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# THE IMPLEMENTATION OF RULES PROTECTING THE PROVISION OF HEALTH CARE IN ARMED CONFLICTS AND OTHER EMERGENCIES: A GUIDANCE TOOL

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# 1. INTRODUCTORY REMARKS

As part of the experts' consultation process of the Health Care in Danger project,[1] a workshop on domestic normative frameworks for the protection of the provision of health care was organized jointly by the International Committee of the Red Cross (ICRC), the Belgian Interministerial Commission for Humanitarian Law and the Belgian Red Cross in Brussels from 29-31 January 2014. The objective of the workshop – directed at civil servants, members of national international humanitarian law committees or similar bodies, and members of parliament – was to identify concrete domestic measures and procedures, in particular legislative and regulatory ones, that can be established by State authorities in order to implement the existing international legal framework for protecting the provision of and access to health care in armed conflicts and other emergencies. Background research on existing domestic normative frameworks conducted by the ICRC's Advisory Service on International Humanitarian Law – including several country studies – formed the basis of the Brussels workshop's discussions.

The present document draws on the recommendations that emerged from the Brussels workshop and the results of the above-mentioned country studies. It has been developed as a practical tool to support State authorities, with consideration for their national specificities, in developing effective domestic legal frameworks, implementation measures and appropriate sanctions in light of their international obligations for protecting the provision of health care in armed conflicts and other emergencies.

[1] Respect for and protection of the wounded and sick, health-care personnel and facilities and medical transports has been at the heart of the development of international humanitarian law since the initial Geneva Convention was adopted in 1864. In November 2011, the 31st International Conference of the Red Cross and Red Crescent asked the ICRC to initiate consultations with experts from States, the International Red Cross and Red Crescent Movement and others in the health-care sector. The aim was, and still is, to make the delivery of health-care services, in armed conflicts and other emergencies, safer. The Health Care in Danger project brought together National Red Cross and Red Crescent Societies and various external stakeholders, such as policymakers, government health-sector personnel, military staff, humanitarian agencies and representatives of academic circles, in order to identify concrete measures and recommendations that authorities and/or health-care personnel can implement to ensure better respect and protection for health-care delivery.

# 2. INTERNATIONAL LEGAL FRAMEWORK FOR PROTECTING THE PROVISION OF HEALTH CARE

In times of armed conflict, either international or non-international, international humanitarian law (IHL) provides rules to protect access to health care. These rules bind States and non-State armed groups. In situations that do not reach the threshold of armed conflict, only International Human Rights Law (IHRL) applies. IHRL applies at all times but States may, in exceptional circumstances, derogate from some of its provisions. Though less specific than IHL, IHRL contains several rules protecting access to health care. The protection offered by IHL and IHRL can be divided into four main issues: (1) the protection of the wounded and sick, and of health-care personnel and facilities and of medical transports; (2) medical ethics and confidentiality; (3) the use of the distinctive emblems (red cross/red crescent/red crystal); and (4) sanctions. Each of these issues has been broken down into three themes, for ease of comprehension of the various obligations and recommendations contained in the present document: legal and regulatory measures, dissemination and training measures, and coordination and institutional capacity measures.

For more information on this topic, see Annex 1: "International Legal Framework" as well as the ICRC Advisory Service's fact sheet, *Respecting and Protecting Health Care in Armed Conflicts and in Situations Not Covered by International Humanitarian Law* (http://www.icrc.org/eng/assets/files/2012/health-care-law-factsheet-icrc-eng.pdf).

# 3. DOMESTIC IMPLEMENTATION MEASURES

The measures described in this part of the document are not meant to be an exhaustive portrait of international obligations and related implementation suggestions. They are rather a compressed compilation of what was set out and discussed at the Brussels workshop.

## 3.1. Protection for the wounded and sick, health-care personnel and facilities, and medical transports

### 3.1.1. Legal and regulatory measures

***Recommendation:** States should develop a better understanding of the nature of violence against health care on their own territory, including all types of undue interference with the provision of health care, in order to elaborate an adequate response.*

To ensure that challenges to the provision of health care are adequately responded to, a good understanding of the situation is necessary, which can be achieved via measures such as:

- Setting up a national system for collecting data on the occurrence of violence against health-care personnel and facilities and medical transports as well as against patients, including all types of interference with the provision of health care; this system should be established in peacetime as a preventive measure and based on the following considerations:
  (1) Be guided by clear criteria (classifying data in context-specific categories)
  (2) Be managed by State authorities
  (3) Be independent and transparent (with a view to ensuring the reliability of the data collected)
  (4) Serve only analytical purposes
  (5) Ensure protection of the use and access to the data collected.

- Advocating for complementing such a system with an international system for consolidation and comparison of data in order to have a comprehensive understanding of the nature of violence against health-care worldwide and to foster cooperation between States in developing global coordinated strategies for the protection of health-care personnel and facilities and medical transports.

***Recommendation:** States must take appropriate measures to implement their international obligations with regard to the protection of health care in their domestic legal frameworks. Implementation should be done in a way that takes into account their national specificities and ensures effective protection of the provision of, and access to, health care in all circumstances.*

With regard to this objective, a number of considerations must be taken into account, such as:

- When developing a domestic legal framework for the protection of health care, consider the advantages and disadvantages of both specific legislation applicable to armed conflict and other emergency situations not governed by IHL and general legislation applicable in all circumstances
- When developing a domestic legal framework for the protection of health-care delivery, consider the advantages and disadvantages of both specific legislation regarding the protection of health care and of introducing provisions on that subject in existing legislation with a broader scope (penal codes, regulations on health services, disaster mitigation laws, etc.)
- When implementing the international legal framework for the protection of health-care delivery, States must take into account the specificities of each domestic legal system (e.g. civil vs common-law approach, monist vs dualist), the distribution of legislative, judicial and administrative powers within the structure of the State (e.g. federal vs centralized States), and the repartition of responsibilities and tasks within the health sector.

Regarding the protection of the **wounded and sick**, the following measures are necessary to comply with the relevant norms under IHL and IHRL:

(1) Including the right to health in the national constitution
(2) Enshrining an obligation for everyone to rescue or provide assistance to persons in urgent need of medical care
(3) Penalizing, in administrative and criminal law, violations of international law norms protecting health care (see, *infra*, Section 3.4 on sanctions)
(4) Taking all relevant measures to guarantee access to the health-care system in a timely manner for wounded and sick persons during armed conflicts and other emergencies, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other criteria
(5) Giving special attention to addressing the needs of persons with specific vulnerabilities, in particular victims of rape or other forms of sexual violence.

It is important for victims of rape and other forms of sexual violence to have access to medical, psychosocial and psychological care. Such services should be provided without interference and with respect for the principle of medical confidentiality.

'Rape and other forms of sexual violence' is a medical emergency, potentially resulting in severe physical and psychological health consequences for victims. It is crucial that they have unimpeded access to quality and timely medical care within 72 hours to reduce, for example, the risk of infections. It is important that judicial processes safeguard victims' anonymity and confidentiality, in keeping with legal, social and cultural norms.

***Recommendation:** Specific legislative and practical measures should be adopted in order to adequately address the needs of victims of rape and other forms of sexual violence in armed conflicts and other emergencies.*

Regarding the specific needs of victims of sexual violence, the following practical measures can be used to adequately address them:

- Raise awareness of health-care personnel on the specific needs of victims of sexual violence and their particular vulnerabilities
- Include the issue of sexual violence as an integral part of health-care personnel's education and of training programmes for them, on the basis of a multidisciplinary approach including psychological and psychosocial training
- Provide health-care facilities with at least one properly trained health-care staff person to help victims of sexual violence who need immediate assistance.

Regarding the protection of **health-care personnel**,[2] relevant measures to be taken in domestic legal frameworks comprise:

- Providing, within the domestic legal framework, a broad definition of 'health-care personnel' and of their activities, including traditional medicine

[2] The notion of *health-care personnel* referred to in this guidance tool and in the whole of the Health Care in Danger project includes all persons engaged in care for the wounded and sick, in order to comprehensively address the problem of violence impacting on activities for the exclusive benefit of the wounded and sick. It includes but goes beyond the different categories of *medical personnel,* protected under IHL and entitled to use the red cross, red crescent or red crystal emblems.

**Nepal** has developed a domestic normative framework for traditional Ayurvedic medicine.[3] According to the World Health Organization, "[t]he policy of the Government, based on five-year plans, involves a system of integrated health services in which both allopathic and ayurvedic medicine are practised. Ayurvedic clinics are considered to be part of the basic health services, and there is a section responsible for ayurvedic medicine in the Office of the Director General of Health Services. The programmes for health services included in the Fifth Five-Year Plan make provision for four ayurvedic hospitals, one in each of the four development regions. The Ayurvedic Governmental Pharmaceutical Unit works to provide inexpensive medicaments." (For more information, please refer to World Health Organization, *Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review*, 2001, http://apps.who.int/medicinedocs/pdf/h2943e/h2943e.pdf)

- Issuing, in accordance with the obligations imposed on the High Contracting Parties to the 1949 Geneva Conventions, identification cards and armlets to health-care personnel
- Establishing exceptional measures for providing health care in emergency situations
- Creating specific tools and mechanisms for ensuring the safety of health-care personnel (e.g. hotlines that health-care personnel could use to request State authorities for evacuation or protection); these could be a concrete follow-up to information on incidents collected by national data-gathering mechanisms
- Penalizing, through adequate sanctions, any attack or act of violence against health-care personnel (see, *infra*, Section 3.4 on sanctions).

In **Belgium**, according to Royal Decree No. 78 of 10 November 1967 on the exercise of health-care professions, those who are not lawfully qualified to practise medicine may do so under exceptional circumstances: they are entitled to perform certain medical tasks after a disaster or during a war.

Regarding the protection of **health-care facilities** and **medical transports**, one of the basic legislative measures that should be taken at the national level is to define 'health-care facilities' and 'medical transports', either in the laws that organize and regulate the health-care system or in those that protect the use of the red cross/red crescent/red crystal emblem.

In **Belarus,** Article 2 of the emblem law[4] defines 'medical units' as "stationary or mobile medical institutions and other civil or military formations created on the permanent or temporary basis for searching, picking up, diagnosing or treating the wounded and the sick, shipwrecked persons, including rendering of first aid, and also for preventive measures against diseases." It defines 'medical transports' as "air, surface, sea, river military and civil means of transportation, used on a permanent or temporary basis, intended exclusively for transporting of the wounded and the sick, shipwrecked persons, medical personnel, medical property, and also for other medical purposes."

### 3.1.2. Dissemination and training measures

***Recommendation:** Preventive and safety measures for protecting the provision of and guaranteeing safer access to health care should include education, training and dissemination of the existing legislation and regulations.*

Relevant measures comprise:

- Training the armed and security forces, civil servants, health-care personnel and the population at large about international law and the domestic legislation protecting the provision of and access to health care and about the right to health (see below for more information)
- Raising awareness on the importance of respecting health-care personnel and facilities and medical transports, for example, by integrating this question into the training of armed and security forces, and in the regulations applicable to them.

[3] The Ayurvedic Medical Council Act, No. 21 of 2045 (1988). *International Digest of Health Legislation,* 1992, 43:24.

[4] Law of the Republic of Belarus, 12 May 2000, No. 382-Z, "On Use and Protection of Emblems of the Red Cross, the Red Crescent, the Red Crystal, Distinctive Signals, and also of Designations 'the Red Cross', 'the Red Crescent', 'the Red Crystal'."

### 3.1.3. Coordination and institutional capacity measures

***Recommendation:** States should take appropriate measures to enhance coordination between the different stakeholders involved in the provision of emergency health-care services in order to allow better organized and more efficient emergency response.*

Measures that could be taken include:

- Regulating the roles and responsibilities of the different stakeholders acting in the provision of emergency health care
- Taking appropriate measures to ensure knowledge on the part of the different stakeholders acting in the provision of emergency health care about each other's roles and responsibilities in order to ensure their comprehensive understanding of the organization of emergency response
- Establishing a plan of coordination, ideally provided for in domestic legislation and involving all stakeholders, to organize emergency response and the provision of health-care services in times of armed conflict or other emergencies.

In **Senegal**, a "plan for the organization of emergency services," referred to as Plan ORSEC, can be launched by State authorities when certain conditions are met. This plan identifies the different State institutions involved in emergency response and provides for the establishment of a coordination mechanism as well as a crisis cell responsible for following up the provision of health care in such circumstances. This plan is coordinated by the Ministry of Internal Affairs. Senegalese law also provides for a requisition of State services in times of emergency.[5]

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

In **Argentina**, the Federal System of Emergencies defines a national response to complement the efforts of the provincial and municipal governments when they are overwhelmed. The commander-in-chief of the Armed Forces is in charge of coordinating operations when the Ministry of Defence or other State authority authorizes the use of the armed forces, including their medical services.

In **Peru**, the Disaster Response Law defines the roles of the different stakeholders acting in situations of emergency and establishes mechanisms of joint intervention, which coexist with associations of health-care professionals and hospitals' own internal regulations, for the purpose of channelling medical assistance in situations of emergency.

In **Belgium**, Royal Decree No. 78 of 10 November 1967 on the exercise of health-care professions provides that, wherever health care is lacking or inadequate in a province, the medical commission shall, on its own initiative or at the request of the provincial governor, request that certain organizations or practitioners set up health-care services or supplement existing ones.

[5] Decree No. 2005-1271 of 29 December 2005. See also Article 8 of Law No. 2005-22 of 5 August 2005.

## 3.2. Rules on health-care ethics and medical confidentiality

On this issue, State authorities and national associations of health-care personnel are invited to refer to the World Medical Association's guidelines,[6] as well as the ICRC's Health Care in Danger reference publication on the responsibilities of health-care personnel working in armed conflicts and other emergencies.[7]

### 3.2.1. Legal and regulatory measures

***Recommendation: States need to protect medical confidentiality as an abiding principle of health-care ethics in all circumstances (in peacetime as well as in armed conflict and other emergencies); exceptions to medical confidentiality must be limited and strictly circumscribed in domestic legislation.***

Several measures are to be taken to reach this objective:

- Approaching medical confidentiality as a right of the patient and not only as a simple privilege and ethical duty of health-care personnel

- Limiting and strictly defining and circumscribing exceptions to medical confidentiality in domestic legislation. In practice, this would comprise:
  - **(1)** Defining medical confidentiality as an abiding principle to be respected at all times and in all circumstances
  - **(2)** Identifying all the circumstances in which these exceptions would apply

In **Belgium**, the Code of Medical Ethics (Section 55) requires doctors to ensure professional secrecy **regardless of the circumstances**. Section 458 of the Belgian Penal Code condemns any violation of professional secrecy, unless the provider is called upon to testify in a court or before a parliamentary commission of inquiry, or required by law to disclose confidential information that has been entrusted to him.

In **Russia**, medical confidentiality is established in accordance with Federal Law No.323-FZ (Article 13); there is also an exhaustive list of situations in which confidential medical information may be disclosed to third parties. This list does not indicate whether such confidentiality is applicable to armed conflict or other emergencies, but it references certain situations related to emergencies: (i) threat of epidemic or mass poisoning, and (ii) investigation of accidents at work.

  - **(3)** Using precise wording in order to limit arbitrary application
  - **(4)** Circumscribing the notion of 'international danger to public health' (e.g. a cholera epidemic) in domestic legislation so as to avoid an unduly broad interpretation by State authorities of obligations to disclose certain health-related information
  - **(5)** Granting regulatory and judicial authorities competences to assess the balance between the rights of the patient and health-care personnel, and the interests of public health and security, on the basis of general guiding principles defined in domestic legislation, and this phrased as precisely as possible

In **Belgium**, the law on the rights of the patient (22 August 2002) is an example of the inclusion of medical ethics in legislation dealing with other rights of the patients, such as patient consent, protection of privacy, and the right to information and access to medical records.

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6 The World Medical Association (WMA) International Code of Medical Ethics (http://www.wma.net/en/30publications/10policies/c8/), the *WMA Medical Ethics Manual* (http://www.wma.net/en/70education/30print/10medical_ethics/) and the WMA Regulations in Times of Armed Conflict and Other Situations of Violence (http://www.wma.net/en/30publications/10policies/a20/).

7 ***Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflicts and Other Emergencies*** is an ICRC publication intended to help health-care personnel adapt their working methods to the exigencies of armed conflict and other emergencies. While it does not seek to provide precise or final answers to the various ethical dilemmas that health-care personnel can face in such circumstances, this publication aims at providing such personnel with guidance and prompting reflection on issues related to their ethical obligations. It can be downloaded or ordered at: https://www.icrc.org/eng/resources/documents/publication/p4104.htm

(6) A duty of health-care personnel should be established to report to State authorities visible signs of violence against minors or persons who are not in a position to give informed consent, which they have observed while performing their medical duties (this would be an exception to medical confidentiality)

In **Colombia**, gunshot wounds are reported to the authorities in a way that does not reveal the origins of the wounds.

- Enabling health-care personnel who are under a legal duty to disclose patient information protected under medical confidentiality to take all necessary precautions in order to protect patients' other personal and health-care-related information, and only disclose the information strictly required
- Inserting in domestic legislation and codes of ethics that disclosure by health-care personnel of patients' personal and health-care-related information, either accidentally or intentionally, without the patient's consent and in the absence of a legal obligation to do so, constitutes a violation of a professional duty under their code of ethics and is subject to administrative or disciplinary measures by their professional association.

In **Belgium**, violation of medical confidentiality (referred to as "professional confidentiality") is punishable under the criminal code by imprisonment of eight days to six months and a fine of 100 to 500 euros.[8]

In **Nigeria**, disclosure of confidential medical information constitutes a criminal offence under the Penal Code and is punishable by imprisonment of two months to a year and by a fine of 10,000 to 200,000 nairas.[9]

***Recommendation:** Ensure clarity and coherence of domestic legislation concerning ethical duties applying to health-care personnel.*

This includes:

- Ensuring coherence and consistency of domestic laws and regulations applying to health-care personnel, including criminal laws, in accordance with their ethical duties, and adequately protecting independence and impartiality of health care.
- Clearly defining, in domestic legislation, the rights and responsibilities of health-care personnel, for example, in laws regulating access to health-care professions or in codes of ethics adopted by associations of health-care professionals.

The **Colombian** Ministry of Health and Social Protection has adopted, through a Resolution,[10] the *Manual of the Medical Mission* (2012), which aims at strengthening respect and protection for the medical mission and is applicable to both armed conflict and "other situations of violence." It sets out, among other things:

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

The *Manual* also incorporates the **World Medical Association**'s regulations for armed conflicts.[11]

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

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

10 Resolution No. 4481 of 2012.

11 The **WMA Regulations in Times of Armed Conflict and Other Situations of Violence** were adopted by the 10th World Medical Assembly in 1956. Last revised in 2012, they set out general guidelines as well as a code of conduct to be observed by physicians in all circumstances. They can be found at http://www.wma.net/en/30publications/10policies/a20/

### 3.2.2. Dissemination and training measures

***Recommendation:** States need to ensure proper training for health-care personnel to apply and respect their ethical duties, particularly for resolving dilemmas when confronted with legal obligations to disclose patients' personal and health-care-related information.*

Several measures can been taken at the national level to reach this objective:

- Providing proper training to law enforcement officials (police, prosecutors, etc.) on the ethical duties of health-care personnel and on the importance of respecting medical confidentiality
- Including guidance for health-care personnel in publications such as practical guidelines and handbooks
- Providing comprehensive special training to health-care personnel for resolving dilemmas when legal obligations to disclose patient information conflict with their ethical duties, both in peacetime and during armed conflict or other emergencies. Such special training should have certain specific objectives, such as:
  - (1) To provide strong theoretical knowledge of health-care personnel's ethical duties
  - (2) To provide practical guidance for applying those duties to real-life situations, for example, by means of simulation exercises
  - (3) To be part of health-care personnel's vocational training.

In **Colombia**, such measures were taken through the *Manual of the Medical Mission* and in **Côte d'Ivoire**, through a white paper on the rights and responsibilities of doctors confronted by violence in times of crisis and armed conflict.[12]

### 3.2.3. Coordination and institutional capacity measures

Coordination relates to health-care personnel's interaction with the media and with police officers and other law enforcement officials or State armed forces, in particular in stressful situations such as armed conflict or other emergencies, when medical confidentiality may be endangered. In such situations, measures to manage health-care personnel's interactions with the media and relevant State agents include:

- Adoption of specific regulations or guidelines on this question by associations of health-care professionals. Guidelines for health-care personnel's interactions with the media should also be included in preventive coordination plans for the organization of emergency response
- Designating one health-care staff member as focal point in each working team for all interactions with the media; other health-care staff members should be precluded from interacting with the media
- Adoption of specific measures by State authorities or associations of media professionals to enhance the knowledge of the media with regard to the ethical duties of health-care personnel
- Making respect for health-care personnel's obligation towards medical confidentiality an ethical duty and including clauses to this effect in the code of ethics of media associations
- Facilitation or establishment of regular platforms of dialogue between health-care professionals and police officers, other law enforcement officials and members of State armed forces to enable discussions on dilemmas arising from potential conflicts between legal and ethical duties.

[12] Livre blanc, *Droits et devoirs des médecins face à des actes de violence en période de crise et de conflits armés,* 2013.

## 3.3. Use of the distinctive emblems protected under international humanitarian law (IHL) and of other signs to identify health-care providers

### 3.3.1. Legal and regulatory measures

#### a) Distinctive emblems[13]

***Recommendation:** States need to ensure domestic implementation and dissemination of the international laws and regulations governing the indicative and protective use of the red cross/red crescent/red crystal.*

This obligation should be met by the following measures:

- Adopting specific legislation on the use of the red cross/red crescent/red crystal emblems with a view to clearly regulating who and in what circumstances may use them and reinforcing their value as a visible sign of the protection conferred by IHL on the wounded and sick and on health-care personnel and facilities and medical transports[14]
- Identifying, in domestic legislation, the entities allowed to use the red cross/red crescent/red crystal emblems and designating the national authority competent to authorize and supervise their use. With regard to the use of emblems by medical services of the armed forces, such authority must be a competent military authority (e.g. the Ministry of Defence) (Article 39 of the First Geneva Convention). Regarding civilian health-care personnel, medical units and transports, there is more flexibility as to which State authority may authorize the use of the emblems (e.g. the Ministry of Health) (Article 18, paragraph 3, of the Fourth Geneva Convention; Article 18, paragraph 4, of Protocol I of 8 June 1977 additional to the Geneva Conventions (Additional Protocol I)).

In carrying out these measures, it is important that the distinctive signals used by medical units or transports (light signal, radio signal, and electronic identification) also be covered.[15]

Finally, it is fundamental that the measures to prevent misuse apply to everyone, including members of the armed forces. This may be achieved through State regulations on military discipline and disciplinary procedures.

For more detailed guidance, please refer to the Model Law Concerning the Use and Protection of the Emblem (https://www.icrc.org/en/document/national-legislation-use-and-protection-emblem-model-law#.VHS3POktDcs) and Chapter 4 of the ICRC publication titled *The Domestic Implementation of International Humanitarian Law: A Manual* (https://www.icrc.org/eng/resources/documents/publication/pdvd40.htm).

***Recommendation:** Reinforce measures of control of the use of the red cross/red crescent/red crystal emblems as well as of repression mechanisms for misuse of the emblems.*

This objective may be achieved by measures such as:

- Establishing national monitoring for tracking and sanctioning misuse of the emblem. National legislation must include a designated State authority to monitor and sanction misuse of the emblem. Such control of the use of the emblem may be exercised by military authorities, or by the ministry of health regarding the use of the emblems by civilian hospitals and other medical facilities and transports and by health-care personnel

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13 'Distinctive emblems' is used here to identify the emblems (red cross/red crescent/red crystal) protected by the Geneva Conventions of 1949 and the Protocols of 8 June 1977 and of 8 December 2005 additional to the Geneva Conventions.

14 The regulation of the use of the emblem can be addressed either through the adoption of a specific legislation or through the integration of ad hoc provisions in general laws of incorporation of the Geneva Conventions.

15 See Chapter III of Annex I ("Regulations concerning identification") of Protocol I of 8 June 1977 additional to the Geneva Conventions.

- Encouraging the reporting of misuse of the emblem to the designated appropriate State authority and taking appropriate measures to make public the results of the reporting of violations of laws or regulations on the distinctive emblems

National Red Cross and Red Crescent Societies can play a significant role in assisting the authorities of their respective countries in the monitoring of the use of the distinctive emblems.

In **Switzerland**, the Swiss Red Cross has included in its regulations the conditions of use established by the Federal Law on the Protection of the Emblem and the Name of the Red Cross. The Swiss Red Cross is thus, in peacetime, the organization authorized to use the red cross in accordance with Swiss legislation.[16] When made aware of a case of misuse by imitation (use of a sign which, by reason of its colour and/or shape, may be mistaken as one of the distinctive emblems) or usurpation (use of the emblem by unauthorized persons/entities), the Swiss Red Cross will ask for the misuse to stop. If met with refusal, it will engage in further negotiations. If this measure also fails, judicial procedures will be initiated.[17]

In **El Salvador**, in case of misuse of the emblem, the Salvadorean Red Cross Society or any moral or physical person can file judicial proceedings against those responsible for the misuse, as prohibited by the Law on the Protection of the Emblems and Names of the Red Cross/Red Crescent.[18] The National Registry Centre (*Centro Nacional de Registros*) does not authorize any drawings, logos, or texts to be registered if they are contrary to the Law.[19]

- Imposing criminal sanctions, as well as administrative and disciplinary measures, to repress unauthorized or improper use of the emblem or designations constituting imitations thereof. Perfidious use of the emblem constitutes a war crime and must be repressed as such (see, *infra,* Section 3.4 on sanctions).

In **Belgium**, a specific law[20] provides that misuse of the distinctive emblems is punishable by imprisonment and/or by the payment of a fine, the punishment being more severe when the misuse occurs in times of armed conflict.

In **Serbia**, under the Criminal Code,[21] misuse of the distinctive emblem is punishable by imprisonment of up to three years, and by a minimum of six months and up to five years when committed in a situation of armed conflict.

### b) The use of signs other than the red cross/red crescent/red crystal emblems to identify health-care personnel and facilities and medical transports

In view of the strict conditions regulating the use of the red cross/red crescent/red crystal emblems and the fact that they may be used only exceptionally in situations that do not qualify as armed conflict, health-care activities can also be identified by means other than the distinctive emblems found under the Geneva Conventions and their Additional Protocols.

This involves:

- Ensuring that signs other than the red cross/red crystal/red crescent emblems used to identify health-care activities are established and regulated by State authorities and that a clear distinction is made with the distinctive emblems whose use is regulated by the 1949 Geneva Conventions and their Additional Protocols. This implies:

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16 See Art. 3 (3) of the Statutes of the Swiss Red Cross; Arts 4 and 6 of the Federal Law on the Protection of the Emblem and the Name of the Red Cross (1954).

17 For an example of such judicial procedures, please see Tribunal fédéral suisse, Case T0/2, 4A_41/2014 of 20 May 2014.

18 Law on the Protection of the Emblems and Names of the Red Cross/Red Crescent, 2000, Article 15.

19 Law on the Protection of the Emblems and Names of the Red Cross/Red Crescent, 2000, Article 15.

20 The Law of 4 July 1956 protecting red cross designations, signs and emblems.

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

**Colombia** has, through resolutions of its Ministry of Health and Social Protection,[22] created and adopted specific means of identification for health-care activities (referred to in the resolutions as the "medical mission"). Its use is supervised by the Ministry of Health and Social Protection as well as by the departmental, district and local health secretariats.


(1) Ensuring that other signs are not too numerous in the same country
(2) Adopting legislation and regulations that clearly identify the other signs chosen, the entities permitted to use them, the use for which they are authorized and the national authority competent to regulate their use

- Ensuring that the creation and/or use of signs other than the red cross/red crescent/red crystal emblems to identify health-care activities responds to the necessity of protecting the provision of health care in a specific context. This includes the fact that the use of signs other than those protected under IHL should not occur at the expense of the prestige and meaning of the distinctive emblems.

### 3.3.2 Dissemination and training measures

Four practical implementation measures can be recommended:

- Taking appropriate preventive measures to promote and enhance knowledge of the proper use of the red cross/red crescent/red crystal emblems among the population at large
- Ensuring training for the armed forces on how to properly use and respect the emblems in times of armed conflict and other emergencies
- Taking all possible measures to disseminate to non-State armed groups obligations related to the use of the red cross/red crescent/red crystal emblems
- Establishing a concrete plan for disseminating widely information on the purpose and use of other signs, when such signs are established by State authorities, and for educating all stakeholders concerned and the population at large. Such dissemination should comprise:
  (1) Insisting on the differences between the other signs and the emblems as a visible expression of specific protection under IHL
  (2) Special attention to ensuring respect for impartiality by the users of other signs, for instance, by adopting guidelines on their roles and responsibilities.

National Red Cross and Red Crescent Societies can play a significant role in assisting the authorities of their respective countries in the dissemination of the regulations concerning the use of the emblems.

In **Belgium**, the Belgian Red Cross's statutes impose on it a duty to spread knowledge of the Fundamental Principles of the International Red Cross and Red Crescent Movement and IHL.

In **Serbia**, the Law on the Red Cross[23] imposes on the Red Cross Society of Serbia the duty to ensure respect for IHL, educate citizens in various aspects of this body of law and carry out preventive activities to improve public health.

When contemplating means to identify protected health-care activities, State authorities need to also consider means to enhance respect for the red cross/red crescent/red crystal emblems. These could include:

- Issuing health-care personnel with identification cards and armlets indicating their status
- Distinctive signals, as mentioned in Chapter III of Annex I ("Regulations concerning identification") of Additional Protocol I (see Section 3.3.1 (a), above)
- New technologies and other ways to identify health-care providers and facilities and medical transports, such as GPS and bar codes, to locate and identify health-care providers, and reflective colours to identify medical facilities and vehicles (For more information, please see the Advisory Service's fact sheet, ***Means of Personal Identification***: https://www.icrc.org/en/document/means-personal-identification#.VHS1duktDcs).

[22] Colombia, Ministry of Health, Resolutions 1020/2002 and 441/2012.
[23] Law on the Red Cross of Serbia (2005), Art. 2.

## 3.4. Sanctions: Sanctioning violations against health-care personnel and facilities and medical transports

### 3.4.1. Legal and regulatory measures

#### a) Types of sanction

To comply with the relevant international norms protecting health care, States must take all necessary measures to prevent and, when they occur, suppress and penalize violations against the wounded and sick, health-care personnel and facilities, and medical transports. They have to incorporate relevant sanctions in their domestic legal systems and ensure that these are known and properly enforced. Applicable sanctions may be of various kinds: criminal, disciplinary or administrative; different types of sanction and sanction mechanism may be combined, depending on the gravity of the violation.

- **Criminal sanctions:** These constitute the essential and unavoidable method for addressing all acts of violence against the provision of health care that amount to a grave breach of the 1949 Geneva Conventions and Additional Protocol I **thereto**,[24] **another serious violation of IHL committed in the context of an international or a non-international armed conflict amounting to a war crime, or another international crime.** The most serious violations of IHL and IHRL protecting health care trigger individual criminal responsibility and are to be punished under domestic criminal law in accordance with the respective repression regimes provided in international law. Criminal sanctions[25] may also be an effective means to prevent and repress other undue interference with the provision of health care. Notably, their public nature and the fact that they are subject to media attention reinforce their deterrent effect on the population at large. The advantages of criminal sanctions are the following:
  (1) They are public, thus tend to be more open and transparent than other sanctions, such as military procedures
  (2) They may apply to acts of violence committed outside the territory of the relevant State and offer a basis for extradition
  (3) Their public nature and the fact that they are thus subject to media attention reinforce their deterrent effect on the population at large.

To be effective, the severity of criminal sanctions needs to match the gravity of the crime.

- **Administrative and disciplinary sanctions**: These should be established in parallel to or in addition to criminal sanctions, and should be directed at specific categories of perpetrator depending on their function, role or status. They can take several forms, including but not limited to the payment of a fine, withdrawal of an authorization or demotion or suspension of the perpetrators from their functions or, for more serious violations, expulsion from their professional association or from the public force of which they are members. Sanctions of this kind, in particular disciplinary sanctions, have various advantages:
  (1) They form part of the perpetrators' reference system (e.g. military discipline, code of medical ethics)
  (2) If properly enforced, they have immediate effect and consequences and, as a result, also have a better deterrent effect on perpetrators than criminal sanctions
  (3) The prospect of being judged by a community of peers adds to the effectiveness of disciplinary sanctions against members of the armed or security forces or of professional associations
  (4) Their public nature and the fact that they are thus subject to media attention reinforce their deterrent effect on the population at large.

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24 For a comprehensive list of applicable provisions, see Annex 1, "International Legal Framework."

25 *Ibid.*

In **Kenya**, the Geneva Conventions Act[26] provides for the repression of grave breaches of the Conventions. In addition, section 8 of the International Crimes Act gives the High Court jurisdiction over war crimes committed in Kenya or elsewhere if either the perpetrator or the victim is a Kenyan citizen or if the perpetrator is currently in the country. The Kenyan Defence Forces Act[27] also provides for disciplinary measures for some of the offences under the Act; these include dismissal from the forces, reprimands, fines and prison sentences. Violations of IHL are also subject to disciplinary measures under the military manuals of **Belarus** and **Russia**.

In **Serbia**, the Criminal Code includes war crimes committed against the civilian population and the wounded and sick; cruel treatment of the wounded and sick and prisoners of war; and misuse of internationally recognized emblems.[28] As far as administrative sanctions[29] are concerned, health-care facilities can be fined for (i) violating data protection rules and (ii) in epidemics and other disasters, when they do not submit accurate data on the situation to the pertinent State bodies. The law also provides for the fining of people responsible for health-care facilities.[30] Furthermore, the Law on the Use and Protection of the Emblem and the Name of the Red Cross establishes fines for unauthorized use of the red cross emblem.[31]

In **Senegal**, according to the Law Relating to the Use and to the Protection of the Red Cross and Red Crescent Emblem,[32] an offender may be sentenced to a fine and/or up to five years of imprisonment. The length of the sentence is doubled if the violation is committed during armed conflict. A number of provisional measures are envisaged in the Senegalese domestic normative framework, including seizure of the objects bearing the distinctive emblem, the person responsible for the violation shouldering whatever expense this entails.[33]

### b) How to include these types of sanction in an effective legal framework

The ICRC Advisory Service on International Humanitarian Law has developed several tools, including specific fact sheets, to assist States in meeting their international obligations regarding the implementation of IHL in their domestic legal framework. You are invited to consult the following for more detailed information and examples on how to include sanctions for IHL violations effectively in a domestic legal framework:

***The Domestic Implementation of International Humanitarian Law: A Manual,* Chapter 3:** https://www.icrc.org/eng/resources/documents/publication/pdvd40.htm

***National implementation of IHL: Thematic documentation, including a set of fact sheets on specific aspects linked to the repression of IHL violations:*** https://www.icrc.org/en/document/national-implementation-ihl-thematic-documentation#.VIhkh-ktDct

***Preventing and Repressing International Crimes: Towards an "Integrated" Approach Based on Domestic Practice: Report of the Third Universal Meeting of National Committees for the Implementation of International Humanitarian Law*, Chapter 5:** https://www.icrc.org/eng/resources/documents/publication/p4138.htm

The obligations deriving from IHL and IHRL, to incorporate sanctions in the domestic legal order for violations of international rules protecting the provision of health care, can be met in different ways:

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26 Section 3 and (6(1)(c)).

27 See Kenya Defence Forces Act, 2012, ss 87 (2), s. 120, 155-156, 184.

28 Criminal Code of the Republic of Serbia (as amended in 2012), Arts 372 (2)-373, 381, 385.

29 Art. 256, Law on Health Care (Official Gazette of RS, No. 107/05, 72/09, 88/10, 99/10, 57/11, 119/12).

30 Art. 256, *ibid*.

31 Arts 12-13, Law on Use and Protection of the Emblem and Name of Red Cross.

32 Art. 10 of Law No. 2005 -19 of 5 August 2005 Relating to the Use and to the Protection of the Red Cross and Red Crescent Emblem.

33 Law No. 2005 - 19 of 5 August 2005 Relating to the Use and to the Protection of the Red Cross and Red Crescent Emblem.

- **Criminal sanctions for serious violations of IHL and IHR:** Criminal sanctions for violence against health care that amounts to a "grave breach" of the Geneva Conventions and their Additional Protocols of 8 June 1977, or to a war crime committed in connection with an international or a non-international armed conflict or to some other international crime:
  - **(1)** By applying existing domestic criminal law (in particular existing criminal offences) to violence against the provision of health care
  - **(2)** By adopting a specific stand-alone piece of criminal legislation for international crimes, including serious violations of IHL and IHRL
  - **(3)** By incorporating specific offences corresponding to certain violations of the rules protecting the provision of health care in armed conflicts and other emergencies in domestic criminal law (either specific criminal laws such as a criminal code of international crimes, a Geneva Conventions Act or relevant sections of the penal codes and military justice codes)[34]
    The content of such legislation may:
    - make reference to the treaties to which the State is party, to international law in general (including IHL and IHRL norms) or contain a generic reference to rules of customary international law
    - define specific offences and corresponding sanctions
  - **(4)** By adopting a mixed approach to criminalization that would combine incorporation in domestic criminal legislation of a generic reference to the IHL and IHRL rules protecting the provision of health care (see Section 2) and specific criminalization of certain serious offences
  - **(5)** By allowing domestic courts to apply international rules protecting the provision of health care without the requirement of specific references to these rules in domestic legislation: this option requires the adoption of a statute or a provision in the constitution that would either:
    - recognize conventional and/or customary international law as a direct and legitimate legal basis for the criminalization of undue interference with the provision of health care or
    - give international law precedence over domestic law.

Whatever the method, the criminal sanctions must cover both individual and superior responsibility, and comply with all elements and requirements contained in the relevant repression regime under IHL and IHRL. Please refer to the above-mentioned references for more specific guidance.

For more detailed information on the incorporation of sanctions, see the Advisory Service fact sheets:

***Penal Repression: Punishing War Crimes*:** https://www.icrc.org/en/document/penal-repression-punishing-war-crimes#.VHTGxuktDcs
***Methods of Incorporating Punishment into Criminal Law*:** https://www.icrc.org/en/document/methods-incorporating-punishment-criminal-law-factsheet#.VHS6yOktDcs

- **Criminal sanctions for other violations of IHL and IHRL:** Criminal sanctions for other undue interference with health-care provision:
  Incorporating specific crimes in domestic legislation is essential also for effective criminalization and sanctioning of undue obstacles to the provision of health-care services that do not amount to 'grave breaches' under the Geneva Conventions and Additional Protocol I, war crimes or other international crimes, and are thus not covered by those instruments. Undue obstacles covered by specific legislation may be:
  - **(1)** Intentional impediments to or denial of the delivery of health care: for example, delaying the passage of ambulances at checkpoints or denying such passage
  - **(2)** Attacks against health care resulting from a failure to take precautionary measures:
    - Parties to the conflict should, as far as possible, ensure that medical units are situated in such a manner that attacks against military objectives do not endanger their safety[35]

[34] It must be noted, however, that because the criminal legislative system and the relationship between ordinary criminal law and military criminal law vary from State to State, it may be difficult to favour one of the two options mentioned above.

[35] See Art. 19, para. 2, First Geneva Convention; Art. 18, para. 5, Fourth Geneva Convention; Art. 12, para. 4, Additional Protocol I; Customary International Humanitarian Law Study, Volume 1: Rules, p. 96.

– They must also, to the greatest extent possible, limit the effects of attacks by removing the wounded and sick and medical personnel, units and transports from the vicinity of military objectives.[36]

***Recommendation:*** *Domestic legislation that High Contracting Parties to the Geneva Conventions are under an obligation to implement should go beyond the repression regime provided for in the Conventions, both in terms of situations covered and conduct criminalized.*

- **Other types of sanction:** Other types of sanction for undue interference with health-care provision:
  Endowing administrative authorities or specialized supervisory bodies with investigative powers and the ability to report unlawful acts to State authorities competent to conduct investigations or to impose sanctions, thereby helping to ensure that violations are reported to the appropriate bodies and that perpetrators are effectively sanctioned. Such bodies should have the authority to receive information from third parties on unlawful behaviour against the provision of health care and to report the alleged violations to the appropriate State authorities.

In **Belgium**, misuse of the emblem is subject to criminal sanctions under the Law of 4 July 1956 protecting red cross designations, signs and emblems,[37] but when committed by the armed forces, it is also subject to disciplinary measures, since it could be considered as a violation of an obligation incumbent on militaries according to laws or regulations applicable to the armed forces (Act of 14 January 1975 setting out the disciplinary code applicable to the armed forces).

**When establishing sanctions, States should also take the following aspects into consideration:**

- Ensuring that all types of sanction are combinable, i.e. that violations committed against health-care personnel and infrastructure and medical transports could be subject to two or more types of sanction
- Guaranteeing that all types of sanction are graduated to ensure that the penalty is proportionate to the seriousness of the violation committed, taking into account aggravating and mitigating circumstances. In practice, this objective may be achieved by:
  (1) Sanctioning deliberate attacks against the delivery of health care more severely than, for instance, attacks resulting from a failure to take precautionary measures. This can be done 1) by creating a specific crime in the domestic legislation or 2) by taking into consideration the deliberate character of the violation as an aggravating factor
  (2) Allowing, in domestic legislation, judges to gauge both aggravating and mitigating circumstances in order for them to determine the appropriate level of sanction to be imposed on the perpetrator.

For more detailed information on ensuring the effectiveness of sanctions, please see the Advisory Service fact sheet: ***Elements to Render Sanctions More Effective***: https://www.icrc.org/en/document/elements-render-sanctions-more-effective-factsheet#.VHTH1uktDcs) and the *International Review of the Red Cross* issue on sanctions (2008, Vol. 870): https://www.icrc.org/fre/resources/international-review/review-870-sanctions/index.jsp

### 3.4.2. Dissemination and training measures

***Recommendation:*** *State authorities should take appropriate measures to ensure that sanctions are effectively applied and that they play their preventive role.*

**In order to ensure that sanctions for violations against health-care personnel and infrastructure and medical transports are effectively applied and that they play their preventive role, State authorities can take a number of measures,** particularly with regard to the dissemination of knowledge. Dissemination measures are designed to create detailed awareness among potential perpetrators as to the type of sanctions available and their methods of application. This serves to enhance the deterrent effect of sanctions, and as a result, contributes to preventing violations of the rules protecting health-care personnel and facilities and medical transports. Such measures may include:

[36] See Art. 58 (a), Additional Protocol I; Rule 24, Customary International Humanitarian Law Study, Volume 1: Rules.
[37] Arts 1-2.

- Ensuring that the population at large, and especially potential perpetrators, are aware of the sanctions applicable to violations of the rules protecting the provision of health care. Indeed, informing relevant stakeholders about the enforcement of the rules protecting the provision of health care and about the various types of sanction and their methods of application is essential to enhance the deterrent effect of sanctions and, as a consequence, to limit violations against health-care personnel and infrastructure and medical transports
- Organizing training activities with the persons who are instrumental in or directly concerned with enforcing the rules protecting the provision of health care, namely, State armed forces, State security forces, health-care personnel, civil servants and, when applicable and feasible, non-State armed groups. Such training should be conceived so as to trigger genuine reflex reactions, particularly among weapon-bearers
- Including information about sanctions in professional or military training, as well as in the professional or military manuals and guidelines designed for members of the armed forces, health-care personnel and civil servants
- Making sanctions and condemnations public in order to inform the population at large.

### 3.4.3 Coordination and institutional capacity measures

Any message about the imposition of sanctions for violations of the rules protecting the provision of health care must be accompanied by measures intended to improve adherence to the rules and respect for them, including the ones proposed below.

- Strengthen the existing institutional framework to oversee compliance with the rules protecting health care: several initiatives may be considered to encourage reporting of violations of the rules protecting health care and, more generally, to ensure compliance to these rules, including:
  - **(1)** Empowering administrative authorities or specialized supervisory bodies with investigating and reporting powers. Unlawful acts may be reported to State authorities competent to conduct investigations or to impose sanctions, i.e. administrative or military authorities
  - **(2)** Making complaints procedures safe and accessible for victims, including for victims of rape and other forms of sexual violence.

- Ensure:
  - **(1)** Integrity and independence of the judicial system
  - **(2)** Transparency of the administrative authorities empowered to sanction perpetrators of violations of the rules protecting the provision of health care
  - **(3)** Respect for essential judicial guarantees in relation to criminal procedures.

The effectiveness of sanctions also relies on their implementation, which is itself intrinsically linked to the conformity of the judicial and administrative system with the main legal principles and judicial guarantees of criminal justice, and on respect from empowered administrative authorities for essential procedural guarantees.

Information on these elements as well as on the means to make sanctions more effective can be found in the Advisory Service fact sheet: ***Elements to Render Sanctions more Effective*** (https://www.icrc.org/en/document/elements-render-sanctions-more-effective-factsheet#.VHTH1uktDcs), the *International Review of the Red Cross* issue on sanctions (2008, Vol. 870: https://www.icrc.org/fre/resources/international-review/review-870-sanctions/index.jsp) as well as in the other documents mentioned at the beginning of the previous section (3.4.1. b)).

States have specific obligations in terms of minimum legal safeguards applicable to persons accused of serious violations of any of the four Geneva Conventions or of Additional Protocol I**. Judicial guarantees** include the right of an accused to be judged by an independent and impartial court without undue delay, the right to defence, and the presumption of innocence. More information on judicial guarantees is available in the Advisory Service fact sheet: ***Judicial Guarantees and Safeguards*** (https://www.icrc.org/en/document/judicial-guarantees-and-safeguards-factsheet#.VHTGGektDcs).

# ANNEX 1

## INTERNATIONAL LEGAL FRAMEWORK

| INTERNATIONAL LEGAL FRAMEWORK | | |
|---|---|---|
| | **International Humanitarian Law** | **International Human Rights Law** |
| **Protection of the Wounded and Sick** | Common Art. 3, GC I, II, III and IV<br>Arts 6, 7, 9, 10, 12, 15, 18, 19 and 46, GC I<br>Arts 6, 7, 9, 10, 12, 18, 21, 28, 30 and 47, GC II<br>Art. 30, GC III<br>Arts 16 and 91, GC IV<br>Arts 10, 11 and 44 (8), AP I<br>Arts 7 and 8, AP II<br>Rules 109-111, Customary IHL Study | Art. 25, Universal Declaration of Human Rights<br>Art. 2, ECHR<br>Arts 6 (1) and 9, ICCPR<br>Art. 12, ICESCR<br>Art. 4, ACHR<br>Art. 4, ACHPR<br>Basic Principles on the Use of Force and Firearms by Law Enforcement Officials<br>CESCR, General Comments No. 3 and No. 14<br>CESCR, An Evaluation of the Obligation to take Steps to the "Maximum of Available Resources" Under an Optional Protocol to the Covenant[38] |
| **Protection of Health-Care Personnel** | Arts 24-27, 28-30 and 32, GC I<br>Arts 36 and 37, GC II<br>Art. 20, GC IV<br>Arts 15 and 16, AP I<br>Arts 9 and 10, AP II<br>Rules 25 and 26, Customary IHL Study | ICCPR<br>ECHR<br>ACHR<br>ACHPR |
| **Protection of Health-Care Facilities and Medical Transports** | Arts 19-23 and 33-37, GC I<br>Arts 21-35 and 38-40, GC II<br>Arts 18,19, 21, 22 and 57, GC IV<br>Arts 12-14 and 21-31, AP I<br>Art. 11, AP II<br>Rules 28 and 29, Customary IHL Study | CESCR, General Comment No. 14 |
| | **International Humanitarian Law** | |
| **Distinctive Emblems** | Arts 36, 38-44, 53 and 54, GC I<br>Arts 39, 41 and 43-45, GC II<br>Arts 18 and 20-22, GC IV<br>Arts 8, 18, 23, 38 and 85, AP I<br>Annex 1, AP I<br>Art. 12, AP II<br>AP III<br>Rules 30, 59 and 60, Customary IHL Study<br>Regulations on the Use of the Emblem of the Red Cross or the Red Crescent by the National Societies | |
| **Health-Care Ethics and Confidentiality** | Art. 16, AP I<br>Art. 10, AP II<br>Rule 26, Customary IHL Study<br>WMA (World Medical Association) Regulations in Times of Armed Conflict and Other Situations of Violence | |
| **Sanctions** | Arts 49-54, GC I<br>Arts 50-53, GC II<br>Arts 146-149, GC IV<br>Art. 85, AP I<br>Rules 156, 157 and 158, Customary IHL Study<br>Art. 8 (2) (b) (vii), (ix), (xxiv) and Art. 8 (2) (e) (ii), (iv), Rome Statute | |
| **It is also worth mentioning that the international rules and principles of medical ethics[39] governing health-care personnel in the performance of their duties also contain rules that are aimed at protecting the wounded and sick.** | | |

[38] UN Doc. E/C.12/2007/1, 10 May 2007.

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

**Rules on the protection of the wounded and sick**

| INTERNATIONAL AND NON-INTERNATIONAL ARMED CONFLICTS | SITUATIONS NOT GOVERNED BY IHL |
|---|---|
| **Attacking, Harming or Killing** | |
| The rights of the wounded and sick must be respected in **all circumstances**; attempts upon their lives and violence against their person are strictly prohibited.<br><br>Wilfully killing them or causing great suffering or serious injury to their bodies or to their health constitutes, as grave breaches of the Geneva Conventions, **war crimes.** | Except under very particular circumstances, set out in the United Nations' Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, the wounded and sick are protected under IHRL from attempts upon their lives or violence against their person.<br><br>Individuals have a right to personal security and States have a **non-derogable** obligation not to subject any individuals under their jurisdiction or control to arbitrary deprivation of life.<br><br>The murder of wounded and sick people, as well as other inhumane acts of a similar character **intentionally** causing great suffering or serious injury to body or to mental or physical health, may amount to **crimes against humanity**. |
| In certain circumstances, the denial of medical treatment may constitute cruel or inhuman treatment, an outrage upon human dignity (in particular in case of humiliating and degrading treatment), or even torture if the necessary criteria are met. | |
| **Searching for and Collecting** | |
| Parties to an armed conflict must take **all possible measures** to search for and collect the wounded and sick without delay. If circumstances permit, parties must make arrangements for the removal or exchange of the wounded and sick. | Under the right to health, States have a **non-derogable obligation** to "ensure the right of access to health facilities, goods and services on a non-discriminatory basis" (GC No. 14). Similar obligations exist under the right to life, especially in life-threatening-circumstances. |
| **Protection and Care** | |
| All parties to an armed conflict must protect the wounded and sick from **pillage and ill-treatment**. They must also ensure that **adequate medical care** is provided to them as far as practicable and with the least possible delay. | States have an obligation to protect the wounded and sick from ill-treatment; they must also protect the right to health of the wounded and sick, including by taking all necessary measures to "safeguard persons within their jurisdiction from infringements of the right to health by third parties" (GC No. 14). |
| **Treatment without Discrimination** | |
| The wounded and sick must be treated without discrimination. If distinctions are to be made among them, it can be only on the basis of their **medical condition**. | The right to health must be exercised without discrimination. This obligation is **immediate and non-derogable**.<br><br>Any **restrictions** on the right to health must be done in accordance with the law (including human rights standards), compatible with the nature of the rights protected by the CESCR, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society (GC No. 14). |

**Rules on the protection of medical personnel**

| INTERNATIONAL AND NON-INTERNATIONAL ARMED CONFLICTS | SITUATIONS NOT GOVERNED BY IHL |
|---|---|
| **Protecting and Respecting** | |
| Personnel engaging in medical tasks must always be respected and protected, unless they commit, outside of their humanitarian function, acts that are harmful to the enemy. When they carry and use weapons to defend themselves or to protect the wounded and sick in their charge, medical personnel do not lose the protection to which they are entitled.<br><br>The wounded and sick under their care remain protected even if the medical personnel themselves lose their protection. | Medical personnel have the right to protection against arbitrary deprivation of life and the right to security in the same way as the wounded and sick. |
| **Provision of Care** | |
| Parties to an armed conflict may not impede the provision of care by unduly preventing the passage of medical personnel. They must **facilitate access** to the wounded and sick, and provide the necessary assistance and protection to medical personnel.<br><br>Medical personnel may not be punished for providing impartial care. | States must not prevent medical personnel from treating the wounded and sick. Under the right to health, States have an obligation to "refrain from interfering directly or indirectly with the enjoyment of the right to health" (GC No. 14).<br><br>Arresting medical personnel for providing care may amount to a violation of the protection against arbitrary arrest and detention, **even if it is done lawfully under domestic law**. The Human Rights Committee of the United Nations has stated that inappropriateness and injustice in legislation can amount to arbitrariness. |
| **Medical Ethics** | |
| Parties to an armed conflict should not compel medical professionals to carry out activities that are contrary to medical ethics or prevent them from fulfilling their ethical duties. Further, parties should not prosecute medical professionals for acting in accordance with medical ethics.<br><br>Medical professionals must protect the **confidentiality** of information obtained in connection with the treatment of patients and should not be compelled, unless required to do so by the law, to give information concerning the wounded and sick who are or have been under their care, if this information would prove harmful to the patients or their families. | Resolution 37/194 of the United Nations General Assembly on the Principles of Medical Ethics states that in 'other emergencies' as well as in times of armed conflict, States should not punish medical personnel for carrying out medical activities compatible with medical ethics or compel them to undertake actions that contravene these standards.<br><br>Medical ethics remain the same during armed conflict and in peacetime. |

## Rules on the protection of health-care facilities and medical transports

| INTERNATIONAL AND NON-INTERNATIONAL ARMED CONFLICTS | SITUATIONS NOT GOVERNED BY IHL |
|---|---|
| **Protecting Health-Care Facilities** | **Protecting Health-Care Facilities and Medical Transports** |
| Medical units, such as hospitals and other facilities that have been set up for medical purposes, must be respected and protected in all circumstances. Medical units may not be attacked and access to them may not be arbitrarily limited. Parties to an armed conflict must take measures to protect medical units from attacks, such as ensuring that they are not situated in the vicinity of military objectives.<br><br>Medical units will lose the protection to which they are entitled if they are used, outside their humanitarian function, to commit acts harmful to the enemy. However, this protection can be withdrawn only after **due warning** has been given with a reasonable time limit and only after that warning has gone unheeded. | Under the right to health, States have a non-derogable obligation to ensure **access** to health infrastructure. They must therefore respect medical units and transports. States may not target them or use them to launch law enforcement operations or to carry out other similar measures. States must also take measures to protect medical units and transports from attacks or misuse by third parties. |
| **Protecting Medical Transports** | |
| Any means of transportation that is assigned **exclusively** to the conveyance of the wounded and sick, medical personnel and/or medical equipment or supplies must be respected and protected in the same way as medical units. If medical transports fall into the hands of an adverse party, that party becomes responsible for ensuring that the wounded and sick in their charge are cared for. | |
| **Prohibition of Perfidy** | |
| Parties to an armed conflict who use medical units or transports with the intent of leading the opposing parties to believe they are protected, while using them to launch attacks or carry out other acts harmful to the enemy, commit acts of perfidy. If such an act of perfidy results in death or injury to individuals belonging to an adverse party, it constitutes a **war crime**. | |

## Rules on the use of the distinctive emblems

| INTERNATIONAL AND NON-INTERNATIONAL ARMED CONFLICTS | SITUATIONS NOT GOVERNED BY IHL |
|---|---|
| **Use of the Distinctive Emblems** | |
| When used as a **protective device**, the emblem – the red cross, the red crescent or the red crystal – is the visible sign of the protection conferred by the Geneva Conventions and their Additional Protocols on medical personnel, medical units and medical transports. During an armed conflict, this includes **military medical personnel, units and transports**; **National Red Cross and Red Crescent Societies' medical personnel**, **units and transports that have been recognized by the State and authorized to assist the medical services of the armed forces**; **State-certified civilian medical units authorized to display the emblem**; and **medical personnel in occupied territory**. To secure the best protection, the emblem used as a protective device should be **large enough** to ensure visibility. Medical units and transports may also use distinctive signals (such as light and radio signals).<br><br>When used as an **indicative device**, the emblem links the person or object displaying it to an institution of the **International Red Cross and Red Crescent Movement**. In this case, the sign should be relatively **small**.<br><br>Attacking buildings, material, medical units and transports or personnel displaying the distinctive emblems is a **war crime**. | Under Article 44, Paragraph 1, of the First Geneva Convention, **military medical personnel, units and transports** can use the emblem as a **protective device** in time of peace, and in situations of violence other than armed conflict. **National Red Cross and Red Crescent Societies' medical units and transports**, whose assignment to medical duties in the event of an armed conflict has been decided, can also use the emblem as a protective device, as long as they have been **authorized** to do so by the appropriate authority. Finally, in certain cases, **civilian medical units** may be **authorized** to use the emblem as a protective device. This requires the medical units to have been **recognized** as such by the State and the State to allow this use of the emblem. However, this use should be limited to the preparation of medical units for an armed conflict: for example, painting the emblem on the roof of a hospital.<br><br>The emblem may also be used as an **indicative device** by **ambulances and first-aid stations**, when they are exclusively assigned to provide free treatment to the wounded and sick. In this case, the use must be in conformity with domestic legislation and **authorized** by the National Society. |
| **Misuse of the Emblems** | |
| Any use of the emblem not prescribed by IHL is considered to be improper. Perfidious use of the emblem – to protect or hide combatants, for example – constitutes a **war crime** when it results in death or serious injury. | |

# ANNEX 2

## RECOMMENDATIONS FROM THE WORKSHOP ON DOMESTIC NORMATIVE FRAMEWORKS FOR THE PROTECTION OF THE PROVISION OF HEALTH CARE (BRUSSELS, 29-31 JANUARY 2014)

The recommendations,[40] which emerged from the discussions on the four topics addressed in the workshop, involved three major types of measure:

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

### Making legal protection for the wounded and sick, health-care personnel and facilities and medical transports more effective

**RECOMMENDATION (1): States must take appropriate measures to implement their international obligations with regard to the protection of health care in their domestic legal framework in a way that takes into account their national specificities and ensures effective protection and access to health care in all circumstances.**

1. When developing their domestic legal framework for the protection of health care, State authorities should consider the advantages and disadvantages of both specific legislation applicable to armed conflict and other emergencies and general legislation applicable in all circumstances.
2. Implementation of the international legal framework for the protection of health care must take into account the specificities of each domestic legal system (e.g. civil vs common-law systems) and distribution of jurisdictional competencies (e.g. federal vs centralized States).

**RECOMMENDATION (2): States should develop a better understanding of the nature of violence against health care on their own territory, including all types of undue interference with the provision of health care, in order to elaborate an adequate response.**

1. Set up a **national system for collecting data** on the occurrence of violence against health-care personnel and facilities and medical transports as well as against patients, including all types of interference with the provision of health care. A national data-collection system should, notably:
   a. **Be guided by clear criteria**, classifying data in context-specific categories (for example, the legislation creating such a system should precisely define what type of information is to be collected and how it is to be organized)
   b. **Be managed by State authorities** (e.g. Ministry of Health and the Interior and, where such a post exists, an Ombudsman[41]) and involve all stakeholders concerned with the health-care system (medical associations, etc.), coordination between all stakeholders being essential
   c. **Be independent and transparent** with a view to ensuring the reliability of the data collected
   d. **Serve the purposes of analysis only** (not intended to be used in criminal prosecution)
   e. **Ensure protection of the use of and access** to the data collected.

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

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[40] For more details on the background for these recommendations, please refer to *Health Care in Danger – Domestic Normative Frameworks for the Protection of the Provision of Health Care: Report of the Brussels Workshop, 29-31 January 2014.*

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

**RECOMMENDATION (3): Preventive and safety measures for protecting the provision of and guaranteeing safer access to health care should include education, training and dissemination of the existing legislation.**

1. States should take appropriate measures to train the armed and security forces, civil servants, health-care personnel and the population at large about the domestic legislation protecting the provision of and access to health care (including the right to health).
2. State authorities should raise awareness of the importance of respecting health-care personnel and facilities and medical transports.
3. There should be an obligation to rescue or provide assistance to people in need of urgent medical care under domestic law that is applicable and subject to criminal sanctions in all circumstances, including armed conflict and other emergencies.

**RECOMMENDATION (4): States should take appropriate measures to enhance coordination between the different stakeholders involved in the provision of emergency health-care services in order to allow better-organized and more efficient emergency response.**

1. Domestic legislation should clearly define the respective roles and responsibilities of the different stakeholders acting in the provision of emergency health care.
2. State authorities should take appropriate measures to ensure knowledge on the part of the different stakeholders acting in the provision of emergency health care about each other's roles and responsibilities in order to ensure their comprehensive understanding of the organization of emergency response.
3. Every State should have a plan of coordination involving all stakeholders to organize emergency response and the provision of health-care services in times of armed conflict or other emergencies.

**RECOMMENDATION (5): Specific legislative and practical measures should be adopted in order to adequately address the needs of victims of rape and other forms of sexual violence in armed conflicts and other emergencies.**

1. Health-care personnel should be specifically trained on how to assist victims of sexual violence on the basis of a multidisciplinary approach, including social, psychological and communications training.
2. The staff of health-care facilities should include at least one properly trained person to assist victims of rape and other forms of sexual violence who need immediate assistance.
3. Domestic legislation should address the specific consequences of sexual violence for women, such as pregnancy.

**RECOMMENDATION (6): When appropriate, traditional medicine should be included in the sphere of protected health-care activities and measures should be taken to facilitate access to this type of medicine by the population at large.**

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## Legally improving proper use of the distinctive emblems, whose use is regulated under international law, and of other signs used for identifying health-care activities

**RECOMMENDATION (7): Ensure more effective domestic implementation and dissemination of the legislation regulating the indicative and protective use of the red cross/red crescent/red crystal emblems.**

1. When implementing international law protecting the use of the red cross/red crescent/red crystal emblems at the domestic level, States should adopt specific legislation with a view to reinforcing the prestige and meaning of the emblems.
2. Domestic legislation should, already in peacetime, identify the entities permitted to use the red cross/red crescent/red crystal emblems and designate the national authority competent to regulate their use.
3. States should take appropriate preventive measures to promote and enhance knowledge of the proper use of the red cross/red crescent/red crystal emblems among the population at large and ensure training of the armed forces in order to prevent misuse of the emblem.

**RECOMMENDATION (8): Reinforce measures of control of the use of the red cross/red crescent/red crystal emblems as well as of repression mechanisms for misuse of the emblems.**

1. Measures repressing unauthorized or improper use of the emblem should include not only criminal sanctions but also administrative and disciplinary measures, and misuse of the emblems, such as imitation and improper use, must be severely repressed. Perfidious use of the emblems constitutes a war crime and must be repressed as such.
2. National monitoring should be put in place for tracking and repressing misuse of the emblem.
3. States should take appropriate measures to encourage reporting of emblem misuse to the appropriate State authorities and make such cases public.

**RECOMMENDATION (9): The use of signs other than the red cross/red crescent/red crystal emblems to identify health-care activities needs to be further examined, considering each specific context and whether the use of such signs would enhance protection of health care.**

1. Bearing in mind the need to avoid a proliferation of emblems, the creation and/or use of signs other than the red cross/red crescent/red crystal emblems to identify health-care activities should respond to the necessity of enhanced protection of the provision of health care in a specific context.
2. If signs other than the red cross/red crystal/red crescent emblems are to be used to identify health-care activities, they must be established and regulated by State authorities and a clear distinction should be made from the distinctive emblems whose use is regulated under international law in order to avoid confusion.
3. The adoption of an additional emblem to identify health-care activities must be accompanied by wide dissemination and education about its purpose and use.
4. The potential use of new technologies for identifying health-care providers (e.g. GPS, bar codes) and other means of identifying health-care facilities and medical transports (e.g. reflective colours) should be further explored.

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## Providing legal protection for health-care ethics and medical confidentiality during armed conflict and other emergencies

**RECOMMENDATION (10): Ensure clarity and coherence of domestic legislation concerning ethical duties applying to health-care personnel.**

1. The rights and responsibilities of health-care personnel should be clearly defined in domestic legislation, for example in laws regulating access to health-care professions or in codes of ethics adopted by professional associations.
2. States should ensure coherence and consistency of domestic laws and regulations applying to health-care personnel, including criminal laws, in accordance with their ethical duties, and adequately protect the independence and impartiality of health care.

**RECOMMENDATION (11): Reaffirm the necessity to protect medical confidentiality as an abiding principle of health-care ethics in all circumstances (in peacetime as well as in armed conflict and other emergencies): exceptions to medical confidentiality must be limited and strictly circumscribed in domestic legislation.**

1. Approach medical confidentiality as a right of the patient rather than a simple privilege and ethical duty of health-care personnel.
2. Exceptions to medical confidentiality may vary from one State to another and be context-specific, but they should in any event be limited and strictly defined and circumscribed in domestic legislation for all circumstances.
3. When under a legal duty to disclose patient information protected under medical confidentiality, health-care personnel should take all necessary precautions in order to protect patients' other personal and health-care-related information and only disclose the information strictly required.
4. Disclosure by health-care personnel of patients' personal and health-care-related information without their consent where there is no legal obligation to do so should constitute a violation of professional duty under their code of ethics and be subject to administrative or disciplinary measures.

**RECOMMENDATION (12): Ensure proper training for health-care personnel to apply and respect their ethical duties, particularly for resolving dilemmas when confronted with legal obligations to disclose patients' personal and health-care-related information.**

1. Health-care personnel should be given special training for resolving dilemmas when legal obligations to disclose patient information conflict with their ethical duties, both in peacetime and in armed conflict or other emergencies, for example, by means of simulation exercises.
2. Law enforcement officials (police, prosecutors) should be properly trained in the ethical duties of health-care personnel.
3. Appropriate measures should be taken to manage health-care personnel's interactions with the media, particularly in emergency situations, in order to better protect medical confidentiality. The media should also be made aware of the ethical duties of health-care personnel, and respect for medical confidentiality should be enshrined in their code of ethics.

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## Effectively repressing and sanctioning violations of the rules protecting the provision of health care

**RECOMMENDATION (13): The different types of sanctions (criminal, administrative, disciplinary) available in domestic law to punish violations of the rules protecting the provision of health care should be subject to a graduated approach and combinable according to the gravity of the violation committed.**

1. In addition to criminal sanctions, perpetrators of violations of the rules protecting health care should be subject to administrative and disciplinary sanctions according to their titles or functions, and these sanctions must be combinable.
2. Criminal, administrative and disciplinary sanctions provided for in domestic legislation should be graduated to ensure that the penalty is proportionate to the seriousness of the violation committed, taking into account aggravating and mitigating circumstances. Deliberate attacks against the delivery of health care should be considered as an aggravating factor.
3. Violence against health care that amounts to a grave breach of the Geneva Conventions must be repressed as such in application of the relevant regime. Where it does not yet exist, such a regime needs to be established in domestic law and must cover both individual and command responsibility.

**RECOMMENDATION (14): Domestic legislation should go further than the Geneva Conventions with regard to criminal repression, both in terms of situations covered and conduct criminalized.**

1. Domestic legislation should sanction all kinds of undue interference with the provision of health care in armed conflict, including threats against health-care personnel and other undue obstacles to the provision of health-care services.
2. Domestic legislation should also sanction all kinds of undue interference with the provision of health care in situations that fall short of armed conflict.
3. Before adopting specific legislation to criminalize certain violations of the rules protecting the provision of health care, States should assess whether they are already covered by their own general criminal legislation, and special attention should be given to preserving the coherence of the normative framework as well as the predictability of sanctions.

**RECOMMENDATION (15): State authorities should take appropriate measures to ensure that sanctions are effectively applied and that they play their preventive role.**

1. Ensure enhanced knowledge among the population at large, and especially among potential perpetrators, of sanctions applicable to violations of the rules protecting the provision of health care.
2. Strengthen the existing institutional framework to oversee compliance with the norms, for example, by allowing administrative authorities or specialized supervisory bodies to report unlawful acts to the State authorities competent to conduct investigations or to impose sanctions.
3. Ensure the integrity and independence of the judicial system and respect for judicial guarantees in relation to criminal procedures (e.g. fair trial, right to defence, presumption of innocence) as well as the transparency of administrative authorities empowered to sanction perpetrators of violations of the rules protecting the provision of health care.
4. States should do everything feasible considering the resources at their disposal to enhance their capacity to enforce existing sanctions provided by law.

# ANNEX 3

## CHECKLIST OF MEASURES FOR THE DOMESTIC IMPLEMENTATION OF INTERNATIONAL RULES PROTECTING THE PROVISION OF HEALTH CARE

This list proposes a number of measures that State authorities may take to implement, through their domestic legal framework, international rules protecting the provision of health care.

### A. Legal implementation

**(Please also see the Advisory Service's National Implementation Database: https://www.icrc.org/ihl-nat)**

- Establish a list of international rules to be implemented at national level, including rules applicable in times of armed conflict and during other emergencies.
- Translate international rules protecting the provision of health care into the national language.
- Assess the existing domestic legal framework and identify the laws that are already dealing with protection for the provision of health care, the laws that might require updating/modification, and the laws that need to be created.
- Enact domestic legislation repressing violence against health care that amounts to a 'grave breach' of the Geneva Conventions as a war crime, and legislation that would allow for suppression of other kinds of interference with health-care delivery**.**
- Enact legislation on the rights and responsibilities of health-care personnel, in line with their ethical duties.
- Establish priorities for implementation.
- Assess the resources necessary and available for implementation.
- Choose the means and methods of implementation, taking into account national specificities.
- Strengthen the national institutional framework to oversee compliance with the rules protecting health care.
- Adopt measures to prevent the misuse of the red cross, the red crescent and other symbols and emblems provided for in the Geneva Conventions and their Additional Protocols.
- Establish a national data collection system that could inform specific protection responses for health-care providers who have fallen victim to violence, or are under the threat of violence.

### B. Dissemination

**(Please see the Advisory Service fact sheet: *The Obligation to Disseminate International Humanitarian Law*)**

- Appoint and train qualified persons in the legal, military and medical sectors to provide appropriate training to the persons who are instrumental in or directly concerned about the application of the rules protecting the provision of health care and of the pertinent sanctions.
- Train the media on the rules protecting the provision of health care and the applicable sanctions, and to encourage diffusion of these rules among the general public.
- Include notions on the rules protecting the provision of health care and the applicable sanctions in university curricula and manuals (specifically in law and medicine faculties) and in the curricula of secondary schools.
- Include notions on the rules protecting the provision of health care and the applicable sanctions in programmes and manuals of administration and military instruction.

## C. Coordination

- Ensure that health-care personnel and facilities and medical transports are properly identified, marked and protected.
- Establish preventive coordination plans, involving all relevant stakeholders, to organize emergency response.
- Identify new technologies available for marking health-care personnel and facilities and medical transports.
- Create a mechanism for regular exchanges of views, on problems prevailing in the specific context regarding violence against health-care providers, between the various stakeholders concerned, including various ministries, national associations of health-care professionals, National Red Cross and Red Crescent Societies, the ICRC and relevant NGOs, or task an existing mechanism to perform this function.

# ANNEX 4

## TABLE OF TREATIES AND ABBREVIATIONS

| INTERNATIONAL HUMANITARIAN LAW | INTERNATIONAL HUMAN RIGHTS LAW |
|---|---|
| GC I: Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Geneva, 12 August 1949 | ACHPR: African Convention on Human and Peoples' Rights (1981) |
| GC II: Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea. Geneva, 12 August 1949 | ACHR: American Convention on Human Rights (1969) |
| GC III: Convention (III) relative to the Treatment of Prisoners of War. Geneva, 12 August 1949 | CESCR: Committee on Economic, Social and Cultural Rights |
| GC IV: Convention (IV) relative to the Protection of Civilian Persons in Time of War. Geneva, 12 August 1949 | ECHR: European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) |
| AP I: Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts. Geneva, 8 June 1977 | ICCPR: International Covenant on Civil and Political Rights (1966) |
| AP II: Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts. Geneva, 8 June 1977 | ICESCR: International Covenant on Economic, Social and Cultural Rights (1966) |
| AP III: Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem (Protocol III). Geneva, 8 December 2005 | GC No.: General Comment of the United Nations Committee on Economic, Social and Cultural Rights |

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