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

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Abstract

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

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

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

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

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

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

1 See, e.g., Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, 22 August 1864, Arts. 6–8, 10, 11, 13; Convention (II) with Respect to the Laws and Customs of War on Land and its annex: Regulations concerning the Laws and Customs of War on Land, 29 July 1899, Art. 21; Convention (III) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention of 22 August 1864, 29 July 1899, Arts. 1–4, 6–8; Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, 6 July 1906, Arts. 1, 3, 5–9, 14, 15, 17; Convention (IV) respecting the Laws and Customs of War on Land and its annex: Regulations concerning the Laws and Customs of War on Land, 18 October 1907, Art. 21; Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, 27 July 1929, Arts. 1, 3, 5–9, 14, 15, 17.

2 References to the four Geneva Conventions and their three Additional Protocols will be abbreviated hereinafter as follows: GC I, II, III and IV; AP I, II and III. See GC I, Arts. 12, 15, 18, 19, 21, 22–27, 35, 36; GC II, Arts. 12, 18, 21–40; GC IV, Arts. 14–22; GC I–IV, Art. 3; AP I, Arts. 8, 10, 12, 13, 15–17, 21–28; AP II, Arts. 2, 7–11, 18. The conventional provisions related to health care largely reflect customary international law, as shown by the following rules of the ICRC Study on Customary International Humanitarian Law: Rule 25 – Medical Personnel; Rule 26 – Medical Activities; Rule 28 – Medical Units; Rule 29 – Medical Transports; Rule 35 – Hospital and Safety Zones and Neutralized Zones; Rule 109 – Search for, Collection and Evacuation of the Wounded, Sick and Shipwrecked; Rule 110 – Treatment and Care of the Wounded, Sick and Shipwrecked; Rule 111 – Protection of the Wounded, Sick and Shipwrecked against Pillage and Ill-Treatment.

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

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

3 The category of 'wounded and sick' is not limited to the wounded and sick in the strict sense of these terms but also covers, for instance, maternity cases. The term is used in this document in accordance with the definition in IHL, i.e. Art. 8(a) of AP I: '"Wounded" and "sick" mean persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility. These terms also cover maternity cases, new-born babies and other persons who may be in need of immediate medical assistance or care, such as the infirm or expectant mothers, and who refrain from any act of hostility.' This definition accords with the broad understanding of the various dimensions of the right to health, interpreted by the Committee on Economic, Social and Cultural Rights (CESCR) in its 2000 General Comment on the right to health. For this reason, the same terminology of 'wounded and sick' expressly used only under IHL is also regarded as appropriate for persons in need of health care under international human rights law.

4 'Medical transports' is generally understood in this document in a broader sense than the technical IHL definition contained in Art. 8(g) of AP I (which requires an exclusive assignment to medical transportation and control of a competent authority of a party to the conflict) and also encompasses, for instance, private cars used to transport the wounded and sick to a health-care facility. However, where the legal situation of 'medical transports' is analysed specifically under IHL, the scope of the notion is limited to that found under IHL.

5 'Medical units' are defined in Art. 8(e) of AP I as facilities and other units, whether military or civilian, that are organised for medical purposes – that is, to search for, collect, transport, diagnose or treat (including first aid) the wounded, sick and shipwrecked, or for the prevention of disease. The term includes hospitals and other similar units, blood transfusion centres, preventive medicine centres and institutes, medical depots and the medical and pharmaceutical stores of such units. Medical units may be fixed or mobile, permanent or temporary. The term 'health-care facilities' is broader in that it covers the various facilities mentioned in Art. 8(e) of AP I, but without requiring an exclusive assignment to medical purposes by a party to the conflict.

6 'Health-care personnel' is understood in this document in the broadest possible sense and covers all persons engaged in care for the wounded and sick, such as nurses, physicians, first-aid workers and ambulance drivers. It is broader than the technical legal term 'medical personnel' as described in Art. 8(c) of AP I, which is defined as 'those persons assigned, by a Party to the conflict, exclusively to the medical purposes enumerated under subparagraph (e) or to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either permanent or temporary.' Where the term 'medical personnel' is used, it will be used in the sense of Art. 8(c) of AP I. It is to be emphasised that under IHL those who are not specifically assigned to medical functions by a party to a conflict would not benefit from specific protection as medical personnel, but – if they are civilians – would generally be protected as civilians. On the other hand, there is a broader protection of any persons engaged in medical activities compatible with medical ethics contained in Art. 16 of AP I and Art. 10 of AP II.

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

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

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

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

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

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

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

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

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

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

10 R. Coupland, above note 7, p. 12.
11 Resolution 5, 31st International Conference of the Red Cross and the Red Crescent, 30 November 2011, available at: www.rcrcconference.org/docs_upl/en/R5_HCiD_EN.pdf.
12 *Ibid.*, op. para. 14.
13 These efforts are also supported by a communication project entitled the Life and Death Campaign, aimed at creating awareness of and mobilising support for this initiative.

related to health-care personnel involved threats rather than direct violence against them.[14]

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

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

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

14 ICRC, *Violent Incidents Affecting Health Care*, above note 7.
15 *Ibid.*, op. para.1.
16 *Ibid.*, op. paras. 2 and 6.
17 Draft resolution and background document on 'Health Care in Danger: respecting and protecting health care in armed conflicts and other situations of violence', available at: www.rcrcconference.org/docs_upl/en/31IC_Health_Care_in_danger_EN.pdf.
18 Further elaboration is provided later in the article.

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

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

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

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

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

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

Material scope of application

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

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

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

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

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

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

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

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

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

25 International Law Commission, above note 23.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40 *Ibid.*, para. 47.

ensure equitable distribution of all health facilities, goods and services; and to adopt and implement a national public health strategy and plan of action.[41]

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

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

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

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

41 *Ibid.*, para. 43.
42 *Ibid.*, para. 44.
43 *Ibid.*, para. 12.
44 *Ibid.*, paras. 30–37.
45 CESCR, General Comment No. 14, above note 29, para. 40.

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

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

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

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

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

47 GC IV, Arts. 55, 56.

48 GC IV, Art. 56(1).

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

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

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

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

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

50 ICRC, *Expert Meeting*, above note 26, p. 65; S. Vité, above note 46, pp. 632–633.
51 ICRC, *Expert Meeting*, above note 26, p. 67; S. Vité, above note 46, p. 641.
52 Paula E. Brentlinger, 'Health sector response to security threats during the civil war in El Salvador', in *British Medical Journal*, Vol. 313, 1996, p. 1472 (describing initiatives by Salvadorean and international aid agencies in training villagers as primary health-care workers, known as health promoters, who studied first aid but also responses to communicable diseases like malaria).
53 Mahmood Adil, Paul Johnstone, Andrew Furber, Kamran Siddiqi and Dilshad Khan, 'Violence against public health workers during armed conflicts', in *The Lancet*, Vol. 381, 26 January 2013, p. 293, available at: www.thelancet.com/pdfs/journals/lancet/PIIS0140673613601270.pdf.
54 CESCR, General Comment No. 14, above note 29, paras. 12 and 35.
55 *Ibid.*, paras. 12 and 44.

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

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

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

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

56 Geneva Conventions, Common Art. 1; AP I, Art. 1(1); Customary IHL Study, Rule 139, pp. 495–498.
57 Geneva Conventions, Arts. 47/48/127/144; Customary IHL Study, Rules 142 and 143, pp. 501–508.
58 One notable exception under IHL is contained in Art. 5 of GC IV, which allows a party to an international armed conflict to derogate from especially rights of communication in relation to protected persons who are suspected of or engaged in activities hostile to the security of the state.
59 ICCPR, Art. 4; ECHR, Art. 15; ACHR, Art. 27; European Social Charter, 18 October 1961, CETS No. 35, Art. 30; Revised European Social Charter, 3 May 1996, CETS No. 163, Art. F.
60 Dominic McGoldrick, 'The interface between public emergency powers and international law', in *International Journal of Constitutional Law*, Vol. 2, 2004, p. 383.
61 Human Rights Committee (HRC), General Comment No. 29: States of emergency, 31 August 2001, UN Doc. CCPR/C/21/Rev.1/Add.11; Manfred Nowak, *U.N. Covenant on Civil and Political Rights: CCPR Commentary*, 2nd ed., N. P. Engel, Kehl-Strasbourg-Arlington, 2005, pp. 89–91.
62 ICCPR, Art. 4(2).
63 ICCPR, Art. 4(1).

international law, particularly under IHL, where applicable, and must not involve discrimination.[64]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

86 SC. Res. 1906, 23 December 2009, op. paras. 10–11; SC. Res. 1925, 28 May 2010, op. paras. 12(c) and 18.

87 SC. Res. 1612, 26 July 2005, Preamble para. 8 and op. paras. 1, 2(a) and 5; SC. Res. 1882, 4 August 2009, Preamble para. 11 and op. paras. 1, 3, 5(a)(b)(c); SC. Res. 1998, 12 July 2011, Preamble para. 10 and op. paras. 3(b), 6(d) and 11.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

95 Note that the terminology used by the ICRC is 'responsibilities' and thus falls short of recognising legally binding obligations. See ICRC, 'International Humanitarian Law and the challenges of contemporary armed conflicts', 31st International Conference of the Red Cross and Red Crescent, available at: www.rcrcconference.org/docs_upl/en/31IC_IHL_challenges_report._EN.pdf.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

104 *Ibid.*

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

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

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

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

109 Principle 5(c), Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Cuba, 27 August–7 September 1990, UN Doc. A/CONF.144/28/Rev. 1.

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

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

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

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

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

110 In accordance with Art. 7(1) of the ICC Statute, crimes against humanity must be committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack. Art. 7(2)(a) of the ICC Statute defines an 'attack directed against any civilian population' as a course of conduct involving the multiple commission of acts referred to in para. 1 against any civilian population, pursuant to or in furtherance of a state or organisational policy to commit such attack.

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

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

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

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

definition under IHL, persons must refrain from acts of hostility in order to benefit from the protected status of wounded and sick.[115]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

136 *Ibid*., paras. 560–561; Commentary on GC I, Art. 22, p. 203. See also Bosnia and Herzegovina, *Military Instructions*, 1992, Item 15, para. 2; South Africa, *Law of Armed Conflict Manual*, 1996, para. 59 (both manuals are available at: www.icrc.org/customary-ihl/eng/print/v2_rul_rule28); United States, *Army Health System*, Army Tactics, Techniques, and Procedures, No. 4-02, August 2013, p. 3–9, para. 3.31; http://armypubs.army.mil/doctrine/DR_pubs/DR_a/pdf/attp4_02.pdf.

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

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

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

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

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

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

139 GC I, Art. 21; GC II, Art. 34(1); GC IV, Art. 19(1); AP I, Art. 13(1); AP II, Art. 11(2); Customary IHL Study, Rules 25, 28, 29.

140 Jean Pictet (ed.), *Commentary on the Geneva Conventions of 12 August 1949*, International Committee of the Red Cross, Geneva, 1960, Art. 21 of GC I, pp. 201-202; and Art. 19 of GC IV, p. 155. See also Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds.), *Commentary on the Additional Protocols*, ICRC, Geneva 1987, Art. 13 of AP I, p. 176; and Art. 11 AP II, p. 1436.

141 See AP I, Art. 57(2)(c). It would seem that the condition of a 'warning' for the loss of protection of medical personnel, units and transports would at least in the overwhelming majority of cases be a mandatory requirement that cannot be dispensed with. However, in exceptional circumstances, such as when there is an imminent and serious threat to the lives of advancing combatants or fighters (i.e. when they momentarily receive fire), it might not be realistic to expect an attacker to meet the warning requirement. See Australia, *The Manual of the Law of Armed Conflict*, 2006, para. 9.69; Peru, *International Humanitarian Law Manual*, 2004, Chapter V, para. 88(b)(2); Israel, Supreme Court, sitting as High Court of Justice, *Physicians for Human Rights* v. *IDF Commander in the West Bank*, No. 2936/02, Judgment of 8 April 2002 (all available at: www.icrc.org/customary-ihl/eng/print/v2_rul_rule28). On the other hand, as the time limit is subject to the explicit caveat 'in all appropriate cases', it follows that this requirement may be dispensed with more broadly where military necessity so requires.

142 See Peru, *International Humanitarian Law Manual*, above note 140, para. 88(b)(2), stating in the context of an attack as a result of a loss of protection of a medical unit: 'In any event, an attempt must be made to protect the wounded and sick.'

143 Alexandra Boivin, *The Legal Regime Applicable to Targeting Military Objectives in the Context of Contemporary Warfare*, Research Paper Series No. 2, University Centre for International Humanitarian Law, 2006, p. 56; Jann K. Kleffner, 'Protection of the wounded, sick and shipwrecked', in Dieter Fleck (ed.), *The Handbook of International Humanitarian Law*, 2nd ed., Oxford University Press, Oxford, 2008, p. 344.

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

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

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

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

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

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

148 *Ibid.*, Principle 9.

149 *Ibid.*, Principles 9 and 10.

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

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

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

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

150 Noam Lubell, 'Challenges in applying human rights law to armed conflict', in *International Review of the Red Cross*, Vol. 87, No. 860, 2005, pp. 745–746.
151 ICCPR, Art. 7; CAT, Art. 16; Manfred Nowak, 'Challenges to the absolute nature of the prohibition of torture and ill-treatment', in *Netherlands Quarterly of Human Rights*, Vo. 23, 2005, pp. 676–678.
152 *Ibid.*, p. 678.
153 *Ibid.*
154 Commentary on GC I, Art. 12, p. 137; Commentary on AP III, Art. 8, p. 1415, para. 4655.
155 J. K. Kleffner, above note 142, p. 331.

interfere with their work, for example by preventing supplies from reaching medical units.[156]

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

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

156 See, for instance, Commentary on AP I, Art. 12, para. 517.
157 GC I, Art. 15; GC II, Art. 18; AP II, Art. 8; Customary IHL Study, Rule 109.
158 Customary IHL Study, commentary on Rule 109, p. 398.
159 See note 35 above.
160 CESCR, General Comment No. 14, above note 29, paras. 34, 43, 47 and 50.
161 *Ibid.*, para. 28.
162 ICESCR, Art. 4; P. Alston and G. Quinn, above note 66, p. 202.
163 ICESCR, Art. 5; CESCR, General Comment No. 14, above note 29, para. 29.
164 One of the thematic areas with which the Health Care in Danger project is concerned, notably the improvement of standard operating procedures to expedite controls at military and security checkpoints, may lead to a strengthening of respect for the prohibition against arbitrarily limiting or denying, as much as possible, access to health care. This will be among the issues to be discussed in the Health Care in Danger military expert workshop in Sydney in December 2013. Under the right to health, the adoption of

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

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

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

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

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

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

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

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

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

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

The term 'medical ethics' refers to the moral duties of medical professionals, usually decreed by the professional medical associations of each state.[171]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

193 HRC, General Comment No. 16, above note 191, paras. 3–4.

194 HRC, General Comment No. 29, above note 61, paras. 4–5.

195 Commentary on GC I, Arts. 19, 24 and 35, pp. 196, 220 and 280; Commentary on AP I, Arts. 12 and 21, pp. 166 and 250, paras. 518 and 840–842; Commentary on AP II, Arts. 7, 9 and 11, pp. 1408, 1421 and 1433, paras. 4635, 4674 and 4714.

196 GC I, Art. 15; GC II, Art. 18; GC IV, Art. 16; AP II, Art. 8; Customary IHL Study, Rule 111, pp. 403–405.

197 CESCR, General Comment No. 14, above note 29, para. 37; Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Principle 5(c).

third persons from interfering with medical treatment given to the wounded and sick, including where third persons limit access to health services.[198]

The red cross, red crescent and red crystal emblems shall not be employed except to identify protected health-care personnel, facilities, medical transport, and associated medical equipment or medical supplies authorised to use them in armed conflicts or to indicate that persons or objects are linked to the Red Cross and Red Crescent Movement. All necessary measures shall be taken to prevent and repress misuse of the emblems

Under IHL, the protective use of the emblems constitutes the visible sign of protection in armed conflicts.[199] In contrast, the indicative use is intended to show that persons or objects are linked to the Red Cross and Red Crescent Movement.[200] While the protective emblem must be identifiable from as far away as possible, and may be as large as necessary to ensure recognition,[201] the indicative emblem shall be comparatively small in size and may not be placed on armlets or on the roofs of buildings.[202]

It must be emphasised that a protective emblem is not constitutive of the protection of medical personnel, units and transports; it is applicable IHL that confers specific protection on account of their function.[203] There is also no

198 Cf. CESCR, General Comment No. 14, above note 29, paras. 33 and 35.

199 The authorised users of the protected emblems are: medical services of armed forces and sufficiently organised armed groups; medical personnel units and transports of National Red Cross and Red Crescent Societies that have been duly recognised and authorised by their governments to assist the medical services of the armed forces, when they are employed exclusively for the same purposes as the latter and are subject to military laws and regulations; civilian hospitals (public or private) that are recognised as such by state authorities and authorised to display the emblem; in occupied territories and in zones of military operations, persons engaged in the operation and administration of such civilian hospitals (and also in the search for, removal, and transport of and provision of care for wounded and sick civilians, the infirm and maternity cases); civilian medical personnel in occupied territories and where fighting takes place or is likely to take place; civilian medical units and transports, as defined under AP I, recognised by the competent authorities and authorized by them to display the emblem; other recognised and authorised voluntary aid societies, subject to the same conditions as those for National Red Cross and Red Crescent Societies. The ICRC and the International Federation of Red Cross and Red Crescent Societies may use the emblem for protective purposes in armed conflicts without further restrictions. See GC I, Arts. 39–44; GC II, Arts. 22–23, 26–28, 34–37, 39 and 41–44; AP I, Art. 18(1)(4); AP II, Art. 12; AP III, Art. 2.

200 GC I, Art. 44; Regulations on the Use of the Emblem of the Red Cross and Red Crescent by the National Societies, last revised November 1991, Art. 1. The authorised users are: National Red Cross and Red Crescent Societies; and ambulances and first-aid stations operated by third parties, when exclusively assigned to provide free treatment to the wounded and sick, as an exceptional measure, on condition that the emblem is used in conformity with national legislation and that the National Red Cross and Red Crescent Society has expressly authorised such use. See GC I, Art. 44 (2); GC I, Art. 44(4). The ICRC and the International Federation of Red Cross and Red Crescent Societies may use the emblem for indicative purposes with no restriction. See GC I, Art. 44(3).

201 GC I, Arts. 39–44; AP I, Art. 18; Regulations on the Use of the Emblem of the Red Cross or the Red Crescent by the National Societies, adopted by the 20th International Conference of the Red Cross and the Red Crescent, Vienna, 1965, and revised by the Council of Delegates, Budapest, 1991, Art. 6.

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

203 Commentary on AP I, Art. 18, pp. 225 and 228, paras. 746 and 763; Commentary on AP II, Art. 12, p. 1440, para. 4742; Customary IHL Study, commentary on Rule 30, pp. 103–104.

obligation to wear or display an emblem; it is generally recognised as an option, despite the wording under various IHL provisions that medical personnel, units and transports 'shall' be identified by a protective emblem.[204]

Accordingly, should a commander decide for tactical reasons – for instance, where military medical units or transports are systematically targeted or in order to conceal the presence or real strength of armed forces – that medical units or transports should remove or cover up (camouflage) the distinctive emblem, this does not take away the protection to which medical units or transports are entitled under IHL.[205] However, it is evident that it will then be difficult for the opposing party to the conflict to recognise that certain objects are protected as medical units or transports; given this difficulty, the existing Geneva Convention commentaries already recommended that this option should only be used when the tactical situation on the ground would make it absolutely necessary.[206]

The distinction between protective and indicative use of the emblems is necessary to avoid any confusion as to who is entitled to bear the visible sign of protection in armed conflicts.[207] Therefore, the Regulations on the Use of the Emblem of the Red Cross or the Red Crescent by the National Societies stipulate that National Red Cross and Red Crescent Societies shall endeavour, even in peacetime, to take necessary measures to ensure that the indicative emblem is comparatively small.[208]

However, the Commentary to these Regulations makes it clear that this has the character of a recommendation and that 'the use of a large-size emblem is not excluded in certain cases, such as events where it is important for first-aid workers to be easily identifiable'.[209] In this regard, the ICRC *Study on Operational and Commercial and other Non-operational Issues Involving the Use of the Emblems* recommended that first-aid workers (and facilities) belonging to National Red Cross and Red Crescent Societies display a large-sized indicative emblem in situations of internal disturbances and tensions if (a) it might enhance their medical assistance to victims of violence, and (b) it is authorised, or at least not forbidden, by national legislation.[210]

204 GC I, Art. 39; GC IV, Art. 18(3); AP I, Art. 18(4); AP II, Art. 12; however, see Commentary on GC I, Art. 39, p. 307; Commentary on GC IV, Art. 18, p. 149; Commentary on AP II, Art. 12, p. 1440, para. 4742.

205 See Commentary on GC I, Arts. 39, 42 and 44, pp. 307, 320 and 325.

206 See Commentary on GC I, Art. 42, p. 325. Military doctrine has followed up on this recommendation. For instance, North Atlantic Treaty Organization (NATO) Standardization Agreement (STANAG) 2931 provides that a decision to camouflage medical facilities may only be ordered at a certain level of the military hierarchy, i.e. brigade level or equivalent. Secondly, such an order is to be temporary and local in nature only and must be rescinded as soon as the security situation on the ground permits. Finally, this possibility is not envisaged for fixed, large medical establishments.

207 GC I, Art. 44(2).

208 Regulations on the Use of the Emblem, Art. 4.

209 Commentary on Regulations on the Use of the Emblem, Art. 4.

210 ICRC, *Study on the Use of the Emblems: Operational and Commercial and Other Non-Operational Issues*, Geneva, 2011, pp. 117–121.

All necessary measures, including adopting national legislation, shall be taken by competent authorities to prevent and repress – at all times – misuses,[211] including imitations,[212] improper use,[213] or perfidious use of the emblems.[214]

Conclusion

The analysis of IHL and IHRL applicable to insecurity and violence against the delivery of impartial health care in armed conflicts and other emergencies shows that generally these international legal regimes adequately address the various manifestations of violence identified in this context.

Indeed, there are significant commonalities between the specific obligations to provide care for the wounded and sick, and to respect and protect them, as well as medical personnel, units and transports, under IHL and applicable non-derogable IHRL, in particular under the right to health and the right to life in both armed conflicts and other emergencies. IHL and IHRL may also be usefully resorted to, and complement each other, in addressing certain specific indirect consequences of general insecurity and individual violent acts affecting impartial health-care delivery in armed conflicts, like the loss of available health-care personnel due to their exodus in massive numbers or the termination and interruption of essential health-care programmes, where the state's capacity to adopt far-reaching measures to ensure the availability and quality of health-care services is not impaired by active hostilities, such as in situations of prolonged calm occupation.

Given that these international legal frameworks comprehensively address these various challenges, the focus should not be on the development of new international legal rules but on how to better implement the existing ones. In this regard, there is a need to develop – or where they already exist, strengthen – domestic normative frameworks, policy and operational practices, and sharing of good practices to that effect. For instance, not only should domestic criminal repression of attacks on, and other violent interferences with, health-care personnel be strengthened, but it would also be desirable to foresee preventive operational protection mechanisms for threatened health-care personnel by state authorities, which should be based on domestic systems for collecting information on threats and violence against health-care providers.[215] Another area where domestic normative frameworks should be strengthened is in ensuring an adequate balance

211 GC I, Art. 54; AP II, Art. 12; AP III, Art. 6.
212 This refers to the use of a sign which, owing to its shape and/or colour, may be confused with the emblem.
213 This refers to the use of the emblem by people usually authorised to do so, but in a manner inconsistent with IHL provisions on its use; or to the use of the emblem by entities or persons not entitled to do so (commercial enterprises, pharmacists, private doctors, NGOs, ordinary individuals, etc.) or for purposes that are inconsistent with the Fundamental Principles of the Movement. For the relevant IHL treaty provisions, see above note 144.
214 For the definition of perfidy, see above note 144.
215 See, as good practice in this regard, Colombia, Resolución No. 4481, 28 December 2012, 'Por la cual se adopta el Manual de Misión Médica y se establecen normas relacionadas con la señalización y divulgación de su Emblema', section 2.2.

between protecting the discretion of health-care personnel with regard to medical confidentiality, and legal obligations to disclose information on the wounded and sick. Obligations under national legislation of health-care personnel to denounce information on the wounded and sick to public authorities should be limited to cases where a justifiable collective interest, like public health reasons, prevails over the individual right of a patient to have the confidentiality of his or her personal information preserved. In any event, such obligations should not result in facilitating subsequent harm to a patient. There is also a need to review overly broad offences against public order, for instance under domestic anti-terrorism legislation, that have the effect of criminalising the mere fact of providing health care to certain parts of the population. The scope of domestic normative frameworks is also critical to ensure that all health-care providers are encompassed, in particular those delivering health care in their own local communities, as well as to ensure that these frameworks properly take the challenges of insecurity and violence in armed conflicts and other emergencies into account. In terms of identification, it is important to properly prevent and address misuses of the emblems; one vital prerequisite in this regard is the adoption of the domestic regulations required for designating the national authorities competent to issue the necessary authorisations for the use of the emblem.

Better implementation of existing international legal obligations also requires work on military doctrine and practice, for instance on military manuals and standard operating procedures to prevent arbitrary delays, and denials to the passage of medical transports or armed entries into health-care facilities that result in the undue delay or in the denial of medical treatment to the wounded and sick. Moreover, military doctrines and practice should reflect respect for the specific IHL precautionary obligations in relation to the delivery of impartial health care.

While there are significant commonalities between IHL and IHRL, one fundamental difference between the two is the controversy over the applicability of IHRL to non-state armed groups. This controversy is not likely to be resolved in terms of greater consensus on applying IHRL as a matter of law to non-state armed groups, not least because of political sensitivities on the part of states that doing so would imply political recognition of these actors as having legitimate authority over their territory. Still, non-state armed groups must also be addressed by efforts to improve respect for impartial health-care delivery because they are very much part of the problem of insecurity and violence against health-care personnel, facilities and medical transports, and their perspectives must be taken into account in devising solutions. This must be done in a manner that does not alienate states. Where a legal dialogue with non-state armed groups is possible, such a dialogue must be framed in a manner that reflects their specificities. This is not a new challenge – the ICRC, for example, has engaged with non-state armed groups on IHL issues for a long time.[216]

216 On the specific challenges in ensuring compliance for IHL by non-state organised armed groups that are party to the conflict, see, for example, ICRC, *Increasing Respect for International Humanitarian Law in Non-International Armed Conflicts*, 2008.

The behaviour of health-care providers themselves is also critical, as their access to the wounded and sick depends very much on acceptance of their work by all parties to the conflict, actors in other emergencies, and local communities. In this regard, they must of course scrupulously respect relevant IHL and IHRL rules and medical ethics that overlap significantly with IHL and IHRL, particularly in the fundamental requirement to provide care in an impartial/non-discriminatory manner. It must also be emphasised that they should exclusively remain engaged in health-care activities, as becoming involved in the military operations of parties to the conflict or violence emanating from one of the opposing actors in other emergencies may cause a loss of their own protection as well as endanger the safety and security of colleagues and the wounded and sick they are caring for. For these purposes, it is of the utmost importance that health-care personnel possess knowledge on the international legal frameworks relevant to them, and that they are aware of any possible ethical dilemmas before they arise during their work in armed conflicts and other emergencies. The need to specifically train health-care personnel on IHL and IHRL, as well as the ethical dilemmas they may face, cannot be overemphasised. One of those dilemmas, notably that of how to strike an acceptable balance between their own safety and the need to rapidly provide life-saving health-care services, which is especially accentuated in unlawful intentional follow-up attacks against health-care personnel arriving on the scene of a prior attack, requires adaptation of existing security procedures for first responders.

The various expert workshops conducted as part of the Health Care in Danger project will continue to enable us to discuss these and other challenges and provide possible recommendations. Ultimately, however, the success of this project and other efforts in seeking to strengthen respect for impartial health-care delivery in armed conflicts and other emergencies will depend on whether improvements can be felt by the wounded and sick, and by health-care providers on the ground.