

PROTECTING HEALTH CARE

GUIDANCE FOR THE ARMED FORCES

HEALTH CARE
DANGER & DEATH

IT'S A
MATTER
OF LIFE
& DEATH



ICRC

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FOREWORD

Protecting health-care workers, facilities and vehicles lies at the heart of international humanitarian law (IHL) and is central to its origins. Despite sustained collective efforts, medical personnel and assets continue to face violence and attacks. Health Care in Danger (HCiD), an initiative led by the International Committee of the Red Cross (ICRC), aims to address this very issue by engaging widely with weapon bearers, policymakers, health-care workers and the general public.

United Nations Security Council Resolution 2286 (2016) was adopted in the wake of repeated attacks against health-care personnel and facilities. It calls on states to “develop effective measures to prevent and address acts of violence, attacks and threats against medical personnel ... their means of transport and equipment, as well as hospitals and other medical facilities in armed conflict ... and to share challenges and good practice”.

This guidance document is the result of focused engagement with armed forces and military experts, which was carried out as part of a HCiD study, supported by the Government of Sweden, on the protection of health care by state armed forces. It sets out concrete, practical ways that armed forces can better protect medical workers and equipment, and safeguard access to care, in armed conflict – provided they are willing to carry out the meticulous work of reviewing their doctrine and practice.

We encourage all weapon bearers to incorporate this guidance into their military operations in order to keep health-care personnel and facilities safe from harm.

Maciej Polkowski

Head of the Health Care in Danger Initiative

ACKNOWLEDGEMENTS

The ICRC would like to express its gratitude to the Government of Sweden for its generous support for a 2018–2020 study on the protection of health care by state armed forces. We also wish to thank the Swedish Red Cross, which was heavily involved in conceptualizing the research. This guidance document is based on the outcomes of the study.

The study's lead researcher was Jan Ninck Blok, HClD military researcher. The researcher is grateful to all ICRC delegations and members of the Unit for Relations with Arms Carriers who were involved in the research, and to the more than 15 armed forces and international organizations with a military component that took part. Military experts in operations, targeting, training, personnel, civil-military coordination, and medical and legal affairs provided important insights into current doctrine and practice as it applies to the protection of health care. Government and non-governmental experts further contributed to the study, and a number of specialists reviewed drafts of this guidance document and provided valuable feedback. The author wishes to express his appreciation to all the experts, whose names will not be disclosed here for confidentiality reasons.

Lastly, existing secondary literature on the protection of health care in armed conflict was fundamental in understanding the issues at stake. The author is grateful to all authors, within and outside the ICRC, whose work has paved the way.

INTRODUCTION

Health-care workers, vehicles and facilities come under frequent attack during armed conflict and other emergencies. An analysis of protection activities from 16 ICRC operations between 2015 and 2017 reveals a total of 1,261 violent incidents against medical personnel. The top five categories of attack were as follows: destruction and damage of a medical facility or vehicle, forced interference in a health-care facility (including armed entry), threats against health-care workers, denial of access to the wounded and sick, and obstruction of or interference with a medical vehicle. Incidents like these disrupt access to health-care services and bring curative and preventive health-care programmes to a halt, reversing decades of public-health development work.

In 2013, the ICRC held a round table in Sydney, Australia, on military doctrine and practice as it relates to the protection of health-care personnel and facilities in armed conflict and other emergencies, after consulting with more than 30 state armed forces and international organizations with a military component. The consultation exercise and associated publication¹ provides a clear conceptual framework for engaging with armed actors on this issue.

Between late 2018 and mid-2020, the ICRC carried out a follow-up study on the same subject with the support of the Government of Sweden. We sought input from more than 15 state armed forces and international organizations with a military component on their current doctrine and practice, as well as studying open-source literature and archives relating to a further 20 state armed forces. The exercise covered all regions of the world and different types of military organization. Through our research, we identified a series of practical measures that state armed forces can take to keep medical personnel and equipment safe from harm while carrying out military operations.

This guidance document combines the recommendations of the Sydney round table with the outcomes of the more recent study.

¹ ICRC, *Promoting Military Operational Practice that Ensures Safe Access to and Delivery of Health Care*, ICRC, Geneva, 2014.

AIM OF THIS GUIDE

This document provides practical guidance on the measures armed forces can take to protect health-care workers and to limit the impact of armed conflict on access to, and delivery of, health-care services. It touches on matters relating to training, planning, operational readiness and the conduct of both domestic and extraterritorial military operations.

In compiling this guidance, the ICRC recognizes that armed forces and other weapon bearers may not always have the opportunity or capacity to implement some of these measures. Similarly, this document is not exhaustive. Other measures not covered here may be relevant in the context of a specific military operation.

This guidance document is therefore intended to help armed forces think about ways to build the protection of health-care workers, vehicles and facilities into the planning and conduct of operations. Commanders and military staff are not expected to follow the recommendations to letter, but rather to use them as guidelines for developing context-specific measures.

Aside from this English version, the guidance is also available in Arabic, French, Russian and Spanish.

FOCUS AREAS

The measures in this guidance document are arranged into nine focus areas, each appearing as a separate section under [Key terms](#) (see page 14).

Focus areas concern situations or capabilities in which the armed forces can make a significant contribution protecting health-care workers and facilities. The nine focus areas are as follows:

- Generic measures
- Armed forces medical services
- Civil-military cooperation
- Rules of engagement
- Precautions
- Targeting process (as part of precautions)²
- CASEVAC and MEDEVAC
- Checkpoints
- Military operations in medical facilities

² The targeting process is integrated in the focus area on precautions during attack, since the suggested basic measures follow the same framework. More specific measures for the targeting process are, however, included in this section.

OPERATIONAL DOMAINS

For ease of reference, the measures are indexed based on ten operational domains. These domains are derived from the generic staff system,³ variations of which are commonly used by armed forces around the world. Commanders and military staff can identify relevant practical measures in each focus area by using the index system to search for specific measures that are applicable to their own functional capacity within their military organization.

The operational domains below describe a generic functional part of the organization of armed forces. The definitions are deliberately broad so as to account for differences between systems and the overlapping of some functions. The domains are not hierarchical.



Personnel

The broad process of human resources and related administrative duties. This may include personnel identification, recruitment management, tracking of education and training, and ranking and assignment of all members of the armed forces.



Intelligence and security

The collection and analysis of information about opposing and other forces, movements or the battlefield environment, including civilian presence/harm and potential collateral damage estimations. This function may also include force security.



Operations

Operations consist of the staff who implement, oversee and adapt plans to achieve military objectives. They deal with the immediate to short-term context of operations. Operations staff will include experts from all other operational domains.



Logistics

The logistical processes that may be part of the military forces, such as procurement, supply chain, maintenance of materials and movement of troops. Here, the focus is on medical support, which is frequently an integral part of logistics.

3 Beyond the nine standard functions, accountability has been added to flag practical measures linked to officers working in procedure, policy and legal affairs.



Plans

Strategies are developed and regularly revised at the national level. At the operational and tactical levels, plans are devised to achieve discrete military objectives to meet strategic objectives. Plans staff will lead elements from other operational domains in creating specific plans.



Signals

Military operations require an effective communication capability and information environment. This will consist of a (joint) protocol and a digital and technological capacity. Cyber security and defence may be part of this too.



Education and training

Military education equips personnel with the required knowledge of relevant aspects of their branch or file. Training, exercises and assessments form part of the career-long integrated curriculum in addition to mission-specific training.



Resource management

Resources may need to be developed, maintained and evaluated to support and maintain the armed forces' capabilities. This could entail assessment of military structures, programmes, techniques or material.



Civil-military coordination

In military operations, it is often necessary to establish and maintain relations with the civilian population and/or humanitarian organizations in order to coordinate, compliment and exchange functions. Engagement with the civil authorities and civilian health-care providers may be part of this.













Accountability

It is important that armed forces have in place a fully integrated legal framework and a transparent system to provide legal guidance, carry out oversight and allocate responsibility, as well as to address disciplinary measures and sanctions.

INDEX

Users can navigate the practical measures by selecting the focus area in the left column and the operational domain in the top row. For context, refer to the opening paragraph of each section and subsection in the relevant focus area.

OPERATIONAL DOMAIN		Pers. 	Intelligence 	Operations 	Logistics 	Plans 	Signals 	Education 	Resource 	Civil-military 	Accountability 
FOCUS AREA											
GENERIC MEASURES	1	-	a-g, l	-	-	a-i	-	j	-	a-c, e, i	h
	2	-	b	-	b, c, e-g	a, b	f	h	-	a-h	c, d, g
	3	-	-	g, i, m	j	c-e, h, k, m	c, d	g, l	-	a, c-f, i, j, l	a-m
	4	-	-	-	a-e	a-e	-	e	-	-	a-e
ARMED FORCES MEDICAL SERVICES	1	l	a-k	g-l	a-l	a-c, e, f, j-l	-	-	-	b-k	-
	2	-	b	e-h	a-i	c	e	-	-	a-d, f-i	c, f, i
	3	c	a, g, i	i	a-m	a-i, k-m	-	-	c, d, k-m	a, f, g, i, j, l, m	b, e-g, i, j, m
	4	-	-	d, e	a-e	a-c	-	-	-	a-e	-
	5	g	-	-	a-h	a-e, g	-	b, e, g, h	g	a-e, g	a, c, d, h
CIVIL-MILITARY COOPERATION	1	-	a-d	a-d, f, g	a-f	e-g	-	-	-	a-g	e
	2	-	a	a-c, e, f, h-j, l	a-c, e-l	a-g, j	-	m	-	a-m	e
	3	d	p	k	a-e, g-k, m, n, p, q, r	a, e-r	-	b, c	d	a-r	a, e, j, q, r
	4	-	-	-	a-c	a, b	-	c	-	a-c	a, b
RULES OF ENGAGEMENT	1	-	-	B	a	a-c	-	c	-	-	a, b
	2	-	-	-	a, b, k	a-l	-	-	-	k	a-l
	3	-	-	-	a-c, f	a-f	-	-	-	-	a, b, d-f
PRECAUTIONS DURING ATTACK	1	-	a	-	a, c	a-g	-	-	-	g	a-f
	2	-	a-d	a	a	a-c	-	-	-	a, c, d	-
	3	-	-	c	a, b	a-c	-	-	-	a-c	c
	4	-	b, d-g, j	g-l	e, h, k, l	a-c, f-h, k, m	i	m	-	e, g-k	a-e, g
	5	-	e, g, h, k, l, n	f, h-o	f-l, m, o	a-i, p	j	p	-	f, h-j, l	a-d, f, h, k, n
TARGETING	6	-	a, b, d-h, k, l, n	a-n	A	d, f, k-o	J	m	-	a, c, j, l	f, o
MEDEVAC AND CASEVAC	1	-	a-d	a-d	a-d	a-c	-	-	-	a-d	-
	2	-	a	a-k	a-k	a, e-k	c	k	-	b-k	f, h
	3	d	-	b, c, e-i	a-h	a-i	-	-	d	e, f	a, i
	4	d	-	e, f	a-h	a-h	-	c, g, h	d	a, b	a, b, c
CHECKPOINTS	1	-	a-d	a-d	-	a-d	-	-	-	a-d	-
	2	-	-	a-i	a-c, e, f, i	a-c, g-i	d, g, h	-	-	a-i	e, f
	3	h	-	a-k	-	e-f, h-k	e, f	i-k	H	g	-
	4	-	-	b-e	-	a-d	-	-	-	b, d, e	a
MILITARY OPERATIONS IN MEDICAL FACILITIES	1	-	c	c, d	a	a-d	-	-	-	a-c	a
	2	-	-	a, b, e, f	c-e	a, c-e	-	f	-	a-f	b
	3	m	-	l	a, c-n	a-m	-	f, n	m	e, i, j, m	a, c-e, g-j
	4	-	-	e, g	-	a-h	-	h	-	h	b-f

KEY TERMS⁴

Health care encompasses activities that aim to preserve or restore health through the prevention, diagnosis, treatment, cure, recovery and/or rehabilitation of any physical and/or mental health condition.⁵ **Health care** might also refer to the organized system through which these activities are carried out. **Health-care service** refers to the provision of care within different levels and scopes (such as a pre-hospital health-care service, a primary health-care service or a rehabilitation service), while a **health-care provider** is the agent responsible for that activity – a medical or a non-medical agent, which can be either an individual or a group.

Medical ethics⁶ 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:

- providing health care impartially
- maintaining confidentiality
- respecting the patient's dignity
- acting in the patient's best interest
- doing no harm to patients
- treating individuals and groups without discrimination.⁷

Medical facilities include hospitals, laboratories, clinics, first-aid posts, blood transfusion centres, forensic medical facilities, and the medical and pharmaceutical stores of these facilities.

Medical personnel include doctors, nurses, paramedic staff, first-aiders, forensic medical staff and support staff assigned to medical functions. The term also encompasses the administrative staff of health-care facilities and ambulance personnel.

⁴ Where a definition goes beyond what is stated in a specific treaty, it should not be interpreted as extending that definition in law. Nothing in this document extends any definitions or obligations in IHL or in any other body of law. A legal framework is included for reference in [Annex 1: Legal framework](#).

⁵ The Constitution of the World Health Organization, which was adopted by the International Health Conference, New York, 1946 and which entered into force in 1948, defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

⁶ Adapted from: World Medical Association (WMA), *WMA Medical Ethics Manual*, 2005, pp. 6–9.

⁷ A set of ethical principles of health care was developed as part of the HCiD initiative. It is reproduced in [Annex 2: Ethical principles of health care](#).

Medical vehicles include ambulances, medical ships and aircraft, whether military or civilian, and any other vehicles transporting medical supplies or equipment.

An **ambulance**, for the purposes of this publication, is a locally available means of transport that carries, as safely and comfortably as possible, wounded and sick people to a place where they can receive the emergency medical and/or surgical care they need. It is also where the condition of these patients is stabilized. Ambulances may transport patients from the site of an emergency to a medical facility or between two medical facilities.

The **wounded and sick** include all people, whether military or civilian, who are in need of medical assistance and who refrain from any act of hostility. The term includes pregnant women, newborn babies and the infirm.

PRACTICAL MEASURES

Each focus area contains lists of practical measures. Each measure is marked with pictograms of the [Operational domains](#) to which the measure may be of relevance. This is cross-referenced with the Index. Note that a measure does not apply exclusively to the indicated operational domain(s), but there is a clear link between the measure in question and the role that the domain may play in its application. Measures could be applicable to other operational domains, depending on context and operational relevance.




For all measures relating to interactions and coordination with medical personnel, it is important to recall that medical personnel have a duty to respect human life, to act in the patient's best interest and to use health-care resources in a way that best benefits patients and their community. Medical confidentiality must be respected, and medical personnel should never be forced to disclose sensitive information.








I. GENERIC MEASURES



The practical measures in this section apply across a broad range of operations and situational contexts. They are the starting point for most plans and should inform thinking on situations not covered elsewhere. These measures are based on the basic considerations for the protection of health-care services, providers, and the wounded and sick, and should be implemented whenever feasible and operationally relevant:

1. ENHANCING UNDERSTANDING OF THE OPERATIONAL ENVIRONMENT IN ORDER TO MINIMIZE THE IMPACT OF MILITARY OPERATIONS ON THE CIVILIAN HEALTH-CARE SYSTEM IN THE AREA OF OPERATIONS

The operational environment should be assessed both prior to, and at regular intervals during operations. Doing so will help to ensure that measures intended to minimize the impact on health care can be adapted to the specific context, and to limit the humanitarian consequences of operations.




-    a. Identify, map and regularly update the locations of medical facilities and assess their relevance and capacity for the delivery of health-care services both within the area of operations and in its immediate vicinity (map and assess facilities by type: hospital, clinic, primary health-care centre, first-aid post, etc.).






-  b. Identify and regularly update the different types of health-care provider (formal or informal) and their vehicles operating within and outside the area of operations (ambulances, unmarked civilian vehicles, etc.).
-  c. Identify and regularly update the officially endorsed and/or recognized vehicle identification systems (type of vehicle, markings, electronic tracking, etc.), visual and non-visual facility identification markings and symbols (by day and night) including identification from the air, and personnel identification arrangements (IDs, uniforms, etc.).
-  d. Develop and continuously update the list of non-strike and sensitive areas by identifying the location of all medical facilities and the essential services on which they depend.
-  e. Identify and regularly update the existence of a coordination platform, if any, for emergency services, and assess its functioning.
-  f. Assess the potential indirect impacts on health-care delivery of military operations on military objectives, such as the disruption of essential utilities and access for patients and their families (breakdown of electricity and water supply, obstruction of emergency services and supply routes, etc.).
-  g. Measure the proximity of medical facilities to military objectives (both one's own and those of the opposing forces) and assess potential direct damage on the basis of the available ordnance.
-  h. Provide guidance (in standard operating procedures (SOPs), operational orders and/or other relevant documentation) on the criteria under which a medical facility would lose its protected status, as well as criteria for on-site verification of the loss of protection.

-  i. Provide and update all hazards to the safety of medical personnel due to military actions, including explosive remnants of war (scatterable mines and mined areas, and damage to areas with dangerous forces such as industrial chemicals).
-  j. Provide continuing education and training to all staff on the legal framework as it relates to personnel and facilities involved in providing medical care.

2. COORDINATING WITH HEALTH-CARE PROVIDERS AND RELEVANT AUTHORITIES IN ORDER TO MINIMIZE THE IMPACT OF MILITARY OPERATIONS ON HEALTH-CARE SERVICES IN THE AREA OF OPERATIONS



Prior to operations, armed forces should coordinate with health-care providers, relevant nongovernmental organizations (NGOs), the ICRC and other organizations providing health-care assistance within and outside the area of operations. Coordination should then be maintained throughout operations in order to increase mutual understanding and cooperation.

-  a. Participate in an existing coordination platform, if any. If this is not possible, or if no such platform exists, consider creating one.
-  b. Establish contact with health-care authorities and providers in order to:
- fully understand the role that an individual facility plays in the wider health-care system, as well as what, if any, back-up medical infrastructure exists
 - gain a thorough understanding of functioning resupply routes (for medicines, water, electricity, food, etc.) and their back-up systems
 - identify available alternative resupply routes (for medicines, water, electricity, food, etc.), using medical intelligence.
-  c. Agree on coordination measures and procedures with health-care providers and relevant authorities (as a minimum) and, if possible, with opposing forces.

























-  d. Keep health-care providers informed about what could lead to or constitute a loss of protected status.
-  e. Appoint a liaison officer to regularly update health-care providers.
-  f. Assign a dedicated radio frequency or other channel of communication between medical personnel and the military. If possible, do the same with opposing forces.
-  g. In addition to legal advisers, involve military medical personnel (and, where relevant, cultural and gender advisers) in the coordination process.
-  h. Appoint a staff position in charge of reviewing and updating lessons learned from coordination between the military and health-care providers and from incidents arising due to a lack of coordination.

3. ENABLING CIVILIAN MEDICAL PERSONNEL TO PERFORM THEIR DUTIES AND MINIMIZING DISRUPTION TO PUBLIC HEALTH-CARE SERVICE PROVISION⁸

These measures are intended to guide the planning and conduct of military operations while minimizing disruption to health-care service provision and supporting the delivery of, and safe access to, health care in the area of operations.

-  a. Identify and agree on the means of identification used by medical personnel (ID cards, uniforms, etc.).
-  b. Identify and agree on the means of identification of vehicles used by medical personnel: display, markings (emblems, plate numbers, etc.), other visual means (blue light, other lights, symbols, flags, etc.), or any other means of identification (siren, etc.).

⁸ For operational measures applicable to military medical personnel, see [Armed forces medical services](#). For specific measures applicable to medical facilities, see [Military operations in medical facilities](#).

-    c. Establish clear procedures for notifying the military of medical personnel and vehicles (plate numbers, ID cards, dates, routes, etc.) involved in planned transports.
-    d. Establish clear procedures for notifying the military of medical personnel and vehicles involved in emergency transports.
-    e. Agree with health-care providers on a regular schedule for routine medical vehicle movements (e.g. for patients requiring dialysis).
-   f. Set rules on exceptions for medical evacuations in the event of a curfew.
-    g. Train military personnel that identifying medical vehicles, facilities and personnel and notifying movements and emergency transports is not always feasible, and that this does not affect the protected status of health-care workers and vehicles.
-   h. Set rules (in SOPs, operational orders and/or other relevant documentation) on the level of authority by which, and the exceptional circumstances in which, movement of medical personnel and vehicles in an area of operations may be restricted.
-    i. Ensure that formal health-care providers are informed of routing affected by military operations.
-    j. Agree on appropriate interaction or conduct between medical and military personnel on the ground, both in general terms and during and following incidents with military and/or civilian casualties.
-   k. Allow patients and their families unrestricted and timely travel to medical facilities for treatment and, where feasible, assist in this process.



- l. Establish and continuously update a reporting system to track incidents involving the military and health-care providers or their vehicles and to learn lessons.



- m. Adopt the necessary measures, under military criminal law and disciplinary rules, to ensure that commanding personnel do not unnecessarily or deliberately make decisions or issue orders, in their area of responsibility, that have the effect of delaying or denying the delivery of, or limiting or restricting access to, health care.

4. SETTING RULES ON THE CONDUCT OF MILITARY PERSONNEL IN MILITARY OPERATIONS IN ORDER TO MINIMIZE THE IMPACT ON HEALTH-CARE SERVICES

Measures to regulate the conduct of military personnel should be decided in advance and included in training prior to operations. These measures should then be implemented consistently in theatre, in order to limit the potential humanitarian consequences of military operations.



- a. Prior to operations or deployment, design SOPs, operational orders and/or other relevant documentation in a way that minimizes disruption to health-care service provision according to the specific operation and context.



- b. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on how military medical personnel should interact with non-military health-care workers and the wounded and sick.



- c. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on the nature and scope of questions that may be asked of medical personnel and patients.



- d. Set out (in SOPs, operational orders and/or other relevant documentation) the ethical and legal responsibilities of medical personnel vis-à-vis patients, and make clear the legal obligation to allow patients to receive medical treatment without undue interference.



- e. Train military personnel, during pre-deployment and in theatre, on the rights and responsibilities of medical personnel working in armed conflict. Ensure they are familiar with the SOPs, operational orders and/or other relevant documentation designed to minimize disruption to health-care provision.

II. ARMED FORCES MEDICAL SERVICES

Military medical personnel provide health-care support to the armed forces. In line with medical principles and IHL, and in considering the humanitarian consequences of military operations, they may be required to support the delivery of civilian or opposing forces' health-care services, or to provide health-care services where such services are absent or lack capacity. Similarly, civilian health-care providers may provide services to the armed forces during operations when required. This section sets out measures that armed forces medical services can take to provide support in the area of operations. These should be implemented whenever feasible and operationally relevant:

1. ENHANCING UNDERSTANDING OF THE OPERATIONAL ENVIRONMENT IN ORDER TO ENABLE THE PROVISION OF ESSENTIAL HEALTH-CARE SERVICES TO BOTH COMBATANTS AND NON-COMBATANTS































The operational environment should be assessed throughout the planning and conduct of operations so that measures intended to minimize the impact on health-care services can be adapted, and that the humanitarian consequences of operations can be limited.




- a. Prepare a profile of the area of operations (demographics, local culture, languages, customs, climate, etc.) prior to operations or deployment. Include available country-specific information and data (from national authorities, WHO and/or other public health institutions), as well as medical intelligence when feasible, as relevant to the planned operation and context.



- b. Identify, map and regularly update the locations of medical facilities. Assess their importance and capacity for the delivery of health-care services, and the quality of care they provide, both within the area of operations and in its immediate vicinity (map and assess facilities by type: hospital, clinic, primary health-care centre, first-aid post, etc.).


-    c. Assess the availability of medical personnel and the quality of care they provide. Assess the medical supply chain and stocks, and review the presence and activities of, and coordination between, national and international health-care providers in the area of operations.
-    d. Consider the likelihood that refugees and/or internally displaced people potentially requiring health-care services may be present in the area of operations and in its immediate vicinity.
-     e. Assess the capacity of existing health-care services to provide medical care to civilian casualties, estimating casualty numbers based on planned military operations.
-     f. Assess the capacity of existing health-care services to provide, or assist in the provision of, medical care to military casualties, estimating casualty numbers based on planned military operations.
-     g. Identify and regularly update the different types of health-care provider (formal or informal) and their vehicles operating within and outside the area of operations (ambulances, unmarked civilian vehicles, etc.).
-     h. Identify the officially endorsed and/or recognized vehicle identification systems (type of vehicle, markings, electronic tracking, etc.) and personnel identification arrangements (IDs, uniforms, etc.).
-     i. Identify and regularly update the existence of a coordination platform, if any, for emergency services, and assess its functioning.
-     j. Consider the health risks for the civilian population in the area of operations because of the deployment of forces, including the presence of opposing forces.


-  k. Consider the likelihood of outbreaks of high-risk diseases and/or epidemics.


-  l. Prior to the operation or deployment, design medical capabilities based on the above assessments, and adjust the capabilities during the operation or deployment in line with medical field reporting and battlefield intelligence, as required.



















2. COORDINATING WITH HEALTH-CARE WORKERS AND RELEVANT AUTHORITIES TO ENABLE THE PROVISION OF ESSENTIAL HEALTH-CARE SERVICES TO BOTH COMBATANTS AND NON-COMBATANTS

Prior to operations, armed forces should coordinate with health-care providers, relevant NGOs and other organizations providing health-care assistance within and outside the area of operations. Coordination should be maintained throughout operations in order to increase mutual understanding and cooperation.

-  a. Participate in an existing emergency coordination platform, if any. If this is not possible, or if no such platform exists, consider creating one.


-  b. Establish contact with health-care authorities and providers in order to:
- fully understand the role that an individual facility plays in the wider health-care system, as well as what, if any, back-up medical infrastructure exists
 - gain a thorough understanding of functioning resupply routes (for medicines, water, electricity, food, etc.) and their back-up systems
 - identify available alternative resupply routes (for medicines, water, electricity, food, etc.).


-  c. Agree on coordination measures and procedures with health-care providers and relevant authorities on the health-care services, including the provision of supplies, available to the civilian population (as a minimum) and, if possible, with opposing forces.


-   d. Appoint a movement control liaison officer to regularly update military medical personnel involved in medical transport on aerial, sea and ground conditions. Share these updates with civilian health-care providers.
-    e. Assign a dedicated radio frequency or other channel of communication between medical personnel and the military (to communicate about routing of medical vehicles, military movements, etc.). If possible, do the same with opposing forces.
-     f. Agree on appropriate interaction or conduct between civilian and military medical personnel. Address concerns civilian medical personnel might have with regard to perceptions of partiality when engaging with military personnel. Ensure medical personnel are able to carry out their duties with neutrality.
-    g. Define the requirements that apply to military medical personnel in terms of notifying and liaising/consulting with civilian health-care providers and local authorities.
-    h. Share and gather information on the incidence of infectious diseases and other potential health-related hazards in populated areas, at medical facilities and among at-risk or marginalized communities within the area of operations.
-    i. Appoint a staff position in charge of reviewing and updating lessons learned from coordination between the military and health-care providers and from incidents arising due to a lack of coordination.


3. CONTRIBUTING TO THE PROVISION OF CIVILIAN HEALTH-CARE SERVICES AND ASSISTING CIVILIAN PATIENTS IN THE AREA OF OPERATIONS


Military medical personnel have a duty to provide the best available care and to alleviate the suffering of the wounded and sick without distinction.⁹ Given the potential humanitarian consequences of military operations, armed forces medical services may need to assist in providing services to the civilian population, without disrupting the provision of civilian health-care services.

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a. Prior to operations or deployment, provide military medical personnel with a profile of the area of operations (demographics, local culture, languages, customs, climate, etc.), based on available country-specific information and data (from national authorities, WHO and/or other public health institutions) as well as medical intelligence.
- 

b. Prior to operations or deployment, determine (in SOPs, operational orders and/or other relevant documentation) the level and capacity of medical care that may be provided to the civilian population.
- 







c. Deploy sufficient military medical personnel, equipment and vehicles to provide medical care to military and civilian casualties, including opposing forces, based on the public-health profile of the area of operations and on estimated military and civilian casualties.
- 

d. Consider deploying additional field clinics to provide treatment specifically to the civilian population, keeping these separate from the primary force locations. Also consider deploying field clinics immediately outside of the area of operations, particularly when civilians are displaced.
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e. Ensure that the level and capacity of medical care provided to the civilian population is the same across the area of operations, in order to maintain impartiality in health-care

⁹ See [Annex 2: Ethical principles of health care](#).

delivery. Take into account social, cultural and gender issues as reflected in local civilian health-care facilities and services. Maintaining the same level and capacity of medical care across the area of operations is particularly important in a coalition when health-care services are provided by various partners.

-  f. Consider preventive health-care and sanitation programmes for the civilian population to avert disease outbreaks. Such programmes should take into account social, cultural and gender issues as reflected in local civilian health-care facilities and services.
-  g. Consider setting up separate bays in primary assessment areas on a military base for own forces, opposing forces and civilians, if security concerns exist.
-  h. Prior to operations or deployment, identify means of transport and routing (air/road, civilian/military) between point of injury and medical facilities, and between facilities (civilian and military), so that civilian and military patients can be evacuated. Consider options of dedicated and non-dedicated means of transport. When identifying means of transport, take into account social, cultural and gender issues as reflected in local civilian health-care facilities and services.¹⁰
-  i. Consider documentation and route-planning requirements for border crossings and checkpoints.
-  j. Set out (in SOPs, operational orders and/or other relevant documentation) the reporting requirements that apply to the medical officer in charge as regards civilian patients in the care of military medical personnel.
-  k. Ensure that military medical personnel have sufficient personal protective equipment to deal with infectious disease outbreaks and other potential health-related hazards.

¹⁰ See [CASEVAC](#) and [MEDEVAC](#).



- l. Plan an exit strategy to ensure that the civilian population continues to receive appropriate health-care services following the planned withdrawal of armed forces medical services from the area of operations.



- m. Consider donating medical equipment and materials to civilian health-care providers when withdrawing from the area of operations. Before doing so, give due consideration to issues such as the lifespan of the equipment, training requirements, the supply of consumables, and waste management.

4. SEEKING ADVICE FROM MILITARY MEDICAL PERSONNEL IN THE PLANNING AND EXECUTION OF ATTACKS AGAINST MILITARY OBJECTIVES

Military medical personnel should be called on to advise on ways of reducing negative impacts on the provision of civilian health-care services in the planning, decision-making and conduct of military operations.




- a. Ask military medical personnel to assess how planned attacks on military objectives could indirectly affect the delivery of civilian health-care services, including disruption to essential utilities (electricity, water, logistics, etc.) and access for patients and their families.




- b. Ask military medical personnel to help assess the extent to which planned military operations could cause damage or destruction, and how such damage or destruction could undermine the resupply of medical facilities.




- c. Ask military medical personnel to advise on preparing a contingency plan to address the estimated disruption to the provision of civilian health-care services and to re-establish full service delivery as soon as possible. Consider measures both for the (precautionary) evacuation of patients and medical personnel and for them to be taken properly in charge.


-  d. Facilitate and/or implement measures to quickly restore health-care service provision (medical support for the medical facility, engineering support for construction and repair, etc.) after an attack, taking into account the potential risk posed by deploying military personnel in the vicinity of civilian medical facilities.


-  e. Report, through the chain of command, on the impact of an attack on health-care service delivery and on the measures facilitated or implemented to restore provision of these services.

5. SETTING RULES ON THE CONDUCT OF MILITARY MEDICAL PERSONNEL IN ORDER TO PREVENT DISRUPTION TO MEDICAL ACTIVITIES AND TO ENSURE SUCH PERSONNEL FULFIL THEIR DUAL RESPONSIBILITIES (AS MEMBERS OF THE FORCES AND AS REPRESENTATIVES OF THE MEDICAL PROFESSION)

Rules on the conduct of military medical personnel should be decided in advance and included in training prior to operations. These rules should then be implemented consistently in theatre.

-  a. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on how military medical personnel should interact with civil authorities, civilian medical personnel and civilian patients (in terms of medical, social, cultural, gender or religious considerations), as relevant to the operation and context. Consider any cultural restrictions on the provision of medical care. Consult with the local community prior to developing guidance.

-  b. Provide guidance on respecting the authority and standards of care of civilian medical personnel and their principal role in the management of civilian health-care services.

-  c. Define (in SOPs, operational orders and/or other relevant documentation) the circumstances and conditions in which civilian patients may be removed from military medical facilities (e.g. to be transferred to a detention facility), so as to ensure that legal requirements in relation to the provision

of medical care are met, and that removal decision-making and execution is led by medical assessments (treatment as per the detention SOP).



- d. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on procedures relating to the personal equipment of military medical personnel (carriage of light weapons, body armour, helmets, medical ID badges, etc.).



- e. Provide guidance on the precautions that medical personnel and patients should take to protect themselves from infectious diseases. Provide guidance and training to non-medical military personnel who are exposed to the same health risks (hygiene standards, prescription of prophylactics, vaccination programmes, use of personal protective equipment, treatment, etc.).



- f. Establish a health surveillance system, including individual reporting, to track and respond to health-related issues among military personnel and to prevent the spread of diseases outside military bases in the area of operations.



- g. Provide guidance and deploy sufficient forces and/or resources to provide medical care to civilian patients, giving due consideration to social, cultural and gender issues (interpreters, male-to-female ratio among medical staff, etc.).






- h. During pre-deployment and in theatre, deliver appropriate training to military medical personnel so they are familiar with and sensitive to the local cultural context.

III. CIVIL-MILITARY COORDINATION





Coordination with civil authorities and civilian health-care providers can be beneficial for the armed forces and the non-military partners, allowing both sides to share public-health information¹¹ and provide mutual services. Civil-military coordination also enables the force to better understand the operating environment and to meet the health-care needs of the civilian population. This is important when regular health-care services are disrupted or when surge capacity is needed to cope with high patient numbers. The following measures should be implemented whenever feasible and operationally relevant:

1. ENHANCING UNDERSTANDING OF THE OPERATIONAL ENVIRONMENT BY FACILITATING COORDINATION WITH CIVIL AUTHORITIES AND CIVILIAN HEALTH-CARE PROVIDERS

Armed forces should map civil authorities, civilian health-care providers, relevant NGOs and other organizations involved in assisting the wounded and sick prior to operations, keep this map updated during operations, and liaise as appropriate.


-  a. Identify, map and regularly update the locations of medical facilities and assess their importance and capacity for the delivery of health-care services both within the area of operations and in its immediate vicinity (map and assess facilities by type: hospital, clinic, primary health-care centre, first-aid post, etc.).
-  b. Identify and regularly update the different types of health-care provider (formal or informal) and their vehicles operating within and outside the area of operations (ambulances, unmarked civilian vehicles, etc.).
-  c. Identify the officially endorsed and/or recognized vehicle identification systems (type of vehicle, markings, electronic tracking, etc.) and personnel identification arrangements (IDs, uniforms, etc.).





¹¹ In line with the principle of medical confidentiality, patients' personal information cannot be shared through these channels.

-  d. Identify and regularly update the existence of a coordination platform, if any, with health-care providers. If no such platform exists, consider creating one and integrate this into the civil-military coordination.
-  e. Involve military medical personnel as well as legal, cultural and gender advisers (when available and required) in interaction with civilian agencies.
-  f. Avoid, as far as possible, potential affronts to religious, gender and cultural sensitivities, or other factors, when interacting with civilian agencies. Base this on consultations with the local community where necessary.
-  g. Include press and information officers in civil-military activities to better manage media coverage (e.g. to mitigate possible negative implications for both health-care providers and the military).

2. COORDINATING WITH CIVIL AUTHORITIES AND HEALTH-CARE PROVIDERS SUPPORTING CIVIL-MILITARY COORDINATION TO ASSIST IN THE PROVISION OF MEDICAL SERVICES AND TO MINIMIZE THE IMPACT OF MILITARY OPERATIONS ON THE CIVILIAN HEALTH-CARE SYSTEM

Prior to operations, armed forces should liaise with health-care providers, relevant NGOs and other organizations providing health-care assistance in the area of operations. Liaison should be maintained throughout operations in order to increase mutual understanding, information-sharing and coordination.

-  a. Establish contact with health-care authorities and providers in order to:
- fully understand the role that an individual facility plays in the wider health-care system, as well as what, if any, back-up medical infrastructure exists
 - gain a thorough understanding of functioning resupply routes (for medicines, water, electricity, food, etc.) and their back-up systems
 - identify available alternative resupply routes (for medicines, water, electricity, food, etc.).

-  b. Participate in an existing coordination platform, if any. If this is not possible, or if no such platform exists, consider creating one and integrate this into the civil-military coordination.
-  c. Agree on coordination measures and procedures with health-care providers and relevant authorities prior to the start of shared activities.
-  d. Appoint a civil-military liaison officer to collect information from and regularly update health-care providers.
-  e. Define (in operational orders or similar documents) the requirements that apply to notifying and liaising/consulting with health-care authorities and providers.
-  f. Make arrangements for military medical personnel to participate in interactions with civilian health-care providers.
-  g. Define the roles of, and division between, civil-military and military medical officers in coordinating with civilian health-care providers. Consider having a military health-care specialist embedded in civil-military coordination.
-  h. Share and gather information on the incidence of infectious diseases and other potential health-related hazards within the area of operations.
-  i. Assign a dedicated radio frequency or other channel of communication between civilian medical personnel and the military. If possible, do the same with opposing forces.
-  j. Agree on appropriate interaction or conduct between medical and military personnel. Address concerns civilian medical personnel might have with regard to perceptions of partiality when engaging with military personnel. Ensure medical personnel are able to carry out their duties with neutrality.



- k. Keep health-care providers informed about what could lead to or constitute a loss of protected status.



- l. Establish clear procedures for notifying the military of medical personnel and vehicles (plate numbers, ID cards, dates, routes, etc.) involved in routine, planned and emergency transports.



- m. Appoint a staff position in charge of reviewing and updating lessons learned from coordination between the military and health-care providers and from incidents arising due to a lack of coordination.

3. INVOLVING CIVIL-MILITARY COORDINATION OFFICERS AND OTHER PERSONNEL IN SUPPORTING CIVILIAN HEALTH-CARE SERVICES AND MINIMIZING THE IMPACT OF MILITARY OPERATIONS ON HEALTH CARE

Civil-military coordination officers and personnel may assist the civil authorities and civilian health-care services in preventing, preparing for and responding to the humanitarian and other adverse impacts of military operations.



- a. Prior to operations or deployment, define (in SOPs, operational orders and/or other relevant documentation) the conduct of civil-military coordination officers and personnel in order to minimize disruption to health-care services.



- b. Establish a reporting system and appoint a staff position to track incidents involving civil-military coordination (lack of clarity on division of responsibilities, miscommunication, etc.), update the reporting system and learn lessons.


































- c. Conduct mission-specific training for civil-military personnel, both during pre-deployment and in theatre, on coordinating with the civil authorities.



- d. Deploy sufficient forces or resources to operate a civil-military coordination platform, including a centre.



-     e. Set out (in SOPs, operational orders and/or other relevant documentation) the reporting requirements that apply to the officer in charge of civil-military affairs.
-   f. Consider opening a civil-military coordination centre in a location that is easily accessible for civil authorities and civilian health-care providers, but not in the immediate vicinity of protected sites such as medical facilities.
-    g. Collect information from civil authorities and civilian health-care providers on civilian casualties and match to updated records of civilian casualty reports.
-    h. Collect information from civil authorities and civilian health-care providers on the political, cultural and religious context. Feed this information to military medical personnel so they can adjust how they interact with the local civilian population. Include consultations with the local community where necessary. Recognize that information may be sensitive and act accordingly.
-    i. Work with civil authorities and health-care workers to identify sites that pose a potential public-health risk (sites holding chemical, biological, radiological or nuclear materials, industrial facilities, etc.).
-     j. Work with civilian health-care providers to risk-assess the consequences of potential epidemic outbreaks for the civilian population.
-     k. Identify and assess the impact of planned and completed military operations on the civilian population.
-   l. Provide civilian health-care providers with security information (curfews, mines, border statuses and routings). Share maps of explosive remnants of war (unexploded ordnance, cluster munitions, etc.) that may impact health-care services.

-  m. Discuss and provide transport and logistical support to the civilian health-care supply chain.
-  n. Agree with the civil authorities and civilian health-care providers on casualty evacuation (CASEVAC) and medical evacuation (MEDEVAC) procedures for civilian casualties.¹²
-  o. Contribute to the targeting process by identifying and assessing infrastructure to avoid damage to civilian medical facilities and to minimize disruption to health-care services.¹³
-  p. Coordinate with the civil authorities and civilian health-care providers on assistance (e.g. military engineering capacity) for the rapid restoration of health-care services, main access routes and essential utilities (repair and construction) following military operations.
-  q. Prepare a contingency plan, with the civil authorities and civilian health-care providers, to address potential disruption to medical services due to military operations and to re-establish full delivery as soon as possible. Consider measures both for the evacuation of patients and medical personnel and for them to be taken properly in charge.
-  r. Proceed according to the “do no harm” principle and take steps to avoid civil-military coordination having adverse consequences for civilian health-care providers.¹⁴ Recognize that engaging with civil authorities and health-care providers may present risks for them or their activities. Agree on the extent of health-care assistance (complementing civilian health-care services, providing surge capacity when civilian casualties are anticipated, restoring disrupted health-care services, etc.) and have an exit strategy for the end of the mission.

¹² See [CASEVAC and MEDEVAC](#).

¹³ See [Precautions during attacks \(offence and defence\)](#) and [Targeting process](#).

¹⁴ Activities should only make a positive contribution to, and not negatively affect, the civilian population.

4. SETTING RULES ON THE CONDUCT OF MILITARY PERSONNEL INVOLVED IN CIVIL-MILITARY COORDINATION TO SUPPORT THE PROVISION OF CIVILIAN HEALTH-CARE SERVICES AND TO MINIMIZE THE IMPACT OF MILITARY OPERATIONS ON HEALTH CARE

Measures to regulate the conduct of civil-military personnel should be decided in advance and included in training prior to operations. These measures should then be implemented consistently in theatre.



- a. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on how civil-military personnel should interact with civil authorities and civilian health-care providers in the specific context (in terms of medical, ethical, cultural, gender or religious considerations) and on the possible risks this interaction may entail. Base this on consultations with the local community where necessary.



- b. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on procedures regarding personal protective equipment (carriage of weapons, body armour, helmets, etc.) during meetings with civil authorities and health-care providers, in accordance with the prevailing circumstances.



- c. During pre-deployment and in theatre, deliver appropriate training to civil-military personnel (including military medical personnel) so they are familiar with SOPs, operational orders and/or other relevant documentation on civil-military matters relating to health care.

IV. RULES OF ENGAGEMENT

Rules of engagement (ROE), or orders regulating the use of force, are issued prior to an operation from a senior military command. They are generally issued for a specific operation and context. ROE provide guidance on when and in what circumstances force may be employed, as well as setting limits on the use of force and employment of capabilities. ROE may also include post-fire procedures and rules on the use of force to support civil authorities. The protection of civilian health-care personnel and facilities should therefore be taken into account when drafting ROE. Consideration should be given to the use of non-kinetic effects (such as electronic warfare and cyber warfare) that may have an impact on the health-care system. The following measures should be considered whenever feasible and operationally relevant:

1. ENHANCING UNDERSTANDING OF THE OPERATIONAL ENVIRONMENT SO THAT ROE CAN BE DRAFTED IN A WAY THAT MINIMIZES THE IMPACT OF MILITARY OPERATIONS ON HEALTH CARE

When planning and drafting ROE, due consideration should be given to the protection of health-care personnel and facilities in the area of operations. This, in turn, will help to limit the impact of the use of force on civilian health-care services and assist in the provision of medical care.



- a. Bring in military medical personnel to advise on ROE design and planning for the specific operation and context.








- b. Ensure that ROE comply with international and domestic law as it relates to the protection of health care.







- c. Train staff involved in the design and drafting of ROE for a given operation and context on integrating specific measures to protect medical personnel and to safeguard continuity of care and assistance for the wounded and sick.





2. INCLUDING, IN THE ROE, SPECIFIC MEASURES TO PROTECT HEALTH-CARE PERSONNEL AND FACILITIES, AND TO SAFEGUARD CONTINUITY OF CARE, WHEN FORCE IS EMPLOYED IN MILITARY OPERATIONS



ROE should be drafted in a way that protects medical personnel, facilities and vehicles, including restrictions or rules on the use of force that are tailored to the specific operation and context.

-  a. Define, in the ROE, the level of authority by which, and the circumstances in which, the use of force is permitted to protect medical personnel, facilities and vehicles (e.g. responding to unlawful attacks by opposing forces).
-  b. Set rules, in the ROE, on identifying safety zones surrounding civilian medical facilities and essential utilities (electricity, water, logistics, etc.).
-  c. Define, in the ROE, restrictions on positioning force units in the vicinity of medical facilities.
-  d. Set rules, in the ROE, permitting the use force to prevent interference with the freedom of movement of medical vehicles and personnel.
-  e. Set rules, in the ROE, restricting the use of force when medical vehicles approach forces.
-  f. Define, in the ROE, the exceptional circumstances and conditions in which attacks on a military objective in the vicinity of medical facilities may take place.
-  g. Set rules, in the ROE, on the verification procedures for protected sites, including medical facilities, when identifying and using effects against a target.
-  h. Define, in the ROE, the exceptional circumstances in which a medical facility may lose its protected status.

  i. Define, in the ROE, the exceptional circumstances and conditions in which medical facilities may be searched, and the exceptional circumstances and conditions in which force may be used within a medical facility.




  j. Set rules, in the ROE, on the use of physical, non-explosive obstacles and barriers in the vicinity of medical facilities, in order to prevent access to such facilities being restricted.



    k. Provide guidance, in the ROE, on assisting local authorities in responding to major events such as endemic and epidemic disease outbreaks and mass-casualty incidents. Consider operational restraints, such as (refraining from) the use of force in these circumstances.



  l. Restrict and/or prohibit, in the ROE, the carrying of weapons in medical facilities. Consider a no-weapon policy for entering medical facilities.

3. INCLUDING, IN THE ROE, SPECIFIC MEASURES TO ASSIST IN CARING FOR THE WOUNDED AND SICK IN THE CONDUCT OF MILITARY OPERATIONS


ROE should include measures on providing medical care to military and/or civilian casualties and on recording incidents following the use of force.


   a. Consider including, in the ROE, requirements on providing assistance to civilian casualties, based on the capacity and capabilities of both military and civilian medical services.


   b. Include, in the ROE post-fire procedures, the timely provision of medical assistance to military and civilian casualties, as far as practical.

  c. Set rules, in the ROE, requiring the provision of first aid to casualties after firing, without discrimination. Medical assistance must be provided to injured military personnel, opposing troops and civilians, based solely on an assessment of clinical need and benefit.¹⁵

¹⁵ See [Annex 2: Ethical principles of health care](#) (point 7).

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d. Include, in ROE search and detention procedures, a requirement to assess the medical condition of detainees and to provide medical care where needed.
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e. Set rules, in the SOPs based on the ROE, requiring the officer in charge to record and account for military and civilian casualties after the use of force. This should include statements on persons injured, the force used and why.
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f. Identify and assign, in the SOPs and operational orders based on the ROE, the relevant medical facility or facilities for primary assessment of both civilian and military casualties in the area of responsibility.¹⁶











V. PRECAUTIONS DURING ATTACKS (OFFENCE AND DEFENCE)




The military advantage likely to be gained from attacking military objectives located in the vicinity of medical facilities, or medical facilities that have lost their protected status, should be carefully weighed against the humanitarian consequences likely to result from the incidental damage or destruction caused to those facilities. The following measures should be taken to minimize the direct and indirect impact of such an attack on the provision of health-care services, whenever feasible and operationally relevant:

1. ENSURING THAT ATTACKS ON MILITARY OBJECTIVES IN THE VICINITY OF A MEDICAL FACILITY, OR ON MEDICAL FACILITIES THAT HAVE LOST THEIR PROTECTED STATUS, ARE ONLY CARRIED OUT IN EXCEPTIONAL CIRCUMSTANCES

An attack close to or on a medical facility, even one that has lost its protected status, may have significant second- and third-order effects on the delivery of health care. Such attacks require careful consideration and constraint. Measures should acknowledge the exceptional nature and risks to health care of such attacks, which should only be considered when essential to the broader mission.



¹⁶ See [CASEVAC](#) and [MEDEVAC](#).


-    a. When considering an attack, weigh the risk to health-care delivery against the mission, intent and end-state as defined by the commander. Consider kinetic strikes as a measure of last resort. Consider options other than launching an attack:
- Contain the threat by cordoning off the area where the medical facility in question is located.
 - Negotiate an agreement with the other combatant party to leave the medical facility or to surrender.
 - Negotiate an agreement with the other combatant party on the evacuation of medical personnel and their patients.
 - Employ third parties, such as local formal or non-formal authorities (e.g. community elders), to convince the other combatant party to leave the immediate area or to surrender.
-   b. Identify (in SOPs, operational orders and/or other relevant documentation) the level of authority by which, and the circumstances in which, a decision to strike a military objective in the vicinity of a medical facility, or a medical facility that has lost its protected status, may be taken (e.g. threshold of necessity as evidenced by the facts on the ground).
-    c. Define (in SOPs, operational orders and/or other relevant documentation) the authorization process for a request to strike a military objective in the vicinity of a medical facility, or a medical facility that has lost its protected status (evidence of military necessity, concrete and direct military advantage expected, incidental damage expected to the medical facility, etc.).
-   d. Adopt the necessary measures to make commanding personnel involved in planning, authorizing and executing attacks on military objectives in the vicinity of a medical facility, or on medical facilities that have lost their protected status, accountable for their actions under military law (approving authority, officer in charge of the attack, recording and pre-serving decisions, etc.).


-  e. Describe (in SOPs, operational orders and/or other relevant documentation) the oversight measures to be taken by the approving authority (communication, investigation in case of an incident, etc.).
-  f. Describe (in SOPs, operational orders and/or other relevant documentation) the reporting requirements that apply to the officer in charge of a strike on a military objective in the vicinity of a medical facility, or on a medical facility that has lost its protected status (timing, battle-damage assessments, etc.).
-  g. Appoint a staff position in charge of reviewing and updating lessons learned from coordination between military and health-care providers and from incidents arising due to a lack of coordination.

2. ENHANCING UNDERSTANDING OF THE OPERATIONAL ENVIRONMENT IN THE EVENT OF AN ATTACK ON A MILITARY OBJECTIVE IN THE VICINITY OF A MEDICAL FACILITY, OR ON A MEDICAL FACILITY THAT HAS LOST ITS PROTECTED STATUS

The operational environment should to be assessed both prior to, and at regular intervals during any operation. Doing so will help to ensure that measures intended to guide the planning and conduct of an attack are adapted to the context, and to limit the humanitarian consequences of the attack.


-  a. Identify, map and regularly update the locations of medical facilities and assess their importance and capacity for the delivery of health-care services both within the area of operations and in its immediate vicinity (map and assess facilities by type: hospital, clinic, primary health-care centre, first-aid post, etc.).
-  b. Measure the proximity of medical facilities to military objectives (both one's own and those of the opposing forces) and assess potential direct damage based on the effects of the available ordnance.


-  c. Assess the potential indirect impacts on health-care delivery of the planned attacks on military objectives, such as the disruption of essential utilities (electricity, water, logistics, etc.) and access for patients and their families.


-  d. Develop and continuously update the list of non-strike and restricted-fire areas by identifying the location of all medical facilities, access and supply routes, and the essential services on which they depend.

3. COORDINATING WITH HEALTH-CARE WORKERS AND RELEVANT AUTHORITIES TO MINIMIZE THE IMPACT OF ATTACKS ON MILITARY OBJECTIVES LOCATED IN THE VICINITY OF A MEDICAL FACILITY, OR ON MEDICAL FACILITIES THAT HAVE LOST THEIR PROTECTED STATUS

Establish and maintain coordination with health-care providers and relevant NGOs to support decision-making around attacks on or near a medical facility.














-  a. Participate in an existing emergency coordination platform, if any. If this is not possible, or if no such platform exists, consider creating one.


-  b. Establish contact with health-care authorities and providers in order to:
- fully understand the role that an individual facility plays in the wider health-care system, as well as what, if any, back-up medical infrastructure exists
 - gain a thorough understanding of functioning resupply routes (for medicines, water, electricity, food, etc.) and their back-up systems
 - identify available alternative resupply routes (for medicines, water, electricity, food, etc.).


-  c. Keep health-care providers informed about what could lead to or constitute a loss of protected status.


4. PLANNING AND CONDUCTING AN ATTACK ON A MILITARY OBJECTIVE IN THE VICINITY OF A MEDICAL FACILITY


Before planning and carrying out a direct or indirect attack on a military objective in the vicinity of a medical facility, armed forces should take measures to limit its potential humanitarian consequences. These measures should then be implemented throughout the operation.


-   a. Define (in SOPs, operational orders and/or other relevant documentation) the circumstances and conditions in which attacks on a military objective in the vicinity of a medical facility may take place.
-    b. Define (in SOPs, operational orders and/or other relevant documentation) the approval process for authorizing a strike on a military objective in the vicinity of a medical facility and the associated intelligence required (evidence of the military necessity, military advantage expected, estimated incidental damage to the medical facility, etc.).
-   c. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on minimizing the humanitarian consequences of an attack on a military objective in the vicinity of a medical facility (e.g. avoiding or minimizing disruption to services), tailored to the specific operation and context.
-   d. Develop a deliberate and immediate targeting process based on IHL/the law of armed conflict (LOAC) and incorporating terrain analysis, weapons effects and means of delivery.
-     e. Include military medical personnel as well as legal, cultural and gender advisers (where available and appropriate) in the planning, decision-making and conduct of an attack on a military objective in the vicinity of a medical facility, in particular to estimate the potential damage caused to the medical facility.


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f. Conduct an impact assessment prior to any action to gain a clear understanding of the extent to which the planned attack could cause damage or destruction, and how such damage or destruction could undermine the resupply of the medical facility.
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g. Assess and select measures to keep the degree of disruption in proportion to the military necessity and to mitigate the (direct and indirect) effects on health-care delivery (destruction vs. neutralization of the objective, ordnance, methods, timing, etc.).
- 

h. Prepare a contingency plan to address the estimated disruption to health-care services and to re-establish full delivery as soon as possible. Consider measures both for the evacuation of patients and medical personnel and for them to be taken properly in charge.
- 

i. Give sufficient and timely warning prior to launching a strike (e.g. via communication with third parties of influence).
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j. Assess battle damage constantly and keep the degree of disruption in proportion to the military necessity. Interrupt the attack if incidental damage is excessive relative to the expected military gain.
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k. After the attack, facilitate or implement measures for the rapid restoration of health-care services (e.g. provide military medical support for the civilian medical facility).
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l. After the attack, report the impact on health-care delivery, and the remedial measures facilitated or implemented, up the chain of command.
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m. Provide training, both during pre-deployment and in-theatre, so that military personnel are familiar with, and prepared to implement, SOPs, operational orders and/or other relevant documentation designed to minimize disruption to a medical facility when carrying out an attack on a nearby military objective.


5. PLANNING AND CONDUCTING AN ATTACK ON A MEDICAL FACILITY THAT HAS LOST ITS PROTECTED STATUS


Before carrying out an attack on a medical facility, regardless of its protected status, armed forces should take measures to limit its potential humanitarian consequences. These measures should then be implemented throughout the operation, whenever possible:


-  a. Define (in SOPs, operational orders and/or other relevant documentation) the circumstances and conditions in which attacks on a medical facility that has lost its protected status may take place.
-  b. Define (in SOPs, operational orders and/or other relevant documentation) the approval process for authorizing a strike on a medical facility that has lost its protected status and the associated intelligence required (e.g. evidence of the loss of protected status, military advantage expected, estimated damage to the medical facility, etc.).
-  c. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on minimizing the humanitarian consequences of a strike on a medical facility that has lost its protected status (e.g. avoiding or minimizing disruption to services), tailored to the specific operation and context.
-  d. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on the criteria under which a medical facility loses its protected status, as well as on-site verification of the loss of protection.
-  e. Develop, in the planning process, a deliberate and immediate targeting process based on IHL/LOAC and incorporating terrain analysis, weapons effects and means of delivery in relation to engagement of a sensitive target such as a medical facility that has lost its protected status.
-  f. Include military medical personnel as well as legal, cultural and gender advisers (where available and appropriate) in the planning, decision-making and conduct of an attack on a


medical facility that has lost its protected status, in particular to estimate the potential damage caused to the medical facility and to develop contingency plans.


- 


g. Conduct an impact assessment prior to any action to understand the extent to which the planned attack could cause damage or destruction, and how such damage or destruction could undermine the resupply of the medical facility.
- 

h. Assess and select measures to keep the degree of disruption in proportion to the military necessity and to mitigate the effects on health-care delivery (e.g. destruction vs. neutralization of the objective, ordnance, methods, timing, etc.).
- 


i. Prepare a contingency plan to address the estimated disruption to health-care services and to re-establish full delivery as soon as possible. Consider measures both for the evacuation of patients and medical personnel and for them to be taken properly in charge.
- 


j. Where possible, give sufficient and timely warning to those inside the medical facility (medical personnel, patients, visitors, combatants or fighters) prior to an attack (e.g. via communication with third parties of influence).
- 


k. Request that opposing forces using a medical facility for their military operations leave the site. Give sufficient and timely warnings to opposing forces of an imminent strike on a medical facility that has lost its protected status. Postpone kinetic strikes to allow opposing forces to leave the facility.
- 

l. Assess battle damage constantly and keep the disruption level in proportion to military necessity. Interrupt the attack if anticipated incidental damage is excessive relative to the expected military gain.
- 

m. After the attack, quickly facilitate or implement measures to rapidly restore health-care services (e.g. provide military medical support for the civilian medical facility).

- 

n. Interrupt the attack if the facility no longer meets the criteria leading to the loss of protected status (e.g. combatants or fighters have fled from the medical facility).
- 

o. After the attack, report the impact on health-care delivery, and the remedial measures facilitated or implemented, up the chain of command.
- 


p. Provide training, both during pre-deployment and in theatre, so that military personnel are familiar with, and prepared to implement, SOPs, operational orders and/or other relevant documentation designed to minimize disruption to the medical facility.

VI. TARGETING PROCESS AND JOINT FIRE SUPPORT EFFECTS

These measures supplement, and should be read in conjunction with, the previous focus area on [Precautions during attacks \(offence and defence\)](#). They should be implemented whenever feasible and operationally relevant.



















1. PLANNING AND CONDUCTING THE TARGETING OF AIR-TO-GROUND AND OTHER JOINT FIRE SUPPORT¹⁷ OPERATIONS IN A WAY THAT MINIMIZES THE IMPACT ON HEALTH CARE



















When planning and conducting air-to-ground and other joint fire support operations on military objectives located in the vicinity of a medical facility, or on medical facilities that have lost their protected status, the anticipated military advantage should be weighed carefully against the humanitarian consequences likely to result from the incidental damage or destruction caused to those facilities. Armed forces should take the following measures to minimize the direct and indirect impact of these types of weapons on health-care capabilities:

- 

a. Use medical intelligence when planning an attack in the vicinity of medical facilities to confirm the locations and investigate the impact on health-care facilities, essential services and supply/evacuation routes.

¹⁷ Joint fire support includes the use of indirect fire, electronic warfare and tactical cyber capabilities to create an effect on a target. It may be delivered by platforms on land, in the air or at sea. It may include mortars, artillery, naval gunfire, rockets and missiles.

-   b. Establish restrictive fire-control measures within the vicinity of medical facilities, supply/evacuation routes and essential services.
-   c. Give health-care providers in the vicinity of a deliberate target a timely warning before a strike.
-    d. Request that opposing forces using a medical facility for their military operations leave the site. Give sufficient and timely warnings to opposing forces of an imminent strike on a medical facility that has lost its protected status. Postpone kinetic strikes to allow opposing forces to leave the facility.
-   e. Confirm the visual symbols and markings used to identify health-care facilities, vehicles and personnel to ensure observers can make an informed targeting decision.
-     f. Require pilots and observers to verify positive identification (including visual) with controllers prior to the strike, and to provide a damage and casualty assessment immediately after the strike.
-   g. Maintain a positive identification of the target both pre-strike and before re-striking. Repeat damage and casualty assessment between strikes.
-   h. Continuously calculate the proximity of medical facilities and essential utilities (electricity, water, logistics, etc.) in relation to a moving target. Adjust weapon selection and ensure enough distance is observed in order to minimize damage to the facilities and disruption to the provision of health-care services.
-  i. Continuously evaluate the military necessity and proportionality of attacking the target. Cancel or postpone the attack if this has changed.

-    j. Ensure that health-care providers have direct access to the tactical command through an emergency platform so they can raise concerns following the targeting.¹⁸
-    k. Consider less damaging and disruptive alternatives to joint fires, such as target location away from medical facilities and supply/evacuation routes (particularly in urban environments), weapon choice or other means of the use of force. Consider reducing the number of air strikes.
-     l. After a strike, assess and verify damage or disruption to the provision of health-care services (if any) and report findings, including the number of civilian casualties, up the chain of command.
-    m. Provide training and guidance to targeting analysts, weaponeers and others involved in the targeting process on the indirect impacts of the planned attacks on military objectives on health-care delivery, and in particular on disruption to essential utilities (electricity, water, logistics, etc.) and access to medical facilities for patients and their families.
-    n. Be aware of the potential impact of non-kinetic attacks on health-care facilities (including the use of electronic and cyber warfare, which can disrupt communications for CASEVAC) and on the delivery of medical supplies, and of attacks on infrastructure impacting essential services.
-   o. Adopt the necessary measures, under military criminal law and disciplinary rules, to make all personnel involved in the targeting cycle accountable for aerial attacks that unnecessarily and/or deliberately delay/deny the delivery of, or limit/restrict access to, health care.

18 See coordination measures in Section V 3 ([Precautions during attacks](#)).

VII. CASEVAC AND MEDEVAC

These measures cover two procedures: casualty evacuation (CASEVAC), which involves transporting casualties from the point of injury in non-dedicated vehicles (with or without medical care during the evacuation) to a treatment location away from the combat zone, and medical evacuation (MEDEVAC) from one medical facility to a higher level of care by a medically equipped means of transport. In both cases, armed forces may need to transport wounded and/or sick civilians in addition to combatants. Likewise, patients may need to be evacuated from a civilian to a military medical facility, or vice versa. The following measures address these situations and should be considered whenever feasible and operationally relevant:

1. ENHANCING UNDERSTANDING OF THE OPERATIONAL ENVIRONMENT IN ORDER TO CARE FOR CIVILIAN CASUALTIES IN A CASEVAC OR MEDEVAC OPERATION

Armed forces should map health-care providers, relevant NGOs and other organizations assisting in the evacuation of the wounded and sick both prior to, and at regular intervals during operations in order to facilitate a CASEVAC/MEDEVAC operation.







- a. Identify, map and regularly update the locations of medical facilities and assess their importance and capacity for the delivery of health-care services both within the area of operations and in its immediate vicinity (map and assess facilities by type: hospital, clinic, primary health-care centre, first-aid post, etc.).



- b. Identify and regularly update the different types of health-care provider (formal or informal) and their vehicles operating within and outside the area of operations (ambulances, unmarked civilian vehicles, etc.).










- c. Identify the officially endorsed and/or recognized vehicle identification systems (type of vehicle, markings, electronic tracking, etc.) and personnel identification arrangements (IDs, uniforms, etc.).





-     d. Identify and regularly update the existence of a coordination platform, if any, for emergency services, and assess its functioning.




2. COORDINATING BETWEEN MILITARY MEDICAL PERSONNEL, CIVILIAN HEALTH-CARE PROVIDERS AND RELEVANT AUTHORITIES TO FACILITATE CARE FOR CASUALTIES IN A MEDEVAC OR CASEVAC OPERATION




Liaising and coordinating with health-care providers and relevant NGOs will help to ensure that casualties are evacuated quickly and safely to appropriate primary treatment facilities and higher levels throughout the area of operations. Ideally, military forces should aim to establish relationships with health-care providers and NGO representatives through meetings and training exercises before an operational need arises.

-     a. Appoint a movement control liaison officer to regularly update military medical personnel involved in CASEVAC/MEDEVAC operations on aerial, sea and ground conditions.

-    b. Ensure that formal health-care providers are informed of CASEVAC/MEDEVAC procedures for civilian casualties.

-     c. Assign a dedicated radio frequency or other channel of communication between military medical personnel, commanding officers and movement control personnel.

-    d. Participate in an existing emergency coordination platform, if any, to facilitate and coordinate potential CASEVAC/MEDEVAC operations involving civilian casualties. If this is not possible, or if no such platform exists, consider creating one.

-    e. Agree on coordination measures and procedures with civilian health-care providers and relevant authorities. As a minimum, establish general procedures to be followed in the event of a CASEVAC/MEDEVAC operation involving civilian casualties.



f. Agree on appropriate interaction or conduct between civilian medical personnel and military personnel. Address concerns civilian medical personnel might have with regard to perceptions of partiality when engaging with military personnel. Ensure medical personnel are able to carry out their duties with neutrality.



g. Agree on procedures for record-keeping and hand-over of medical files between military and civilian medical personnel during CASEVAC/MEDEVAC operations to ensure patient information is kept confidential.



h. Establish clear procedures by which civil authorities and civilian health-care providers can request military assistance with CASEVAC/MEDEVAC operations involving civilian casualties.



i. Establish clear procedures by which civil authorities and civilian health-care providers should notify the military if civilian casualties requiring CASEVAC/MEDEVAC are transported in civilian health-care vehicles.










j. Ensure that military medical personnel are involved in the transfer of civilian casualties between military and civilian health-care providers.






k. Appoint a staff position in charge of reviewing and updating lessons learned from coordination between the military and health-care providers and from incidents arising due to a lack of coordination.

3. PREPARING MILITARY MEDICAL AND OTHER PERSONNEL TO EVACUATE CIVILIAN CASUALTIES AS PART OF A CASEVAC/MEDEVAC OPERATION

These measures are designed to prepare military medical and other personnel to evacuate civilian casualties and will make CASEVAC/MEDEVAC operations more effective, both within and outside the area of operations.





-  a. Establish SOPs, operational orders and/or other relevant documentation for CASEVAC/MEDEVAC operations, tailored to the specific operation and context.
-  b. Identify the means of transport and routing (air/road, civilian/military) between point of injury and medical facilities, and between facilities (civilian and military), so that civilian and military patients can be evacuated. Consider options of dedicated and non-dedicated means of transport.
-  c. Consider documentation and route-planning requirements for border crossings and checkpoints in the planning of CASEVAC/MEDEVAC operations.
-  d. Deploy sufficient military medical personnel, equipment and means of transport to evacuate anticipated military and civilian casualties, including opposing forces.
-  e. Assist civilian health-care providers in evacuating patients if imminent military operations are planned in the vicinity of medical facilities.
-  f. Consider arranging humanitarian assistance for civilians with non-urgent medical conditions requiring MEDEVAC for treatment outside the area of operations.
-  g. Record the number of evacuated civilian casualties (including injuries and/or diseases, location, etc.) and report up the chain of command.





-    h. Consider and facilitate the return of civilians after receiving treatment, particularly when no other means of transport are available.





-    i. Set rules on exceptions for civilian medical vehicles involved in CASEVAC/MEDEVAC operations in the event of a curfew.





4. SETTING RULES ON THE CONDUCT OF MILITARY PERSONNEL INVOLVED IN CASEVAC/MEDEVAC OPERATIONS TO FACILITATE INTERACTION WITH CIVILIAN MEDICAL PERSONNEL AND CIVILIAN CASUALTIES













Rules on the conduct of military personnel involved in CASEVAC/MEDEVAC operations should be decided in advance and included in training prior to operations. These rules should then be implemented consistently in theatre.

-     a. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on how combat personnel should account and care for civilian casualties.

-     b. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on how military medical personnel should interact with civilian medical personnel and patients during CASEVAC/MEDEVAC operations.

-     c. Stipulate (in SOPs, operational orders and/or other relevant documentation) that designated MEDEVAC aircraft and vehicles may only be used to transport medical personnel, their personal protective equipment (including light weapons), civilian casualties and personnel *hors de combat*. Other military personnel, including members of the opposing forces, and their weapons should not be allowed to use designated medical vehicles.

-     d. Provide guidance and deploy sufficient forces and/or resources to provide medical care to civilian patients, giving due consideration to local cultural and gender issues (interpreters, male-to-female ratio among medical staff, etc.).

-    e. Provide guidance on precautions that military and civilian medical personnel, patients and non-medical personnel should take in order to comply with health and safety guidelines in CASEVAC/MEDEVAC operations.
-    f. Where circumstances require, provide guidance on precautions that military and civilian medical personnel, patients and non-medical personnel should take in order to protect themselves from infectious diseases in CASEVAC/MEDEVAC operations.
-    g. Provide training, during pre-deployment and in theatre, to military personnel (including military medical personnel) likely to play a role in CASEVAC operations, such as field medics and combatants trained as first responders. Adequate training will ensure that such personnel are familiar with ethical principles of health care and the protected status of civilian casualties. Medical assistance must be provided to injured military personnel, opposing troops and civilians, based solely on an assessment of clinical need and benefit.¹⁹
-    h. Provide training and carry out exercises on CASEVAC/MEDEVAC operations involving civilian casualties, in line with available guidance as suggested above.

¹⁹ See [Annex 2: Ethical principles of health care](#).

VIII. CHECKPOINTS

Armed forces may need to set up checkpoints to control movement within a territory. These cause delays for all vehicles, including those evacuating the wounded and sick either formally (authorized by the state or other competent authorities, and identifiable as such) or informally (any vehicle transporting the wounded and sick in an emergency). A balance needs to be struck between security requirements and the necessity for patients to access medical facilities as quickly as possible. The following four sets of measures should be taken to minimize the negative effects of stopping and searching medical evacuation vehicles, whenever feasible and operationally relevant:

1. ENHANCING UNDERSTANDING OF THE OPERATIONAL ENVIRONMENT IN ORDER TO MINIMIZE MEDICAL EVACUATION DELAYS AT CHECKPOINTS

Armed forces should map health-care providers, relevant NGOs and other organizations involved in medical evacuations both prior to, and at regular intervals during any operation. Doing so will help to ensure that measures intended to minimize delays are adapted to the context, and to limit the humanitarian consequences of such delays.







- a. Identify, map and regularly update the locations of medical facilities and assess their importance and capacity for the delivery of health-care services both within the area of operations and in its immediate vicinity (map and assess facilities by type: hospital, clinic, primary health-care centre, first-aid post, etc.).



- b. Identify and regularly update the different types of health-care provider (formal or informal) and their vehicles operating within and outside the area of operations (ambulances, unmarked civilian vehicles, etc.).























- c. Identify the officially endorsed and/or recognized vehicle identification systems (type of vehicle, markings, electronic tracking, etc.) and personnel identification arrangements (IDs, uniforms, etc.).


-     d. Identify and regularly update the existence of a coordination platform, if any, for emergency services, and assess its functioning.


2. COORDINATING WITH HEALTH-CARE PROFESSIONALS AND RELEVANT AUTHORITIES PROVIDING FOR THE EVACUATION OF THE WOUNDED AND SICK IN ORDER TO MINIMIZE MEDICAL EVACUATION DELAYS AT CHECKPOINTS


Armed forces should coordinate with health-care providers, relevant NGOs and other organizations involved in medical evacuations within and outside the area of operations. Such coordination should be established prior to operations and maintained throughout. Local community leaders and other relevant authorities should be included in these coordination arrangements, since other parties may be involved in evacuating the wounded and sick beyond formal health-care vehicles and personnel.


-     a. Participate in an existing emergency coordination platform, if any. If this is not possible, or if no such platform exists, consider creating one.
-     b. Agree on coordination measures and procedures with health-care providers (as a minimum). If possible, do the same with opposing forces.
-     c. Appoint a ground movement liaison officer to regularly update health-care providers on road conditions.
-    d. Assign a dedicated radio frequency or other channel of communication between medical personnel and the military, and between different checkpoints.
-     e. Agree on the means of identification used by medical personnel, how such identification will be displayed on arrival at checkpoints, and on markings (emblems, plate numbers, etc.), other visual means (blue light, flags, other lights, etc.), or any other means of identification (siren, etc.) used for health-care vehicles.

- 

f. Agree on appropriate interaction or conduct between medical and military personnel. Address concerns civilian medical personnel might have with regard to perceptions of partiality when engaging with military personnel. Ensure medical personnel are able to carry out their duties with neutrality.
- 

g. Establish clear procedures for notifying the military of medical personnel and vehicles (plate numbers, ID cards, dates and routes, etc.) involved in planned transports.
- 


h. Establish clear procedures for notifying the military of medical personnel and vehicles involved in emergency transports.
- 


i. Appoint a staff position in charge of reviewing and updating lessons learned from coordination between the military and health-care providers and from incidents arising due to a lack of coordination.
- 

j. Agree on a regular schedule for routine medical vehicle movements, avoiding the busiest times at checkpoints (e.g. for patients requiring dialysis).
























3. PRIORITIZING PASSAGE THROUGH CHECKPOINTS IN ORDER TO MINIMIZE MEDICAL EVACUATION DELAYS

Measures to regulate checkpoints should be decided in advance and included in training prior to operations. These measures should then be implemented consistently in theatre in order to limit the potential humanitarian consequences of delays.

- 

a. Establish procedures for conduct at checkpoints specific to the operational context in order to minimize delays. Include these procedures in SOPs, operational orders and/or other relevant documentation, and provide training to personnel.
- 

b. Set up a fast lane if appropriate in the circumstances (security considerations, topography, distances and time of day, workload at the checkpoint, etc.).

-   c. Clearly identify the fast lane, if any, well in advance of the checkpoint to enable health-care vehicles to avoid queuing.
-   d. Where setting up a fast lane is not feasible, clearly indicate, as appropriate, that health-care vehicles are permitted to drive to the front of the queue and be given priority.
-    e. Ensure that the relevant checkpoints are notified quickly of the pending arrival of formal health-care vehicles.
-    f. Ensure that checkpoints communicate so they can forewarn each other of the passage of health-care vehicles.
-   g. Establish a reporting system and have checkpoint leaders constantly update the system to track incidents involving the military and health-care providers or their vehicles.
-    h. Deploy sufficient forces or resources to operate checkpoints efficiently (e.g. to give health-care vehicles priority).
-    i. Train checkpoint personnel to keep the length of identification checks on formal medical personnel and vehicles as short as possible.
-    j. Train checkpoint personnel to prioritize the passage of non-formal or non-notified health-care vehicles (e.g. someone transporting a wounded family member in their own car).
-    k. Provide training, both during pre-deployment and in theatre, so that military personnel likely to have checkpoint control duties are able to implement SOPs, operational orders and/or other relevant documentation that ensure priority passage for health-care vehicles. Design such training in line with mission specifics and draw on lessons learned.

4. MINIMIZING THE IMPACT ON MEDICAL EVACUATIONS WHENEVER PASSAGE THROUGH A CHECKPOINT IS DENIED FOR REASONS OF IMPERATIVE MILITARY NECESSITY

Denying passage to medical evacuation vehicles is an extreme measure that may have a serious impact on the life or health of the wounded and sick. It should therefore only be taken on the grounds of imperative military necessity and remain exceptional. The following four sets of measures should be taken to minimize the negative impact of such a decision, and should be maintained throughout the operation.



- a. Establish (in SOPs, operational orders and/or other relevant documentation) the level of authority by which, and the exceptional circumstances in which, a decision to deny passage through checkpoints may be taken.



- b. Ensure that formal health-care providers are informed of alternative routes.



- c. Ensure that informal health-care providers blocked at closed checkpoints are informed of alternative routes.



- d. Set rules on exceptions for medical evacuations in the event of a curfew.







- e. Appoint a staff position in charge of reviewing and updating lessons learned from coordination between the military and health-care providers and from incidents arising due to a lack of coordination.

IX. MILITARY OPERATIONS IN MEDICAL FACILITIES

Military necessity may require armed forces to conduct operations in medical facilities. These operations could include interrogating and searching patients, visitors and medical personnel and, in some circumstances, even detaining or arresting people. Actions such as these may disrupt the normal running of medical facilities and should therefore be an exceptional measure, taken only after a concerted effort has been made to achieve a balance between the expected military advantage and the humanitarian impact. The following four sets of measures should be taken to minimize the effects of military operations in medical facilities, whenever feasible and operationally relevant:

1. ENHANCING UNDERSTANDING OF THE OPERATIONAL ENVIRONMENT IN ORDER TO MINIMIZE THE IMPACT OF SEARCHES IN MEDICAL FACILITIES ON BOTH PATIENTS AND MEDICAL PERSONNEL

The operational environment should be monitored and evaluated throughout the planning and conduct of the military operation. Careful consideration should be given to environmental changes that could affect the safety of patients and medical personnel.

-  a. Include military medical personnel as well as legal, cultural and gender advisers (where available) in the planning, decision-making and conduct of search operations in medical facilities.
-  b. Avoid, where possible, potential affronts to sensitivities in the planning and conduct of a search operation in a specific medical facility (e.g. while interviewing personnel and patients or when walking through or entering gender-specific wards). This may include issues of religion, gender and local culture.
-  c. Choose the most appropriate timing for searches (e.g. day or night operations).
-  d. Include press and information officers in the planning and conduct of searches in a specific medical facility to better manage media coverage (e.g. to mitigate possible negative implications for both the medical facility and the military).

2. COORDINATING WITH HEALTH-CARE WORKERS AND RELEVANT AUTHORITIES IN ORDER TO MINIMIZE THE IMPACT OF SEARCH OPERATIONS IN MEDICAL FACILITIES

Prior to operations, armed forces should coordinate with health-care providers, relevant NGOs and other organizations providing health-care assistance within and outside the area of operations. Coordination should be maintained throughout in order to facilitate search operations and keep misunderstandings to a minimum.



- a. Participate in an existing emergency coordination platform, if any, to facilitate and coordinate potential search operations in a specific medical facility. If this not possible, or if no such platform exists, consider creating one.



- b. Agree on coordination measures and procedures with health-care providers and relevant authorities. As a minimum, establish general procedures to be followed in the event of a search (timing, appropriate notice, etc.).



- c. Define the requirements for notifying and liaising and/or consulting with health-care authorities and providers.



- d. Have military medical personnel work with civilian medical personnel in preparing for potential search operations in a specific medical facility.









- e. Share and gather information on the incidence of infectious diseases and other potential health-related hazards in medical facilities within the area of operations.


























- f. Appoint a staff position in charge of reviewing and updating lessons learned from coordination between the military and health-care providers and from incidents arising due to a lack of coordination.


3. SETTING RULES ON THE CONDUCT OF MILITARY PERSONNEL WHILE CARRYING OUT SEARCH OPERATIONS IN A SPECIFIC MEDICAL FACILITY

Rules on the conduct of search operations in a specific medical facility should be decided in advance and included in training prior to operations. These rules should then be implemented consistently in theatre in order to limit the potential humanitarian consequences of such operations.

-  a. Establish specific procedures to minimize disruption to health-care services during a search operation in a medical facility, and carry out exercises on these procedures.
-  b. Prepare a checklist that personnel should follow during a search operation in a specific medical facility, and include this list in SOPs, operational orders and/or other relevant documentation.
-  c. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on the nature and scope of questions that may be asked of medical personnel and patients.
-  d. Set out (in SOPs, operational orders and/or other relevant documentation) the ethical and legal responsibilities of medical personnel vis-à-vis patients, and make clear the legal obligation to allow patients to receive medical treatment without undue interference.
-  e. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on the respect due to patients and their privacy (considerations based on medical, cultural, gender, religious or similar grounds).
-  f. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on how military medical personnel should interact with medical personnel and patients.





-    g. Define (in SOPs, operational orders and/or other relevant documentation) the circumstances and conditions in which individuals may be removed from medical facilities (e.g. to be transferred to a detention facility), so as to ensure that legal requirements in relation to the provision of medical care are met, and that removal decision-making and execution is guided by medical opinions (treatment as per the detention SOP).
-    h. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on the specific circumstances in which it is permissible to collect biometric data from patients during search operations and how this should be done.
-     i. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on procedures relating to personal equipment (carriage of weapons, body armour, helmets, etc.), in accordance with the prevailing circumstances.²⁰
-     j. Provide guidance (in SOPs, operational orders and/or other relevant documentation) on the circumstances and conditions in which force may be used within the medical facility.
-   k. Provide guidance on the precautions that troops, medical personnel and patients should take in order to comply with health and safety guidelines, to protect themselves from infectious diseases, and to avoid spreading such diseases.
-    l. Abstain from conducting operations in isolation areas (neonatal and other intensive care units, wards for immunosuppressed patients, etc.).
-     m. Deploy sufficient forces or resources to conduct searches and ensure that search units include military medical personnel and female officers, as relevant to the circumstances (e.g. social, cultural and/or gender issues).











²⁰ The ICRC and other humanitarian organizations observe no-weapon policies in medical facilities.

-  n. Provide training to military personnel (including military medical personnel) likely to have to conduct search operations in medical facilities. Adequate training will ensure that such personnel are familiar with, and prepared to implement, SOPs, operational orders and/or other relevant documentation designed to minimize disruption during searches.

4. ENSURING THAT MEDICAL FACILITY SEARCHES AND THE REMOVAL OF INDIVIDUALS FROM THESE FACILITIES ARE ONLY CARRIED OUT IN EXCEPTIONAL CIRCUMSTANCES, IN ORDER TO MINIMIZE THE IMPACT ON PATIENTS AND MEDICAL PERSONNEL

When considering conducting a search operation in a medical facility or removing a patient from a facility, armed forces should weigh the anticipated military advantage against the humanitarian consequences of such an action. They should take measures to ensure that such decisions are only made in exceptional circumstances.

-  a. Consider alternatives to military searches of a specific medical facility (e.g. use of civilian police).
-  b. Set rules (in SOPs, operational orders and/or other relevant documentation) on the level of authority by which, and the exceptional circumstances in which, a decision may be taken to conduct searches in a specific medical facility.
-  c. Define (in SOPs, operational orders and/or other relevant documentation) the authorization process for a request to conduct searches in a specific medical facility, and what documentation is required (evidence of the military necessity, military advantage expected, etc.).
-  d. Define (in SOPs, operational orders and/or other relevant documentation) the level of authority by which, and the exceptional circumstances in which, an individual may be removed from a medical facility (e.g. to be transferred to a detention facility).

-    e. Adopt the necessary measures, under military criminal law and disciplinary rules, to ensure that commanding personnel involved in both decisions on, and the conduct of, searches in medical facilities neither issue orders to conduct searches in a manner that unduly impedes or denies the provision of health-care in those facilities, nor fail to take feasible measures within their power to prevent or punish searches conducted in such a manner by their subordinates when they know or should have known about such conduct.
-   f. Describe (in SOPs, operational orders and/or other relevant documentation) the oversight measures to be taken by the approving authority (communication, investigation in case of an incident, etc.).
-   g. Describe (in SOPs, operational orders and/or other relevant documentation) the reporting requirements that apply to the officer in charge of the search operation in a specific medical facility (timing, information, etc.).
-    h. Appoint a staff position in charge of reviewing and updating lessons learned from coordination between the military and health-care providers and from incidents arising due to a lack of coordination.

ANNEX 1: LEGAL FRAMEWORK

In times of armed conflict, international humanitarian law (IHL) provides rules to protect access to health care. These rules bind states and non-state armed groups. In situations that do not reach the threshold of armed conflict, only international human rights law (IHRL) and domestic law apply. In principle, IHRL applies at all times, unless states decide to derogate from it. Though less specific than IHL, IHRL contains several rules protecting access to health care.²¹

INTERNATIONAL AND NON-INTERNATIONAL ARMED CONFLICT

THE WOUNDED AND SICK

Attacking, harming or killing

The wounded and sick must be respected in all circumstances; attempts upon their lives and violence against their person are strictly prohibited (First Geneva Convention of 1949 (GC I), Art. 12; Second Geneva Convention of 1949 (GC II), Art. 12; Fourth Geneva Convention of 1949 (GC IV), Art. 16; Additional Protocol I of 1977 (AP I), Art. 10; Additional Protocol II of 1977 (AP II), Art. 7). Wilfully killing them or causing great suffering or serious injury to their bodies or to their health constitutes war crimes as grave breaches of the Geneva Conventions (GC I, Art. 50; GC II, Art. 51).

In certain circumstances, the denial of medical treatment may constitute cruel or inhuman treatment, an outrage upon human dignity, in particular humiliating and degrading treatment, or even torture if the necessary criteria are met.

Searching for and collecting

Parties to an armed conflict must take all possible measures to search for and collect the wounded and sick without delay. If circumstances permit, parties must make arrangements for the removal or exchange of the wounded and sick (GC I, Art. 15; GC II, Art. 18; AP II, Art. 8; ICRC Study on Customary International Humanitarian Law (Customary IHL Study), Rule 109; see also AP I, Art. 17 on the role of the civilian population and aid societies in relation to the wounded, sick and shipwrecked).

²¹ The framework is derived from the ICRC factsheet *Respecting and Protecting Health Care in Armed Conflicts and in Situations Not Covered by International Humanitarian Law*. See <https://www.icrc.org/en/document/respecting-and-protecting-health-care-armed-conflicts-and-situations-not-covered>, all web addresses accessed 29 May 2020.

Protection and care

All parties to an armed conflict must protect the wounded and sick from pillage and ill-treatment. They must also ensure that adequate medical care is provided to them as far as practicable and with the least possible delay (GC I, Art. 15; GC II, Art. 18; GC IV, Art. 16; AP II, Arts 7 and 8; Customary IHL Study, Rule 111).

Treatment without discrimination

The wounded and sick must be treated without discrimination. If distinctions are to be made among them, it can be only on the basis of their medical condition (GC I, Art. 12; GC II, Art. 12; AP II, Art. 7(2); Customary IHL Study, Rule 110).

MEDICAL PERSONNEL***Protecting and respecting***

Medical personnel exclusively assigned to medical duties/purposes must always be respected and protected, unless they commit, outside of their humanitarian function, acts that are harmful to the enemy (GC I, Art. 24; AP I, Art. 15; Customary IHL Study, Rule 28). When they carry and use weapons to defend themselves or to protect the wounded and sick in their charge, medical personnel do not lose the protection to which they are entitled (GC I, Art. 22(1); GC II, Art. 35(1); AP I, Art. 13(2)(a)). The wounded and sick under their care remain protected even if the medical personnel themselves lose their protection.

Provision of care

Parties to an armed conflict may not impede the provision of care by preventing the passage of medical personnel. They must facilitate access to the wounded and sick, and provide the necessary assistance and protection to medical personnel (GC I, Art. 15; GC II, Art. 18; GC IV, Art. 17; AP I, Art. 15(4)).

HEALTH-CARE PROFESSIONALS***Impartial care***

No health-care professional may be punished for having carried out activities compatible with medical ethics, such as providing impartial care (AP I, Art. 16(1); AP II, Art. 10(1)); see also GC I, Art. 18 on the role of the population; Customary IHL Study, Rule 26).

Medical ethics

Health-care professionals, such as physicians, have certain ethical duties to fulfil. These duties are protected by various provisions of IHL. Parties to an armed conflict must not compel medical professionals to carry out activities that are contrary to medical ethics or prevent them from fulfilling their ethical duties. Further, parties must not prosecute medical professionals for acting in accordance with medical ethics (AP I, Art. 16(1) and (2); AP II, Art. 10(1) and (2); Customary IHL Study, Rule 26).

Health-care professionals must protect the confidentiality of information obtained in connection with the treatment of patients: this is one of the most important principles of medical ethics. Under Protocols I and II of 8 June 1977 additional to the Geneva Conventions, persons engaged in medical activities may not, unless required to do so by law, be compelled to give information concerning the wounded and sick who are or have been under their care either to their own party or to an adverse party, if this information would prove harmful to the patients or their families (AP I, Art. 16(3); AP II, Art. 10(3) and (4)).

The World Medical Association is of the view that medical ethics remain the same during armed conflict and in peacetime.²²

MEDICAL UNITS AND TRANSPORTS

Medical units

Medical units, such as hospitals and other facilities organized for, and exclusively assigned to, medical purposes, must be respected and protected in all circumstances. Medical units may not be attacked and access to them may not be limited. Parties to an armed conflict must take measures to protect medical units from attacks, such as ensuring that they are not situated in the vicinity of military objectives (GC I, Art. 19; GC II, Art. 22; GC IV, Art. 18; API, Art. 12; AP II, Art. 11; Customary IHL Study, Rule 28).

Medical units will lose the protection to which they are entitled if they are used, outside their humanitarian function, to commit acts harmful to the enemy, such as sheltering able-bodied combatants or storing arms and

²² World Medical Association (WMA), *WMA Regulations in Times of Armed Conflict and Other Situations of Violence*, 1956 (last revision in 2012): https://www.med.or.jp/jma/jma_infoactivity/jma_activity/2012wma/2012_13e.pdf. See also WMA, *Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies*, 2015: https://healthcareindanger.org/wp-content/uploads/2016/04/4245_002_ethical_principles_of_health_care-eng.pdf.

ammunition. However, this protection can be suspended only after due warning has been given with a reasonable time limit and only after that warning has gone unheeded (GC I, Arts 21–22; AP I, Art. 13; AP II, Art. 11; Customary IHL Study, Rule 28).

Medical transports

Any means of transportation that is assigned exclusively to the conveyance of the wounded and sick, medical personnel and/or medical equipment or supplies must be respected and protected in the same way as medical units. If medical transports fall into the hands of an adverse party, that party becomes responsible for ensuring that the wounded and sick in their charge are cared for (GC I, Art. 35; GC II, Arts 38–39; AP I, Arts 21–31; AP II, Art. 11; Customary IHL Study, Rules 29 and 119).

Perfidy

Parties to an armed conflict who use medical units or transports with the intent of leading the opposing parties to believe they are protected, while using them to launch attacks or carry out other acts harmful to the enemy, commit acts of perfidy. If such an act of perfidy results in death or injury to individuals belonging to an adverse party, it constitutes a war crime (AP I, Arts 37 and 85(3)(f); Customary IHL Study, Rule 65).

USE OF THE DISTINCTIVE EMBLEMS PROTECTED UNDER THE GENEVA CONVENTIONS AND THEIR ADDITIONAL PROTOCOLS

When used as a protective device, the emblem – the red cross, the red crescent or the red crystal – is the visible sign of the protection conferred by the Geneva Conventions and their Additional Protocols on medical personnel, medical units and medical transports. However, no such emblem confers as such protection; it is the fact that persons or objects meet the requirements for qualifying as medical personnel and objects and the fact that they discharge medical functions that are constitutive of protection (GC I, Art. 38; GC II, Art. 41; AP I, Arts 8(1); AP II, Art. 12; Additional Protocol III of 2005 (AP III); Customary IHL Study, Rule 30). During an armed conflict, the authorized users of a protective emblem include military medical personnel, units and transports; National Red Cross and Red Crescent Societies' medical personnel, units and transports that have been recognized by the state and authorized to assist the medical services of the armed forces; state-certified civilian medical units authorized to display the emblem; and medical personnel in occupied territory. The emblem used as a protective device should be large enough to ensure

visibility so that an adversary could recognize medical units from a distance on the battlefield. Medical units and transports may also use distinctive signals (such as light and radio signals) (GC I, Arts 39–44; GC II, Arts 42–43; AP I, Arts 39–44; AP II, Art. 12).

When used as an indicative device, the emblem links the person or object displaying it to an institution of the International Red Cross and Red Crescent Movement. In this case, the sign should be relatively small (GC I, Art. 44).

Attacking buildings, material, medical units and transports or personnel displaying the distinctive emblems is a war crime.

Misuse of the emblem

Any use of the emblem not prescribed by IHL is considered to be improper (GC I, Art. 53; AP I, Arts 37–38 and 85; AP II, Art. 12; Customary IHL Study, Rule 59). Perfidious use of the emblem – to protect or hide combatants, for example – constitutes a war crime when it results in death or serious injury (AP I, Art. 85; Customary IHL Study, Rule 65).

SITUATIONS OTHER THAN ARMED CONFLICTS

Under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), states must take steps to ensure the right of everyone to enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of physical and mental health (the right to health).

General Comment No. 14 of the United Nations Economic and Social Council (General Comment No. 14) states that the right to health contains the core obligations to maintain essential primary health care, access to minimum essential food, basic shelter, housing and sanitation, and an adequate supply of safe and potable water, as well as the obligation to provide essential drugs. These core obligations are non-derogable and require states to respect, protect and ensure the right to health.

The right to medical care is also provided under Article 25 of the Universal Declaration of Human Rights, an instrument accepted by most as international customary law.

Access to health care is also articulated in several other important instruments of international human rights law.²³

THE WOUNDED AND SICK

Attacking, harming or killing

The wounded and sick have the right – just like any other individual under a state's jurisdiction – not to be arbitrarily deprived of their lives. This is a non-derogable obligation of states under Article 6 of the International Covenant on Civil and Political Rights (ICCPR). Individuals also have a right to personal security under Article 9 of the ICCPR.

The use of force against an individual may be justifiable in certain cases where it is absolutely necessary. The United Nations' Basic Principles on the Use of Force and Firearms by Law Enforcement Officials sets out the situations in which the use of force is permissible. However, the lethal use of force is justified only when protecting life. A warning must be given prior to the use of force, and sufficient time allowed for it to be observed.

In certain circumstances, the denial of medical treatment may constitute cruel, inhuman and degrading treatment, or even torture if the necessary criteria are met.

In addition, under the Rome Statute of the International Criminal Court, the murder of wounded and sick people, as well as other inhumane acts of a similar character intentionally causing great suffering or serious injury to body or to mental or physical health, may amount to crimes against humanity. (Rome Statute, Art. 7(1)(a) and (k)).

Protection

States have an obligation to protect the wounded and sick from ill-treatment; they must also protect the right to health of the wounded and sick. The Human Rights Committee of the United Nations has stated on many occasions that states have an obligation under the right to security to take the necessary

²³ See Art. 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (1965); Arts 11(1)(f), 12 and 14(2)(b) of the Convention on the Elimination of All Forms of Discrimination against Women (1979); Art. 24 of the Convention on the Rights of the Child (1989); Arts 28, 43(e) and 45(c) of the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990); and Art. 25 of the Convention on the Rights of Persons with Disabilities (2006).

measures to protect individuals under their jurisdiction, even protecting them from private individuals. The right to health also requires that states take all necessary measures to “safeguard individuals within their jurisdiction from infringements of the right to health by third parties” (General Comment No. 14).

Searching for, collecting, and providing care

Under the right to health, states have a non-derogable obligation to “ensure the right of access to health facilities, goods and services” (General Comment No. 14). When individuals are unable to realize this right by themselves, as may be the case for the wounded and sick, states must take the necessary measures to provide this access, which may entail searching for and collecting the wounded and sick.

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

Treatment without discrimination

Under Articles 2.2 and 3 of the ICESCR, the right to health must be exercised without discrimination. Access to health care for the wounded and sick must be equitable. This obligation is immediate and non-derogable. Under Article 4 of the ICESCR, states are entitled to place restrictions on the right to health. However, this must be done in accordance with the law, including human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society (General Comment No. 14).

MEDICAL PERSONNEL

Protecting and respecting

Medical personnel have the right to protection against arbitrary deprivation of life and the right to security in the same way as the wounded and sick.

Provision of care

States must not prevent medical personnel from treating the wounded and sick. Under the right to health, states have an obligation to “refrain from interfering directly or indirectly with the enjoyment of the right to health” (General Comment No. 14).

Arresting medical personnel for providing care may amount to a violation of the protection against arbitrary arrest and detention, even if it is done lawfully under national law. The Human Rights Committee of the United Nations has stated that inappropriateness and injustice in legislation can amount to arbitrariness.

Medical ethics

Resolution 37/194 of the UN General Assembly on the Principles of Medical Ethics states that in these situations as in times of armed conflict, states should not punish medical personnel for carrying out medical activities compatible with medical ethics or compel them to undertake actions that contravene these standards.

MEDICAL UNITS AND TRANSPORTS

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

USE OF THE DISTINCTIVE EMBLEMS PROTECTED UNDER THE GENEVA CONVENTIONS AND THEIR ADDITIONAL PROTOCOLS

During situations other than armed conflicts, the use of the emblem is restricted. Under GC I, Art. 44(1), military medical personnel, units and transports can use the emblem as a protective device in time of peace, and in situations of violence other than armed conflict. National Societies' medical units and transports, whose assignment to medical duties in the event of an armed conflict has been decided, can also use the emblem as a protective device, as long as they have been authorized to do so by the appropriate authority. Finally, in certain cases, civilian medical units may be authorized to use the emblem as a protective device. This requires the medical units to have been recognized as such by the state and the state to allow this use of the emblem. However, this use should be limited to the preparation of medical units for an eventual armed conflict: for example, painting the emblem on the roof of a hospital.

The emblem may also be used as an indicative device by ambulances and first-aid stations, when they are exclusively assigned to provide free treatment to the wounded and sick. In this case, the use must be in conformity with national legislation and authorized by the National Society.

MAINTAINING HEALTH-CARE SYSTEMS DURING ARMED CONFLICTS AND IN SITUATIONS NOT COVERED BY IHL

In all circumstances, in times of peace and during conflict, states have an obligation to maintain a functioning health-care system. They must maintain essential primary health care, access to minimum essential food, basic shelter, housing and sanitation, and an adequate supply of safe and potable water, as well as provide essential drugs, while respecting the principles of non-discrimination and equitable access. States must also design and implement public health strategies (General Comment No. 14). Similar provisions exist in IHL that require states to provide food and medical supplies to the population. In occupied territory, pursuant to GC IV, Art. 56, the Occupying Power (with the cooperation of national and local authorities) must, to the fullest extent of the means available, ensure and maintain medical and hospital establishments and services and public health and hygiene, and adopt the prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics. Though both IHL and IHRL allow states to predicate their obligations on the resources available to them, a lack of resources does not justify inaction. Even in cases where resources are extremely limited, states should adopt low-cost programmes that target the most disadvantaged and marginalized members of the population.

Humanitarian relief

Under IHL, if a civilian population lacks essential supplies, the party concerned has the obligation to ensure that humanitarian assistance is provided. It may therefore have to allow an organization or a third state to enter its territory to provide humanitarian assistance or even to request it. This obligation is circumscribed by the requirement to secure the consent of the receiving party; however, to justify its refusal, the receiving party must produce reasons whose validity cannot be contested. In occupied territory, the Occupying Power does not have the option to refuse.

All states and all parties to an armed conflict must allow and facilitate the unimpeded passage of humanitarian relief on their territories to populations in need, subject to their right of control. This obligation is not limited to parties to the conflict; it also applies to third states through which relief consignments must pass in order to reach populations in need.

Under the right to health, states have an obligation to take all necessary steps and use their resources to the maximum extent available, which includes available humanitarian relief.

DOMESTIC NORMATIVE AND PRACTICAL MEASURES

DISSEMINATION

To ensure protection of access to health care, states need to disseminate the content of both IHL and IHRL obligations at all levels. This information should be provided to the armed forces and to civil defence and law enforcement officials, as well as to medical personnel and civilians in general.²⁴ Dissemination may require the translation of legal texts.

States must provide military commanders and law enforcement officials with legal advisers to help them apply and teach IHL and IHRL.²⁵

USE OF THE DISTINCTIVE EMBLEMS PROTECTED UNDER THE GENEVA CONVENTIONS AND THEIR ADDITIONAL PROTOCOLS²⁶

The responsibility for authorizing the use of the red cross, red crescent and red crystal emblems, and for suppressing misuse and abuse, rests with the state, which must regulate their use in accordance with the terms of the Geneva Conventions and their Additional Protocols.

States should therefore adopt internal measures to: identify and define the emblems that have been recognized and are protected by the state; determine which national authorities are competent to regulate and monitor the use of the emblems; decide which entities are entitled to use the emblem; and identify the uses for which permission is required.

States must enact domestic legislation prohibiting and punishing unauthorized use of the distinctive emblems and their denominations at all times, for any form of personal or commercial use, and prohibit imitations or designs that could be mistaken for the emblems.

²⁴ For more information on dissemination, please refer to the factsheet prepared by the Advisory Service of the ICRC and titled *The Obligation to Disseminate International Humanitarian Law*.

²⁵ For more information on legal advisers in armed forces, please refer to the factsheet prepared by the Advisory Service of the ICRC and titled *Legal Advisers in Armed Forces*.

²⁶ For more information on the use of the emblem, please refer to the factsheet prepared by the Advisory Service of the ICRC and titled *The Protection of the Red Cross/Red Crescent Emblems*.

States should also take measures to prevent the misuse of the emblems by the armed forces.

Medical personnel

In times of armed conflict, medical personnel should wear armlets and carry identity cards displaying the emblem.

Medical units and transports

In times of armed conflict, parties should use the emblem to clearly mark their medical units and transports on the ground, at sea and in the air.

REPRESSION OF VIOLATIONS²⁷

Measures should be implemented at the national level to ensure an effective system for fixing individual criminal responsibility and for suppressing crimes against the wounded and sick, medical personnel, medical units and medical transports.

Under Article 2 of the ICCPR, states have an obligation to enact legislation to give effect to the rights contained in the Covenant and to provide effective remedy. This might require states to enact criminal sanctions for certain violations, such as torture.

OTHER MEASURES²⁸

Parties to an armed conflict should do everything feasible to verify that the objectives to be attacked are neither civilians nor civilian objects and are not subject to special protection (as is the case for medical personnel, units and transports) but are military objectives.

When targeting military objectives or choosing means and methods of attack, parties to an armed conflict must take all feasible precautionary measures to avoid harming, or at least to minimize the danger to, medical personnel, units and transports.

²⁷ For more information on the repression of violations, please refer to the factsheet prepared by the Advisory Service of the ICRC and titled *Penal Repression: Punishing War Crimes*.

²⁸ For more information on the implementation of IHL, please refer to the factsheet prepared by the Advisory Service of the ICRC and titled *Implementing International Humanitarian Law: From Law to Action*.

This requires: choosing means and methods of attack that inflict the least incidental injuries to the wounded and sick and to medical personnel; cancelling attacks where it becomes apparent that they could result in excessive injury or damage, that the objectives are not military in character or that these objectives enjoy special protection; and giving effective advance warning of attacks that might affect the civilian population.

Parties to an armed conflict must also, to the greatest extent possible, limit the effects of attacks by removing the wounded and sick, medical personnel and medical units and transports from the vicinity of military objectives.

When planning the occupation of a territory, Occupying States should include provisions on public health in their standard operating procedures.

ANNEX 2: ETHICAL PRINCIPLES OF HEALTH CARE

Ethical Principles of Health Care in Times of Armed Conflict and other Emergencies

Within the framework of the HCiD initiative, 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. Medical 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 medical 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 medical 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, medical 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. Medical 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, medical 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. Medical personnel respect patients' right to confidentiality. It is ethical for medical 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. Medical 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 medical personnel

10. Medical personnel, as well as medical 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 medical personnel to patients, medical facilities and equipment shall not be unduly impeded, nor shall patients' access to medical facilities and medical personnel be unduly impeded.
12. In fulfilling their duties and where they have the legal right, medical 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. Medical 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 3: THE HEALTH CARE IN DANGER INITIATIVE

The ICRC's Health Care in Danger (HCiD) initiative seeks to create a world where weapon bearers, political authorities and populations in countries affected by conflict and other emergencies respect the inviolability of health care at all times. To realize our vision and reach our objectives, the ICRC will work together with its partners along three axes of engagement:

Operationalization

The HCiD initiative supports the identification and implementation of concrete, practical measures and operational responses at national and local levels to prevent violence and safeguard health care in armed conflict and other emergencies. This is done by focusing on countries where it matters the most in order to achieve maximum impact.

Evidence-based strategies




It will not be possible to devise the right strategies to protect health care from violence, or to promote the use of these strategies on the proper scale, without the necessary evidence base. This is why the ICRC's approach to generating evidence on violence against health care, and on the effectiveness of activities to prevent it, focuses on partnering with public-health institutes and other relevant research bodies embedded within the health systems of countries affected by conflict and other emergencies. Research conducted locally in this way will not only enable local prevention strategies to be based on a nuanced understanding of patterns of violence, but will, in time, also contribute to creating a global overview of trends.

Influencing and coalition-building

The ICRC will focus its mobilization efforts at the national and subnational levels, where selected delegations will create and foster "communities of concern" that bring together representatives of health-care providers affected by violence, health-care policymakers, and other stakeholders who can contribute to developing a solution to the violence. Local communities of concern will play a role in mobilizing a broader range of government and civil-society stakeholders, generating evidence, and jointly designing and implementing activities or responses aimed at providing more effective protection for health care.

The ICRC helps people around the world affected by armed conflict and other violence, doing everything it can to protect their lives and dignity and to relieve their suffering, often with its Red Cross and Red Crescent partners. The organization also seeks to prevent hardship by promoting and strengthening humanitarian law and championing universal humanitarian principles.

People know they can count on the ICRC to carry out a range of life-saving activities in conflict zones and to work closely with the communities there to understand and meet their needs. The organization's experience and expertise enables it to respond quickly and effectively, without taking sides.

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