



PROMOTING MILITARY OPERATIONAL PRACTICE THAT ENSURES SAFE ACCESS TO AND DELIVERY OF HEALTH CARE

**HEALTH IT'S A
CARE MATTER
IN OF LIFE
DANGER & DEATH**



ICRC



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TABLE OF CONTENTS

1. FOREWORDS	7
1.1 Mr Peter Varghese, AO Secretary, Department of Foreign Affairs and Trade, Australian Government	7
1.2 Dr Helen Durham Director of International Law and Policy, International Committee of the Red Cross	8
2. EXECUTIVE SUMMARY	11
3. DEFINITIONS	13
4. IDENTIFYING MITIGATING PRACTICAL MEASURES WITH STATE ARMED FORCES	17
4.1 The point of departure	17
4.2 Bilateral consultations with State armed forces	18
4.3 The military experts' workshop in Sydney, Australia	19
4.4 Sourcing process	20
5. ISSUES AND PRACTICAL MEASURES	23
Issue 1: Ground evacuations	23
1.1 Humanitarian problem	23
1.2 Humanitarian consequences	23
1.3 Applicable law	24
1.4 Practical measures	24
Issue 2: Search operations in health-care facilities	25
2.1 Humanitarian problem	25
2.2 Humanitarian consequences	25
2.3 Applicable law	26
2.4 Practical measures	26
Issue 3: Precautions during attacks (offence and defence)	27
3.1 Humanitarian problem	27
3.2 Humanitarian consequences	28
3.3 Applicable law	28
3.4 Practical measures	29
6. REFERENCES	31
7. ANNEXES	33
Annex 1 – Compendium of practical measures	33
1.1 Ground evacuations	33
1.2 Search operations in health-care facilities	36
1.3 Precautions during attacks (offence and defence)	38
Annex 2 – The Health Care in Danger Project	43
Annex 3 – Patterns and impact of violence perpetrated by State armed forces	46



1. FOREWORDS

1.1 Mr Peter Varghese, AO Secretary, Department of Foreign Affairs and Trade, Australian Government

The ICRC-led Health Care in Danger project addresses the serious and ongoing humanitarian challenge posed by violence against health care workers, health care facilities and patients during armed conflicts and other situations of violence. The ICRC's study of data from 16 countries collected between 2008 and 2010 demonstrated a worrying pattern of violence and insecurity ranging from denial of access to health care, arrests of health workers and direct attacks on health workers and health care facilities in violation of international humanitarian and human rights law.

Since 2012, the ICRC has been engaged in a critical and timely project in consultation with health care professionals, States Parties to the Geneva Conventions and other stakeholders to develop practical recommendations aimed at improving the effective and impartial delivery of health care during armed conflict and other times of crisis.

Consistent with Australia's longstanding support for the implementation of the Geneva Conventions, Australia is pleased to be a diplomatic partner of the ICRC in its delivery of the Health Care in Danger project. Australia recognises the ICRC's global significance in the delivery of humanitarian protection, particularly because of its unique access and willingness to assist vulnerable people in the most dangerous and remote parts of the world. Since 2013, Australia's support has included AUD 1.5 million to assist in the delivery of the project, in addition to the provision of annual core funding (AUD 44 million over 2013 and 2014).

In its role as a key diplomatic partner of the Health Care in Danger project, Australia co-hosted with the ICRC an expert workshop on military operational practices in Sydney from 9 to 12 December 2013. This was one in a series of research activities and consultations conducted by the ICRC with stakeholders on a range of themes as part of the project. The workshop brought together 27 representatives of State armed forces and international organisations to discuss practical measures to help ensure that civilian and military wounded and sick have safe access to effective and impartial health care during armed conflict and other situations of violence.

Australia welcomes this report as the culmination of the global consultations and research activities on military operational practices undertaken by the ICRC as part of the Health Care in Danger project. The report is a useful contribution to the enhancement of protections related to health care during times of armed conflict and other situations of violence.

1.2 Dr Helen Durham

Director of International Law and Policy, International Committee of the Red Cross

One hundred and fifty years ago the First Geneva Convention was signed in order to provide protection for the sick and wounded and for the health-care services tending them on the battlefields on land. That short legal instrument was the result of the proposals and activism of Henry Dunant, the founder of the International Red Cross and Red Crescent Movement. Five years previously he had witnessed the aftermath of the battle of Solferino in northern Italy and been appalled at the sight of the vast number of military victims, which far exceeded the limited resources of the medical services and the goodwill of the local people.

One hundred years ago, as the deadly battles of the First World War unfolded, no armed forces were prepared to absorb and treat the countless casualties of the conflicts of the industrial age. The Red Cross National Societies – another achievement of Henry Dunant’s vision – were to play an essential and unprecedented role on all fronts as well as on all sides as auxiliaries to the military medical services. Immense progress was made in that period, including, for example, the provision of blood transfusions and the prevention of septicaemia in field hospitals.

Today, in spite of the significant progress that has been made in medicine, knowledge and acceptance of international humanitarian law, the ICRC is still striving to improve the safe access and delivery of health-care services for the victims of armed conflicts and other emergencies. In contemporary armed conflicts, parties to the conflict all too frequently launch direct attacks on health-care facilities so as to deprive their enemies of medical services. While the impact of such tactics is easy to identify for the sick and the wounded, the knock-on effect on the whole population, which is consequently unable to access those essential services, is simply dramatic and all too often overlooked as a humanitarian issue.

The ICRC has been working for more than a year with military personnel all around the world in order to identify practical measures to mitigate the impact of their operations on health-care services, the sick and the wounded while still performing their duty. The present report contains the measures developed as a result of those consultations. Military personnel involved in the process demonstrated professionalism and a constructive spirit, confirming that they are part of the solution and key actors in the protection of health-care delivery.

Through its network of specialist delegates to the armed forces, the ICRC stands ready to provide support for all armed forces animated by the same constructive spirit to implement the set of practical measures proposed for their consideration. As ever, assistance without distinction or discrimination of all victims of armed conflicts and other emergencies remains the organization’s core concern.



2. EXECUTIVE SUMMARY

In many parts of the world violence continues to disrupt or cripple health-care services when they are needed most – namely during armed conflicts and other emergencies. As a result, untold numbers of wounded and sick civilians, combatants or fighters die of injuries that they would normally survive, while countless others suffer unnecessarily from easily treatable health problems. Yet, despite its devastating impact, this violence is a largely overlooked humanitarian issue.

Concerned by the lack of respect for the protection afforded to health-care providers and their beneficiaries under international humanitarian law (IHL) and other applicable bodies of law, the International Committee of the Red Cross (ICRC) launched a multifaceted Health Care in Danger (HCID) project in August 2011. A series of ICRC-led meetings conducted in partnership with different States and organizations have thus considered the various aspects of the provision of health-care services in times of armed conflict and other emergencies. For this purpose, recognizing the holistic nature of the issues at hand, key stakeholders were mobilized to find practical solutions within their own spheres of responsibility. Considering the essential role played by State armed forces and the impact that military operations may have on the safe access to or delivery of health care, the ICRC engaged in a broad consultation process with military personnel around the world. Bilateral confidential consultations were conducted with military personnel in 29 countries as well as with two multilateral organizations of a military or defence character. In addition, a workshop that was held in Sydney and brought together 27 senior officers from 20 countries was co-organized by the ICRC and the Australian government.

Consultations focused on the identification of practical measures to mitigate the effects of military operations in three specific areas or instances, due to their major impact on safe access to and delivery of health care:

- Delays in or denials of passage of medical transports, affecting the ground evacuation of the sick and wounded, particularly during controls at checkpoints;
- The negative impact of military search operations in hospitals and other health-care facilities;
- Harm to health-care personnel, transports and facilities or their patients caused by deploying military objectives inside or in close vicinity to health-care facilities, or when attacking enemy military objectives located within or in close vicinity to health-care facilities.

Overall, the consultations tended to demonstrate that there was scope and willingness to develop practical measures that could be incorporated into orders, rules of engagement, standard operating procedures or other relevant documents, and training in order to address the issues identified. Consequently and as a result of the whole consultation process with the military, the ICRC has produced the present report, compiling a complete set of practical measures covering aspects related to both the planning and the conduct of military operations. It is hoped that, by adopting and implementing these practical measures, whenever feasible and operationally relevant, the State armed forces and their respective authorities will avoid their operations having negative effects on the safe access to and delivery of health care or minimize those effects.



3. DEFINITIONS¹

As the Health Care in Danger project deals with a number of different situations, the terms used in this publication – for instance, “health-care personnel,” “health-care facilities” and “medical transports” – should be understood more broadly than the terms “medical personnel,” “medical units” and “medical transports” used in international humanitarian law (IHL), which applies during armed conflict. Medical personnel, units and transports fall within the IHL definition when they are “assigned exclusively to medical purposes by a competent authority or party to the conflict.” In the context of Health Care in Danger, health-care personnel, health-care facilities or medical transports can fall within the scope of persons and objects addressed by the project even if they have not been assigned by a party to a conflict.

Health-care facilities include hospitals, laboratories, clinics, first-aid posts, blood transfusion centres, and the medical and pharmaceutical stores of those facilities.^a

Health-care personnel include:

- people with professional health-care qualifications, e.g. doctors, nurses, paramedics, physiotherapists, pharmacists;
- people working in hospitals, clinics and first-aid posts, ambulance drivers, administrators of hospitals or personnel working in the community in their professional capacity;
- staff and volunteers of the International Red Cross and Red Crescent Movement involved in delivering health care;
- medical personnel of armed forces;
- personnel of health-oriented international and non-governmental organizations;
- first-aiders.^b

Medical transports include ambulances, medical ships or aircraft, whether civilian or military, and means of transport conveying the wounded and sick, health-care personnel and medical supplies or equipment. The term includes all vehicles used for health-care purposes, even if not assigned exclusively to medical transportation and under the control of a competent authority of a party to a conflict, such as private cars used to transport the wounded and sick to a health-care facility, transport vehicles for medical supplies and people-carriers transporting medical staff to places of work (e.g. for local vaccinations or to work in mobile clinics).

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

IHL defines “transport,” “transportation,” “medical vehicles,” “medical ships and craft” as well as “medical aircraft” in Article 8 (f) – (j) of Protocol I of 8 June 1977 additional to the Geneva Conventions (Additional Protocol I).

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

^b ICRC, *Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflict and Other Emergencies*, ICRC, Geneva, 2012.

¹ Where a definition given above goes beyond what is stated in a specific treaty, it should not be interpreted as extending that definition in law. Furthermore, nothing in this document extends any definitions or obligations in IHL or in any other body of law.

IHL also addresses “transport” or “transportation” in connection with:

- the use of the emblem;
- the medical purposes listed in Article 8 (e) of Additional Protocol I;
- the same protection for medical vehicles as for mobile medical units under Articles 12 and 21 of Additional Protocol I;
- the activities of medical personnel in relation to the wounded and sick and the protection of medical transports and of the distinctive emblems under rules 25, 29–30 and 109 of customary IHL equivalent to treaty IHL.^c

^c Jean-Marie HENCKAERTS, Louise DOSWALD-BECK, *Customary International Humanitarian Law, Volume I: Rules*; and Jean-Marie HENCKAERTS, Louise DOSWALD-BECK (eds), *Customary International Humanitarian Law, Volume II: Practice, Parts I and II*, Cambridge University Press, 2005. See also the updated Customary IHL database: <http://www.icrc.org/customary-ihl/eng/docs/home> (last visited on 10 July 2014).



4. IDENTIFYING MITIGATING PRACTICAL MEASURES WITH STATE ARMED FORCES

4.1 The point of departure

The ICRC's multifaceted HCID project was launched in August 2011 against a backdrop of growing humanitarian concern over the lack of respect for the protection afforded to health-care providers and their beneficiaries under IHL and other applicable bodies of law.

Much of the impetus for the four-year HCID project was generated by an ICRC study on patterns of violence undermining health-care provision observed in 16 countries between July 2008 and December 2010.²

The study outcomes paint a bleak picture of the widespread and multifaceted nature of violence against patients and the delivery of health-care services; however, it fell short of capturing the full scope of the problem, particularly in areas inaccessible to aid organizations and the media.

Among the study's main findings were that:

- attacks on health-care facilities during armed conflict and other emergencies fall into four main categories:
 - deliberate targeting to gain military advantage;
 - deliberate targeting for political, religious or ethnic reasons;
 - unintentional bombardment/shelling or “collateral damage”;
 - looting of drugs and medical equipment.
- such attacks affect the delivery of health care by:
 - preventing patients, medical staff and suppliers from accessing health-care facilities;
 - disrupting water and energy supplies;
 - causing the displacement of civilians, including health-care personnel, to safer areas where health facilities may be lacking or inadequate;
 - hampering the implementation of important preventive health-care programmes such as vaccination campaigns.

The study concluded that there are serious and widespread consequences for the wounded and sick and health-care services in armed conflict and other emergencies. It illustrated an urgent need to secure the safety of the wounded and the sick and of the provision of health-care services in those situations.

The serious nature and frequency of such violations and incidents prompted the 31st International Conference of the Red Cross and Red Crescent held in November 2011³ to request the ICRC to initiate consultations with key stakeholders with a view to formulating practical measures to make access to and delivery of health care safer, and to report back on progress to the 32nd International Conference in 2015.

² International Committee of the Red Cross, *Health Care in Danger: A sixteen-country study*, ICRC, Geneva, August 2011, available at: <http://www.icrc.org/eng/assets/files/reports/report-hcid-16-country-study-2011-08-10.pdf> (last visited on 10 July 2014).

³ International Committee of the Red Cross, *31st International Conference 2011: Resolution 5 - Health Care in Danger*, available at: <http://www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm> (last visited on 10 July 2014).

Following up on the trends identified by the 16-country study, ICRC field teams in 23 countries where the ICRC is operational were asked to systematically collect information on incidents affecting access to health-care services. That information was then centralized on a monthly basis. On the basis of that exercise, the ICRC released a second report in May 2013 that analysed data on 921 violent incidents affecting health care collected from January to December 2012⁴ and a third report released in April 2014, analysing data on 1,809 incidents collected from January 2012 to December 2013.⁵ A summary of the data collected between January 2012 and December 2013 and concerning State armed forces is presented at the end of the report, in Annex 3.

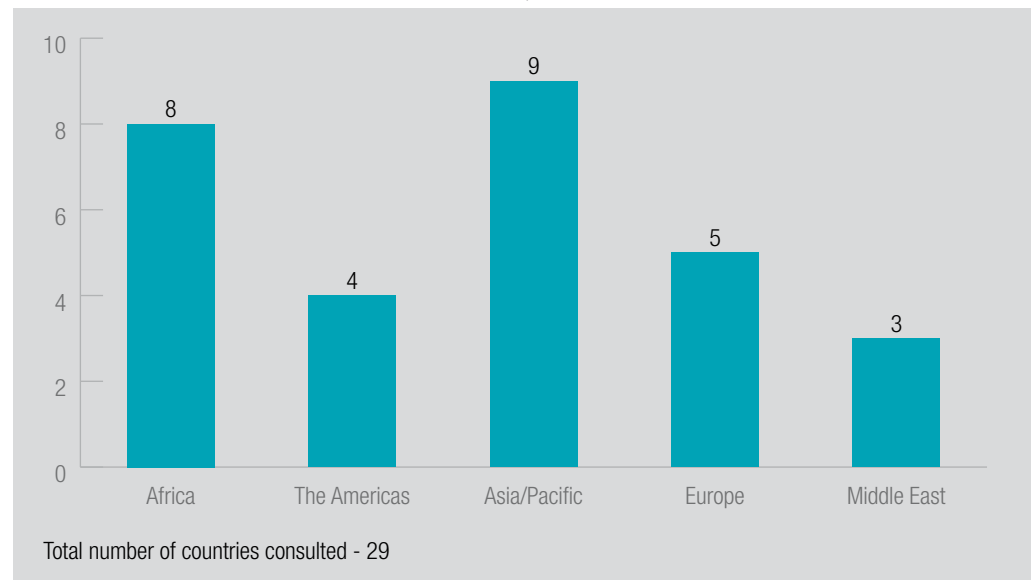
4.2 Bilateral consultations with State armed forces

Drawing on its operational experience and the aforementioned studies, the ICRC has identified three areas relevant to the operations and practices of State armed forces that potentially have a major impact on safe access to health care, namely:

1. Delays or denials in the context of ground evacuation of wounded and sick (including passing through checkpoints);
2. Search operations in health-care facilities disrupting health-care delivery;
3. Harm to health-care personnel, transports and facilities caused when deploying military objectives inside or in close vicinity to health-care facilities, or when attacking enemy military objectives located within or in close vicinity to health-care facilities.

In preparation for the Sydney workshop the ICRC conducted 31 confidential bilateral consultations with State armed forces' representatives from 29 countries as well as with two multilateral organizations of a military or defence character. As consultations were conducted under the condition of anonymity, the names of participating countries are not revealed. However, care was taken to ensure worldwide representation of State armed forces with recent combat experience.

Figure 1: Consultations conducted with countries, by region



The aim of the consultations was to identify existing practical operational measures to ensure the protection of patients, health-care workers, facilities and medical transports from the consequences of military operations in armed conflicts and other emergencies.

⁴ International Committee of the Red Cross, *Health Care in Danger: Violent incidents affecting health care, January to December 2012*, ICRC, Geneva, May 2013, available at: http://www.icrc.org/eng/assets/files/reports/4050-002_violent-incidents-report_en_final.pdf (last visited on 10 July 2014).

⁵ International Committee of the Red Cross, *Health Care in Danger: Violent incidents affecting health care, January 2012 to December 2013*, ICRC, Geneva, April 2014, available at: <http://www.icrc.org/eng/assets/files/publications/icrc-002-4196.pdf> (last visited on 10 July 2014).

More concretely, the objectives were to analyse the three issues described above from five angles:

- Whether existing doctrine (in the widest sense of the term) provides any theoretical guidance on how to address the issues identified;
- Whether standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation provide practical measures to address the issues identified;
- Whether, in operational practice, specific measures are developed to address the issues identified beyond the theoretical guidance provided by doctrine or practical measures directly ordered by higher echelons;
- Whether military education provides theoretical knowledge on how to address the issues identified and/or whether training provides practical experience for the same purpose;
- Whether mechanisms exist to report and sanction inappropriate behaviour.

Overall, the consultations tended to demonstrate that there was scope to develop practical measures that could be incorporated into doctrine, orders and training to address the three issues identified as particularly relevant to State military forces. However, it would be over-simplistic to conclude that armed forces generally ignore these issues. While the discussions were constructive and productive, they nonetheless highlighted the difficulty that members of armed forces have to freely exchange information on doctrinal matters and military orders that are usually classified. The outcomes of the discussions also depended largely on the personal experience of the officers interviewed.

It was clear from the bilateral consultations that State armed forces had practical solutions to the issues that affect the wounded and sick, health-care facilities, health-care personnel and medical transports during armed conflict and other emergencies and that were identified by the ICRC in its research on the topic.

4.3 The military experts' workshop in Sydney, Australia

The overall aim of the workshop was to identify and discuss the implementation of practical measures to make access to and delivery of impartial health care safer while permitting the conduct of military operations to be achieved. In doing so, participants took into consideration the outcomes of the bilateral consultations as well as the lessons learned throughout that process.

At the workshop, the participants' task was to identify and develop practical measures to facilitate the provision of health-care services rather than considering how to address potential breaches after they had occurred. Accordingly, participants drew on their own experience as operational, medical or legal experts recently deployed in conflict areas when discussing and further developing these practical measures.

The participants did not seek to assess whether the incidents identified in the ICRC's research and findings were violations of IHL. Similarly, participants did not consider or assess the effectiveness of international and domestic law in addressing such breaches.⁶ Furthermore, the participants did not assess the appropriateness of existing law in terms of whether health-care providers and facilities were afforded sufficient protection by existing law or whether existing law was being used effectively to sanction alleged perpetrators.

Similarly, the workshop participants did not seek to analyse or validate the findings of the ICRC's research relating to the effect of violence on the wounded and sick, health-care facilities, health-care personnel and medical transports. Rather, the participants accepted that identifying, disseminating and, where feasible, adopting better practical measures that facilitated access to and the provision of health-care services in times of armed conflict and other emergencies would assist in achieving better outcomes for the military, the sick and wounded and health-care providers. Furthermore, the workshop participants did not seek to allocate blame (e.g. to non-State actors or non-compliant States for attacks on health-care providers).

⁶ Domestic normative frameworks were subject to separate consultations in another HCID workshop in Brussels in January 2014.

Accordingly, workshop participants confined their discussions to the three issues which were identified by the ICRC as of particular concern and which formed the basis for the prior global consultations with armed forces representatives from 29 countries: ground evacuation, search operations in health-care facilities and precautions in attacks.

The workshop included both plenary sessions and three working groups. A background document highlighting the issues raised in the global discussions with State armed forces referred to earlier formed the basis for the discussions in the three working groups. Each question was tackled by a working group from a planning, conduct or coordination angle, resulting in the issues being analysed from a different angle, each one overlapping with and complementing the others.

Overall, the Sydney workshop was considered a success by both the participants and the organizers. The dynamic mix of experts present and their prior preparation contributed to the lively and constructive discussions. Two general points are worth noting. First, drawing on their recent operational experiences, participants demonstrated a real interest and willingness to propose practical solutions to the issues identified by the ICRC as major concerns. Second, not only was the relevance of IHL (and other applicable legal regimes) reaffirmed, but a general tendency and willingness to go beyond what is legally required under these bodies of law where feasible and practical were also observed.

Interestingly, while fully recognizing that circumstances vary significantly depending on the operational context (e.g. in terms of command and control, threat and security), participants considered that the proposed practical measures with respect to ground movement controls and searches of medical facilities could be applied to any military operation regardless of the legal classification of the situation, i.e. whether it reaches the threshold of an armed conflict or not. Participants were of the view that it was not necessarily the classification of the conflict itself but the specificities and practicalities of each activity (e.g. the physical and risk environment of the checkpoint or the nature of search) that would determine whether practical measures were relevant in the circumstances, or more particularly, whether or not such measures could be implemented.

During the last day of the workshop, participants went through the measures that were identified during the confidential bilateral consultations and highlighted in the workshop background document. Those elements were validated by the participants and represent an interim result in the whole process. A second working group focused on the format of the outcomes of the process in order to increase its effect. Consequently, they recommended that three products needed to be developed as a result of the whole process, namely:

- a cover letter to be addressed to Chief of Staff or Minister level summarizing the issues and the need for action;
- a report explaining the issues and process in greater detail;
- an Annex listing the practical measures in a straightforward way to facilitate their implementation by commanders.

4.4 Sourcing process

The present report was produced by the ICRC as the culmination of the whole consultation process. Accordingly, a set of practical measures was developed for consideration by State armed forces in order to mitigate the effect of military operations on safe access to and delivery of health care. Those practical measures are based on:

- the 16-country study;
- other ICRC reports published on health-care-related issues;
- the confidential bilateral consultations with State armed forces' representatives;
- the Sydney workshop background document as validated on the last day of the workshop;
- the minutes and presentations of the working groups at the Sydney workshop;
- the intermediary co-chairs' report on the Sydney workshop;
- the recommendations at the Sydney workshop on the products to be developed;
- the ICRC's first-hand understanding and experience of health-care-related issues in the field.

During the drafting of the practical measures, based on field experience and in coherence with the other proposed measures, two elements not mentioned during the bilateral consultations and the workshop were added. Notably, for the first focal area, *ground evacuations*, a measure to regulate exceptions for medical evacuations in the event of a curfew was added. Second, it was felt that many coordination measures identified for the first focal area, *ground evacuations*, and for the second focal area, *search operations in health-care facilities*, would also make sense for the third focal area, *precautions during attacks*.



5. ISSUES AND PRACTICAL MEASURES

ISSUE 1: GROUND EVACUATIONS

1.1 Humanitarian problem

For the success of their operations and in meeting humanitarian objectives, armed or security forces often exercise control over ground movements within their area of responsibility. Controlling territory during armed conflict or other emergencies can generate a range of security challenges for the party or the actor exercising control. Military personnel manning roadblocks or checkpoints may feel, and often are, particularly vulnerable when performing these tasks, as they are especially exposed. Security challenges also arise whenever there is risk that parties to armed conflicts may misuse medical transports for non-medical purposes (including military purposes). While performing security controls, military personnel must refrain from arbitrarily delaying, or denying, the timely evacuation of the wounded and sick, including those of the enemy.

1.2 Humanitarian consequences

According to the ICRC's 16-country study and the data collected by 22 delegations since January 2012, delays and denials of passage at checkpoints for ambulances or other vehicles either transporting or on their way to assisting the wounded or sick or transporting medical supplies constitute one of the principal forms of interference and/or violence affecting medical vehicles. It is acknowledged that the operation of checkpoints may be a necessary security measure and that in and of itself a checkpoint is usually lawful and legitimate.

From a health-care perspective, problems may arise at roadblocks or checkpoints because of different factors, for example:

- lack of orders or improper or imprecise orders concerning the correct behaviour of personnel at checkpoints;
- limited experience of the personnel in charge at checkpoints;
- lack of coordination or communication at the different levels, i.e. internally,⁷ and with ambulance services, i.e. externally;⁸
- slow decision-making processes;⁹
- retribution for attacks on own medical vehicles;
- denying the other side medical services, which is illegal;
- curfews or no-movement orders;
- misuse of medical transports for non-medical purposes (including military purposes).

⁷ Sometimes failure of or breakdowns in communication between the hierarchy and troops on the ground has directly endangered the delivery of health-care services and hampered efforts to evacuate the wounded and sick.

⁸ For example, after being granted permission to enter areas to provide life-saving humanitarian assistance and to evacuate the wounded and sick, some convoys have been shot at by members of the military forces that granted entry. Taxi drivers transporting wounded persons in the absence of an ambulance service have also been detained, leaving the wounded unattended.

⁹ Lengthy delays between requests to evaluate the wounded and sick from areas sealed off by the military and the granting of permission (if at all).

As a result, wounded people have been known to be left for long periods without adequate health care, and some have died waiting for an ambulance or while en route to hospital. Pregnant women have given birth at checkpoints without proper medical help. Medical supplies have failed to reach the destinations where they were needed. Delays and abuses by military personnel at checkpoints can have substantial knock-on effects. For example, they can generate fear which deters civilians from attempting to reach health-care facilities on the other side of the checkpoint. Health-care workers, patients and their families and the wider community are all affected by acts and omissions that hamper the collection and evacuation of the wounded and sick.

1.3 Applicable law

Under IHL, the passage of medical personnel and supplies may not be arbitrarily prevented.¹⁰ This obligation derives from the fundamental obligations to respect, protect, collect and care for the wounded and sick,¹¹ which includes handing them over to a medical unit or permitting transport to a facility where they can be adequately cared for and the obligation to respect medical personnel and transports.¹² Arbitrary measures impeding access to health-care facilities by the wounded and sick are contrary to this obligation. Establishing and operating a checkpoint is not necessarily in and of itself an arbitrary measure. Under international human rights law, the obligation to respect the right to access health-care facilities 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.¹³ However, properly marked vehicles, including ambulances, are sometimes used by State armed forces and non-State armed groups for non-humanitarian purposes, including smuggling fighters and weapons or launching attacks. Under international humanitarian law, such conduct amounts to improper use of one of the distinctive emblems and if done with the specific intent to deceive the adversary in order to kill, injure or capture, constitutes perfidy.

1.4 Practical measures

The need to control a territory may require the establishment of checkpoints. By definition, these cause delays for all vehicles passing through, including those evacuating wounded or sick people. Such evacuations may be formal (i.e. authorized by the State or other competent authorities and identifiable as such) or informal (i.e. any vehicle transporting wounded and sick people in an emergency). A balance needs to be struck between security requirements and the necessity for patients to access health-care facilities as quickly as possible. To achieve this balance, armed forces may consider adopting and implementing the following practical measures whenever feasible and operationally relevant (e.g. extent of control and access to the territory, capacity to coordinate with medical staff in the vicinity).

- I. Measures to enhance understanding of the operational environment in order to minimize medical evacuation delays at checkpoints.

Mapping of health-care providers, relevant NGOs and others providing for the evacuation of the wounded and sick needs to be carried out both prior to and regularly during any operations in order to adapt to the specific context the measures aimed at minimizing delays and the resulting humanitarian consequences.
- II. Coordination measures with health-care professionals and relevant authorities providing for the evacuation of wounded and sick people in order to minimize medical evacuation delays at checkpoints.

Coordination with health-care providers, relevant NGOs and others providing for medical evacuations operating in and out of the area of responsibility needs to be established prior to the operations and then maintained throughout. Local community leaders or other relevant authorities need to be included in this coordination as the evacuation of the wounded and sick is not necessarily performed by formal health-care transport means or personnel only.

¹⁰ Yves SANDOZ, Christophe SWINARSKI and Bruno ZIMMERMANN (eds), *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949*, ICRC, Geneva, and Martinus Nijhoff Publishers, Dordrecht, 1987: commentary on Article 12 of Additional Protocol I, p. 166, para. 517.

¹¹ Jean S. PICTET (ed.), *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, Vol I of *The Geneva Conventions of 12 August 1949: Commentary*, ICRC, Geneva, 1952: commentary on Article 12, p. 134.

¹² *Idem*: commentary on Article 12 GC I, p. 137; Yves SANDOZ, Christophe SWINARSKI and Bruno ZIMMERMANN (eds), *op. cit.*: commentary on Article 8 of Additional Protocol II, p. 1415, para. 4655.

¹³ UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: *The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4, paras. 34, 43, 47, 50.

- III. Prioritization measures at checkpoints to minimize medical evacuation delays.
Measures to regulate checkpoints need to be predefined and included in training prior to operations and then implemented consistently in theatre in order to limit the potential humanitarian consequences of such action.
- IV. Specific measures to minimize the impact on medical evacuations whenever passage through a checkpoint is denied for reasons of imperative military necessity.
Denying passage to medical evacuation is an extreme measure, which may have a serious impact on the life or health of the wounded and sick. It should therefore only be taken on the grounds of imperative military necessity and remain exceptional. Measures should be adopted prior to the operation and maintained throughout in order to reduce the negative impact of such a decision.

ISSUE 2: SEARCH OPERATIONS IN HEALTH-CARE FACILITIES

2.1 Humanitarian problem

In the conduct of their operations, military units may have to search health-care facilities. Such searches may be deemed necessary for numerous reasons, including where intelligence suggests that the facility is possibly being used in a manner inconsistent with IHL or to question those inside and detain those who pose a security threat. Where wounded or sick enemy combatants or fighters are seeking treatment or visiting patients in health-care facilities, searches of those facilities may be deemed a matter of military necessity. Such operations are not, however, without a number of challenges for the protection of health-care facilities and their staff. These include:

- the disruption of normal services owing to the presence of armed personnel;
- the risk that, owing to the military presence (however temporary), the health-care facility will be considered by the other side as no longer exclusively dedicated to medical purposes or even as a military objective;
- the ethical dilemmas facing health-care staff urged to provide information about patients in their care.

While the decision to search for enemy combatants or fighters on health-care premises may be fully justified and legal, what remains problematic is the way that such operations are conducted. According to the ICRC's 16-country study published in 2011 and the data collected by 22 ICRC delegations since January 2012, one of the most common forms of violence affecting health care is armed entry into health-care facilities by State entities, including the military.

2.2 Humanitarian consequences

According to the 16-country study conducted in 2011, the main purpose of such armed entry was to arrest or interrogate the wounded and the sick. However, during the conduct of searches, soldiers have also sealed off access to hospitals for hours, obstructed access by doctors to parts of hospitals, and removed medical items for use in their own clinics.

The ICRC's field experience has also shown that, when unsuccessful in their search, soldiers have rounded up the staff and ordered them to report the presence of "enemy fighters" seeking treatment. Where staff have refused to provide certain information, citing medical ethics, soldiers have threatened them, their relatives and others, including patients. Some were kidnapped or ill-treated and others were killed. Soldiers have also removed patients, sometimes those still receiving life-saving treatment, from health-care facilities despite protests by surgeons that their medical condition advised against it. Patients have been taken to military hospitals where minimal care was offered.

Search operations by soldiers in health-care facilities can have serious, direct and wide-ranging consequences for health-care delivery. Where soldiers have engaged in the abuses described above, services have been suspended for short or long periods. The wounded and sick have been left unattended for hours while search operations were conducted, jeopardizing their chances of recovery and survival. Afterwards, some patients could not be given treatment as a result of theft or destruction caused by the forcible entry of the military or of the arrest or kidnapping of health-care workers.

Even searches that do not involve threats or actual physical violence have knock-on effects that hinder health-care delivery. The mere presence of soldiers in and around hospitals during armed conflict poses serious problems for health-care delivery and the perception of those facilities by the other side and by civilians; therefore, health-care facilities have been targeted. Fearing arrest, interrogation or harassment, some people are afraid to take the wounded and sick to health-care facilities or to seek treatment themselves. Members of armed groups may loot health-care facilities and kidnap health-care staff so that their own sick and wounded can be treated while in hiding. Furthermore, health-care personnel who are harassed or otherwise threatened may leave their jobs or refuse to treat patients in protest at the military's violence, thereby further depriving the sick and wounded of medical assistance.

2.3 Applicable law

Apart from the fact that health-care facilities and personnel are protected against attack, actions that prevent them from functioning may also violate IHL. However, IHL neither specifically prohibits searches of health-care facilities nor describes ways or means of conducting searches.¹⁴

A hospital is not a zone outside the purview of the authorities and does not offer immunity from arrest or detention. While armed entry is not unlawful, it should be closely regulated. Armed forces and armed groups ought not to put patients and staff at undue risk by their presence. Health-care personnel can be required to provide information on the activities, connections, positions or simply the existence of the wounded and sick, as well as the identity of patients with infectious diseases on the basis of domestic law. While refusal to answer such questions could lead to lawful arrest, it is prohibited to molest or punish any person, including health-care workers, for performing medical activities compatible with medical ethics.

It is also prohibited to compel any person engaged in medical activities to give anyone belonging either to an adverse party or to his own party, except as required by the law of the latter party, any information concerning the wounded and sick who are, or who have been, under his or her care if such information would, in his or her opinion, prove harmful to the patients concerned or to their families.¹⁵ The aim of these rules is to remove any fear or apprehension on the part of health-care personnel who are performing their activities in line with medical ethics, including activities for the benefit of wounded and sick enemies of a party to a conflict. In other emergencies, similar rules apply.¹⁶

2.4 Practical measures

Military necessity may require the conduct of searches in health-care facilities, the interrogation and searching of people (patients, visitors and health-care personnel alike) and under certain circumstances even the detention of individuals or the making of arrests. Such operations may be disruptive to the normal running of health-care facilities and should therefore be an exceptional measure taken only after a concerted effort has been made to find a balance between the military advantage expected from such action and its impact in humanitarian terms.

¹⁴ While the military manuals of several States indicate that armed persons may not enter health-care units at all, practice is not extensive enough to indicate clearly that the presence of armed soldiers inside a hospital *per se* is a violation of international humanitarian law.

¹⁵ Article 18 (3) of the First Geneva Convention; Article 16 (1) of Additional Protocol I; Article 10 (1) of Additional Protocol II; Jean-Marie HENCKAERTS and Louise DOSWALD-BECK, *Customary International Humanitarian Law, Volume I: Rules*, Cambridge University Press, 2005: Rule 26, pp. 86-88. See also: Yves SANDOZ, Christophe SWINARSKI and Bruno ZIMMERMANN (eds), *op. cit.*: commentary on Article 16 of Additional Protocol I, p. 206, para. 682. See also the ICRC reference document *Health Care in Danger – the responsibilities of health-care personnel working in armed conflicts and other emergencies*, August 2012, Chapter 11 “Gathering data and witnessing violations of international law,” pp. 87-92, available at: <http://www.icrc.org/eng/assets/files/publications/icrc-002-4104.pdf> (last visited on 10 July 2014).

¹⁶ Harassment, compulsion and arrests of health-care personnel carrying out these activities would also be prohibited under international human rights law, as such conduct would constitute impermissible limitations on the right of the injured to non-discriminatory access to health services. Limitations would only be allowed to the extent that they serve the economic and social well-being of the population of the State. International Covenant on Economic, Social and Cultural Rights, Article 4; UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, *The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4, para. 28. Moreover, the right not to be subjected to arbitrary or unlawful interference with their privacy protects persons under the jurisdiction of a State against undue disclosure of medical and other private data to persons not privy to the physician-patient relationship. However, this guarantee may be derogated from in times of public emergencies. See UN Human Rights Committee (HCR), CCPR General Comment No. 16: *The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation*, 8 April 1988, para. 10.

To minimize the negative effects of searches in health-care facilities, armed forces may consider adopting and implementing the following recommendations, whenever feasible and operationally relevant (e.g. extent of control and access to the territory, capacity to coordinate with medical staff in the vicinity):

- I. Specific measures to guarantee the exceptional nature of health-care facility searches and the removal of an individual from such a facility in order to minimize their impact on patients and health-care personnel.

The necessary balance between the military advantage expected from a search operation in a health-care facility or the removal of a patient and the humanitarian consequences of such an action needs to be calculated. Measures should guarantee the exceptional nature of such decisions.

- II. Measures to enhance understanding of the operational environment in order to minimize the impact of searches in health-care facilities and on patients and health-care personnel.

The operational environment needs to be evaluated both prior to and regularly during any operations to adapt to the specific context the measures aimed at regulating the conduct of military personnel during search operations in health-care facilities and the impact on patients and health-care personnel.

- III. Coordination measures with health-care professionals and relevant authorities providing health-care assistance for the wounded and sick in order to minimize the impact of a search operation in a health-care facility.

Coordination with health-care providers, relevant NGOs and others providing health-care assistance operating in and out of the area of responsibility needs to be established prior to operations and then maintained throughout as a pre-established relationship may facilitate search operations and minimize misunderstandings.

- IV. Measures to regulate the behaviour of military personnel while conducting search operations in a specific health-care facility.

Measures to regulate search operations in a specific health-care facility need to be predefined and included in training prior to operations and then implemented consistently in theatre in order to limit the potential humanitarian consequences of such actions.

ISSUE 3: PRECAUTIONS DURING ATTACKS (OFFENCE AND DEFENCE)

3.1 Humanitarian problem

When conducting operations, military forces must pay special attention to avoid endangering or damaging health-care personnel, transports and facilities by deploying military objectives inside or in close vicinity to health-care facilities, or when attacking enemy military objectives located within or in close vicinity to health-care facilities.

One of the most serious patterns of violence against health-care facilities identified by the ICRC's 16-country study and the data collected by 22 delegations since January 2012 was the use of explosive weapons by armed forces during active hostilities which, intentionally or unintentionally, hit health-care facilities or medical transports, thereby killing and injuring people, depriving patients of health-care services.¹⁷ Attacks on health-care facilities in armed conflicts and other emergencies fall into one of two broad categories.

The first is the deliberate targeting of such facilities. The objective may be to gain a military advantage by depriving opponents and those perceived to support them of medical assistance for their injuries; another aim may be to terrorize a local population by targeting a protected facility.

The second type of attack is unintentional, i.e. bombardment or shelling resulting in incidental damage from indirect fire aimed at a military target. This occurs most frequently when military operations are carried out in densely populated urban areas and where military activities and installations are sometimes deliberately placed in the vicinity of medical facilities so as to avoid or to minimize attack against such military objectives. Those firing the weapons are required to take all feasible precautions to distinguish between legitimate and illegitimate targets and to minimize damage to the civilian population,

¹⁷ In 22.6% (148/655) of the recorded incidents, some kind of explosive weapon was used.

their goods and the environment. Conversely, as far as possible, military objectives must not be located in a manner that endangers the civilian population, their goods and the environment. Recent armed conflicts have all seen serious damage to health-care facilities that was claimed to have been inflicted in error or as a result of lawful and legitimate targeting assessment, which may indeed have been the case. The risk to health-care facilities increases with their proximity to military installations.

3.2 Humanitarian consequences

The consequences of the use of explosive weapons against health-care personnel, medical transports and health-care facilities are very simple: they result in the destruction of the means needed to attend to the wounded and sick and may often lead to their death and at times even to the deaths of those whose exclusive mission is to care for their patients. In many instances, even when the death toll was low, the infrastructure collapsed as water and electricity supplies were cut off. Health-care facilities were forced to close and the wounded and sick were left unattended, which increased the severity of casualties of the attack.

3.3 Applicable law

Health-care facilities must be respected and protected at all times and may not be the object of attack. The wounded, the sick and health-care personnel may not be attacked, arbitrarily killed or ill-treated. The protection from attack to which medical personnel, facilities and transports exclusively assigned to medical purposes by a competent authority of a party to the conflict, whether military, civilian or provided by recognized voluntary aid societies, are entitled under IHL does not cease unless they commit or are used to commit acts, outside their humanitarian function, which are harmful to the enemy.¹⁸ However, even then, a warning must be issued, setting a time limit whenever appropriate. Moreover, even where an attack against medical personnel and objects having lost their protection is justified, the rules on distinction, proportionality and precautions must be complied with for the benefit of any wounded and sick who may still be present in a medical facility or medical transport.

On the other hand, the lethal use of force against health-care personnel and objects other than those specifically assigned to medical purposes by a competent authority of a party to the conflict is governed by the general rules on the conduct of hostilities protecting civilians and civilian objects. This means that an attack against such health-care personnel is justified only for such time as they directly participate in hostilities; attacks on objects devoted to health care are only justified when they have turned into a military objective. Generally under IHL, whenever force is required in armed conflict to fulfil a mission, all feasible precautions must be taken to confirm, in particular, that targets are legitimate military objectives; the means and methods used must also be chosen in such a way as not to inflict excessive incidental harm on health-care personnel, medical transports, health-care facilities or the wounded and sick.

In situations falling short of armed conflicts, when military forces carry out law enforcement operations, they may resort to the use of force only when all other means of achieving a legitimate objective have failed and the use of force can be justified in terms of the importance of this objective. They are urged to exercise restraint when using force and firearms and to act in proportion to the seriousness of the offence and the legitimate objective to be achieved.¹⁹ They are allowed to use only as much force as is necessary to achieve a legitimate objective.

¹⁸ Examples of “acts harmful to the enemy” include the use of health-care facilities to shelter able-bodied combatants, to store arms or ammunition (other than the temporary storage of arms and ammunition taken from the wounded and sick and not yet handed over to the competent authority), as military observation posts or as a shield for military action or the transport of healthy troops, arms or munitions and the collection or transmission of military intelligence or the direct participation by health-care personnel in hostilities, in violation of the principle of strict neutrality and outside their humanitarian function, for instance where they use weapons in combat against enemies to resist capture. Jean-Marie HENCKAERTS and Louise DOSWALD-BECK, *Customary International Humanitarian Law, Volume I: Rules*, Cambridge University Press, 2005: Rules 25, 28, 29; Articles 19 (1), 24-26, 35 of the First Geneva Convention; Articles 23, 36 of the Second Geneva Convention; Articles 18, 20, 21 of the Fourth Geneva Convention; Articles 12 (1), 15, 21 of Additional Protocol I; Articles 9, 11 (1) of Additional Protocol II; Jean-Marie HENCKAERTS and Louise DOSWALD-BECK, *op. cit.*: commentary on Rule 29, pp. 85, 102.

¹⁹ Principles 4 and 5 of the UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officials.

Generally, the wounded, the sick and health-care workers are unlikely to pose an imminent threat that warrants the use of lethal force against them. Even if the use of force is warranted, law enforcement officials must issue a clear warning of their intent to use firearms, with sufficient time for the warning to be observed, unless by doing so the police officer concerned or third parties would be put at risk of death or serious harm.²⁰

3.4 Practical measures

The military advantage expected to be gained from attacking military objectives located in the vicinity of health-care facilities or health-care facilities that have lost their protection needs to be carefully weighed against the humanitarian consequences likely to result from the incidental damage or destruction caused to those facilities.

To minimize the direct and indirect impact on the provision of medical services caused by an attack on a military objective in the vicinity of a health-care facility or on a health-care facility which has lost its protection, armed forces may consider adopting and implementing the following recommendations, whenever feasible and operationally relevant (e.g. extent of control and access to the territory, capacity to coordinate with medical staff in the vicinity):

- I. Specific measures to guarantee the exceptional character of an attack on a military objective in the vicinity of a health-care facility or on a health-care facility which has lost its protection.
In view of the knock-on effect (e.g. disruption of water and electricity supply services) on the delivery of health care caused by an attack on a military objective close to a health-care facility or on a health-care facility which has lost its protection, such attacks need to be strictly regulated. Measures should guarantee the exceptional nature of such attacks.
- II. Measures to enhance understanding of the operational environment in the event of an attack on a military objective in the vicinity of a health-care facility or a health-care facility which has lost its protection.
The operational environment needs to be assessed both prior to and regularly during any operation in order to adapt to the specific context the measures aimed at guiding the planning and conduct of an attack so as to limit the humanitarian consequences of such actions.
- III. Coordination measures with health-care professionals and relevant authorities providing health-care assistance for the wounded and sick in order to minimize the impact of attacks on a military objective located in the vicinity of a health-care facility or of an attack on a health-care facility which has lost its protection.
Coordination with health-care providers, relevant NGOs and others providing health-care assistance operating in and out of the area of responsibility needs to be established prior to operations and then maintained throughout as it may facilitate the decision-making process of attacks.
- IV.a Specific measures to guide the planning and conduct of an attack on a military objective in the vicinity of a health-care facility.
Measures to guide the planning and conduct of an attack on a military objective in the vicinity of a health-care facility need to be adopted prior to the operation and then implemented throughout in order to limit the potential humanitarian consequences of direct or indirect attacks.
- IV.b Specific measures to guide the planning and conduct of an attack on a health-care facility which has lost its protection.
Measures to guide the planning and conduct of an attack on a health-care facility which has lost its protection need to be adopted prior to an operation and then implemented throughout in order to limit the potential humanitarian impact of a direct or indirect attack.

²⁰ Principles 9 and 10 of the UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officials.



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7. ANNEXES

ANNEX 1 – COMPENDIUM OF PRACTICAL MEASURES

This compendium was produced by the ICRC as the culmination of the whole consultation process with State armed forces. It provides a set of practical measures that was developed for consideration by State armed forces in order to mitigate the effect of military operations on the safe access to and delivery of health care. These measures may be adopted or implemented for both the planning and the conduct of military operations, whenever feasible and operationally relevant. Nothing in this document extends any definitions or obligations in IHL or any other body of law.

During the elaboration of these measures, based on field experience and in coherence with the other proposed measures, two elements not mentioned during the bilateral consultations and the workshop were added. Notably, for the first focal area, *ground evacuations*, a measure to regulate exceptions for medical evacuations in the event of a curfew was added. Second, it was felt that many coordination measures identified for the first focal area, *ground evacuations*, and for the second focal area, *search operations in health-care facilities*, would also make sense for the third focal area, *precautions during attacks*.

The proposed measures for consideration are organized as follows:

- 1.1 Ground evacuations:** measures to mitigate delays in or denials of passage of medical transports, affecting the ground evacuation of the sick and wounded, particularly during controls at checkpoints;
- 1.2 Search operations in health-care facilities:** measures to mitigate the negative impact of military search operations in hospitals and other health-care facilities;
- 1.3 Precautions during attacks (offence and defence):** measures to mitigate harm to health-care personnel, transports and facilities or their patients caused by deploying military objectives inside or in close vicinity to health-care facilities or when attacking enemy military objectives located within or in close vicinity to health-care facilities.

1.1 Ground evacuations

The need to control a territory may require the establishment of checkpoints. By definition, these cause delays for all vehicles passing through, including those evacuating wounded or sick people. Such evacuations may be formal (i.e. authorized by the State or other competent authorities and identifiable as such) or informal (i.e. any vehicle transporting wounded and sick people in an emergency). A balance needs to be struck between security requirements and the necessity for patients to access health-care facilities as quickly as possible.

The negative effects of controlling (stopping and searching) medical evacuation vehicles should be minimized primarily through four different types of measures, whenever feasible and operationally relevant:

- 1.1.1 Measures to enhance understanding of the operational environment;
- 1.1.2 Coordination measures with health-care professionals and relevant authorities;
- 1.1.3 Prioritization measures at checkpoints;
- 1.1.4 Specific measures in case of denial of passage.

1.1.1 Measures to enhance understanding of the operational environment in order to minimize medical evacuation delays at checkpoints

Mapping of health-care providers, relevant NGOs and others providing for the evacuation of the wounded and sick needs to be carried out both prior to and regularly during any operations in order to adapt to the specific context the measures aimed at minimizing delays and the resulting humanitarian consequences, whenever feasible and operationally relevant.

- a. Identify and regularly update the mapping of the locations of formal and informal health-care facilities and assess their importance and capacity for the delivery of health-care services both within the area of responsibility and in its immediate vicinity (e.g. analysis according to different types of health-care facilities: hospital, clinic, primary health-care centre, first-aid post, etc.);
- b. Identify and regularly update the different types of health-care providers (formal or informal) and their vehicles operating in and out of the area of responsibility (e.g. ambulances, unmarked civilian vehicles);
- c. Identify the officially endorsed and/or recognized vehicle identification systems (e.g. type of vehicle, markings, electronic tracking) and personnel identification (e.g. IDs, uniforms);
- d. Identify and regularly update the existence of any coordination platform for emergency services and assess its functioning.

1.1.2 Coordination measures with health-care professionals and relevant authorities providing for the evacuation of wounded and sick people in order to minimize medical evacuation delays at checkpoints

Coordination with health-care providers, relevant NGOs and others providing for medical evacuations operating in and out of the area of responsibility needs to be established prior to the operations and then maintained throughout, whenever feasible and operationally relevant. Local community leaders or other relevant authorities need to be included in this coordination as the evacuation of the wounded and sick is not necessarily performed by formal health-care transport means or personnel only.

- a. Participate in any identified existing emergency coordination platform. If not possible or no such platform exists, consider creating one;
- b. Agree on coordination measures and procedures with health-care providers, as a minimum. If possible, do the same with opposing forces;
- c. Appoint a ground movement liaison officer to regularly update health-care providers on road conditions;
- d. Dedicate a selected radio frequency or any other means of communication to facilitate interaction between health-care personnel and the military;
- e. Agree on the means of identification used by health-care personnel, its display on arrival at checkpoints, the markings (e.g. emblems and plate numbers) or other visual means (e.g. blue light, flags, other lights), or any other means of identification (e.g. siren) used for health-care vehicles;
- f. Agree on appropriate interaction or conduct between health-care personnel and military personnel;
- g. Establish clear procedures for notifying the military of health-care personnel and vehicles (e.g. plate numbers, ID cards, dates and routes) involved in planned transports;
- h. Establish clear procedures for notifying the military of health-care personnel and vehicles involved in emergency transports;
- i. Appoint a staff position in charge of continuously updating lessons learned from coordination processes between the military and health-care providers or from incidents relating to the lack of such processes;
- j. Agree on a regular schedule for routine medical vehicle movements, avoiding the busiest hours at checkpoints (e.g. for patients requiring dialysis treatment).

1.1.3 *Prioritization measures at checkpoints in order to minimize medical evacuation delays*

Measures to regulate checkpoints need to be predefined and included in training prior to the operation and then implemented consistently in theatre in order to limit the potential humanitarian consequences of such action, whenever feasible and operationally relevant.

- a. Determine, prior to the operations or deployment, standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation for checkpoints tailored to the specific operation and context in order to minimize delays;
- b. Implement a fast lane if appropriate in the circumstances (i.e. security considerations, topography, distances and time of day or workload at checkpoint);
- c. Provide for clear identification of a fast lane, wherever feasible, well in advance of the checkpoint to enable health-care vehicles to avoid queuing;
- d. Whenever a fast lane is not feasible, clearly indicate, as appropriate, the possibility for health-care vehicles to drive to the front of the queue and be given priority;
- e. Ensure that the relevant checkpoints are notified quickly of the pending arrival of formal health-care vehicles;
- f. Whenever feasible, ensure communication between checkpoints to allow them to forewarn each other of the passage of health-care vehicles;
- g. For the purpose of drawing on lessons learned, ensure that a reporting system is in place and constantly updated by checkpoint leaders to track incidents involving the military and health-care providers or their vehicles;
- h. Deploy sufficient forces or resources to operate checkpoints efficiently (e.g. to give health-care transports priority);
- i. Train checkpoint personnel to limit the duration of identification checks on formal health-care personnel and vehicles to a strict minimum;
- j. Train checkpoint personnel to prioritize the passage of non-formal or non-notified health-care vehicles (e.g. a father transporting a wounded family member in his own car);
- k. Drawing on mission specifics and lessons learned, train military personnel likely to have checkpoint control duties, both during predeployment and in theatre, to implement standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation that ensure priority passage for health-care vehicles.

1.1.4 *Specific measures to minimize the impact on medical evacuations whenever passage through a checkpoint is denied for reasons of imperative military necessity*

Denying passage to medical evacuation is an extreme measure, which may have a serious impact on the life or health of the wounded and sick. It should therefore only be taken on the grounds of imperative military necessity and remain exceptional. Measures should be adopted prior to the operation and then maintained throughout in order to reduce the negative impact of such a decision, whenever feasible and operationally relevant.

- a. Regulate in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the level of authority by which, and the exceptional circumstances in which, a decision to deny passage through checkpoints may be taken;
- b. Ensure that formal health-care providers are informed of alternative routes;
- c. Ensure that informal health-care providers blocked at closed checkpoints are informed of alternative routes;
- d. Regulate exceptions for medical evacuations in the event of a curfew;
- e. Appoint a staff position in charge of the continuous referral to and updating of lessons learned from coordination processes between the military and health-care providers or incidents relating to the lack of such coordination.

1.2 Search operations in health-care facilities

Military necessity may require the conduct of searches in health-care facilities, the interrogation and searching of people (patients, visitors and health-care personnel alike) and under certain circumstances even the detention of individuals or the making of arrests. Such operations may be disruptive to the normal running of health-care facilities and should therefore be an exceptional measure taken only after a concerted effort has been made to achieve a balance between the military advantage expected from such action and its impact in humanitarian terms.

The negative effects of searches in health-care facilities should be minimized primarily through four different types of measures, whenever feasible and operationally relevant:

- 1.2.1 Specific measures to guarantee the exceptional nature of both searches in health-care facilities and the removal of individuals from them;
- 1.2.2 Measures to enhance understanding of the operational environment;
- 1.2.3 Coordination measures with health-care professionals and relevant authorities;
- 1.2.4 Measures to regulate the behaviour of military personnel while conducting search operations in a specific health-care facility.

1.2.1 Specific measures to guarantee the exceptional nature of health-care facility searches and the removal of an individual from such a facility in order to minimize the impact on patients and health-care personnel

The necessary balance between the military advantage expected from a search operation in a health-care facility or the removal of a patient and the humanitarian consequences of such an action needs to be calculated. Measures should guarantee the exceptional nature of such decisions, whenever feasible and operationally relevant.

- a. Consider alternatives to military searches of a specific health-care facility (e.g. use of civilian police);
- b. Regulate in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the level of authority by which, and the exceptional circumstances in which, a decision may be taken to conduct searches in a specific health-care facility;
- c. Define in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the authorization process for a request to conduct searches in a specific health-care facility and the associated documentation required (e.g. evidence of the military necessity, military advantage expected);
- d. Define in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the level of authority by which, and the exceptional circumstances in which, an individual may be removed from a health-care facility (e.g. to be transferred to a detention facility);
- e. Adopt the necessary measures under military law (i.e. penal, disciplinary) to ensure that commanding personnel involved in both decisions on and the conduct of searches in health-care facilities neither issue orders to conduct searches in a manner that results in undue impediments to, or denial of, the provision of health care in those facilities nor fail to take feasible measures within their power to prevent or repress the searches conducted in such a manner by their subordinates when they know or should have known about such conduct;
- f. Regulate in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the oversight measures to be taken by the approving authority (e.g. communication, investigation in case of incident);
- g. Regulate in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the reporting required of the officer in charge of the search operation in a specific health-care facility (e.g. timing, information);
- h. Appoint a staff position in charge of continuously drawing on and updating lessons learned from coordination processes between the military and health-care providers or incidents relating to the lack of such coordination.

1.2.2 Measures to enhance understanding of the operational environment in order to minimize the impact of searches in health-care facilities on both patients and health-care personnel

The operational environment needs to be evaluated both prior to and regularly during any operations in order to adapt to the specific context the measures aimed at regulating the conduct of military personnel during search operations in health-care facilities and the impact on patients and health-care personnel, whenever feasible and operationally relevant.

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

1.2.3 Coordination measures with health-care professionals and relevant authorities providing health-care assistance for the wounded and sick in order to minimize the impact of search operations in health-care facilities

Coordination with health-care providers, relevant NGOs and others providing health-care assistance operating in and out of the area of responsibility needs, whenever feasible and operationally relevant, to be established prior to operations and then maintained throughout as a pre-established relationship may facilitate search operations and minimize misunderstandings.

- a. Participate in any identified existing emergency coordination platform to facilitate and coordinate potential search operations in a specific health-care facility. If not possible, or no such platform exists, consider creating one;
- b. Agree on coordination measures and procedures with health-care providers and relevant authorities; as a minimum, predefine general procedures to be followed in the event of a search (e.g. timing, provision of appropriate notice);
- c. Define the requirements for liaison, notification and/or consultation with health-care authorities and providers;
- d. Provide for participation by military medical personnel in interaction with civilian health-care personnel in preparation for potential search operations in a specific health-care facility;
- e. Exchange and gather information regarding the incidence of infectious diseases and other potential health-related hazards in health-care facilities within the area of responsibility;
- f. Appoint a staff position in charge of continuously updating lessons learned from coordination processes between the military and health-care providers or from incidents relating to the lack of such coordination.

1.2.4 Measures to regulate the behaviour of military personnel while conducting search operations in a specific health-care facility

Measures to regulate search operations in a specific health-care facility need to be predefined and included in training prior to operations and then implemented consistently in theatre whenever feasible and operationally relevant in order to limit the potential humanitarian consequences of such actions.

- a. Design, prior to the operations or deployment, the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation in order to ensure minimal disruption of the medical services provided by the specific health-care facility in which a search operation needs to take place;
- b. Ensure that standard operating procedures (SOPs), operational orders (OPORDs) and/or any other relevant documentation include a checklist of guidelines to be followed during a search operation in a specific health-care facility;

- c. Provide guidance in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation on the nature and scope of appropriate questions that may be asked of health-care personnel and patients on the ethical and legal responsibilities of health-care personnel vis-à-vis patients and the legal obligation to allow patients to receive medical treatment without undue interference;
- d. Provide guidance in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation for all military personnel involved on the respect due to patients and their privacy (i.e. in terms of medical, cultural, gender or religious considerations);
- e. Provide guidance in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation on the interaction of military medical personnel with health-care personnel and patients;
- f. Define in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the circumstances and conditions under which individuals may be removed from health-care facilities (e.g. to be transferred to a detention facility) in order to ensure that legal obligations in relation to the provision of medical care are met and that medical opinions are taken into account when deciding on the removal and its execution (treatment as per the detention SOP);
- g. Provide guidance in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation on the specific circumstances in which it is permissible to collect biometric data from patients during search operations and how this should be done;
- h. Provide guidance in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation on procedures regarding personal equipment (e.g. carriage of weapons, body armour, helmets), in accordance with the prevailing circumstances;
- i. Provide guidance in the standard operating procedure (SOPs), operational orders (OPORD) and/or other relevant documentation on the circumstances and conditions under which force may be used within the health-care facility.
- j. Provide guidance on precautions that should be taken by troops, health-care personnel and patients to protect themselves from infectious diseases;
- k. Deploy sufficient forces or resources to conduct searches and ensure that search units include medical officers and female officers, depending on the circumstances (e.g. cultural, gender);
- l. During predeployment and in theatre, train military personnel (including military medical personnel) that are likely to have to conduct search operations in health-care facilities to ensure that they are familiar with standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation designed to ensure minimal disruption during such searches and are prepared to implement them.

1.3 Precautions during attacks (offence and defence)

Whenever feasible and operationally relevant, the military advantage expected to be gained from attacking military objectives located in the vicinity of health-care facilities or health-care facilities that have lost their protection needs to be carefully weighed against the humanitarian consequences likely to result from the incidental damage or destruction caused to those facilities.

The direct and indirect impact on the provision of medical services caused by an attack on a military objective in the vicinity of a health-care facility or on a health-care facility which has lost its protection should be minimized whenever feasible and operationally relevant by the following measures:

- 1.3.1 Specific measures to guarantee the exceptional character of an attack on a military objective in the vicinity of a health-care facility or a health-care facility which has lost its protection;
- 1.3.2 Measures to enhance understanding of the operational environment;
- 1.3.3 Coordination measures with health-care professionals and relevant authorities;
- 1.3.4.a Specific measures to guide the planning and conduct of an attack on a military objective in the vicinity of a health-care facility;
- 1.3.4.b Specific measures to guide the planning and conduct of an attack on a health-care facility which has lost its protection.

1.3.1 Specific measures to guarantee the exceptional character of an attack on a military objective in the vicinity of a health-care facility or on a health-care facility which has lost its protection

In view of the knock-on effect (e.g. disruption of water and electricity supply services) on the delivery of health care caused by an attack on a military objective close to a health-care facility or on a health-care facility which has lost its protection, such attacks need to be strictly regulated. Measures should guarantee the exceptional nature of such attacks, whenever feasible and operationally relevant.

- a. Measure the impact of an attack on health-care delivery against the mission and end-state as defined by the commander. Accordingly, consider kinetic strikes as a measure of last resort; conduct a threat assessment and consider options other than launching an attack:
 - Contain the threat by, for instance, cordoning-off the area where the health-care facility in question is located;
 - Reach an agreement with the other combatant party to leave the health-care facility or to surrender;
 - Reach an agreement with the other combatant party on the evacuation of health-care personnel and their patients (in the case of a small facility and provided that patients may be transported);
 - Resort to third parties, such as local formal or non-formal authorities (e.g. community elders), to convince the other combatant party to leave the immediate area or to surrender.
- b. Regulate in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the level of authority and the circumstances (e.g. threshold of necessity as evidenced by the facts on the ground) in which a decision to strike a military objective in the vicinity of a health-care facility or of a health-care facility which has lost its protection may be taken;
- c. Define in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the authorization process for a request to strike a military objective in the vicinity of a health-care facility or a health-care facility which has lost its protection (e.g. evidence of military necessity, military advantage expected, incidental damages expected to the health-care facility);
- d. Adopt the necessary provisions to make commanding personnel involved in both the decision to attack and the manner in which the attack is carried out on a military objective in the vicinity of a health-care facility or on a health-care facility which has lost its protection (e.g. approving authority, officer in charge of the attack) accountable for their role in such operations under military law;
- e. Regulate in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the oversight measures to be taken by the approving authority (e.g. communication, investigation in case of incident);
- f. Regulate in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the reporting required of the officer in charge of the strike on a military objective in the vicinity of a health-care facility or on a health-care facility which has lost its protection (e.g. timing, battle damage assessments);
- g. Appoint a staff position in charge of continuously drawing on and updating lessons learned from coordination processes between military and health-care providers or from incidents relating to the lack of such processes.

1.3.2 Measures to enhance understanding of the operational environment in the event of an attack on a military objective in the vicinity of a health-care facility or a health-care facility which has lost its protection

Whenever feasible and operationally relevant, the operational environment needs to be assessed both prior to and regularly during any operation in order to adapt to the specific context the measures aimed at guiding the planning and conduct of an attack so as to limit the humanitarian consequences of such actions.

- a. Identify and regularly update the mapping of the locations of formal and informal health-care facilities and assess their importance and capacity for the delivery of health-care services both within the area of responsibility and in its immediate vicinity (e.g. analysis according to different types of health-care facilities: hospital, clinic, primary health-care centre, health service, first-aid post, etc.);

- b. Measure the proximity of health-care facilities to military objectives (both one's own and those of the enemy) and assess potential direct damage on the basis of the available ordnance;
- c. Assess the potential indirect impacts of the planned attacks on military objectives on health-care delivery, in particular the disruption of essential utilities (e.g. electricity, water, logistics) and access for patients and their families;
- d. Develop and continuously update the non-strike or sensitive areas by identifying the location of all health-care facilities and the essential services on which they depend.

1.3.3 Coordination measures with health-care professionals and relevant authorities providing health-care assistance for the wounded and sick in order to minimize the impact of attacks on a military objective located in the vicinity of a health-care facility or of an attack on a health-care facility which has lost its protection

Coordination with health-care providers, relevant NGOs and others providing health-care assistance operating in and out of the area of responsibility needs, whenever feasible and operationally relevant, to be established prior to operations and then maintained throughout as it may facilitate the decision-making process regarding attacks.

- a. Participate in any identified existing emergency coordination platform. If not possible, or no such platform exists, consider creating one;
- b. Establish contact with health-care authorities and providers in order to:
 - fully understand the role that an individual facility plays in the wider health-care system. There should be a clear understanding of what, if any, back-up medical infrastructures exists;
 - gain a thorough understanding of the functioning resupply routes (e.g. for medicines, water, electricity, food) and their back-up systems;
 - identify available alternative resupply routes (e.g. for medicines, water, electricity, food);
- c. Continuously update the health-care providers on what would lead to or constitute a loss of protection.

1.3.4.a Specific measures to guide the planning and conduct of an attack on a military objective in the vicinity of a health-care facility

Measures to guide the planning and conduct of an attack on a military objective in the vicinity of a health-care facility need, whenever feasible and operationally relevant, to be adopted prior to the operation and then implemented throughout in order to limit the potential humanitarian consequences of direct or indirect attacks.

- a. Define in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the circumstances and conditions in which attacks on a military objective in the vicinity of health-care facilities may take place;
- b. Define in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the approval process authorizing a strike on a military objective in the vicinity of health-care facilities and the associated intelligence required (e.g. evidence of the military necessity, military advantage expected, incidental damage estimated to the health-care facility);
- c. Provide guidance in the form of standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation for an attack on a military objective in the vicinity of a health-care facility, tailored to the specific operation and context, in order to minimize the humanitarian consequences (e.g. avoiding or minimizing disruption to services);
- d. Develop, in the planning process, a deliberate and immediate targeting process based on IHL/LOAC and incorporating terrain analysis, weapons effects and means of delivery;
- e. Include military medical personnel as well as legal and cultural advisers (whenever available and appropriate) in the planning, decision-making and conduct of an attack on a military objective in the vicinity of a health-care facility, in particular to estimate the potential damage caused to the health-care facility;
- f. Conduct an impact assessment prior to any action to gain a clear understanding of the scope and consequences of damage or destruction that would undermine the ability of a health-care facility to assure resupply alternatives;

- g. Assess and select measures to keep the degree of disruption in proportion to the military necessity and to mitigate the effects – direct and indirect – on health-care delivery (e.g. destruction of the objective vs its neutralization, ordnance, methods, timing);
- h. Prepare a contingency plan to address the estimated disruption to medical services in order to re-establish their full delivery as soon as possible. Consider measures both for the evacuation of patients and health-care personnel and for them to be taken properly in charge;
- i. Give sufficient warning prior to launching a strike (e.g. via communication with third parties of influence);
- j. Assess battle damage constantly and keep the degree of disruption in proportion to the military necessity. Interrupt the attack if incidental damage outweighs the expected military gain;
- k. After an attack, facilitate or implement measures for the rapid restoration of health-care services (e.g. medical support for the health-care facility);
- l. Report to superior officers in the chain of command on the attack, its impact on health-care delivery, and the measures facilitated or implemented to restore medical services;
- m. Train military personnel likely to conduct attacks on a military objective in the vicinity of a health-care facility, both during predeployment and in theatre, so that they are familiar with standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation designed to ensure minimal disruption to the health-care facility and are prepared to implement them.

1.3.4.b Specific measures to guide the planning and conduct of an attack on a health-care facility which has lost its protection

Measures to guide the planning and conduct of an attack on a health-care facility which has lost its protection need, whenever feasible and operationally relevant, to be adopted prior to an operation and then implemented throughout in order to limit the potential humanitarian impact of a direct or indirect attack.

- a. Define in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the circumstances and conditions in which attacks on a health-care facility which has lost its protection may take place;
- b. Define in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation the approval process for authorizing a strike on a health-care facility which has lost its protection and the associated intelligence required (e.g. evidence of the loss of protection, military advantage expected, estimated damage to the health-care facility);
- c. Provide guidance in the form of specific standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation for strikes on a health-care facility which has lost its protection, tailored to the specific operation and context, in order to minimize the humanitarian consequences (e.g. avoiding or minimizing disruption to services);
- d. Provide guidance in the standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation on the criteria constituting loss of protection for a health-care facility as well as for on-site verification of the loss;
- e. Develop, in the planning process, a deliberate and immediate targeting process based on IHL/LOAC and incorporating terrain analysis, weapons effects and means of delivery;
- f. Include military medical personnel as well as legal and cultural advisers (whenever available and appropriate) in the planning, decision-making and conduct of an attack on a health-care facility which has lost its protection, in particular to estimate the potential damage caused to the health-care facility;
- g. Conduct an impact assessment prior to any action to gain a clear understanding of the scope and consequences of damage or destruction that would undermine the ability of a health-care facility to assure resupply alternatives;
- h. Assess and select measures to keep the degree of disruption in proportion to the military necessity and to mitigate the effects – direct and indirect – on health-care delivery (e.g. destruction of the objective vs its neutralization, ordnance, methods, timing, etc.);
- i. Prepare a contingency plan to address the estimated disruption to medical services in order to re-establish their full delivery as soon as possible. Consider measures both for the evacuation of patients and health-care personnel and for them to be taken properly in charge;

- j. Give sufficient warning to those inside the health-care facility (i.e. health-care personnel, patients, visitors, combatants or fighters) prior to an attack (e.g. via communication with third parties of influence);
- k. Assess battle damage constantly and keep the disruption level in proportion to military necessity. Interrupt the attack if incidental damage outweighs the expected military gain;
- l. After the attack, quickly facilitate or implement measures to rapidly restore health-care services (e.g. medical support for the health-care facility);
- m. Interrupt the attack if the conditions leading to the loss of protection have ceased to exist (e.g. combatants or fighters have fled from the health-care facility);
- n. Report up the chain of command on the attack, its impact on health-care delivery, and the remedial measures facilitated or implemented;
- o. Train military personnel likely to conduct an attack on a health-care facility which has lost its protection, both during predeployment and in theatre, so that they are familiar with standard operating procedures (SOPs), operational orders (OPORDs) and/or other relevant documentation designed to ensure minimal disruption to the health-care facility and are prepared to implement them.

ANNEX 2 – THE HEALTH CARE IN DANGER PROJECT

Respect for and protection of the wounded and sick, health-care personnel, facilities and medical transports has been at the heart of the development of international humanitarian law (IHL) since the first Geneva Convention was adopted in 1864. Today, however, various forms of violence continue to disrupt or endanger health care in many parts of the world.

Violence – both actual and threatened – against health-care personnel, facilities and medical transports during armed conflicts and other emergencies is widespread and affects individuals, families and entire communities. It is probably one of the most serious humanitarian issues that we have to address; the potential number of people affected by it and the effects on chronic and acute needs warrant this conclusion.

In November 2011, the 31st International Conference of the Red Cross and Red Crescent²¹ 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 and to report to the 32nd International Conference in 2015 on the progress made.

The Health Care in Danger (HCID) project, launched in support of this objective, has drawn attention to the sometimes violent acts that impede or prevent health-care delivery. These range from direct attacks on patients, medical staff and health-care facilities and medical transports to denial of access to and forced entry and looting of health-care facilities. These are, in most cases, likely to breach international law.

It is also acknowledged that there may be situations in which the actions of State armed forces inadvertently and lawfully, but negatively, affect patients, medical staff and health-care facilities and medical transports. Addressing these situations, with the agreement of cooperative State armed forces, to raise awareness about the impact of existing conduct and to modify existing behaviour and procedures would have significant long term benefits. Adopting behaviour and procedures that would effectively protect the wounded and sick, health-care personnel, facilities and medical transports may also motivate other parties to comply with applicable international law and thus achieve a reduction in the incidence and severity of violence that impedes or prevents health-care delivery.

The HCID project brings together National Societies and various external stakeholders such as policy-makers, government health sector personnel, military staff, humanitarian agencies and representatives of academic circles from some 100 countries in a series of ICRC-led expert workshops on the following topics:

- The role and responsibility of National Societies in delivering safe health care in armed conflict and other emergencies (two workshops):
 - Oslo, Norway²²: co-organized by the Norwegian Red Cross and the ICRC – 3-5 December 2012;
 - Tehran, Iran²³: co-organized by the Red Crescent Society of the Islamic Republic of Iran and the ICRC – 2-14 February 2013.
- The rights and responsibilities of health-care personnel (two workshops):
 - London, United Kingdom²⁴: co-organized by the British Red Cross, the ICRC, the British Medical Association and the World Medical Association – 23 April 2012;
 - Cairo; Egypt²⁵: co-organized by the Egyptian Red Crescent Society and the ICRC – 17-18 December 2012.

²¹ International Committee of the Red Cross, 31st International Conference 2011: Resolution 5 – Health Care in Danger, 28 November-1 December 2011, available at: <http://www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm> (last visited on 10 July 2014).

²² An overview of the Oslo workshop is available at: <http://www.icrc.org/eng/resources/documents/event/2012/health-care-in-danger-expert-workshop-oslo-2012-12-03.htm> (last visited on 10 July 2014).

²³ An overview of the Tehran workshop is available at: <http://www.icrc.org/eng/resources/documents/event/2013/02-08-tehran-workshop-health-care-in-danger.htm> (last visited on 10 July 2014).

²⁴ An overview of the London workshop is available at: <http://www.icrc.org/eng/resources/documents/feature/2012/health-care-in-danger-feature-2012-04-25.htm> (last visited on 10 July 2014).

²⁵ An overview of the Cairo workshop is available at: <http://www.icrc.org/eng/resources/documents/event/2012/12-17-egypt-hcid-workshop.htm> (last visited on 10 July 2014).

- Ambulances/pre-hospital services in risk situations (one workshop):
 - Toluca, Mexico²⁶: co-organized by the Mexican Red Cross and the ICRC – 21-24 May 2013.
- The physical safety of health-care facilities (one workshop):
 - Ottawa, Canada²⁷: co-organized by the Canadian Red Cross and the ICRC – 25-27 September 2013;
 - Pretoria, South Africa²⁸: co-organized by the South African government (Department of International Relations and Cooperation, DIRCO) and the ICRC – 8-11 April 2014.
- The role of civil society and religious leaders in promoting respect for health care (one workshop):
 - Dakar, Senegal: organized by the ICRC – 24-25 April 2013.
- Promoting military operational practice that ensures safe access to and delivery of health care (one workshop):
 - Sydney, Australia²⁹: co-organized by the Australian government and the ICRC – 9-12 December 2013.
- Domestic normative frameworks for the protection of health-care provision (one workshop):
 - Brussels, Belgium³⁰: co-organized by the Belgian government, the Belgian Inter-ministerial Commission for Humanitarian Law (CIDH), the Belgian Red Cross and the ICRC – 29-31 January 2014.

Parallel to these efforts, the ICRC has also been raising the issue of violence affecting health-care provision with selected non-State armed groups. In 2013, constructive bilateral confidential consultations were held on this issue with 25 armed groups from 8 different countries. Consultations on this issue with these and other non-State armed entities are expected to be developed further in the years to come.

In addition, various advocacy and guideline tools have been developed as part of the HCID project. For instance, a publication on the responsibilities of health-care personnel³¹ details ethical dilemmas and potential solutions for health-care staff faced with insecurity and violence when carrying out their professional duties. More recently, a report on ambulance and pre-hospital services³² operating in insecure situations was published, outlining practical measures that State authorities, the military and health-care personnel can take to reduce risks confronting health-care providers. These measures include strengthening national legislation; protecting ambulance services; coordinating more effectively with authorities, including the military; and preparedness training for ambulance staff and volunteers.

²⁶ An overview of the Mexico workshop is available at: <http://www.icrc.org/eng/resources/documents/event/2013/05-23-mexico-workshop-health-care-in-danger.htm> (last visited on 10 July 2014).

²⁷ An overview of the Ottawa workshop is available at: <http://www.icrc.org/eng/resources/documents/event/2013/09-24-ottawa-workshop-health-care-in-danger.htm> (last visited on 10 July 2014).

²⁸ An overview of the Pretoria workshop is available at: <http://www.icrc.org/eng/resources/documents/event/2014/hcid-pretoria-workshop.htm> (last visited on 10 July 2014).

²⁹ An overview of the Sydney workshop is available at: <http://www.icrc.org/eng/resources/documents/event/2013/12-06-australia-hcid-military-expert-workshop.htm> (last visited on 10 July 2014).

³⁰ An overview of the Brussels workshop is available at: <http://www.icrc.org/eng/resources/documents/event/2014/hcid-brussels-workshop.htm> (last visited on 10 July 2014).

³¹ International Committee of the Red Cross, *Health Care in Danger: the responsibilities of health-care personnel working in armed conflicts and other emergencies*, ICRC, Geneva, August 2012, available at: <http://www.icrc.org/eng/assets/files/publications/icrc-icrc-002-4104.pdf> (last visited on 10 July 2014).

³² International Committee of the Red Cross, *Ambulance and pre-hospital services in risk situations*, ICRC, Geneva, November 2013, available at: <http://www.icrc.org/eng/assets/files/publications/icrc-002-4173.pdf> (last visited on 10 July 2014).

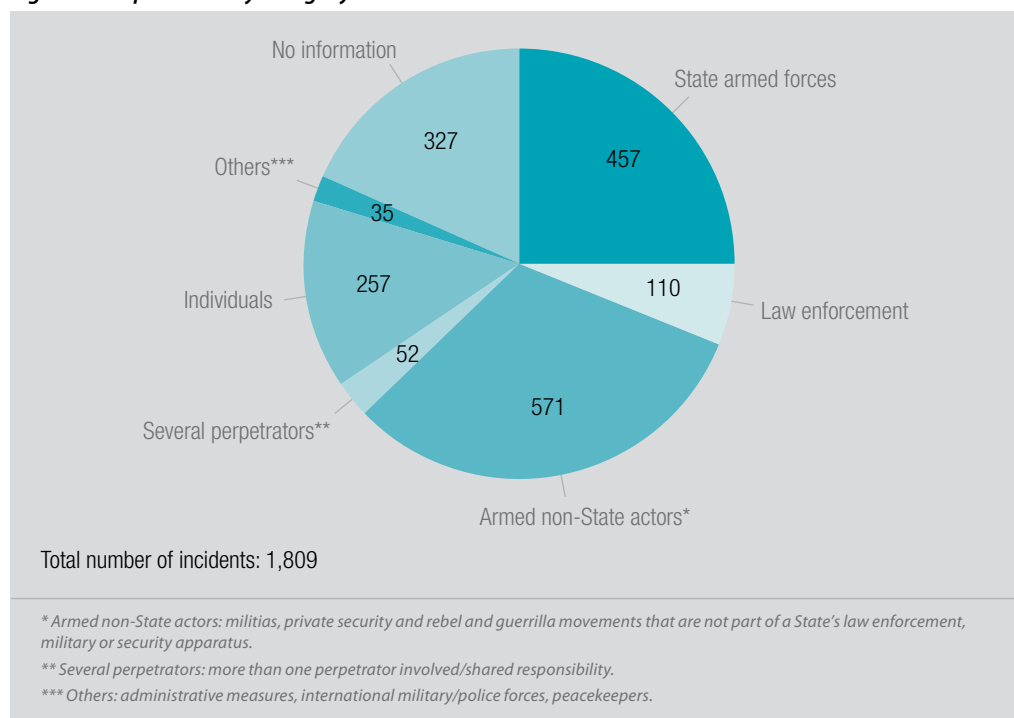
ANNEX 3 – PATTERNS AND IMPACT OF VIOLENCE PERPETRATED BY STATE ARMED FORCES

Notwithstanding the responsibility of non-State armed groups, since this report focuses on military operational practice that ensures safe access to and delivery of health care, the patterns of violence referred to below concern only violations and incidents perpetrated by State armed forces. As mentioned above, the data, which was collected by the ICRC between January 2012 and December 2013, was obtained from health-care providers working on site, including the ICRC, and from trusted open sources such as well-known media. It is important to underline that the data cited below are not exhaustive and only seek to convey general trends in violence that affects the delivery of health care as identified on the basis of the information circulated.

1. Incidents affecting health care by category of perpetrators

As reported in the last interim report *Health Care in Danger: Violent incidents affecting health care, January 2012 to December 2013*, the distribution of perpetrators remained roughly the same in 2012 and 2013. State armed forces and security forces (i.e. military and police) and armed non-State actors are equally responsible, each accounting for approximately 30% of the total number of incidents (see Figure 1).³³

Figure 1: Perpetrators by category



A closer look at the 1,809 incidents collected between January 2012 and December 2013 shows that State armed forces were responsible for 25% (457) of the cited violations undermining health-care provision.

The patterns of violence included bombings and looting of health-care facilities; forced entry into and search operations in health-care facilities; acts or threats of violence targeting patients and health-care personnel; and denial of passage for ambulances at checkpoints.

The following section gives an overview of acts or threats of violence perpetrated by State armed forces against health-care personnel, facilities and vehicles cited by the aforementioned sources.

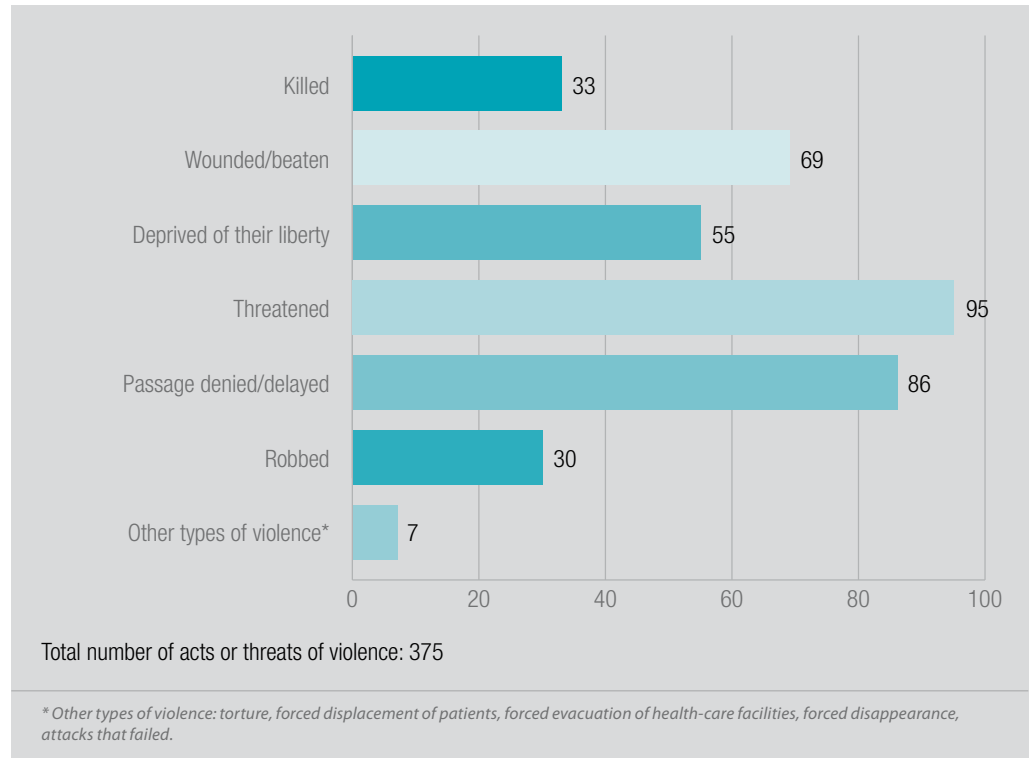
³³ International Committee of the Red Cross, *Health Care in Danger: Violent incidents affecting health care, January to December 2013*, ICRC, Geneva, April 2014, p. 6.

2. Violence perpetrated by State armed forces affecting people

The 457 incidents perpetrated by State armed forces affected a total of 960 people, mostly patients (585) and health-care personnel (326), and represented 1,033 acts or threats of violence.

The next section will focus more specifically on incidents perpetrated by State armed forces and specifically affecting health-care personnel.

Figure 2: Types of violence that affected at least one person³⁴

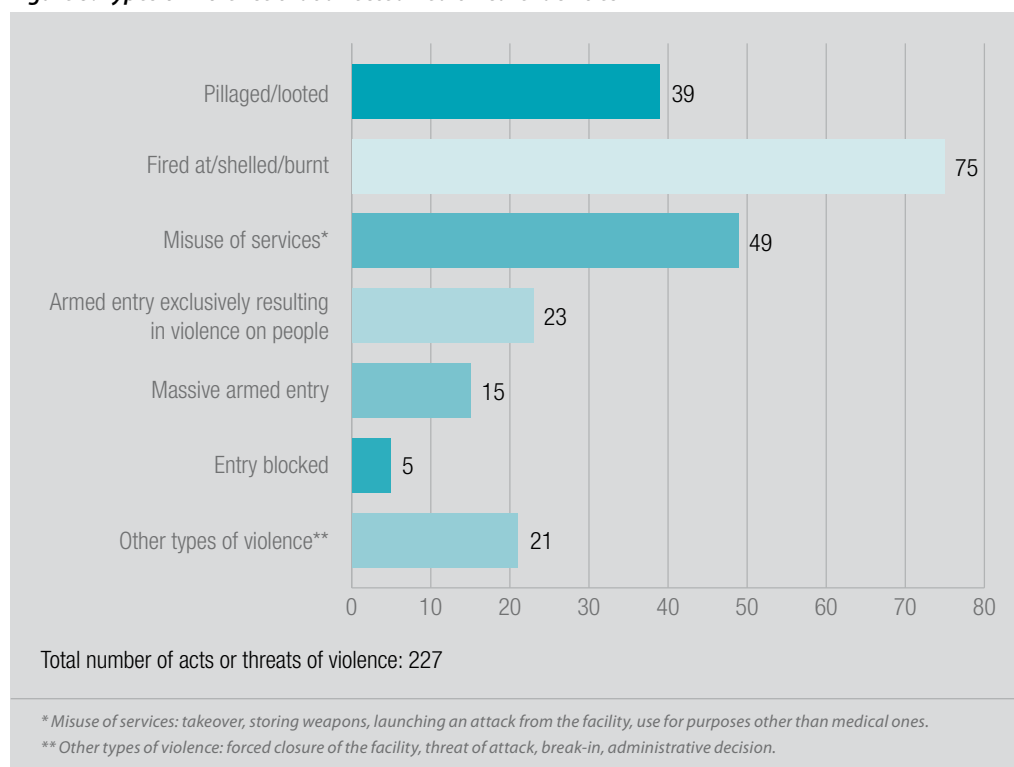


- 326 health-care personnel were affected by 375 acts or threats of violence.
- Of the 326 health-care personnel directly affected, 25% were threatened and 27% were wounded, beaten or killed.
- Health-care personnel accounted for over 50% of people detained as a result of armed groups or armed forces stopping health-care transportation vehicles or searching health-care facilities (others included patients, bystanders and security personnel).

³⁴ One incident can include various categories of victim, affected by different types of violence. In some cases, people may be affected in more than one way by the same incident: for example, someone who is threatened with death if he or she continues to provide medical care to certain communities and is robbed at the same time.

3. Violence perpetrated by State armed forces affecting health-care facilities

Figure 3: Types of violence that affected health-care facilities



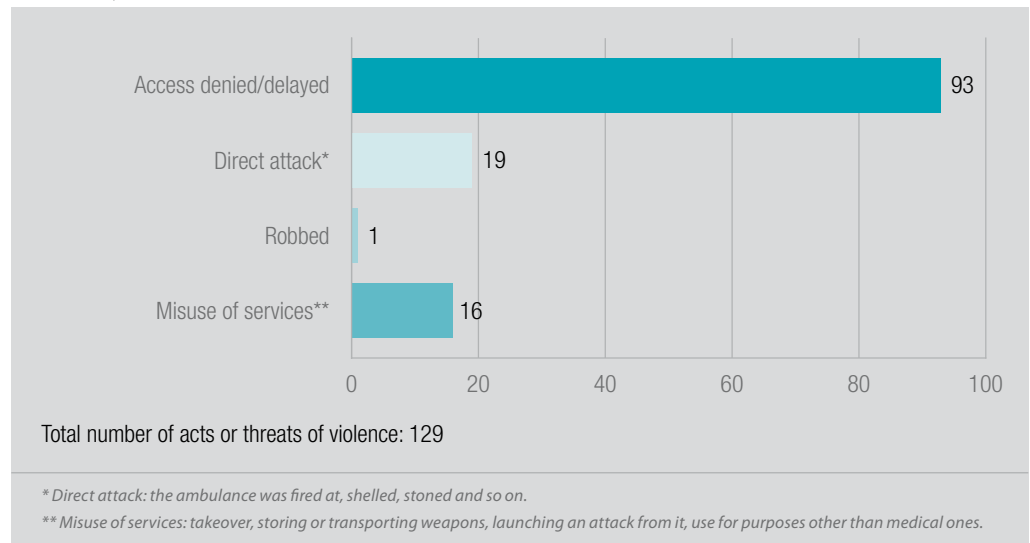
- 212 health-care facilities were affected by 227 acts or threats of violence perpetrated by State armed forces during the period under review.
- 30% of the reported violent incidents affecting health-care facilities were attributed to State armed forces.
- Most of the above categories also involve disruptive forcible armed entry into a health-care facility and therefore represent most of the incidents affecting health-care facilities.
- The third most frequent act or threat of violence perpetrated by State armed forces towards health-care facilities is the misuse of services (49), which means, for example, State armed forces taking over or controlling health-care facilities, transforming those facilities into objects serving military purposes such as a command post; the placement or storage of heavy weapons; or using the facility for launching attacks.

With reference to search operations (one of the three issues discussed during the Sydney workshop), during the period under review the ICRC recorded 35 incidents involving disruptive armed entry by State armed forces and security forces: they were conducting search operations in order to arrest or remove patients from hospitals or were in pursuit of the enemy thought to be hiding in the vicinity of the facility. The ICRC also collected 30 cases of patients who were arrested by State armed forces inside health-care facilities against the wishes of their doctors and prevented from receiving treatment.³⁵

³⁵ International Committee of the Red Cross, *Health Care in Danger: Violent incidents affecting health care, January 2012 to December 2013*, ICRC, Geneva, April 2014, p. 12.

4. Violence perpetrated by State armed forces affecting ambulances

Figure 4: Types of violence that affected ambulances



- State armed forces were responsible for 44% of the incidents affecting ambulances during the period under review.
- The two major types of violence affecting ambulances were denial or delay of access (72%) and direct attack (15%).

5. Violence perpetrated by State armed forces at checkpoints

Of the 457 incidents perpetrated by State armed forces during the period under review, 112 incidents occurred at checkpoints and 179 people (i.e. health-care personnel, patients, family of patient, etc.) were victims of violence (i.e. delay or denial of passage (142), arrest (19), killing (3), threat (23), etc.).

Among the 142 people who were denied passage (98) or whose passage was delayed (44) at a checkpoint by State armed forces, preventing or delaying swift access to health care, 6 died as a direct consequence of that action.

6. General remarks

The identified patterns of insecurity and the recorded forms of violence both highlight the vulnerability of the wounded and sick and of the health-care personnel treating them. Thousands of wounded and sick people can be denied effective health care when hospitals are damaged by explosive weapons or forcibly entered by combatants or fighters, when ambulances are hijacked and when health-care personnel are threatened, kidnapped, injured or killed.

Violence, both real (direct) and threatened (indirect), against the wounded and sick and against health-care facilities, personnel and medical transports in armed conflict and other emergencies increases the acute need for emergency medical assistance at a moment when it is most difficult to deliver. The consequences of such violence are often dire for local communities when health-care facilities, including hospitals, clinics, primary health-care centres or first-aid posts, have to close. Insecurity also deepens chronic needs when the delivery of basic health care can no longer take place, making it impossible to carry out vaccination campaigns, for example.³⁶ There are also areas of many countries in which it is simply too dangerous for health-care personnel to move around or work. The same applies to the wounded and sick or their relatives, who feel that it is unsafe to travel to health-care facilities. Because of its combined effects on chronic and acute needs, the insecurity of health care is one of the most pressing and widespread humanitarian problems worldwide today. However, as a humanitarian issue, it has largely been given insufficient recognition.

³⁶ The impact of general insecurity in one country alone is demonstrated by a study in the Democratic Republic of the Congo, in which an estimated 40,000 deaths per month were said to be caused by easily treatable diseases; the stated reason for these people not receiving the necessary treatment is insecurity resulting from the armed conflict. Polio eradication in various countries is hampered by insecurity, which prevents hundreds of thousands of children from being vaccinated.



MISSION

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.



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