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Health Care in Danger: Respecting and Protecting Health Care in Armed Conflict and Other Situations of Violence

Background document

Document prepared by

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BACKGROUND REPORT

Health Care in Danger:
Respecting and Protecting Health Care in Armed Conflict and Other Situations of Violence[1]

1. Introduction

Violence against patients, health-care personnel and facilities, and medical vehicles is one of today's most serious humanitarian issues, yet one that is frequently overlooked. This issue is of vital concern to the International Red Cross and Red Crescent Movement (Movement), both as founder and custodian of international humanitarian law, which protects patients and health-care services, and as a major actor in the medical field during armed conflict and other situations of violence. Thousands of health-care staff and volunteers are directly affected by such violence each year, and the wounded and sick face obstacles in accessing medical care in armed conflict and other situations of violence all over the world.

Recognizing the importance of this issue and the unique role of the Movement in addressing it, the Council of Delegates, at its last meeting in Nairobi in November 2009, called upon the International Committee of the Red Cross (ICRC), the National Red Cross and Red Crescent Societies and the International Federation of Red Cross and Red Crescent Societies (International Federation) to intensify their efforts to ensure access to, and the protection of, health-care services in armed conflict and other situations of violence. The ICRC was asked, among other things, to continue collecting information on incidents that impede or endanger access to health care, and to report to the 31st International Conference on its findings and recommendations.

Further to this request, the ICRC carried out a sixteen-country study on the issue and on what the organization is doing to address it. The present report gives an overview of the study's main findings, outlines the ICRC's recommendations for how to tackle the issue and highlights the need for greater commitment to safeguarding health care on the part of the Movement, governments, the medical community, State armed forces and non-State armed groups. The report supplements other documents produced on this issue, including the background paper submitted to the Council of Delegates in November 2009,[2] which details the laws protecting health care; the ICRC booklet *Health Care in Danger: Making the Case*,[3]

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[1] The ICRC operates mainly in armed conflict and often together with National Societies. They also respond to needs stemming from "other situations of violence" that, while not reaching the threshold of armed conflict, can have serious humanitarian consequences. In these situations, States have recognized that the ICRC "may take any humanitarian initiative which comes within its role as a specifically neutral and independent institution and intermediary" in conformity with Article 5 of the Statutes of the International Red Cross and Red Crescent Movement (adopted by the Twenty-fifth International Conference of the Red Cross and Red Crescent in Geneva in October 1986 and amended by the Twenty-sixth International Conference of the Red Cross and Red Crescent in December 1995). In such situations, the ICRC takes action only with the full knowledge and consent of the State concerned.

[2] *Respecting and Protecting Health Care in Armed Conflict and Other Situations of Violence*, background document for the Council of Delegates meeting in Nairobi, ICRC, Geneva, October 2009.

[3] *Health Care in Danger: Making the Case*, ICRC, Geneva, August 2011. http://www.icrc.org/eng/assets/files/publications/icrc-002-4072.pdf

which gives a sense of how widespread the problem is; and the full report on the ICRC's sixteen-country study on violence affecting health care.[4]

2. Violence affecting health care: Results of the ICRC study

The ICRC's study on violence affecting health care was launched in 2008 in 16 countries where the ICRC works. Reports of violent incidents were collected over 30 months from a variety of sources, including health-care organizations, Red Cross and Red Crescent staff, and the media. The purpose of the study was to gain insight into the threats to health care and the vulnerability of health-care facilities and personnel, in order to guide the ICRC's preventive and post-incident responses.

By the end of 2010, the ICRC had documented 655 violent incidents, e.g.:

⇒ Violence against, or interference with, health-care facilities, such as clinics, hospitals, medical stores and pharmacies, including bombing, shelling, forced entry, shooting, destroying and looting supplies and equipment.

⇒ Violence against health-care personnel, including killing, kidnapping, harassment, threats, intimidation, robbery, and arrest and detention for providing medical care.

⇒ Violence against patients or those trying to access medical care, including killing and injuring, harassment and intimidation, and blocking or interfering with timely access to care (discrimination, interruption of medical treatment or outright denial of such treatment).

⇒ Violence against medical vehicles, including ambulances and private vehicles transporting the wounded and sick, and interference with the transport of medical supplies and equipment.

Main findings

In the 655 incidents documented, 1,834 people had been killed or wounded, of whom 20 percent were patients. Explosive devices were responsible for more deaths and injuries per incident than any other cause.

Regular armed forces or armed groups were responsible for 70% of the incidents, State armed forces for 33% (216/655), and non-Stated armed groups for 36.9% (242/655). The remainder were associated with robberies or had been committed by relatives of the victims or by unknown people.

The study showed that most of the damage inflicted on **hospitals and other medical facilities** was due to:

⇒ the use by State armed forces, during active hostilities, of weapons that exploded in, or in the vicinity of, the facilities;
⇒ armed entry into the facilities by State actors (armed forces or police) in order to arrest or interrogate patients;
⇒ armed entry into the facilities by armed groups in order to intimidate health-care personnel, steal supplies, occupy the premises, or commandeer vehicles for medical or tactical purposes.

[4] *Health Care in Danger: A Sixteen-Country Study*, ICRC, Geneva, July 2011 (http://www.icrc.org/eng/assets/files/reports/4073-002-16-country-study.pdf).

In nine per cent of the incidents recorded, **health-care personnel** had been killed or injured. In many more incidents, they had faced intimidation, harassment and other forms of violence. Of these, the main ones were:

⇒ the use of explosive weapons by State armed forces during active hostilities;
⇒ kidnapping from their places of work by non-State armed groups;
⇒ the killing of expatriates by non-State armed groups;
⇒ arrest (a larger percentage of health-care personnel than wounded and sick had been arrested and removed from medical facilities);
⇒ threats and intimidation related to their work.

The principal forms of violence affecting **medical vehicles** were:

⇒ attacks by State and non-State armed groups while the vehicle was transporting patients and/or personnel;
⇒ improvised explosive devices;
⇒ impediments and delays at checkpoints by State armed forces and police.

Insight into a wider problem

The study provides a glimpse into the types of violence disrupting health-care services in a variety of contexts around the world. The cases recorded, however, represent the tip of the iceberg: the number of incidents reported falls well short of the number actually occurring, especially in areas inaccessible to aid organizations and the media, such as many regions of Pakistan and Afghanistan. Furthermore, the statistics do not reflect the indirect and multiplier effects of attacks on health-care facilities when services are disrupted, hospitals close and health-care personnel flee. The attack on the ICRC field hospital in Novye Atagi in December 1996 left six expatriate staff dead, provoking the withdrawal of the ICRC from the hospital and depriving thousands of potential patients of the care they required. A suicide bombing targeting Somali government ministers at a graduation ceremony in the capital, Mogadishu, in December 2009, killed dozens of people, including some of those graduating as doctors, depriving this worn-torn country of desperately needed skills. There will never be records of the tens of thousands of patients these doctors might have treated in their lifetimes but now cannot.

The disruptive impact of insecurity on preventive health-care programmes such as vaccination campaigns can also have long-term consequences. The fight to eradicate polio, for example, has faced setbacks in Afghanistan and Pakistan, where the safety of vaccination teams is difficult to ensure.[5] Conflict frequently causes the displacement of people to areas that are beyond the reach of regular health-care systems, right when they are most vulnerable to disease. A study in the Democratic Republic of the Congo suggests that 40,000 people die each month from diseases that could easily be treated were it not for insecurity arising from the armed conflict.[6]

The ICRC study analysed incidents that occurred prior to 1 January 2011, but events since then illustrate the continuing magnitude of the problem. Heavy fighting in the Ivorian capital, Abidjan, in March 2011 prevented ambulances from collecting the wounded and hospitals from being resupplied with essential drugs and materials. In Mogadishu one month later, 12 shells landed on Medina Hospital. Fortunately only one of them exploded but it injured a

[5] See, for example, the Global Polio Eradication Initiative Strategic Plan 2010-2012, World Health Organization (WHO), Geneva (http://www.polioeradication.org/ResourceLibrary/StrategyAndWork/StrategicPlan.aspx), and Michael Toole, *et al., Report on the Independent Evaluation of the Major Barriers to Interrupting Poliovirus Transmission in Afghanistan.* WHO, Geneva, October 2009.
[6] B. Coghlan, R. Brennan, P. Ngoy, D. Dofara, B. Otto, M. Clements, T. Stewart, "Mortality in the Democratic Republic of Congo: A nationwide survey," *Lancet*, 2006, Vol. 367, pp. 44-51.

guard and sowed panic among patients and staff. The following month in Libya, three ambulances belonging to the Libyan Red Crescent were hit in separate incidents, claiming the life of a nurse and injuring a patient and three volunteers.

Violence incidents affecting health care are a major humanitarian concern that needs to be acknowledged and better understood so that preventive and protective measures can be taken to safeguard patients, health-care personnel and facilities, and medical vehicles.

3. The ICRC's efforts to safeguard health care

The ICRC has intensified its internal focus on the issue of violence against health-care services and strengthened pre-existing activities in the medical field that facilitate access to those services. It has also launched new initiatives to increase understanding of the problem and seek ways to address it.

1. Improving access to health care

The ICRC has continued to facilitate access to health care for the wounded and sick in armed conflict and other situations of violence by providing support for medical facilities. In 2010, the ICRC assisted 294 hospitals and 270 health-care centres and provided war-surgery training for over 1,000 health-care professionals and first-aid training for volunteers in 88 countries.

2. Improving field data collection and action to protect health care

The ICRC performed a review of its field practice in relation to violence against health-care services and identified the need to increase preventive and protective activities in 34 of its 70 delegations around the world. Best practice for preventing, recording and responding to such violence was shared among ICRC delegations, as were lessons learned from innovative practices such as the taxi-referral service in the southern provinces of Afghanistan.[7]

The ICRC has also negotiated safe access for health-care organizations with warring parties in several contexts. The security of many health-care facilities has been strengthened with sandbags and bomb-blast film on windows, and the GPS location of such facilities conveyed to warring parties. The ICRC supports the efforts of National Societies to improve the safety of their staff and volunteers, particularly those striving to assist victims of armed conflict and other situations of violence.

3. Increasing awareness of the laws protecting health care

The ICRC has approached State and non-State actors responsible for violations of the laws protecting patients and health-care personnel, facilities and vehicles. The ICRC has also expressed public concern about incidents in several contexts and reminded combatants of their legal obligations. It has issued press releases in relation to incidents in Afghanistan, Chad, Colombia, Georgia, Iraq, Israel and the occupied Palestinian territories, Lebanon, Libya, Nepal, Somalia, Sri Lanka, Sudan, and Yemen. The organization has also used radio broadcasts in Afghanistan and Nepal to spread knowledge of the rights and obligations related to health care.

4. Mobilizing international action

[7] The ICRC operates a referral service from first-aid posts to hospitals in six regions of Afghanistan where it is unsafe for either ICRC or Afghan Red Crescent vehicles to travel.

In August 2011, the ICRC launched a major campaign called Health Care in Danger, which is set to run for four years. The campaign aims to mobilize the ICRC's network of delegations, the Movement, States party to the Geneva Conventions, the health-care community and other actors to come up with practical recommendations for tackling violence against patients, health-care facilities and medical personnel. The ICRC is also submitting a resolution (above) to the Conference that will affirm the commitment of States and National Societies to safeguarding health care.

4. Recommendations

To start improving the situation on the ground, the ICRC recommends the following actions:

1. Building a community of concern

The ICRC aims to mobilize support for this issue within the Movement and among health-care professionals, medical aid organizations, military forces and governments around the world. This community of concern, working together to influence international public opinion, to help position the problem as a major humanitarian issue, to advocate for the adoption of appropriate solutions and to enhance respect for the law, should foster a culture of responsibility among all those concerned with safeguarding health care.

2. Regular and methodical information gathering

Reports of incidents should be more systematically collected and exchanged so as to foster a better understanding of violent incidents affecting health care and a more efficient response to them.

3. Consolidating and improving field practice

The ICRC has undertaken many initiatives to improve access to and safeguard health care in the various contexts in which it works. Experiences and best practice should be shared more widely within the Movement and the health-care community at large in order to encourage more and better initiatives on this front.

4. Ensuring physical protection

Hospitals and other health-care facilities in countries affected by armed conflict or other situations of violence should be given assistance in organizing the physical protection of their premises and in developing procedures for notifying others of their location and of the movements of their vehicles.

5. Facilitating safer access for Red Cross and Red Crescent staff and volunteers

The ICRC will encourage Red Cross and Red Crescent staff and volunteers to step up their work on behalf of the wounded and sick in armed conflict and other situations of violence, in particular by collecting data on, and responding to, threats to patients, health-care staff and volunteers, health-care facilities, and medical vehicles.

6. Engaging with States on effective legal implementation

The ICRC will encourage States to step up their efforts to adopt national implementation measures to ensure the protection of patients, health-care staff and facilities, and medical vehicles in armed conflict and other situations of violence. All States that have not yet

introduced domestic legislation in this regard will be encouraged to do so. This includes enacting and enforcing legislation on limiting use of the red cross and red crescent emblems and developing or adapting criminal legislation to allow for the suppression of violations of protective laws.

7. Engaging with national armed forces

The ICRC will encourage all national armed forces that have not yet incorporated provisions into their standard operating procedures with respect to safeguarding health care to do so. These procedures must address, among other practical issues, the management of checkpoints in such a way as to facilitate the passage of medical vehicles and access to health-care facilities.

8. Engaging with non-State armed groups

The ICRC will systematically approach armed groups operating outside State control and encourage them to enter into dialogue on laws and practices pertaining to safeguarding the delivery of health care.

9. Engaging with professional health-care institutions and health ministries

The ICRC will step up dialogue with health ministries and health-care institutions in order to generate solidarity on this issue and improve reporting on, and the response to, violence against patients and health-care workers and facilities.

10. Encouraging interest in academic circles

The ICRC will encourage other educational institutions and think tanks to incorporate modules on the implications of, and various means to address, violence against patients and health-care workers and facilities into public-health studies.

Annex 1: Overview of international humanitarian law and international human rights law protecting patients, health-care workers and facilities, and medical vehicles in armed conflict and other situations of violence.

ANNEX 1

Overview of international humanitarian law and international human rights law protecting patients, health-care workers and facilities, and medical vehicles in armed conflict and other situations of violence

International humanitarian law (IHL) contains detailed rules designed to safeguard respect and protection for the wounded and sick, health-care workers and facilities, and medical vehicles in armed conflict. These rules bind both States' armed forces and non-State armed groups.[8]

However, in situations of violence other than armed conflict (other situations of violence, OSV),[9] only international human rights law (IHRL), not IHL, applies.[10] IHRL is less precise than IHL in that it does not enshrine specific protection for health-care personnel and facilities. Specific rules are often extracted from broader IHRL provisions.

Nevertheless, some basic rules apply regardless of the classification of the situation. The purpose of this Annex is to present the basic rules governing the protection of health-care personnel and facilities in both armed conflict and OSV, although it is not meant to be an exhaustive treatment of the matter.

The rules identified should be understood in the light of existing IHL and IHRL. A short commentary will follow each rule, explaining its legal basis and providing guidelines on how it should be interpreted. Where IHL applies, this extends to all parties to armed conflict. However, in OSV, when only IHRL applies, the rules apply to States exclusively. The latter limitation is due to the fact that while IHRL binds States, one cannot conclude at present that it also binds non-State armed groups, such as opposition movements.[11]

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

Under IHL, all parties to armed conflict have the basic obligation to provide the wounded and sick with medical care and attention as far as practicable and with the least possible delay. Such care and attention must be provided without any adverse distinction based on grounds other than medical ones.[12] The qualification of "as far as practicable and with the least possible delay" means that this obligation is not absolute, but rather requires parties to take all possible measures subject to their resources and to the feasibility of such measures in the midst of hostilities.[13] However, no one may wilfully be left without medical assistance.[14]

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[8] These rules were described in the background report Respecting and Protecting Health-Care in Armed Conflict and Other Situations of Violence," CD/09/13.1, October 2009, submitted to the Council of Delegates in Nairobi, Kenya, on 23-25 November 2009.

[9] A definition of OSV is beyond the scope of this report. See the reference to "internal disturbances and tensions, such as riots, isolated and sporadic acts of violence and other acts of a similar nature" in Art. 1(2) AP II, specifying that these situations do not amount to armed conflicts.

[10] IHRL applies in addition to domestic law.

[11] However, under applicable international criminal and domestic law, individual members of non-State armed groups must respect the wounded and sick, health-care personnel and medical facilities and, in life-threatening circumstances, provide all feasible medical care.

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

[13] *Commentary* on Art. 10 AP I, paras 446, 451.

[14] Art. 12(2) GC I-II.

Under IHRL, States have an obligation to ensure the non-derogable right to life by refraining from deliberately withholding or delaying the provision of health care to individuals under their jurisdiction in life-threatening circumstances.[15] Furthermore, the *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials*, a soft-law instrument, states that whenever the lawful use of force and firearms is unavoidable, law-enforcement officials must ensure that assistance and medical aid are rendered to any injured or affected persons at the earliest possible moment.[16]

Under the right to health, States also have an obligation to ensure the non-discriminatory provision of at least essential health care, including preventive, curative and rehabilitative services.[17] While this obligation is non-derogable, its fulfilment is not absolute in that it is dependent on the available resources of a State.[18] However, States are obliged to make use of their existing resources and – where those are insufficient – they must actively seek resources available from the international community through international cooperation and assistance.[19] Any other limitations placed on the right to health must comply with the law (including IHRL) compatible with the nature of this right, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare of society. Furthermore, such limitations must be of limited duration and subject to review.[20]

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

Under IHL, whenever circumstances permit, and particularly after the fighting is over, all parties to armed conflicts must, without delay, take all possible measures to search for, collect and evacuate the wounded and sick without adverse distinction.[21]

Within the scope of the right to health in IHRL, States have the non-derogable obligation to ensure access to health-care facilities, goods and services on a non-discriminatory basis,[22] subject to available resources.[23] While health-care facilities, goods and services must be within safe physical reach for all sections of the population, States have a special obligation to take all possible measures – including search, collection and evacuation of the wounded and sick, as in this case – to enable individuals to enjoy their right to access health care where they are unable to realize that right themselves by the means at their disposal for

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[15] This was recognized by the European Court of Human Rights in *Cyprus v. Turkey,* Application No. 25781/94, Judgement, 10 May 2001, paras 219-221. See also, more generally, Human Rights Committee, General Comment No. 6: The right to life, 30 April 1982, http://www.unhchr.ch/tbs/doc.nsf/0/84ab9690ccd81fc7c12563ed0046fae3 (accessed 9 May 2011), para. 5; M. Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary, 2nd* edition, Kehl-Strasbourg-Arlington: N. P. Engel, 2005, pp. 123-124.

[16] Moreover, Art. 6 of the Code of Conduct for Law Enforcement Officials states: "Law enforcement officials shall ensure the full protection of the health of persons in their custody and, in particular, shall take immediate action to secure medical attention whenever required."

[17] Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 3: The nature of States parties obligations (Art. 2, para. 1 of the Covenant), 14 December 1990, para. 10; *id.*, General Comment No. 14 on the right to the highest attainable standard of health, UN Doc. E/C.12/2000/4, 11 August 2000, para. 43.

[18] Art. 2 (1), International Covenant on Economic, Social and Cultural Rights (ICESCR), 19 December 1966, 999 UNTS 171.

[19] CESCR, General Comment No. 3, para. 10; CESCR, "An Evaluation of the Obligation to take Steps to the 'Maximum of Available Resources' Under an Optional Protocol to the Covenant," UN Doc. E/C.12/2007/1, 10 May 2007, para. 10.

[20] Art. 4, ICESCR; CESCR, General Comment on the right to health, paras 28-29.

[21] Art. 15 (1) GCI; Art. 18 GCII; Art. 8 APII; Rule 109, *Customary IHL Study*.

[22] CESCR, General Comment No. 14 on the right to the highest attainable standard of health, UN Doc. E/C.12/2000/4, 11 August 2000, para. 43.

[23] Art. 25, Universal Declaration of Human Rights, 10 December 1948, UN-GA Res. 217, Annex; Art. 12, ICESCR.

reasons beyond their control.[24] Since in many cases it is not possible for the wounded and sick in OSV to access health-care facilities owing to their condition and/or the prevailing violence, fulfilling this obligation entails an active duty to search, collect and evacuate the wounded and sick.

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

Under IHL, the basic obligation to respect the wounded and sick entails, in particular, not to attack, kill, ill-treat or harm them in any way.[25]

Moreover, medical personnel, units and vehicles, pursuing their exclusively humanitarian task, whether military or civilian, may not be attacked or harmed, unless they commit, outside their humanitarian work, acts harmful to the enemy.[26] Examples of "acts harmful to the enemy" include the use of medical units to shelter able-bodied combatants, to store arms or ammunition, as military observation posts or as a shield for military action;[27] or the transport of healthy troops, arms or munitions and the collection or transmission of military intelligence.[28] However, certain acts are not considered to fall within this exception, for example: carrying light individual weapons for self-defence or defence of the wounded and sick; the presence of, or escort by, military personnel; and the possession of small arms and ammunition taken from the wounded and sick and not yet handed over to the proper authority.[29]

Under IHRL, States have the obligation not to subject any individuals under their jurisdiction, including the wounded and sick, and health-care personnel, to arbitrary deprivation of life.[30] The use of force by State agents against health-care personnel is justified only where it is absolutely necessary to defend a person from an imminent threat to life or limb.[31] Generally, neither the wounded and sick, nor health-care personnel, would pose such an imminent threat warranting the use of force against them. Even then, law-enforcement officials must issue a clear warning of their intent to use firearms, with sufficient time for the warning to be observed, unless to do so would create a risk of death or serious harm to the police officer concerned or third persons.[32]

Access to health-care facilities shall not be arbitrarily denied or limited

Under IHL, the obligation to respect medical personnel, units and vehicles, performing their exclusively medical duties, entails not arbitrarily preventing the passage of health-care

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[24] See CESCR, General Comment on the right to health, paras 12, 37, 43.
[25] Art. 12 GC I; Art. 12 GC II; Art. 16 GC IV; Art. 10 AP I; Art. 7 AP II; *Commentary* on Art. 10 AP I, para. 446. Under IHL, by definition the wounded and sick refrain from any act of hostility. See Art. 8 (a), API.
[26] Rules 25, 28, 29, *Customary IHL Study*; Arts 19(1), 24-26, 35 GC I; Arts 23, 36 GC II; Arts 18, 20, 21 GC IV; Arts 12(1), 15, 21 AP I; Arts 9, 11(1) AP II.
[27] *Commentary* on Art. 21 GC I, pp. 200-201; *Commentary* on Rule 28, *Customary IHL Study*, p. 97.
[28] *Commentary* on Rule 29, *Customary IHL Study*, p. 102.
[29] Art. 22 GC I; Art. 13 AP I; *Commentaries* on Rules 25, 29, *Customary IHL Study*, pp. 85, 102.
[30] Article 6(1) International Covenant on Civil and Political Rights, 999 UNTS 171; Art. 2, European Convention on Human Rights and Fundamental Freedoms (ECHR), 4 November 1950, CETS No. 5; Art. 4, American Convention on Human Rights (ACHR), 22 November 1969, OAS Treaty Series No. 36, 1144 UNTS 123; Art. 4, African Charter on Human and Peoples' Rights (ACHPR), 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5.
[31] Art. 2(2) ECHR; HRC, *Guerrero v. Colombia*, Communication No. R.11/45, UN Doc. Supp. No. 40(A/37/40), 31 March 1992, paras 13.2, 13.3; Inter-American Court of Human Rights (IACtHR), *Las Palmeras*, Judgement, 26 November 2002, Ser. C No. 96 (2002); Nowak, *op. cit.*, p. 128; Principles 9, 10, *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials*, UN Doc. A/CONF.144/28/Rev. 1 (1990).
[32] Principles 9, 10, *Basic Principles on the Use of Force*, *op. cit*.

personnel and supplies.[33] Like all other obligations in relation to health-care personnel and facilities, this obligation derives from the fundamental duty to respect, protect and care for the wounded and sick.[34] Since the obligation to ensure adequate care for the wounded and sick, for instance, includes handing them over to a medical unit or ensuring their transport to a place where they can be adequately cared for,[35] measures impeding access to health-care facilities by the wounded and sick are contrary to it. More generally, parties to a conflict are required to allow and facilitate rapid and unimpeded passage of humanitarian relief, which is impartial in character and conducted without any adverse distinction, for civilians in need.[36] While the delivery of relief consignments remains subject to consent by the parties concerned, [37] such consent must not be withheld arbitrarily.[38]

Under IHRL, the non-derogable obligation to respect the right to health, which includes access to health-care facilities, goods and services on a non-discriminatory basis, requires States to abstain from arbitrarily denying or limiting such access by the wounded and sick, for instance as a punitive measure against political opponents.[39] Restrictions on access by doctors to persons requiring treatment who are believed to be opposed to a government constitute an arbitrary limitation, as a State imposing such a limitation could hardly show that this is compatible with the essential nature of the right of access to health care. [40] Moreover, limitations on the grounds of national security could only be invoked if they served the economic and social well-being of a State's population.[41] This would not be the case where a part of the population would be deprived of urgently needed health care.

Health-care personnel shall not be hindered in the performance of their exclusive medical tasks nor shall they be harassed for simply assisting the wounded and sick.

Under IHL, the obligation to respect medical personnel who are performing exclusively medical duties also entails an obligation to refrain from arbitrarily interfering with those duties so as to allow the wounded and sick to be treated.[42] Parties to a conflict shall not molest **(harass? mistreat?)** or punish medical personnel for performing activities compatible with medical ethics, nor shall they compel them to perform activities contrary to medical ethics or to refrain from performing acts required by medical ethics.[43] These rules would preclude practices such as armed takeovers of hospitals by armed forces or groups who harass, intimidate or arrest health-care professionals.

These practices are equally prohibited under IHRL, as the non-derogable obligation to respect the right of non-discriminatory access of the wounded and sick to health-care facilities, goods and services requires States to refrain from direct or indirect interference with the enjoyment of that right.[44]

The wounded and sick, and health-care personnel and facilities must also be protected against interference by third parties

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[33] *Commentary* on Art. 12 AP I, p. 166, para. 517.
[34] *Commentary* on Art. 12 GC I, p. 134.
[35] *Commentary* on Art. 12 GC I, p. 137; *Commentary* on Art. 8 A PII, p. 1415, para. 4655.
[36] Rule 55, *Customary IHL Study*; Art. 70 AP I; Art. 18 (2) AP II. See also Art. 23 GC IV.
[37] *Ibid*.
[38] *Commentary* on Rule 55, *Customary IHL Study*, p. 197.
[39] CESCR, General Comment on the right to health, paras 34, 43, 47, 50.
[40] *Ibid*., para. 28.
[41] Art. 4, ICESCR; P. Alston and G. Quinn, "The nature and scope of States parties' obligations under the International Covenant on Economic, Social and Cultural Rights," 1987, Vol. 9, *Human Rights Quarterly*, p. 202.
[42] *Commentaries* on Arts 19, 24, 35 GC I, pp. 196, 220, 280; *Commentary* on Arts 12, 21 AP I, pp. 166, 250; *Commentary* on Art. 11 AP II, p. 1433.
[43] Art. 18 (3) GC I; Art. 16(1)-(2) AP I; Art. 10(1)-(2) A PII.
[44] CESCR, General Comment on the right to health, paras 33, 43.

Under IHL, the obligation of parties to a conflict to protect the wounded and sick, and medical personnel, units and vehicles, includes a duty to ensure that they are respected by third persons and to take measures to assist such personnel, units and transports in the performance of their tasks. This requires, for instance, removing the wounded and sick from the scene of combat and sheltering them, or ensuring the delivery of medical supplies by providing a vehicle.[45] In particular, the wounded and sick must be protected against ill-treatment and looting of their personal property.[46]

Under IHRL, the obligation of States to ensure the right to access health-care facilities, goods and services on a non-discriminatory basis implies that States must take active measures to enable individuals to enjoy that right.[47] This also means that States must take appropriate measures to prevent third parties from interfering with medical treatment given to the wounded and sick.[48]

The red cross, red crescent and red crystal emblems shall be employed only to identify protected health-care personnel and facilities authorized to use them in armed conflict or to indicate that persons or objects are linked to the International Red Cross and Red Crescent Movement. All necessary measures shall be taken to prevent and suppress any misuse of the emblems.

Under IHL, the emblem may be used for protective or indicative purposes. During armed conflict, it constitutes the visible sign of the protection that IHL affords to the wounded and sick, to health-care personnel and facilities, and to medical vehicles.[49] When used as an indicative device, the emblem is intended to show that persons or objects are linked to the Movement.[50] While the protective emblem must be identifiable from as far as possible, and may be as large as necessary to ensure recognition,[51] the indicative emblem must be comparatively small in size and may not be placed on armlets or on the roofs of buildings.[52] The emblem as such does not confer protection – it is the relevant provisions of IHL that do so.

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[45] *Commentaries* on Arts 19, 24, 35 GC I, pp. 196, 220, 280; *Commentary* on Arts 12, 21 AP I, pp. 166, 250; *Commentary* on Arts 9, 11 AP II, pp. 1421, 1433.

[46] Art. 15 GC I; Art. 18 GC II; Art. 16 GC IV; Art. 8 AP II; Rule 111, *Customary IHL Study*.

[47] CESCR, General Comment on the right to health, para. 37; Principle 5(c), Basic Principles on the Use of Force and Firearms by Law Enforcement Officials.

[48] See CESCR, General Comment on the right to health, paras 33, 37.

[49] Those authorized to use the emblems as protective devices are: medical services of the armed forces and sufficiently organized armed groups; medical units and vehicles of National Red Cross and Red Crescent Societies that have been duly recognized and authorized by their governments to assist armed forces medical services, when they are employed exclusively for the same purposes as the latter and are subject to military laws and regulations; civilian hospitals (public or private) that are recognized as such by the State authorities and authorized to display the emblem; in occupied territory and in areas where military operations are under way, persons engaged in the running and administration of such civilian hospitals (and also in the search for, removal and transport of, and provision of care for wounded and sick civilians, the infirm and maternity cases); civilian medical personnel in occupied territories and where fighting takes place or is likely to take place; civilian medical units and transports, as defined under AP I, recognized by the relevant authorities and authorized by them to display the emblem; other recognized and authorized voluntary aid societies, subject to the same conditions as those applicable to National Societies. The ICRC and the International Federation may use the emblem for protective purposes in armed conflicts with no restrictions. See Arts 39-44, GC I; Arts 22-23, 26-28, 34-37, 39, 41-44, GC II; Arts 18(1)(4), AP I; Art. 12, AP II; Art. 2, AP III.

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

[51] Arts 39-44 GC I; Art. 18 AP I; Art. 6, *Regulations on the Use of the Emblem*.

[52] Art. 44 (2) GC I; Arts 4, 16, *Regulations on the Use of the Emblem*.

The distinction between the two types of use is necessary to avoid any confusion as to who is entitled to bear the emblem in armed conflict.[53] *The Regulations on the Use of the Emblem of the Red Cross or the Red Crescent* stipulate that National Societies shall endeavour, even in peacetime, to take necessary measures to ensure that emblems used for indicative purposes are comparatively small.[54]

However, the *Commentary* to these *Regulations* makes it clear that this has the character of a recommendation and that the use of a large-sized emblem is not excluded in certain cases, such as events where it is important for first-aid workers to be easily identifiable.[55] In this regard, the 2009 ICRC *Study on Operational and Commercial and Other Non-Operational Issues Involving the Use of the Emblems* recommended that first-aid workers (and facilities) belonging to National Societies display a large-sized indicative emblem in situations of internal disturbances and tensions if (a) it might enhance their medical assistance to victims of violence, and (b) it is authorized, or at least not forbidden, to do so by national legislation.[56]

All necessary measures, including adopting national legislation, shall be taken by the relevant authorities to prevent and suppress misuse,[57] including imitations,[58] improper use,[59] or perfidious use.[60]

Domestic law

The ICRC's Advisory Service has endeavoured to identify the different domains in which measures should be taken at the national level. These are presented in a fact-sheet to be circulated among the participants of the 31st International Conference. The fact-sheet, which covers both armed conflict and other situations of violence, refers to IHL and IHRL instruments affording protection to the wounded and sick, and to health-care personnel. The measures identified aim to (a) *prevent* violations of international obligations; (b) *improve compliance with* these obligations wherever they apply and (c) *suppress and punish* violations.

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[53] Art. 44 (2) GC I.
[54] Art. 4, *Regulations on the Use of the Emblem*.
[55] *Commentary* on Art. 4, *Regulations on the Use of the Emblem*.
[56] ICRC in consultation with the International Federation , *Study on Operational and Commercial and Other Non-Operational Issues Involving the Use of the Emblems*, CD/09/7.3.1, October 2009, submitted to the Council of Delegates in Nairobi, Kenya, 23-25 November 2009, pp. 80-82.
[57] Art. 54 GC I; Art. 12 AP II; Art. 6 AP III.
[58] The use of a sign which, owing to its shape and/or colour, may be confused with the emblem.
[59] This refers to the use of the emblem by people usually authorized to do so, but in a manner inconsistent with IHL provisions on its use; or to the use of the emblem by entities or persons not entitled to do so (commercial enterprises, pharmacists, private doctors, non-governmental organizations, ordinary individuals, etc.) or for purposes that are inconsistent with the Fundamental Principles of the Movement. See Art. 38 AP I.
[60] The use of the emblem during an armed conflict for the purpose of misleading the adversary in order to kill, injure or capture him. See Art. 37 AP I. Killing or wounding an adversary by resort to perfidy constitutes a war crime in both international and non-international armed conflict. See Arts 8(2)(b)(xi), 8(2)(e)(xi) ICC Statute.