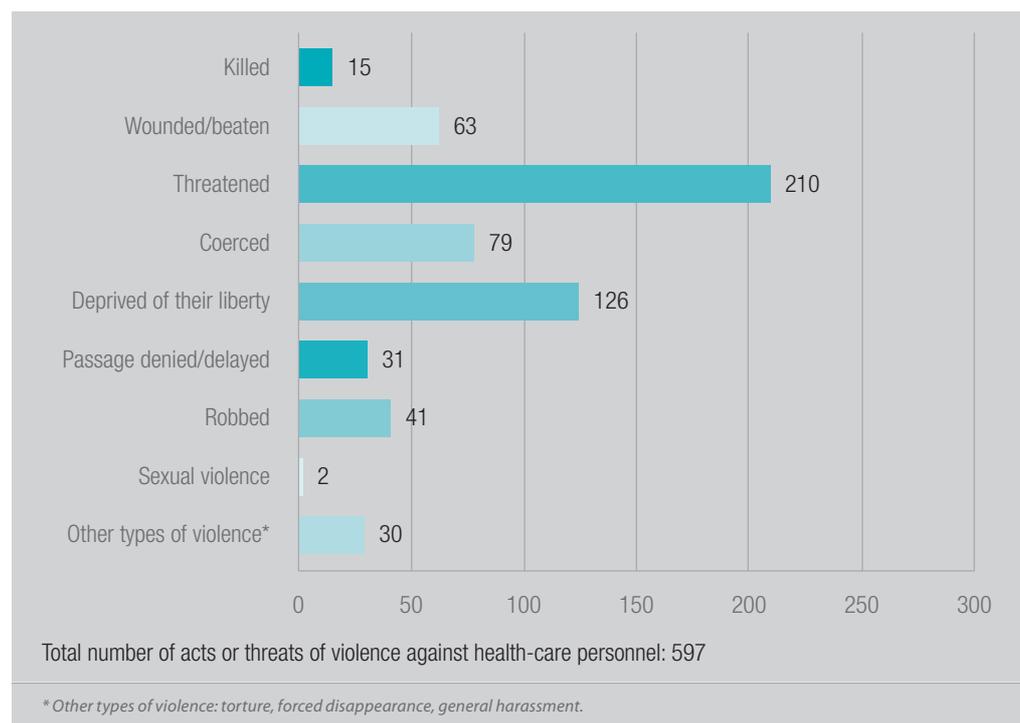


Violence against people that is attributed to armed groups takes different forms. The main types of violence documented by the ICRC were the deprivation of liberty (25%), threats (24%) and injuries and/or beatings (15%). Armed groups were also allegedly responsible for denying or delaying passage to people seeking health care, to drivers on their way to evacuate the wounded and the sick, and to health-care personnel travelling to deliver health care (12%).

⁷⁰ One incident can include various categories of victims who are affected by different types of violence. In some cases, people may be affected in more than one way by the same incident: for example, someone whose life is threatened if that person continues to provide medical care to certain communities and, at the same time, is robbed.

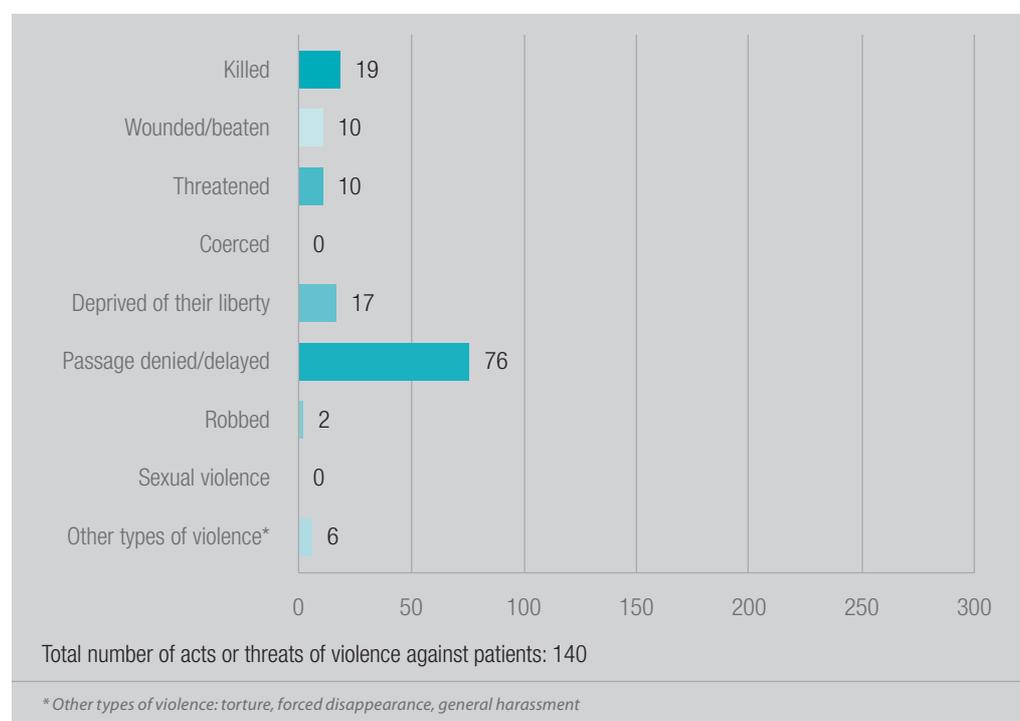
⁷¹ Other categories of people affected include security guards protecting health-care facilities, health-care personnel or vehicles, along with aid-workers and relatives of health-care personnel.

Figure 2. Types of violence affecting health-care personnel



The main types of documented violence affecting health-care personnel were threats (35%) and the deprivation of liberty (21%). In addition, some health-care personnel were allegedly coerced to provide free treatment, act in a manner contrary to health-care ethics and deliver health care in unsafe settings with inadequate equipment (13%).

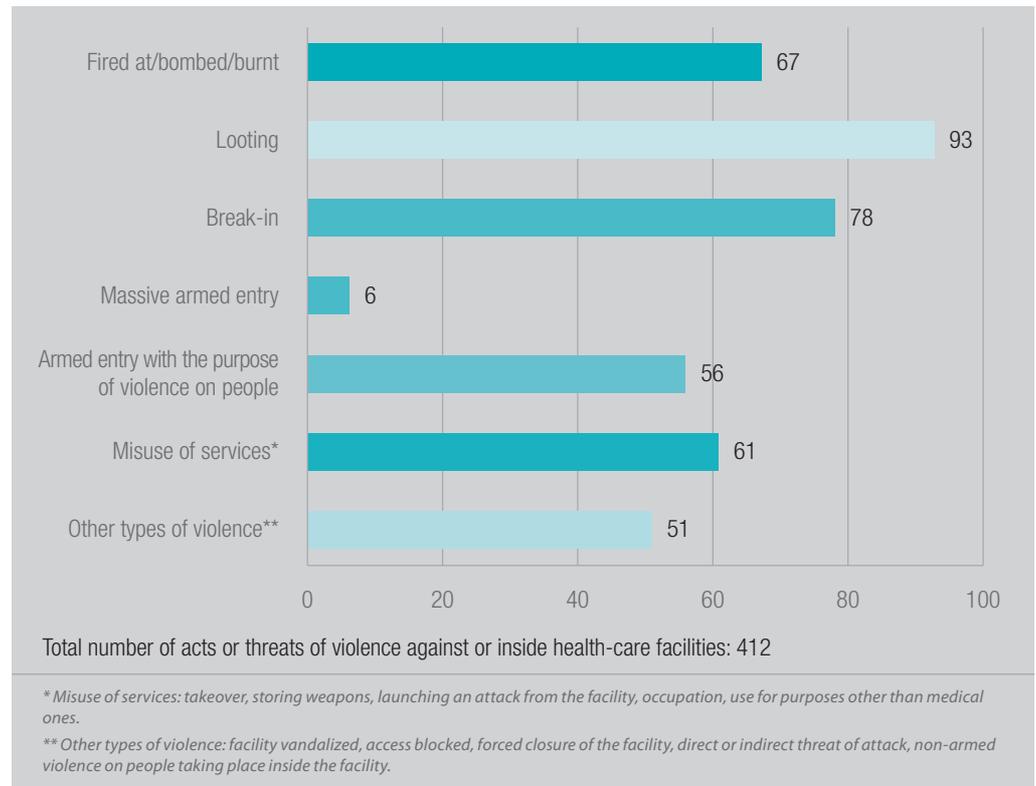
Figure 3. Types of violence affecting patients



The wounded and sick, either inside health-care facilities, on their way to health-care facilities or being evacuated, were also affected by incidents attributed to armed groups. Most often, patients had their access to health care denied or delayed (54%), either at informal checkpoints or on the road to health-care facilities. Numerous patients were also killed by direct or indirect violence (14%) or were victims of kidnapping (12%).

2. Violence attributed to armed groups affecting health-care facilities

Figure 4. Types of violence affecting health-care facilities

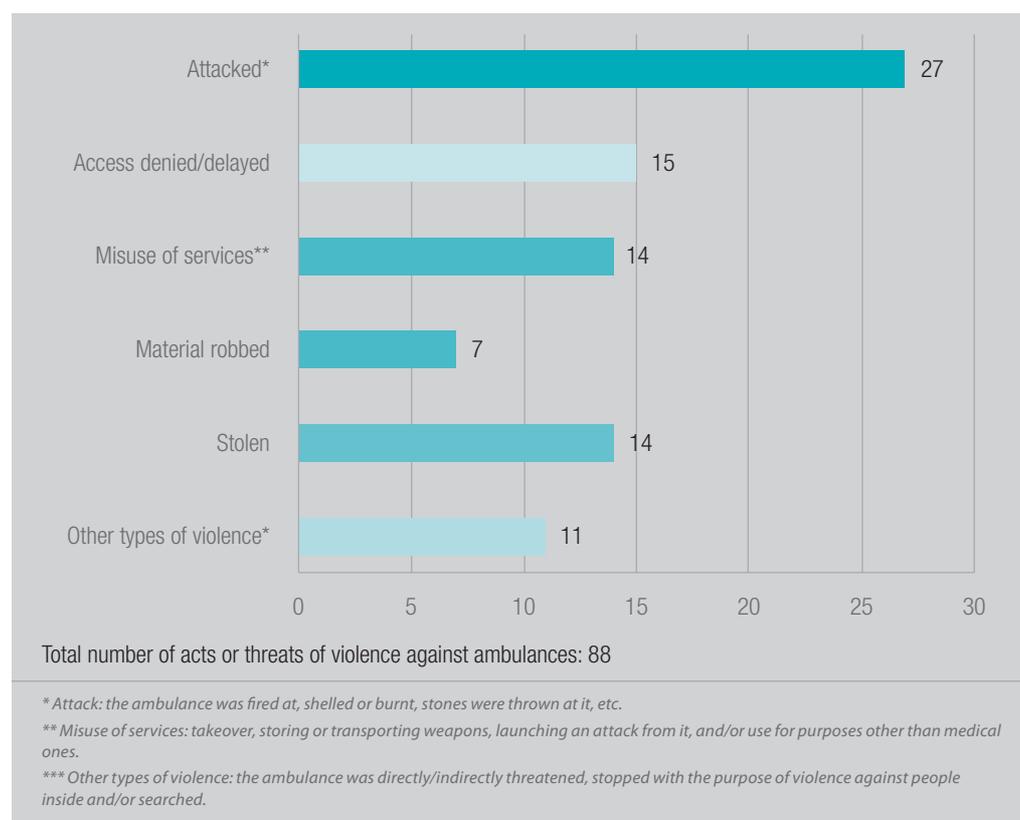


The ICRC documented violence perpetrated against 291 health-care facilities, including hospitals, health-care centres, clinics, aid posts, pharmacies and other facilities involved in the delivery of health care. The most frequent type of violence attributed to armed groups on health-care facilities was looting (23%). Instances of looting often involved break-ins and forceful armed entry into the facilities.⁷² Numerous health-care facilities were also entered for the purpose of committing violence against people inside, such as removing them from the facilities or killing or threatening them (14%). Moreover, several acts of takeover and misuse of health-care services, and of using health-care facilities for purposes other than health-care delivery, were attributed to armed groups (15%). Finally, some of the health-care facilities affected were directly or indirectly attacked by being fired at and bombed, or were burnt (16%).

⁷² An act of looting/pillage often means entering the health-care facility in a forceful way; it can also be carried out, however, by simply threatening the health-care personnel. Some facilities are also affected by the regular requisitioning of medicines and other supplies.

3. Violence attributed to armed groups affecting ambulances

Figure 5. Types of violence affecting ambulances



The majority of medical vehicles affected by incidents were ambulances. The most frequent type of violence affecting ambulances and attributed to armed groups was direct or indirect attacks (31%). In some cases ambulances (16%) were stolen and probably used for purposes other than health-care delivery. Finally, numerous ambulances (17%) were denied or delayed access to the wounded and sick or to health-care facilities, and this can generally be linked to the decision to deny or delay passage to the patients inside.

ANNEX 3: ETHICAL PRINCIPLES OF HEALTH CARE

Ethical Principles of Health Care

In times of armed conflict and other emergencies

Within the framework of the HCiD project, the World Medical Association (WMA), the International Committee of Military Medicine (ICMM), the International Council of Nurses (ICN) and the International Pharmaceutical Federation (FIP) were consulted by the ICRC with the aim of these organizations agreeing on a common denominator of ethical principles of health care applicable in times of armed conflict and other emergencies. The following document, which is the result of these consultations, is without prejudice to existing policy documents adopted by these organizations.

Civilian and military health-care organizations share the common goal of improving the safety of their personnel and other health assets and the delivery of impartial and efficient health care in armed conflicts and other emergencies,

Referring to the principles of humanity, whereby human suffering shall be prevented and alleviated wherever it may be found and impartiality, whereby health care shall be provided with no discrimination.

Bearing in mind the standards of international humanitarian law, in particular the 1949 Geneva Conventions and their 1977 Additional Protocols, and of international human rights law, specifically the Universal Declaration of Human Rights (1948) and the International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights (1966);

Considering the principles of professional ethics adopted by health-care professional associations, including the WMA Regulations in Times of Armed Conflict and Other Situations of Violence.

Endorse the following ethical principles of health care:

GENERAL PRINCIPLES

1. Ethical principles of health care do not change in times of armed conflict and other emergencies and are the same as the ethical principles of health care in times of peace.
2. Health-care personnel shall at all times act in accordance with relevant international and national law, ethical principles of health care and their conscience. In providing the best available care, they shall take into consideration the equitable use of resources.
3. The primary task of health-care personnel is to preserve human physical and mental health and to alleviate suffering. They shall provide the necessary care with humanity, while respecting the dignity of the person concerned, with no discrimination of any kind, whether in times of peace or of armed conflict or other emergencies.
4. Privileges and facilities afforded to health-care personnel in times of armed conflict and other emergencies are never to be used for purposes other than for health-care needs.
5. No matter what arguments may be put forward, health-care personnel never accept acts of torture or any other form of cruel, inhuman or degrading treatment under any circumstances, including armed conflict or other emergencies. They must never be present at and may never take part in such acts.

RELATIONS WITH PATIENTS

6. Health-care personnel act in the best interest of their patients and whenever possible with their explicit consent. If, in performing their professional duties, they have conflicting loyalties, their primary obligation, in terms of their ethical principles, is to their patients.
7. In armed conflict or other emergencies, health-care personnel are required to render immediate attention and requisite care to the best of their ability. No distinction is made between patients, except in respect of decisions based upon clinical need and available resources.

8. Health-care personnel respect patients' right to confidentiality. It is ethical for health-care personnel to disclose confidential information only with the patient's consent or when there is a real and imminent threat of harm to the patient or to others.
9. Health-care personnel make their best efforts to ensure respect for the privacy of the wounded, sick and deceased, including avoiding the use of health care for the wounded and sick, whether civilian or military, for publicity or political purposes.

PROTECTION OF HEALTH-CARE PERSONNEL

10. Health-care personnel, as well as health-care facilities and medical transports, whether military or civilian, must be respected by all. They are protected while performing their duties and the safest possible working environment shall be provided to them.
11. Safe access by health-care personnel to patients, health-care facilities and equipment shall not be unduly impeded, nor shall patients' access to health-care facilities and health-care personnel be unduly impeded.
12. In fulfilling their duties and where they have the legal right, health-care personnel are identified by internationally recognized symbols such as the Red Cross, Red Crescent or Red Crystal as a visible manifestation of their protection under applicable international law.
13. Health-care personnel shall never be punished for executing their duties in compliance with legal and ethical norms.

FINAL

14. By endorsing these ethical principles of health care, the signatory organizations commit themselves to work for the promotion and implementation thereof wherever possible, including by appropriate dissemination amongst their members.

ANNEX 4: RELEVANT EXCERPTS FROM ARMED GROUPS' DOCTRINE

The following are excerpts from armed groups' internal manuals or codes of conduct concerning respect for health care. They represent useful examples that other armed groups may refer to as they draft health-care related obligations for their own doctrine. The excerpts should be considered in conjunction with the relevant IHL obligations, explained in section 6.2 and listed in Annex 6.

Respect for health-care personnel

"Medical personnel must be respected and protected. They must be provided with the assistance they need in order to practice their profession, and they must not be forced to carry out acts that are in conflict with their code of conduct. They must not be prevented from exercising their profession, regardless of who might be the beneficiary."

"Respect and protect medical personnel and objects, including those bearing the red cross/red crescent/red crystal, and other symbols of humanitarian agencies."

"In combat zones, vehicles and facilities that display the red cross symbol must be respected. Our forces are forbidden from using this symbol to deceive the enemy."⁷³

"DO NOT target medical personnel, facilities, transports or equipment. These may be searched if you need to verify they are genuine, but REMEMBER that medical personnel are allowed by law to carry small arms to protect their patients."

Respect for and protection of neutral humanitarian organizations

"Neutral persons or entities and medical personnel, including persons of humanitarian and/or medical organizations like the International Committee of the Red Cross (ICRC), shall be protected and respected. The establishments, facilities, transport and equipment of these persons, entities and organizations; objects bearing the emblem of the red cross and the flag of peaceful intention; and historic monuments, cultural objects and places of worship shall likewise be protected.

The ICRC and other humanitarian and/or medical entities shall be granted facilitation and assistance to enable them to care for the sick and the wounded and to undertake their humanitarian missions and activities."

Respect for health-care facilities

"Health-care structures are never considered military objectives and should be respected. If a military operation endangers the life of a single civilian, it should be aborted."⁷⁴

"In combat zones, vehicles and facilities that display the red cross symbol must be respected. Our forces are forbidden from using this symbol to deceive the enemy."⁷⁵

⁷³ Translated by the ICRC.

⁷⁴ Translated by the ICRC.

⁷⁵ Translated by the ICRC.

Precaution in the planning and conduct of attacks

“Military operations will be carried out selectively on enemy targets, avoiding indiscriminate effects. Efforts will be made to avoid damage to civilian property and facilities, and we will seek to make any repairs.”⁷⁶

“When engaging military objectives, ensure that expected collateral damage does not exceed the expected military advantage. When engaging military objectives, take all feasible precautions to minimize collateral damage.”

Respect for the wounded and sick and for medical vehicles

“It is prohibited to kill or injure an adversary who has surrendered or is *hors de combat*.”

“Give medical treatment to wounded captives.”

“[We] will provide humanitarian treatment to enemies who have surrendered or have been wounded in combat and will respect their dignity and provide them with the aid necessary given their condition.”⁷⁷

“In all cases, the wounded and sick must be protected, regardless of whether they took part in violent action. They must be treated humanely, and must be provided with the medical care required by their state of health to the degree required and as quickly as possible. No distinction must be made between the sick other than through medical criteria.

All steps must be taken without delay to search for the wounded, the sick, and persons who have disappeared, in order to protect them from detention and mistreatment. They must be provided for appropriately.”

“Give immediate medical treatment/first aid to anyone who needs it. There is a duty to search for, collect and aid the injured and wounded from both sides of the battlefield.”

Respect for the protective red cross, red crescent and red crystal emblems

“In combat zones, vehicles and facilities that display the red cross symbol must be respected. You may not use this symbol for our forces in order to deceive the enemy.”

“Medical or distinctive signs – Respect personnel and facilities or persons bearing an object marked with signs as red cross or red crescent, including religious persons, military or civilians carrying white flag used for negotiations, truce or surrender.”

⁷⁶ Translated by the ICRC.

⁷⁷ Translated by the ICRC.

ANNEX 5: PROTECTIVE EMBLEM

The 1949 Geneva Conventions and their Additional Protocols of 1977 and 2005 recognize four emblems: **the red cross, the red crescent, the red lion and sun, and the red crystal.**⁷⁸ The emblems have two distinct uses: **protective and indicative.** Only the protective use is relevant as regards the provision of health care in times of armed conflict.



Protective use of the emblem

The emblem is the visible sign of the specific protection under IHL, especially for certain categories of persons, units and vehicles that are dedicated to medical functions.

Even if they do not make use of one of the emblems, health-care personnel, facilities and vehicles entitled to use them remain specifically protected. The emblems must be respected in all circumstances and must not be used improperly, e.g. as cover to commit hostile acts.⁷⁹ A deliberate attack on a person, on equipment or on a building displaying a protective emblem in accordance with international law is a war crime.⁸⁰ Furthermore, using a protective emblem to trick an adversary into believing that someone or something is protected as medical personnel or a medical object in order to kill, wound or capture that adversary amounts to perfidy.⁸¹ Where such conduct results in killing or injuring an adversary, it is a war crime.⁸²

Medical personnel, facilities and vehicles (including their equipment and supplies) must be duly authorized by a competent authority of a party to the conflict and under the control of that authority in order to use one of the emblems. The following medical personnel and objects are eligible:

Medical personnel, facilities and vehicles belonging to a party to the conflict, including, where Additional Protocol II applies, those of armed groups;⁸³

Civilian medical personnel, facilities and vehicles such as:

- public or private civilian medical personnel and objects;
- medical staff, facilities and vehicles of National Red Cross and Red Crescent Societies; and
- the personnel and objects of local NGOs dedicated to medical care.

In addition to “medical personnel, facilities and vehicles,” **the International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies** may also use the emblem as a protective device.⁸⁴

⁷⁸ Since 1980, no state has used the emblem of the red lion and sun. See The International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies, *Handbook of the International Red Cross and Red Crescent Movement*, Fourteenth Edition, 2008, p. 50.

⁷⁹ AP II, Art. 12; Customary IHL Study, Rules 30, 59.

⁸⁰ Customary IHL Study, Rule 156, pp. 593, 595; ICC Statute, Art. 8(2)(e)(ii).

⁸¹ Customary IHL Study, Rule 65.

⁸² ICC Statute, Art. 8(2)(e)(ix).

⁸³ In situations of NIAC where AP II does not apply, when the medical services of armed groups petition the competent authorities for permission to use the emblem for protective purposes, the ICRC encourages those authorities to grant the necessary authorization provided that the conditions of AP II are otherwise fulfilled (including the stipulation that there be a competent authority that monitors the use of the emblem). See ICRC, *Study on the Use of the Emblems: Operational and Commercial and Other Non-Operational Issues*, Geneva, 2011, pp. 167-169.

⁸⁴ GC I, Art. 39-44; Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, 12 August 1949 (GC II), Art. 22-23, 26-28, 34-37, 39 and 41-44; AP I, Art. 18(1) and (4); AP II, Art. 12; Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem (Protocol III), 8 December 2005 (AP III), Art. 2. For further details on specific conditions with respect to some of the above-mentioned categories, see ICRC, *Study on the Use of the Emblems: Operational and Commercial and Other Non-Operational Issues*, Geneva, 2011.

ANNEX 6: CITED IHL RULES PERTAINING TO THE PROVISION OF HEALTH CARE

Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Geneva, 12 August 1949.

Article 3 – In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions:

(1) Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed ‘hors de combat’ by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.

To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

- (a) violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
- (b) taking of hostages;
- (c) outrages upon personal dignity, in particular humiliating and degrading treatment;
- (d) the passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court, affording all the judicial guarantees which are recognized as indispensable by civilized peoples.

(2) The wounded and sick shall be collected and cared for.

An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict.

The Parties to the conflict should further endeavour to bring into force, by means of special agreements, all or part of the other provisions of the present Convention. The application of the preceding provisions shall not affect the legal status of the Parties to the conflict.

Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), 8 June 1977.

Article 1(1) – This Protocol, which develops and supplements Article 3 common to the Geneva Conventions of 12 August 1949 without modifying its existing conditions of application, shall apply to all armed conflicts which are not covered by Article 1 of the Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I) and which take place in the territory of a High Contracting Party between its armed forces and dissident armed forces or other organized armed groups which, under responsible command, exercise such control over a part of its territory as to enable them to carry out sustained and concerted military operations and to implement this Protocol.

Article 4(2) (g) – Without prejudice to the generality of the foregoing, the following acts against the persons referred to in paragraph 1 are and shall remain prohibited at any time and in any place whatsoever: *g*) pillage;

Article 6(5) – At the end of hostilities, the authorities in power shall endeavour to grant the broadest possible amnesty to persons who have participated in the armed conflict, or those deprived of their liberty for reasons related to the armed conflict, whether they are interned or detained.

Article 7 – 1. All the wounded, sick and shipwrecked, whether or not they have taken part in the armed conflict, shall be respected and protected. 2. In all circumstances they shall be treated humanely and shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones.

Article 8 – Whenever circumstances permit, and particularly after an engagement, all possible measures shall be taken, without delay, to search for and collect the wounded, sick and shipwrecked, to protect them against pillage and ill-treatment, to ensure their adequate care, and to search for the dead, prevent their being despoiled, and decently dispose of them.

Article 9 – 1. Medical and religious personnel shall be respected and protected and shall be granted all available help for the performance of their duties. They shall not be compelled to carry out tasks which are not compatible with their humanitarian mission. 2. In the performance of their duties medical personnel may not be required to give priority to any person except on medical grounds.

Article 10(1) (2) – 1. Under no circumstances shall any person be punished for having carried out medical activities compatible with medical ethics, regardless of the person benefiting therefrom. 2. Persons engaged in medical activities shall neither be compelled to perform acts or to carry out work contrary to, nor be compelled to refrain from acts required by, the rules of medical ethics or other rules designed for the benefit of the wounded and sick, or this Protocol.

Article 11 – 1. Medical units and transports shall be respected and protected at all times and shall not be the object of attack. 2. The protection to which medical units and transports are entitled shall not cease unless they are used to commit hostile acts, outside their humanitarian function. Protection may, however, cease only after a warning has been given setting, whenever appropriate, a reasonable time-limit, and after such warning has remained unheeded.

Article 12 – Under the direction of the competent authority concerned, the distinctive emblem of the red cross, red crescent or red lion and sun on a white ground shall be displayed by medical and religious personnel and medical units, and on medical transports. It shall be respected in all circumstances. It shall not be used improperly.

Article 18 – 1. Relief societies located in the territory of the High Contracting Party, such as Red Cross (Red Crescent, Red Lion and Sun) organizations, may offer their services for the performance of their traditional functions in relation to the victims of the armed conflict. The civilian population may, even on its own initiative, offer to collect and care for the wounded, sick and shipwrecked. 2. If the civilian population is suffering undue hardship owing to a lack of the supplies essential for its survival, such as foodstuffs and medical supplies, relief actions for the civilian population which are of an exclusively humanitarian and impartial nature and which are conducted without any adverse distinction shall be undertaken subject to the consent of the High Contracting Party concerned.

Protocol additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem (Protocol III), 8 December 2005

Article 2 – 1. This Protocol recognizes an additional distinctive emblem in addition to, and for the same purposes as, the distinctive emblems of the Geneva Conventions. The distinctive emblems shall enjoy equal status.

2. This additional distinctive emblem, composed of a red frame in the shape of a square on edge on a white ground, shall conform to the illustration in the Annex to this Protocol. This distinctive emblem is referred to in this Protocol as the “third Protocol emblem”.

3. The conditions for use of and respect for the third Protocol emblem are identical to those for the distinctive emblems established by the Geneva Conventions and, where applicable, the 1977 Additional Protocols.

4. The medical services and religious personnel of armed forces of High Contracting Parties may, without prejudice to their current emblems, make temporary use of any distinctive emblem referred to in paragraph 1 of this Article where this may enhance protection.

Excerpts from *Customary International Humanitarian Law*⁸⁵

Rule 1 – The parties to the conflict must at all times distinguish between civilians and combatants. Attacks may only be directed against combatants. Attacks must not be directed against civilians.

Rule 2 – Acts or threats of violence the primary purpose of which is to spread terror among the civilian population are prohibited.

Rule 3 – All members of the armed forces of a party to the conflict are combatants, except medical and religious personnel.

Rule 4 – The armed forces of a party to the conflict consist of all organised armed forces, groups and units which are under a command responsible to that party for the conduct of its subordinates.

Rule 5 – Civilians are persons who are not members of the armed forces. The civilian population comprises all persons who are civilians.

Rule 6 – Civilians are protected against attack unless and for such time as they take a direct part in hostilities.

Rule 7 – The parties to the conflict must at all times distinguish between civilian objects and military objectives. Attacks may only be directed against military objectives. Attacks must not be directed against civilian objects.

Rule 8 – In so far as objects are concerned, military objectives are limited to those objects which by their nature, location, purpose or use make an effective contribution to military action and whose partial or total destruction, capture or neutralisation, in the circumstances ruling at the time, offers a definite military advantage.

Rule 9 – Civilian objects are all objects that are not military objectives.

Rule 10 – Civilian objects are protected against attack, unless and for such time as they are military objectives.

Rule 11 – Indiscriminate attacks are prohibited.

Rule 12 – Indiscriminate attacks are those:

(a) which are not directed at a specific military objective;

(b) which employ a method or means of combat which cannot be directed at a specific military objective;
or

(c) which employ a method or means of combat the effects of which cannot be limited as required by international humanitarian law;

and consequently, in each such case, are of a nature to strike military objectives and civilians or civilian objects without distinction.

Rule 13 – Attacks by bombardment by any method or means which treats as a single military objective a number of clearly separated and distinct military objectives located in a city, town, village or other area containing a similar concentration of civilians or civilian objects are prohibited.

Rule 14 – Launching an attack which may be expected to cause incidental loss of civilian life, injury to civilians, damage to civilian objects, or a combination thereof, which would be excessive in relation to the concrete and direct military advantage anticipated, is prohibited.

⁸⁵ Henckaerts and Doswald-Beck.

Rule 15 – In the conduct of military operations, constant care must be taken to spare the civilian population, civilians and civilian objects. All feasible precautions must be taken to avoid, and in any event to minimise, incidental loss of civilian life, injury to civilians and damage to civilian objects.

Rule 16 – Each party to the conflict must do everything feasible to verify that targets are military objectives.

Rule 17 – Each party to the conflict must take all feasible precautions in the choice of means and methods of warfare with a view to avoiding, and in any event to minimising, incidental loss of civilian life, injury to civilians and damage to civilian objects.

Rule 18 – Each party to the conflict must do everything feasible to assess whether the attack may be expected to cause incidental loss of civilian life, injury to civilians, damage to civilian objects, or a combination thereof, which would be excessive in relation to the concrete and direct military advantage anticipated.

Rule 19 – Each party to the conflict must do everything feasible to cancel or suspend an attack if it becomes apparent that the target is not a military objective or that the attack may be expected to cause incidental loss of civilian life, injury to civilians, damage to civilian objects, or a combination thereof, which would be excessive in relation to the concrete and direct military advantage anticipated.

Rule 20 – Each party to the conflict must give effective advance warning of attacks which may affect the civilian population, unless circumstances do not permit.

Rule 21 – When a choice is possible between several military objectives for obtaining a similar military advantage, the objective to be selected must be that the attack on which may be expected to cause the least danger to civilian lives and to civilian objects.

Rule 22 - The parties to the conflict must take all feasible precautions to protect the civilian population and civilian objects under their control against the effects of attacks.

Rule 23 – Each party to the conflict must, to the extent feasible, avoid locating military objectives within or near densely populated areas.

Rule 25 – Medical personnel exclusively assigned to medical duties must be respected and protected in all circumstances. They lose their protection if they commit, outside their humanitarian function, acts harmful to the enemy.

Rule 26 - Punishing a person for performing medical duties compatible with medical ethics or compelling a person engaged in medical activities to perform acts contrary to medical ethics is prohibited.

Rule 28 – Medical units exclusively assigned to medical purposes must be respected and protected in all circumstances. They lose their protection if they are being used, outside their humanitarian function, to commit acts harmful to the enemy.

Rule 29 – Medical transports assigned exclusively to medical transportation must be respected and protected in all circumstances. They lose their protection if they are being used, outside their humanitarian function, to commit acts harmful to the enemy.

Rule 30 – Attacks directed against medical and religious personnel and objects displaying the distinctive emblems of the Geneva Conventions in conformity with international law are prohibited.

Rule 52 – Pillage is prohibited.

Rule 55 – The parties to the conflict must allow and facilitate rapid and unimpeded passage of humanitarian relief for civilians in need, which is impartial in character and conducted without any adverse distinction, subject to their right of control.

Rule 59 – The improper use of the distinctive emblems of the Geneva Conventions is prohibited.

Rule 65 – Killing, injuring or capturing an adversary by resort to perfidy is prohibited.

Rule 109 – Whenever circumstances permit, and particularly after an engagement, each party to the conflict must, without delay, take all possible measures to search for, collect and evacuate the wounded, sick and shipwrecked without adverse distinction.

Rule 110 – The wounded, sick and shipwrecked must receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. No distinction may be made among them founded on any grounds other than medical ones.

Rule 111 – Each party to the conflict must take all possible measures to protect the wounded, sick and shipwrecked against ill-treatment and against pillage of their personal property.

Rule 156 – Serious violations of international humanitarian law constitute war crimes.

Rome Statute of the International Criminal Court

Art 8 (2) c – For the purpose of this Statute, ‘war crimes’ means:

(c) In the case of an armed conflict not of an international character, serious violations of article 3 common to the four Geneva Conventions of 12 August 1949, namely, any of the following acts committed against persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention or any other cause:

- (i) Violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
- (ii) Committing outrages upon personal dignity, in particular humiliating and degrading treatment;
- (iii) Taking of hostages;
- (iv) The passing of sentences and the carrying out of executions without previous judgement pronounced by a regularly constituted court, affording all judicial guarantees which are generally recognized as indispensable.

Article 8 (2) e (ii) (v)(ix) – For the purpose of this Statute, ‘war crimes’ means:

(e) Other serious violations of the laws and customs applicable in armed conflicts not of an international character, within the established framework of international law, namely, any of the following acts:

- (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;
- (v) Pillaging a town or place, even when taken by assault;
- (ix) Killing or wounding treacherously a combatant adversary.

ANNEX 7: HEALTH CARE IN DANGER PROJECT REFERENCES

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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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