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Addressing the crisis of medical care in armed conflict

Clarifying the law on respecting and protecting provision of healthcare

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Summary

- Respect for international humanitarian law (IHL) has been eroded in many contemporary conflicts. Violations have been particularly evident in the area of medical care.
- In armed conflicts around the world, hospitals have been targeted, damaged and misused, the wounded and sick have been unable to access medical care, and healthcare providers have been punished for providing assistance.
- The entitlement of the wounded and sick to receive medical care is a foundational principle of IHL. Medical facilities and personnel are granted legal protection that allows them to serve their functions. This specific protection entails obligations and prohibitions that aim to limit its abuse; for example, facilities may not be used to shield belligerents.
- Not all healthcare facilities nor all people who provide medical assistance are entitled to specific protection. It is limited to facilities and personnel that belong to a party to the conflict or are authorized by it, and over whom it retains control.
- IHL also includes important general protections applicable to all civilians and civilian objects, including civilian healthcare providers, medical facilities and transports. These general rules afford important additional protections. They must be applied in a manner that considers the foreseeable consequences of limitations in the ability to provide treatment, and includes the foreseeable longer-term harm resulting from the reduced capacity to operate.
- This paper cannot solve the problem of lack of political will to respect IHL. But it seeks to promote compliance with the law by recommending measures to give effect to IHL obligations and oversight arrangements, and by clarifying the law where that has been shown to be necessary.

Key recommendations

- Armed forces should adopt doctrine, policies and directives that identify how continuity in, and access to, medical care can be impacted by military operations, and develop and implement specific measures to minimize this adverse impact. Organized armed groups should adopt similar measures.
- Channels of communication and coordination should be established between armed forces and civilian medical authorities and humanitarian organizations that provide medical care in their areas of operations. This is essential both to draw up and implement the necessary measures in a manner specific to the context as and to address any problems as swiftly as possible.
- Safeguards for the provision of medical care should be included in all national and international counterterrorism measures.
- The measures of authorization and supervision of medical facilities and transports foreseen by IHL should be adopted. A system that contributes to preventing misuse is extremely valuable in contributing to the trust that is essential to the functioning of the rules.
- There is no reason why domestic and international tribunals should overlook the range of offences relating to medical care that can deprive entire communities of life-saving services. Violations must have consequences for the perpetrators, not just the most vulnerable.

In a geopolitical situation that is leading to deepening global instability and multiple protracted conflicts, compliance with IHL is more important than ever. And, although the international order may be in a state of transition, no model of a world order is conceivable in practice without fundamental humanitarian principles protecting the most vulnerable in armed conflict.

01 Introduction

In the decade since the adoption of UN Security Council Resolution 2286, on protection of the wounded and sick, medical personnel and humanitarian personnel in armed conflict, widespread alarm at the impact of conflict on the provision of medical care has not equated with better protection on the ground.

The number of armed conflicts around the world continues to rise, and with them there has been a weakening of respect for the law that protects civilians and limits suffering.[1] This research paper discusses one aspect of international humanitarian law (IHL) where respect for the rules is being severely eroded: the provision of healthcare in armed conflict.

The entitlement of the wounded and sick to receive medical care is a foundational principle of IHL. Despite this, in many recent conflicts the provision of medical care has been severely impeded. Conflicts in Gaza, Sudan, Syria and Ukraine – among others – provide multiple examples. In the decade since the adoption of UN Security Council Resolution 2286 (2016), on protection of the wounded and sick, medical personnel and humanitarian personnel in armed conflict,[2] stark evidence of the impact of conflict on medical care has not equated with better protection on the ground.

Healthcare facilities and transports have been attacked or damaged by active fighting in their vicinity, leading to casualties among patients and healthcare providers and frequently leaving local populations without medical care. Military and law enforcement operations have been conducted within and around healthcare facilities. Passage of medicines and medical equipment has been delayed and medical facilities looted. Equally problematic are the misuse of medical facilities and transports by belligerents, and the failure to respect the distinctive emblems of the red cross, red crescent and red crystal. These practices put patients, and healthcare

1 International Committee of the Red Cross (2025), *Humanitarian Outlook 2026: A world succumbing to war*, Geneva: ICRC, https://www.icrc.org/en/article/humanitarian-outlook-2026.
2 UN Security Council Resolution 2286 (2016) (SCR 2286), 3 May 2016, https://digitallibrary.un.org/record/827916?ln=en&v=pdf.

providers and facilities at immediate risk, and have longer-term consequences for the continuity of healthcare for entire communities. Less apparent but equally problematic are the interference with access by the wounded and sick to medical assistance, and the intimidation or punishment of those who provide medical care.

The rules of IHL include safeguards to prevent such abuse, but the actors with responsibility for prevention are frequently powerless to prevent the abuse or are themselves responsible for it.

These examples illustrate the current widespread disregard for all aspects of the rules protecting healthcare in armed conflict: the obligation to respect and protect medical facilities; the prohibition on misusing them for military purposes; the entitlement of all wounded and sick to receive treatment; and the prohibition on punishing those who provide it.

Protection is significant but not, as is frequently stated, absolute. Failure to appreciate this point contributes to a narrative of flagrant violation of the law. This is not to understate the gravity of any conduct that impedes the delivery of medical care in armed conflict. Nonetheless, inaccurate reference to absolute protection risks undermining perceptions of the law's ongoing relevance, potentially leading to further violations.

In recognition of the pressing need to improve the situation, the protection of hospitals in armed conflict is one of the seven workstreams of the International Committee of the Red Cross (ICRC) Global Initiative to Galvanize Political Commitment to International Humanitarian Law.[3]

1.1 The protection of medical care under IHL

IHL aims to minimize and alleviate the suffering caused by war. The wounded and sick are among the most vulnerable, and their need to receive medical care was the incentive for the first ever Geneva Convention of 1864.[4] Legal protection that was initially granted only to *military* wounded and sick and medical facilities was progressively expanded to their civilian counterparts. In 1977, Additional Protocol I (AP I) established a unified approach that applies to all the wounded and sick, and to all medical facilities and transports.

To ensure that the wounded and sick receive the medical attention required by their condition, the law grants medical facilities and personnel protection that allows them to serve their functions, sometimes referred to as 'specific' or 'special' protection. This protection is coupled with obligations and prohibitions that aim to limit its abuse.

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3 International Committee of the Red Cross (2026), 'Global Initiative to Galvanize Political Commitment to International Humanitarian Law', https://www.icrc.org/en/global-initiative-international-humanitarian-law.
4 Convention for the Amelioration of the Condition of the Wounded in Armies in the Field (1864 Geneva Convention).

Not all healthcare facilities nor all persons who provide medical assistance are entitled to this specific protection. It is limited to facilities and personnel that belong to a party to the conflict or that are authorized by a party to the conflict, and over which that party retains control.

IHL also includes rules regulating the conduct of hostilities, which are extensively codified in Additional Protocol I. These rules set out important *general* protections applicable to all civilians and civilian objects. Civilian healthcare personnel, facilities or transports that do not belong to the armed forces are civilians or civilian objects, and are thus entitled to the protections afforded to them. The general rules set out protections and prohibitions in more detail than the rules on specific protection, and apply to *all* healthcare providers, facilities and transports.

For historical reasons, the rules granting specific protection to the wounded and sick, medical personnel, and medical facilities and transports are dispersed across multiple instruments in distinct treaty provisions. This is an artificial separation. To give effect to IHL's objective of ensuring that the wounded and sick receive the medical care they require, these rules, complemented by the general rules on the conduct of military operations, must be interpreted and applied in a holistic manner that promotes continuity in the provision of, and access to, medical care in armed conflict.

1.2 About this paper

With a focus on the provision of healthcare by *civilian* rather than military actors, this paper complements the international initiatives mentioned above. It responds to a call for accurate clarification of the rules of IHL relevant to the provision of medical care in armed conflict, addressing specific questions and challenges that have arisen in recent conflicts.

Some of these questions reflect a basic misunderstanding of the extent of the protections under IHL. Others relate to points on which either the law is unclear or, more frequently, in relation to which, in view of contemporary realities, it is challenging to determine *how* the rules apply in practice.

There are, however, issues on which the law is clear, but where belligerents appear unwilling to comply. Most troubling among these are measures that indicate a rejection of the foundational principle that wounded and sick enemy fighters are entitled to medical care, and that medical personnel and others are entitled to provide that care. This is particularly the case in conflicts where a state is fighting a group it labels as 'terrorist' or 'criminal'.

While this paper cannot overcome lack of political will to comply with IHL, it recognizes that practical measures to give effect to IHL obligations and oversight arrangements are key to achieving the protections foreseen by the law.

This purpose of this paper is, accordingly:

1. To clarify specific questions of law that have been identified in consultation with key stakeholders as needing explanation or elaboration;
2. To identify good practice and make recommendations for the range of measures that can be adopted to respect and ensure respect for the law, and to mitigate the adverse impact of military operations on medical care;[5] and
3. To contribute to states' conflict preparedness by identifying concrete measures to ensure ability to comply with IHL, and to facilitate continuity of medical care at home and in areas of operations.

This paper addresses IHL specifically. International human rights law and medical ethics provide additional protections and safeguards.

In this paper:

— 'Fighter' and 'combatant' are used interchangeably to refer to members of state armed forces or organized armed groups.

— 'Healthcare facilities' is a generic term that includes hospitals, clinics and dispensaries.

— 'Medical facilities' are facilities that fall within the definition in Article 8(e) AP I and comply with the conditions in Article 12 AP I. 'Healthcare personnel' are persons with professional medical qualifications, administrators, other operators working in healthcare facilities and ambulance teams.

— 'Medical personnel' are persons who fall within the definition in Article 8(c) AP I.

— 'Military' refers to the forces of states and of organized armed groups.

The paper includes references to particular incidents to illustrate the challenges posed in applying the rules in question. Their inclusion does not endorse the account presented.

This paper has been elaborated on the basis of a desk study and interviews with humanitarian, military and legal practitioners. Its initial findings were discussed at two expert meetings held at Chatham House in 2025, attended by representatives of armed forces, humanitarian organizations and leading academics.[6]

5 The materials developed by the International Red Cross and Red Crescent Movement's Health Care in Danger (HCID) initiative provided valuable guidance on many of the topics addressed in this paper. Two documents were particularly helpful in identifying good practice: International Committee of the Red Cross (2014), *Promoting Military Operational Practice that Ensures Safe Access to and Delivery of Health Care*, Geneva: ICRC, https://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4208-promoting-military-op-practice-ensures-safe-access-health-care.pdf; and International Committee of the Red Cross (2020), *Protecting Health Care: Guidance for the Armed Forces*, Geneva: ICRC, https://healthcareindanger.org/wp-content/uploads/2021/03/4504_002-ebook.pdf. For fuller details of the HCID initiative, see https://healthcareindanger.org.
6 The two meetings of experts, in March and October 2025, were held under the Chatham House Rule.

02 The wounded and sick

In November 2023, a wounded fighter was brought to a hospital in North Gonder Zone in Ethiopia. Government forces, who were already using the hospital unlawfully as a military base, stopped doctors from providing treatment and summarily executed the fighter.[7]

People who fall within the IHL definition of 'wounded and sick' benefit from specific protections under the law. Those who are civilians, persons deprived of their liberty or fighters *hors de combat* are already entitled to protections under IHL; as 'wounded and sick' they have additional specific protections.

2.1 Who are 'the wounded and sick'?

Additional Protocol I lays down the contemporary definition of the wounded and sick for the purposes of IHL:

> [P]ersons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility. These terms also cover maternity cases, new-born babies and other persons who may be in need of immediate medical assistance or care, such as the infirm or expectant mothers, and who refrain from any act of hostility.[8]

7 Human Rights Watch (2024), *"If the Soldier Dies, It's on You": Attacks on Medical Care in Ethiopia's Amhara Conflict*, p. 37, https://www.hrw.org/report/2024/07/03/if-soldier-dies-its-you/attacks-medical-care-ethiopias-amhara-conflict.
8 Article 8(a) Additional Protocol I of 1977 (AP I).

It is generally accepted that this definition reflects customary international law and also applies in non-international armed conflicts. There is no question that, in addition to civilians, wounded and sick members of states' armed forces and of organized armed groups fall within the definition.

Two cumulative conditions must be met for a person to be considered wounded or sick: they must be in need of medical assistance; and they must refrain from any act of hostility.

The first condition does not raise questions of a legal nature. The definition sets out a broad range of grounds for which medical assistance may be required. IHL does not require the medical condition to reach a minimum severity. What matters is the need for medical care.

The second condition – that they refrain from any act of hostility – means that there may be people in need of medical assistance who are nonetheless not considered wounded and sick for the purpose of IHL.

2.2 What does specific protection entail?

There are two key dimensions to the specific protection afforded to the wounded and sick under IHL: they must be respected and protected at all times; and no distinction may be drawn in the provision of medical care other than on medical grounds. The same protections are afforded to *all* the wounded and sick – fighters and civilians, and those 'belonging' to the enemy and a party's 'own'.[9]

The obligation to respect relates to negative obligations – i.e. conduct from which belligerents and others must refrain. The obligation to protect relates to positive obligations – i.e. measures that should be taken to give effect to the protection.

It is not just members of armed forces or organized armed groups who must respect and protect the wounded and sick. The civilian population is also expressly required to do so, even if they belong to the adverse party, and to refrain from acts of violence against them.[10]

2.2.1 The obligation to respect

The obligation to respect the wounded and sick requires belligerents to refrain from acts against them that could cause further harm. This obligation covers both acts related to the conduct of hostilities, and also the treatment to be afforded once the wounded and sick are in the control of a party to the conflict.

Wounded and sick civilians benefit from extensive protections under the general rules on the conduct of hostilities. They must not be targeted; their expected death or injury must be taken into account in proportionality assessments; and, in the conduct of military operations, belligerents must take constant care to spare them.

9 Article 10 AP I.
10 Article 18 First Geneva Convention of 1949 (GC I), and Article 17 AP I.

These protections continue to apply when civilians are wounded and sick. Importantly, even if they carry out 'acts of hostilities', and thus forfeit the additional specific protection afforded to the wounded and sick, the protections to which they are entitled as civilians cease only if the acts amount to taking direct part in hostilities and, even then, only for the duration of such participation.

The position is different for fighters. The obligation to respect them if they are wounded and sick does significantly change their position, as ordinarily it would be permissible to target them. Instead, once they are wounded and sick, for as long as they refrain from acts of hostilities, they may not be attacked.

Beyond this clear prohibition, there is a divergence of views as to how other rules regulating the conduct of hostilities apply to wounded and sick fighters. This includes whether their death or injury should be considered in proportionality assessments; and how, if at all, the rules on precautions apply to them, considering the relevant treaty rules in Additional Protocol I expressly refer to 'civilians'.[11] Nonetheless, there is agreement that, as a minimum, the obligation to respect wounded and sick fighters requires belligerents to take feasible precautions to minimize harm to them, including from attacks directed against military objectives.

The wounded and sick must be treated 'humanely'.[12] IHL treaties provide specific examples of conduct that is inconsistent with humane treatment, including attempts upon their lives, or violence against them; murder or extermination; torture or biological experiments; wilfully leaving them without medical assistance and care; and exposing them to contagion or infection.[13]

The obligation to respect the wounded and sick does not grant them 'absolute immunity' from any type of harm. Intentionally harming them by directing attacks against them or subjecting them to inhumane treatment is prohibited. However, the wounded and sick *may* be injured or killed as a result of an attack directed against a military objective. What matters is that such incidental harm is assessed in accordance with the ordinary rules on proportionality, and that in the conduct of military operations constant care is taken to spare the wounded and sick.

Similarly, the obligation to respect the wounded and sick does not mean they may not be captured or arrested and removed from the facilities where they are being treated. However, such operations must be conducted in a manner that does not unduly aggravate their condition. If removed from the medical facilities and detained, the wounded and sick must continue to receive the medical attention their condition requires.

11 See Sari, A. and Tinkler, K. (2019), 'Collateral Damage and the Enemy', *British Yearbook of International Law*, brz004, https://doi.org/10.1093/bybil/brz004.
12 Article 10(2) AP I, and Article 7(2) Additional Protocol II of 1977 (AP II).
13 Article 12 GC I, and Article12 Second Geneva Convention of 1949 (GC II). Article 11 AP I prohibits medical procedures that are not indicated by a person's state of health and that are inconsistent with generally accepted medical standards, including physical mutilations; medical or scientific experiments; or removal of tissue or organs for transplantation.

Moreover, operations to arrest them must take into account the other people being treated in the facilities and medical personnel. Operations require careful planning to ensure they are carried out in a manner that minimizes the risks to all of these, and to the interruption in the provision of medical treatment. Such operations must also take into account the protection afforded to medical facilities.

2.2.2 The obligation to protect

The obligation to protect the wounded and sick requires belligerents to take positive steps to protect them from harm, including from the acts of third parties. For example, IHL treaties specifically require belligerents to protect the wounded and sick against pillage and ill treatment.[14]

The obligation to protect is also the basis of the duty to collect the wounded and sick and, importantly, to care for them. It is a foundational principle of IHL that all the wounded and sick are entitled to receive, to the fullest extent practicable and with the least possible delay, the medical care required by their condition.[15] The entitlement applies to civilians and fighters alike.

Provision of medical care is an obligation of means, not result. What is required depends on the circumstances, taking into account a variety of factors including the context where medical care is being provided, the number of wounded and sick, and the resources and capacities of the party providing the care.[16] What is clear is that medical care may not be actively withheld or denied.

Despite this uncontroversial requirement, in a number of recent conflicts and without contesting the rules, some states have taken measures that make it impossible for wounded enemy fighters to access medical care. In Syria in 2011, for example, the Homs Health Directorate issued a directive addressed to all government-run and private hospitals, requiring them to send wounded patients to the military hospital and to inform the Health Directorate of all cases of persons wounded in the uprising. In practice, this meant that wounded enemy fighters could not safely access medical care.[17] More practically, merely stationing troops in the vicinity of medical facilities may dissuade wounded enemy combatants from seeking treatment.

While the entitlement to receive medical care, to the extent practicable, is uncontested, what is less clear is who is responsible for providing it. This question received attention following the battle for Mosul in 2016–17. Kurdish and Iraqi

14 Article 15 GC I, Article 16 Fourth Geneva Convention of 1949 (GC IV), and Article 17 AP I.
15 Articles 10 AP I and 7 AP II.
16 See, for example, Eritrea-Ethiopia Claims Commission (2003), *Partial Award, Prisoners of War, Ethiopia's Claim 4, between the Federal Democratic Republic of Ethiopia and the State of Eritrea*, 1 July 2003, The Hague: Permanent Court of Arbitration, para. 70, https://pcacases.com/web/sendAttach/752. The Commission found that '… the requirement to provide POWs with medical care during the initial period after capture must be assessed in light of the harsh conditions on the battlefield and the limited extent of medical training and equipment available to front line troops. On balance, and recognizing the logistical and resource limitations faced by both Parties to the conflict, the Commission finds that Eritrea is not liable for failing to provide medical care to Ethiopian POWs at the front and during evacuation.'
17 Amnesty International (2011), *Health crisis: Syrian government targets the wounded and health workers*, p.21, https://www.amnesty.org/en/documents/mde24/059/2011/en.

authorities did not take responsibility for providing medical assistance to civilians fleeing the city, and the international coalition supporting them had capacity only to treat their own troops.[18]

The Geneva Conventions address the obligation to search for and collect the wounded and sick, but do not specify who is responsible for providing medical care.[19] While armed forces are likely to treat the *military* wounded and sick, there is less clarity with regard to wounded and sick civilians.

A number of different actors have responsibilities or a role to play. In situations of occupation, to the fullest extent of the means available to it, the occupying power must ensure and maintain medical establishments and services.[20] This implies an obligation to treat the wounded and sick, without discrimination.[21]

Although this is not regulated by IHL, in practice states are likely to provide medical care to wounded and sick persons in their territory. The armed forces may assist civilian authorities in this regard. For example, since Russia's full-scale invasion of Ukraine, Ukrainian armed forces have played a key role in providing first aid to civilians injured by military operations and in evacuating the wounded and sick from areas of active hostilities to civilian medical establishments.

The responsibilities of armed forces operating 'overseas' in contested areas towards wounded and sick civilians are less clear. According to the UK Joint Service Manual of the Law of Armed Conflict:

> [T]here is no absolute obligation on the part of the military medical services to accept civilian wounded and sick – that is to be done only so far as it is practicable to do so. For example, the commander of a field hospital placed to deal with casualties from an impending battle would be entitled to refer non-urgent cases elsewhere, even if the hospital had the capacity to treat them at the time. Once the treatment of a patient has commenced, however, discrimination against him on other than medical ground is not permissible.[22]

The Danish Military Manual is more prescriptive, at least with regard to persons in acute need following military engagements. It considers that:

> The fundamental rule is that medical support must be provided in the event that an acute need for such support exists. There are no grounds to provide different care to civilian and military sick and wounded persons in the event of acute medical need after military engagements. In such situations, the medical work must proceed in accordance with general principles, including the principle of triage, in a desire to help as many people as possible as quickly as possible.[23]

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18 Fox, H., Stoddard, A. and Davidoff, J. (2018), *Emergency Trauma Response to the Mosul Offensive, 2016-2017: A Review of Issues and Challenges*, Humanitarian Outcomes, https://humanitarianoutcomes.org/Emergency_Trauma_Response; Beaubien, J. (2018), 'Ethical Dilemma Over Treating Civilians Injured In The Battle For Mosul', NPR Goats and Soda blog, 7 December 2020, https://www.npr.org/sections/goatsandsoda/2017/06/15/527593730/about-us-goats-and-soda.
19 Articles 15 GC I and 16 GC IV.
20 Article 56 GC IV.
21 Article 57 GC IV allows an occupying power to temporarily requisition civilian hospitals in cases of urgent necessity for the care of military wounded and sick, provided suitable arrangements are made in this time for treatment of civilians.
22 Ministry of Defence (2004), *Joint Service Manual of the Law of Armed Conflict* (JSP 383), 2004 edition, Section 7.3.2, https://assets.publishing.service.gov.uk/media/5a7952bfe5274a2acd18bda5/JSP3832004Edition.pdf.
23 Defence Command Denmark (2020), *Military Manual on international law relevant to Danish armed forces in international operations*, Ch. 7.2.6, https://www.forsvaret.dk/en/publications/military-manual.

There is general agreement that while armed forces might not have an obligation to treat civilian wounded and sick, once they do have them in their control, discrimination in the provision of treatment is not permissible.

2.2.2.1 Measures to give effect to protections

While not necessarily providing medical care themselves, belligerents can take measures to facilitate access of wounded and sick civilians to medical facilities – autonomously or in ambulances.

One such measure is the evacuation of the wounded and sick. Whether belligerents are required to conduct evacuations, or merely encouraged to endeavour to do so, depends on who the wounded and sick are.

The First Geneva Convention *requires* belligerents to search for and collect wounded and sick members of the armed forces in the battlefield and to move them to more secure locations where they can be treated.[24]

As far as civilians are concerned, the Fourth Geneva Convention requires belligerents to endeavour to conclude evacuation agreements for certain categories of civilians – wounded, sick, infirm and aged persons, children and maternity cases – from besieged or encircled areas.[25] The provisions do not relate to the evacuation of patients from hospitals if these lose their specific protection.

As for all humanitarian arrangements, key to the safety of evacuations of the wounded and sick is agreement between belligerents. As a minimum, there should be agreement on the locations from which people will be evacuated and to which they will be taken; on the date, times and routes of the evacuation; and on who will be transporting the evacuees. Ideally, belligerents should also agree a suspension of hostilities and military operations for the time and route of the evacuation.[26]

2.2.3 Prohibition of adverse distinction in treatment

> In some cases [in Darfur], people were directly prevented from accessing health facilities or receiving care because of their ethnicity. Two interviewees witnessed non-Arabs with potentially life-threatening injuries being turned away at the makeshift clinic in al-Nuqba school in the Imtidad neighborhood. [One] said she saw RSF forces blocking the entrance of the clinic in early June, telling the family of a man with a bullet wound to his stomach, "No Black people will get medicine here."[27]
>
> They [soldiers] brought a local militia member shot by Fano and ordered us to take a patient out of the operating room. The patient we were treating was bleeding and needed care first. But they didn't care.[28]

24 Article 15 GC I.
25 Article 17 GC IV.
26 Gillard, E. (2024), *Enhancing the security of civilians in conflict: Notifications, evacuations, humanitarian corridors, suspensions of hostilities and other humanitarian arrangements*, Research Paper, London: Royal Institute of International Affairs, Ch. 3, https://doi.org/10.55317/9781784136031.
27 Human Rights Watch (2024), *"The Massalit Will Not Come Home": Ethnic Cleansing and Crimes Against Humanity in El Geneina, West Darfur, Sudan*, pp. 125–26, https://www.hrw.org/report/2024/05/09/massalit-will-not-come-home/ethnic-cleansing-and-crimes-against-humanity-el.
28 Human Rights Watch (2024), *"If the Soldier Dies, It's on You": Attacks on Medical Care in Ethiopia's Amhara Conflict*, p. 39.

In the provision of medical care, distinction may not be drawn on any grounds other than medical ones. For instance, a party may not prioritize treatment of its own troops over that of enemy forces; or, in medical facilities that are treating both, treatment of members of the armed forces over civilians.

While the obligation to provide medical care is an obligation of means, to be discharged 'to the fullest extent practicable',[29] the prohibition of adverse distinction is absolute.

2.3 Loss of specific protection

The specific protection afforded to the wounded and sick is forfeited once they no longer fulfil either of two conditions: they no longer require medical assistance; or they engage in acts of hostility.

IHL treaties do not define or provide examples of 'acts of hostility'. The notion includes, but is broader than, the conduct that amounts to taking direct part in hostilities that can lead a civilian to lose protection against attack.[30] It covers a range of activities that, by their nature and purpose, are intended to cause harm to enemy personnel and equipment.

Some types of acts of hostility are immediately apparent: for example, a combatant who continues fighting despite being wounded; or a patient who engages in hostilities by shooting from a hospital ward. Others can be harder to discern. A case in point is communicating with the party to the conflict to which the patient belongs. Short of prohibiting patients from bringing mobile phones and other communication devices into medical facilities, in the same way that some organizations that operate civilian facilities prohibit weapons from being introduced, those operating civilian medical facilities are not in a position to determine whether a wounded person is communicating with the party to the conflict to which they belong, passing instructions or other information, or planning operations.

As the concept of hostile acts is broader than direct participation in hostilities, carrying out such acts does not necessarily mean that a wounded and sick civilian may be targeted.

The position is different for military wounded and sick, as refraining from hostile acts is the condition for them to be granted protection. If they carry out such acts, they lose the protection against attack. This said, the practical consequences of carrying out hostile acts are likely to depend on where these take place and on their nature. If in a battlefield situation, they are likely to lead to the resumption of hostile acts against the wounded fighter. The position is different if the fighter carries out hostile acts while being treated. In such circumstances, if they are shooting at the enemy

29 Articles 10(2) AP I and 7(2) AP II.
30 According to the ICRC *Interpretive Guidance on the Notion of Direct Participation in Hostilities*, acts that constitute direct participation in hostilities are those 'likely to adversely affect the military operations or military capacity of a party to an armed conflict or, alternatively, to inflict death, injury, or destruction on persons or objects protected against direct attack'. This is the first of three constitutive elements of the notion of direct participation and describes the *threshold* of harm. See International Committee of the Red Cross (2019), *Interpretive Guidance on the Notion of Direct Participation in Hostilities*, Geneva: ICRC, p. 46, https://www.icrc.org/sites/default/files/external/doc/en/assets/files/other/icrc-002-0990.pdf.

from a medical facility, the reaction may be a hostile response from enemy forces. However, if they are carrying out other types of hostile acts, such as communicating with the party to the conflict to which they belong, it is likely to be the staff of the medical facilities who will attempt to make them cease that conduct.

Whatever the position under IHL, it would be incompatible with medical ethics not to provide treatment to a person in need once they are in the care of medical staff, even if they conduct hostile acts that exclude them from the specific protection afforded to the wounded and sick.

Feigning incapacitation by wounds or sickness in order to kill, injure or (in international armed conflicts) capture an adversary is a form of perfidy.[31]

2.4 Good practice

The recommendations set out below relate to measures of specific relevance to the wounded and sick. The recommendations in Chapter 3 on medical personnel, and in Chapter 4 on medical facilities and transports are also relevant to ensuring continuity of and access to medical care for the wounded and sick.

- Armed forces must ensure that their policies, doctrines and operating procedures clearly give effect to the protections afforded to the wounded and sick. These measures should be flowed down into mission-specific operating procedures and instructions, and be disseminated and included in training programmes. Specific issues to be addressed include:
  - The prohibition of directing attacks against the wounded and sick and of any form of ill treatment;
  - The entitlement of all wounded and sick to receive medical care, including enemy fighters, and the consequent prohibition to interfere with access to and the provision of such treatment;
  - The obligation to respect decisions taken by medical personnel on prioritization of treatment; and
  - Measures to facilitate the expedited passage of the wounded and sick through checkpoints, and to share information on safe and open routes for reaching medical facilities.
- Guidance should be developed outlining what conduct constitutes a hostile act that can lead to loss of specific protection. This should take into account the context in which it occurs, including whether it is on the battlefield or when people are already receiving medical care.

31 Article 37 AP I. Neither Common Article 3 GCs nor Additional Protocol II mention perfidy. Nonetheless, as the ICC Statute includes the corresponding war crime in both international and non-international armed conflicts, this presupposes the existence of a prohibition in non-international conflicts too. However, the ICC war crime is framed more narrowly than the prohibition in Article 37 AP I, and does not include abusing protected status to *capture* an adversary.

- Military doctrine should also address the nature and extent of the role of armed forces in providing medical care to wounded and sick civilians in areas under their control.
- Government departments responsible for civilian medical facilities should issue instructions requiring that all the wounded and sick be given access to medical facilities and be treated without discrimination.
- Armed forces should establish channels of communication and coordination with civilian medical authorities and humanitarian organizations that provide medical care in their areas of operations. This is essential for elaborating and implementing these measures in a context-specific manner, and for addressing problems that may arise as swiftly as possible.
- Armed forces and civilian authorities and organizations providing medical care should agree modalities for addressing situations where armed forces consider that wounded and sick persons receiving treatment in a particular facility are engaging in hostile acts.
- Organized armed groups should elaborate and implement similar measures to all those outlined above.

03 Medical personnel and other healthcare providers

In July 2024 MSF announced the suspension of its operations in the Turkish hospital of Khartoum, located in an RSF-controlled area, as the situation had become 'untenable' after a year of multiple violent incidents occurring inside and outside the premises, including violence, harassment and threats made against the lives of MSF staff.[32]

There are two aspects to the protection of healthcare providers under IHL. First, there are specific protections afforded to those who fall within the definition of 'medical personnel': such people must be respected and protected at all times. Medical providers who are civilians are already entitled to protections under IHL; as 'medical personnel' they have additional specific protections. The second aspect is the prohibition on punishing people for having provided medical assistance; this prohibition covers anyone who provides medical care.

32 Médecins Sans Frontières (2024), 'MSF suspends delivery of care in Khartoum's Turkish hospital', 10 July 2024, https://www.msf.org/msf-suspends-delivery-care-turkish-hospital-sudan.

3.1 Specific protection of medical personnel

3.1.1 Who are 'medical personnel'?

Article 8(c) AP I defines medical personnel as persons assigned by a party to the conflict to exclusively carry out certain medical activities, the administration of medical establishments, or the operation or administration of medical transports.[33]

The definition includes two key requirements that aim to limit the risk of abuse of the specific protection. First, the personnel must be 'assigned' to their medical duties by some formal act. Second, they must exclusively carry out medical functions.[34]

It is generally accepted that the definition in Article 8(c) AP I also applies in relation to non-international armed conflicts, taking into account the specificities of such conflicts.[35]

3.1.1.1 Assignment

Not all persons who are qualified or trained to provide medical care fall within the definition of 'medical personnel'. They must be 'assigned' to this role by a party to the conflict. This requirement is a way to ensure that states retain some control over persons entitled to specific protection, coupled with a responsibility to ensure it is not abused.

A licence to practise the medical profession is not an 'assignment' for the purpose of IHL. Doctors, nurses and the staff of medical NGOs who are not assigned to these duties by a party to the conflict are not afforded specific protection. Instead, they benefit from the general protections afforded to civilians.

IHL does not specify how assignment is to be effected, but some formal act by the relevant authorities is required. For military medical personnel, these are the authorities in charge of the armed forces – usually the ministry of defence. For civilian personnel, it has been suggested that medical personnel employed in the public – i.e. state – health service should automatically be considered as 'assigned' because the public health service is part of the state administration of a party to the conflict. For the staff of private healthcare facilities or organizations, a specific act by the state would be required. Ministries of health are frequently entrusted with this role. The precise nature of the legal instrument effecting the assignment will depend on the domestic legal order. It can take the form of laws, decrees, entries in a registry, or the conclusion of memorandums of understanding with the ministry of health.

In relation to non-international armed conflicts, assignment by state authorities continues to be relevant for personnel working in areas under the control of organized armed groups. Organized armed groups must also 'assign' medical personnel. While the procedures for doing this may be less sophisticated than

33 The medical activities ('medical purposes') given in Article 8(e) AP I are the search for, collection, transportation, diagnosis or treatment – including first-aid treatment – of the wounded, sick and shipwrecked, and the prevention of disease.
34 Article 8(c) AP I also sets out an indicative list of categories of medical personnel. All are either 'of a party to a conflict' or assigned to conduct medical activities by such a party.
35 Sandoz, Y., Swinarski, C. and Zimmermann, B. (eds) (1987), *Commentary on the Additional Protocols of 8 June 1977 (ICRC Commentary to the APs)*, para. 4665 *et seq*.

those adopted by states, some formal assignment and the oversight it entails are still required. It has not been possible to find examples of organized armed groups formally assigning medical personnel.

The purpose of limiting specific protection to persons who have been assigned to medical functions is to ensure there is an entity responsible for preventing and responding to abuse of the protection. As far as military medical personnel are concerned, there have been instances of the armed forces taking disciplinary measures against personnel who abused their protected status. It has not been possible to find instances where the civilian authorities that assigned medical personnel intervened to end abuses of the specific protection.

Cognizant of the risks that abuse by their staff of their specific protection would entail for their operations, some medical humanitarian organizations require personnel to sign staff rules and regulations that clearly identify prohibited conduct. This is seen as key to continuity of operations, and to security for patients and staff.

3.1.1.2 Exclusivity

The assignment to carry out medical activities must be 'exclusive'. This is not a temporal requirement: assignment may be temporary or permanent. It is a substantive requirement that relates to the types of activities conducted. It is a precautionary measure to prevent abuse of the protected status, and the corresponding entitlement to wear the distinctive emblem.

Determining the precise limits of exclusive assignment and, consequently, loss of specific protection, is particularly relevant for military medical personnel. As members of armed forces or organized armed groups, they may be targeted as soon as they are no longer entitled to this protection. It is less significant for civilian medical personnel because, even if they forfeit specific protection, provided they are not carrying out activities that amount to taking direct part in hostilities, they remain protected as civilians.

3.1.2 What does specific protection entail?

Medical personnel must be respected and protected.[36]

While both dimensions apply to military and civilian medical personnel, in practice the obligation to *respect* is most significant for military personnel, as this modifies their position under IHL in important ways. In particular, despite being members of the armed forces, they may not be targeted while they meet the conditions of the definition.[37] In contrast, the obligation to *protect* is most relevant for civilian medical personnel as it requires belligerents to facilitate their work, something that is less pertinent for military medical personnel.

36 Articles 24 GC I, 36 GC II, 20 GC IV, 15(1) AP I and 9 AP II.
37 Their position differs from that of 'ordinary' members of the armed forces in other ways, including most notably, in terms of their status and retention if captured. Articles 28 GC I and 37 GC II. This paper does not consider this dimension.

3.1.2.1 The obligation to respect

> The International Committee of the Red Cross is appalled that eight medics from the Palestine Red Crescent Society were killed while carrying out their work, along with first responders from the Civil Defence in Gaza and a staff member of the United Nations. Their bodies were identified today and have been recovered for dignified burial.[38]

The obligation to respect medical personnel prohibits directing attacks against them. Civilian medical personnel are already entitled to significant protections from the effects of hostilities: *inter alia*, attacks must not be directed against them; their incidental death or injury must be taken into account in proportionality assessments; and in the conduct of military operations feasible precautions must be taken to spare them. Any form of ill treatment of medical personnel is prohibited.

One significant consequence of falling within the definition of medical personnel is the entitlement to wear the distinctive red cross/red crescent/red crystal emblem.[39] While the emblem is not the source of the protection, by facilitating the identification of medical personnel it can play an important role in giving effect to that protection.

The obligation to respect medical personnel also prohibits belligerents from requiring medical personnel to take measures that are contrary to medical ethics. For example, they may not be required to prioritize the treatment of any person other than on medical grounds, or to carry out tasks that are incompatible with their humanitarian mission.[40]

3.1.2.2 The obligation to protect

The obligation to protect medical personnel is principally relevant to belligerents' obligations to facilitate their work. Additional Protocol I sets out a number of specific measures that must be taken to assist civilian medical personnel.[41]

All available help must be granted to civilian medical personnel in areas where civilian medical services are disrupted by combat activity. Civilian medical personnel must have access to any place where their services are essential, subject to the supervisory and security measures that relevant parties to the conflict may deem necessary.

In situations of occupation, occupying powers must afford civilian medical personnel every assistance to enable them to perform their humanitarian functions to the best of their ability. Medical personnel of all categories must be allowed to carry out their duties. This requirement is complementary to occupying powers' general obligations in relation to the provision of healthcare.[42]

These are just some indicative examples of the types of measures belligerents can take to assist and, as a minimum, to not unduly impede or interfere with the ability of medical personnel to discharge their functions. None of the examples lays

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38 International Committee of the Red Cross (2025), 'Israel and the occupied territories: ICRC appalled by killing of PRCS medics and first responders', 30 March 2025, https://www.icrc.org/en/news-release/israel-and-occupied-territories-icrc-appalled-killing-prcs-medics.
39 Articles 40 GC I, 42 GC II, 20 GC IV, 18 AP I and 12 AP II. The 2005 Third Additional Protocol, Relating to the Adoption of an Additional Distinctive Emblem, recognized a third distinctive emblem: the red crystal.
40 Articles 15 and 16 AP I and 9 AP II.
41 Article 15 AP I.
42 Article 56 GC IV. See also Article 14 AP I, including the restrictions on requisitioning civilian medical facilities, equipment and the services of their personnel.

down absolute obligations. For example, in combat zones, it is the 'available' help that must be provided. This might be less than what is actually needed. Similarly, the freedom of movement of medical personnel is subject to belligerents' security considerations.

Various actors can play a role in facilitating the work of medical personnel, including the party to the conflict with control of the location of the medical facilities, or of areas through which medical personnel or transports must travel, which might be across conflict lines. The obligations of occupying powers are more onerous, in view of the control they exercise over territory. UN Security Council Resolution 2286 (2016) notes that peacekeeping forces may be mandated to help to contribute to a secure environment to enable the delivery of medical assistance. They could do so, for example, by patrolling particular areas and routes.

Additional Protocol I also addresses the movement of medical personnel. This is key to reaching the wounded and sick and medical facilities. As noted, this entitlement is subject to belligerents' security needs. Drawing on the rules regulating the movement of humanitarian personnel, restrictions on freedom of movement should be imposed only in case of imperative military necessity and, even then, only temporarily.[43] Belligerents are entitled to take measures of control, such as identity checks. As for all measures of control on medical personnel and transports, these should be undertaken as swiftly and efficiently as possible.

3.1.3 The limits of specific protection – not absolute immunity

Specific protection does not grant 'absolute immunity' from any types of harm. Intentionally harming medical personnel by directing attacks against them is prohibited. However, if they are killed or injured by attacks directed against a military objective, that is not necessarily a violation of IHL. What matters is that the risk of such incidental harm is adequately taken into account in proportionality assessments. In the conduct of military operations more generally, constant care must be taken to spare medical personnel. Consideration should be given to the consequences of their death or injury on the availability of medical care.

Similarly, it is not prohibited to deprive civilian medical personnel of their liberty should this be necessary for imperative reasons of security. In such circumstances, such personnel benefit from the same procedural safeguards as other protected persons.[44] It is, however, prohibited to do so on the ground that they have provided medical assistance to the wounded and sick.

The determination of whether internment is necessary must be made on an individualized basis. One factor to consider is a person's role as medical personnel, and the consequences of their deprivation of liberty on the availability of medical care. As internment is the most severe measure of control permissible, consideration should be given to other approaches that address the belligerent's security concerns without depriving the community of medical personnel.[45]

43 Article 71(3) AP I.
44 Article 78 AP I.
45 Article 41 GC IV.

The obligation to respect medical personnel does not mean they may not be arrested. However, as operations to apprehend them can pose a risk to the wounded and sick and to other medical personnel, belligerents should avoid conducting them in medical facilities.

3.2 Loss of specific protection

3.2.1 Conduct that leads to loss of specific protection

The provisions of Additional Protocol I on medical facilities specify the circumstances that lead to those facilities' loss of specific protection: when they are 'used to commit, outside their humanitarian function, acts harmful to the enemy'. Treaty provisions on medical personnel, on the other hand, do not address loss of specific protection.

Nonetheless, it is generally accepted that the logic that underlies medical facilities' loss of specific protection also applies to medical personnel. It is granted to them in view of their functions: exclusively providing medical care. If they carry out acts harmful to the enemy, there is no reason to continue affording them specific protection. It is also generally accepted that the same criterion should be adopted for loss of protection: carrying out acts harmful to the enemy outside their humanitarian duties.[46]

'Acts harmful to the enemy' is a broader notion than direct participation in hostilities. It covers conduct that interferes directly or indirectly in military operations and thereby causes harm to the adverse party. Examples of such acts by medical personnel include engaging in hostilities; driving vehicles transporting able-bodied combatants or ammunition; intentionally hampering or impeding military operations; sharing observations of locations or movements of armed forces or information of military relevance acquired while treating the wounded and sick; or allowing able-bodied fighters to use medical facilities to hide.[47]

Acts that fall within medical personnel's humanitarian duties include providing medical care to the wounded and sick – including combatants; and collecting and transporting such persons to medical facilities.

Drawing an analogy with the position of medical facilities, it has been suggested that specific protection may not be lost before a warning has been issued, identifying the harmful act and giving relevant actors – including the party to the conflict that made the assignment – a time limit to put an end to the conduct.[48]

46 For military medical personnel the position is possibly more restrictive. Their specific protection ends when they carry out acts other than activities related to medical care, as then they would no longer be 'exclusively' engaged in those activities as required by Article 24 GC I.
47 Under Article 22(1) GC I, military medical personnel may carry small arms issued to them, and they may use them in their own defence or in the defence of the wounded or sick in their charge.
48 International Committee of the Red Cross (2025), *Commentary on the Fourth Geneva Convention: Convention (IV) relative to the Protection of Civilian Persons in Time of War (2025 Commentary on GC IV)*, 2nd edn, Geneva: ICRC, para. 1905, https://ihl-databases.icrc.org/en/ihl-treaties/gciv-1949/article-20/commentary/2025. The military manuals that specifically address this point adopt inconsistent positions.

Importantly, loss of specific protection does not mean that civilian medical personnel may be targeted. As previously mentioned, they enjoy protection under IHL by virtue of being civilians. They lose that protection only if the acts harmful to the enemy amount to direct participation in hostilities.

In addition to leading to loss of specific protection, certain types of acts harmful to the enemy can also amount to perfidy.

Feigning protected status by using the distinctive emblem in order to kill, injure, and, in international armed conflicts, capture an adversary constitutes perfidy.[49] For example, it would amount to perfidy if someone not, or no longer entitled to, specific protection were to attack an adversary while wearing an armlet bearing the distinctive emblem in order to lead the adversary to believe that they were obliged to afford them protection.

3.2.2 Consequences of loss of specific protection

As noted, the consequences of loss of specific protection are particularly significant for military medical personnel: as members of the armed forces, they can once again be targeted. The immediate consequences are less drastic for civilian medical personnel. The latter remain civilians and may not be targeted unless the acts harmful to the enemy amount to taking direct part in hostilities; even then, they may only be targeted while carrying out those activities. They remain entitled to all the other protections that IHL affords civilians in relation to the conduct of military operations.

Someone who has forfeited specific protection is no longer entitled to wear the distinctive emblem.

Loss of specific protection also means that belligerents are no longer required to facilitate the work of the person in question, including through measures to expedite the passage of medical personnel at checkpoints or to assist their work.

3.3 Prohibition on punishing people for providing medical care

A second foundational rule of IHL is the prohibition on punishing persons for having carried out medical activities compatible with medical ethics. This rule gives effect to the principle of 'neutrality' of medical activities: everyone – civilian or combatant, friend or foe – is entitled to the medical care required by their condition; and, consequently, providing this care does not amount to supporting one side to the conflict.[50]

49 Article 85(3) AP I.
50 The 'neutrality' of the wounded and sick and of those who assist them is the essence of the 1864 Geneva Convention. See Articles 1, 2 and 5.

3.3.1 Who is protected?

It is only persons who fall within the definition of medical personnel who benefit from the regime of specific protection outlined above. The prohibition to punish is broader and covers *anyone* who provides medical assistance.[51] In addition to people providing medical care, it also covers those involved in the operation and administration of medical facilities, and people with no medical training who provide medical assistance.

The prohibition is framed in terms of punishment and harassment of individuals, but the policy underlying it also applies to organizations that provide medical care.

3.3.2 What is prohibited?

The prohibition is applicable in international and non-international armed conflicts, and is extremely broad. It covers legal measures, including criminal investigations and prosecutions, designation for the purpose of sanctions, and administrative measures such as revocation of medical practitioners' licences, or of non-governmental organizations' registration; as well as any form of ill treatment, intimidation and harassment. In the words of the first Geneva Convention, no one must be 'molested' for having treated the wounded and sick.[52]

Despite this clear prohibition, there have been numerous instances in recent conflicts when the provision of medical care has been penalized. Many of these are in contexts where affected states classify the violence as terrorism and apply domestic counterterrorism laws criminalizing broad forms of support to groups designated as terrorist. As these laws frequently do not include provisions addressing their interplay with IHL, they criminalize conduct that is permitted, or indeed required, by IHL, including the provision of medical care.

Most notorious are the US Material Support Statutes, which adopt an extremely broad definition of 'material support' to groups designated as terrorist. While providing medicines is excluded, courts have interpreted this exception narrowly, determining that the administration of medicine, as well as providing medical care, fall within the scope of the offence.[53]

In the early 2000s, the UN Security Council played a central role in developing the international counterterrorism normative framework. As it became evident that an overly broad approach was undermining protections under IHL, the Council adopted resolutions requiring states to ensure that counterterrorism measures complied with international law, including IHL. Resolution 2664 (2022) more explicitly reminds states of the obligation not to punish people for carrying out medical activities compatible with medical ethics.[54]

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51 Articles 16 AP I and 10 AP II.
52 Article 18(3) GC I.
53 *United States District Court for the Southern District of New York, United States v. Shah, 474 F. Supp. 2d 494*.
54 SCR 2462 (2019) OP 6; and SCR 2664 (2022) PP 6. For a contextualizing discussion, see Gillard, E. (2021), *IHL and the humanitarian impact of counterterrorism measures and sanctions: Unintended ill effects of well-intended measures*, Research Paper, London: Royal Institute of International Affairs, Ch. 3, https://www.chathamhouse.org/2021/09/ihl-and-humanitarian-impact-counterterrorism-measures-and-sanctions.

States' practice in relation to domestic counterterrorism measures is mixed. Some of the more recent instruments have included safeguards. They have either been general – specifying that the laws are not intended to derogate from IHL – or have included exceptions to crimes of material support for terrorism, but these refer only to humanitarian assistance. To date, the provision of medical care has not been expressly mentioned.

There have also been prosecutions under other areas of domestic law. In Ukraine, for example, since Russia's 2022 invasion, hospital directors and administrators in the occupied territories have been prosecuted under the collaboration law. This is in spite of the prohibition in IHL on punishing persons involved in the provision of healthcare, and despite the fact they were providing basic services expressly required under the law of occupation.[55]

Colombian courts have considered medical assistance provided to members of the FARC in prosecutions for the crime of rebellion. While recognizing that the provision of medical care must not be criminalized, the courts adopted a narrow approach as to which activities were protected. They excluded administrative acts by doctors, such as referring patients to specialized clinics; and providing care beyond immediate surgery by prescribing or providing medicines; as well as doctors who charged for treatment. The courts essentially limited the exception to emergency care provided free of charge.[56]

In Cameroon in 2021, two Médecins Sans Frontières (MSF) staff were charged with complicity with secessionists, having been arrested in the southwest of the country while transporting a patient with gunshot wounds to hospital and were. Two others were arrested on similar grounds a few weeks later. After several months of detention, during which MSF suspended its operations in the area, the staff were acquitted by the Buea Military Tribunal.[57]

There are frequent instances when healthcare providers are arrested, even if ultimately no charges are brought. Such actions – often against medical organizations' local staff, who are particularly vulnerable – can amount to prohibited intimidation and have a chilling effect on the provision of medical care.

Belligerents also take practical punitive measures against healthcare providers for having treated wounded enemy fighters. In Ethiopia, for example, federal soldiers are reported to have threatened and beaten medical personnel and seized ambulances for having provided treatment to enemy Fano fighters.[58]

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55 Syniuk, O. et al. (2024), *Survival or crime: how Ukraine punishes collaborationism*, Analytical Report, Kyiv, Human Rights Centre ZMINA, https://zmina.ua/en/publication-en/survival-or-crime-how-ukraine-punishes-collaborationism; Human Rights Watch (2024), *"All She Did Was Help People": Flawed Anti-Collaboration Legislation in Ukraine*, https://www.hrw.org/report/2024/12/05/all-she-did-was-help-people/flawed-anti-collaboration-legislation-ukraine.
56 Linares, E. O. and Chau, M. S. (2013), 'Reflections on the Colombian case law on the protection of medical personnel against punishment', *International Review of the Red Cross* (2013), 95 (890), pp. 251–65, https://international-review.icrc.org/articles/reflections-colombian-case-law-protection-medical-personnel-against-punishment.
57 Médecins Sans Frontières (2022), 'Four months on, an ongoing nightmare for MSF colleagues detained in South-West Cameroon', 28 April 2022, https://www.msf.org/four-months-ongoing-nightmare-msf-colleagues-detained-south-west-cameroon; Médecins Sans Frontières (2023), 'All MSF staff acquitted in military tribunal in Cameroon', 10 January 2023, https://www.msf.org/all-msf-staff-acquitted-military-tribunal-cameroon.
58 Human Rights Watch (2024), *"If the Soldier Dies, It's on You": Attacks on Medical Care in Ethiopia's Amhara Conflict*, p. 32.

3.4 Good practice

- Armed forces must ensure that their doctrines and policies clearly state which activities are incompatible with the assignment of military medical personnel. They must take disciplinary measures if these positions are abused.
- Civilian authorities should issue similar instructions to medical personnel they assign and exercise similar oversight.
- Medical organizations should include similar restrictions in the employment contracts of staff assigned to medical duties and exercise similar oversight.
- Armed forces must ensure that their policies, doctrines and operating procedures clearly give effect to the protections afforded to medical personnel. These measures should be flowed down into mission-specific operating procedures and be disseminated and included in training programmes. Specific issues to address include:
  - The prohibition on directing attacks against medical personnel and on any form of ill treatment.
  - The obligation to respect the decisions taken by medical personnel on prioritization of treatment and the prohibition to put pressure on them to prioritize treatment on other than on medical grounds.
- On the basis of consultations with civilian medical authorities and organizations, armed forces should identify the concrete measures that they can take to facilitate the work of medical personnel. These should be included in doctrines and policies and mission-specific operating procedures and be disseminated and included in training programmes. Specific issues to address include:
  - Protocols for expediting the passage of medical personnel and vehicles through checkpoints. These can include establishing 'fast lanes', or when this is not possible, ensuring personnel staffing checkpoints give medical personnel and vehicles priority in queues; requiring checkpoints to forewarn each other of the passage of medical personnel and vehicles; ensuring sufficient staff is deployed to operate checkpoints efficiently; agreeing the type identification of medical personnel and vehicles involved in movements and for sharing it.
  - Arrangements for communicating information on safe and open routes for reaching medical facilities.
  - Procedures for addressing situations where armed forces consider specific medical personnel are carrying out acts hostile to the enemy.
- Channels of communication and coordination should be established with civilian medical authorities and humanitarian organizations providing medical assistance in armed forces' areas of operations to elaborate and implement these measures, refining them as necessary to the particular context, and to address problems that may arise as swiftly as possible.
- Organized armed groups should elaborate and implement similar measures to all those outlined above.

- All legal measures restricting the provision of goods and services that apply in situations of armed conflict or national emergency including in operations labelled as counterterrorism should include express safeguards excluding the provision of medical care. These should cover everyone who provides medical care, and should adopt a definition of medical assistance that goes beyond emergency care and includes the operational and administrative aspects of medical care.
- The substance of these legal measures should be included in practical policies and directives and be applied by all actors with a role in military operations or law enforcement.

04 Medical facilities and transports

In May 2025 WHO reported that only 19 of Gaza's 36 hospitals remained operational, seven of which were able to provide only basic emergency medical care. All the facilities were struggling under severe supply shortages, lack of health workers, persistent insecurity and a surge of casualties, and WHO described working conditions as 'impossible'. At least 94 per cent of all hospitals in Gaza had been damaged or destroyed.[59]

In times of armed conflict, hospitals must be able to continue operating in safety. They need medicines and medical equipment, water and electricity. The wounded and sick and healthcare staff must be able to access them.

All civilian healthcare facilities and all civilian ambulances constitute civilian objects and are therefore protected under the general rules of IHL. Those rules are set out in section 4.1 of this chapter. Medical facilities and medical transports that fall within the definitions in Additional Protocol I are afforded certain additional *specific* protections; these are discussed in section 4.2.

4.1 Protection under the general rules of IHL

4.1.1 Rules regulating the conduct of hostilities

A number of the rules regulating the conduct of hostilities are of particular relevance to civilian healthcare facilities and transports: the prohibition on directing attacks against civilian objects; the prohibition of indiscriminate attacks, including

59 World Health Organization (2025), 'Health system at breaking point as hostilities further intensify in Gaza', WHO warns', 22 May 2025, https://www.who.int/news/item/22-05-2025-health-system-at-breaking-point-as-hostilities-further-intensify--who-warns.

in particular the rule of proportionality; the rules on precautions in attacks and defence; as well as the broader obligation to take constant care in the conduct of military operations to spare civilians and civilian objects. Other rules, such as the prohibition on looting, and the rules on humanitarian relief operations, are also relevant.

All these rules must be applied bearing in mind the function of the healthcare facilities – i.e. providing care to the wounded and sick – as well as the consequences of such functions – i.e. the wounded and sick, medical personnel and other civilians are likely to be in these facilities or in their vicinity, and must be able to access them.

4.1.1.1 Prohibition of attacks

4.1.1.1.1 Healthcare facilities

Directing attacks against civilian objects is prohibited, including healthcare facilities or locations like pharmacies and dispensaries where medical supplies and equipment are stored.

Healthcare facilities do not benefit from absolute immunity. The protection afforded to civilian objects is lost if, by virtue of its nature, purpose, location or use, an object makes an effective contribution to the military operation and its destruction in the circumstances prevailing at the time offers a definite military advantage.[60] Moreover, even if healthcare facilities retain their civilian status, not all incidental damage is unlawful. What matters is that such damage is appropriately taken into account in proportionality assessments.

Healthcare facilities are most likely to become military objectives by virtue of their use or location, for example if they are used to store weapons or to provide cover to fighters actively engaging in hostilities. Significantly, it is just the part of the facilities where these activities are taking place that becomes a military objective. Determining precisely which part of the facilities constitutes the military objective is key.

Such a determination will have an impact on the choice of means and methods of warfare for neutralizing the objective. It will also impact the application of the rule of proportionality, as attacks against the parts of the healthcare facilities that have become military objectives inevitably affect the functioning of the other parts of the facilities – which remain civilian objects – and put the wounded and sick and medical personnel in the vicinity of the military objective at risk.

The rule of proportionality plays a central role in regulating attacks that adversely impact healthcare facilities. It prohibits attacking a military objective if doing so is expected to cause incidental death or injury to civilians, damage to civilian objects, or a combination thereof that would be excessive in relation to the concrete and direct military advantage anticipated from the attack.[61]

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60 Article 52 AP I.
61 Article 57(2)(b) AP I. See Gillard, E. (2018), *Proportionality in the Conduct of Hostilities: The Incidental Harm Side of the Assessment*, Research Paper, London, Royal Institute of International Affairs, https://www.chathamhouse.org/2018/12/proportionality-conduct-hostilities-incidental-harm-side-assessment.

Proportionality is relevant to attacks that can be expected to adversely impact healthcare facilities in two principal ways.

The first of these concerns the damage that an attack on a military objective is expected to cause to the healthcare facility itself. In addition to the death and injury to civilians expected from the actual attack, consideration must be given to the *function* of the medical facility in preventing other civilian deaths or injury. Proportionality assessments must consider the foreseeable consequences of limitations in their capacity to provide treatment, in terms of death, injury and disease of civilians. This is not limited to the harm that occurs immediately, but includes the foreseeable longer-term harm resulting from the reduced capacity to operate.

Due consideration must also be given to the *context* in which an attack is being conducted. This includes whether other functioning healthcare facilities exist in the area. Damage to a facility that may have been considered proportionate at the beginning of a conflict might no longer be so at a later stage if the number of functioning facilities is reduced. Consideration must also be given to the challenges that may exist in resupplying and repairing facilities – meaning that damage may cause a long-term interruption in the provision of medical care. These and other contextual factors increase the weight to be given to the expected damage to the facilities in proportionality assessments.

The second way that the consequences of attacks on the availability medical care must be factored into proportionality assessments is when such attacks damage objects and infrastructure necessary for the continued operation of healthcare facilities. This includes power-generation and -distribution infrastructure, water distribution systems, and roads and other infrastructure such as bridges. Damage to these can impact the ability of medical facilities to continue operating, in terms of availability of essential services such as electricity and water, and the possibility for medical supplies and personnel and the wounded and sick to reach the facilities.

For proportionality assessments to be conducted in an appropriate manner, it is essential for belligerents to have as comprehensive an understanding as possible of the interconnectivity of systems and infrastructure, and of how damage to these or interruption of the services they provide can impact the provision of medical care.

4.1.1.1.2 Medical supplies, equipment and transports

The rules also apply to medical supplies, equipment and transports.

Medical supplies and equipment are civilian objects. The fact they can be used to treat wounded combatants does not turn them into military objectives. They only become military objectives if they meet the definition in Article 52 AP I. This could be the case if they are diverted and used by armed forces or groups for other purposes.

The same applies to medical transports such as ambulances. They are not military objectives merely because they are used to transfer wounded combatants to medical facilities. However, they can become military objectives if they are used for other

purposes, such as transporting weapons or able-bodied fighters, or if they are stolen and used for military purposes.

Claims that medical transports are used in a manner that turns them into military objectives are often disputed. In view of the adverse consequences of directing attacks against such specialized vehicles – which, once they resume their proper use, play a life-saving role for the wounded and sick, and are often in very limited availability – rather than directing attacks against them, belligerents should consider other feasible ways of responding to improper use.

What is feasible is that which is practically possible, taking into account all the circumstances ruling at the time, including humanitarian and military considerations. This includes the threat posed. For example, the threat posed by a vehicle that is being used to transport weapons is different to that posed by a vehicle from which combatants are shooting. In the former case, it may be possible to search the vehicles and remove the weapons. The circumstances are also relevant, including most notably if a party is in control of the area.

4.1.1.2 Precautions in defence

Belligerents must take also precautions in defence. To the maximum extent feasible they must take necessary precautions to protect civilians and civilian objects under their control from the dangers resulting from military operations.[62] One evident way of complying with this obligation is to avoid locating military objectives within or in the vicinity of healthcare facilities. Doing so exposes the facilities, patients and personnel to the risk of incidental harm – and may even lead to the facilities themselves becoming military objectives.

The rules applicable to medical facilities entitled to specific protection expressly prohibit using medical facilities to shield military objects. The general rules prohibit using the presence of civilians in this manner. In practice, in view of the presence of patients and healthcare personnel in medical facilities, the general rule has a similar effect for functioning healthcare facilities.

4.1.1.3 Obligation to take constant care

In the conduct of military operations, belligerents must take constant care to spare the civilian population, civilians and civilian objects. This obligation is broader in scope than the rules on attacks. Most notably, it applies to all military operations. These are a wider range of activities that may have an adverse impact on the continuity of the provision of medical care, and access to that care, than actual combat.

The rule does not specify the type of harm that should be avoided. ‘Sparing’ the civilian population and civilian objects covers a range of adverse impacts that go beyond incidental death or injury of civilians and damage to civilian objects considered in proportionality assessments.

‘Sparing’ the civilian population and civilian objects requires belligerents to adopt all feasible measures to avoid adverse impact, and/or to mitigate it. It requires taking adverse impact into account in all decision-making relating to military operations.

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62 Article 58 AP I.

Once again, feasible measures are those that are practically possible, taking into account all the circumstances ruling at the time, including humanitarian and military considerations.

4.1.1.3.1 Access to healthcare facilities

Military operations can impact the provision of access to medical care in many ways. The mere presence of military personnel and vehicles in the vicinity of healthcare facilities can dissuade wounded enemy fighters from accessing treatment. Moreover, as they are military objectives that may be targeted by the enemy, their presence exposes the facilities, patients and healthcare providers to harm. Belligerents should avoid locating personnel in close proximity to healthcare facilities.

Military operations can damage roads and bridges, restricting the possible routes for reaching healthcare facilities, impacting the access of people seeking treatment, healthcare providers and necessary supplies.

Efforts should be made to ensure that some access routes to healthcare facilities remain open that are safe to use and as direct as possible. Information on their location should be shared through coordination channels with the actors operating healthcare facilities and, ideally, with the public.

4.1.1.3.2 Essential services

Military operations can also affect availability of electricity and water. Interruption in these services has a very significant impact on the ability of healthcare facilities to continue operating. Supplies to the facilities must not be switched off intentionally. If the electricity or water infrastructure that medical facilities rely on is damaged, the party in control of that infrastructure should use its best endeavours to repair it as soon as is feasible. During periods when electricity is unavailable, the provision of alternative sources of energy – like fuel for generators – should be facilitated. As always, what is feasible depends on the context.

4.1.1.3.3 Movement

Checkpoints and other restrictions on movement can severely impact the ability of the wounded and sick, healthcare personnel, and medical goods and equipment to reach healthcare facilities.

The rules on humanitarian relief operations require the rapid and unimpeded passage of relief consignments, but allow parties to impose measures of control, such as searches. This approach can provide guidance.

Belligerents should elaborate procedures to fast-track the passage of medical personnel, transports and goods destined for healthcare facilities that allow them to address their security concerns without unduly hampering the movement of such persons and goods. Procedures should also be established for facilitating the rapid and safe passage of patients.

These could include ways of identifying medical supplies so that they can be checked and cleared in an expedited manner; lists of goods entitled to transit with minimal search procedures; ways of identifying medical personnel so that their passage can be prioritized; assigning specific lanes at busy locations for the passage of patients,

goods and medical personnel; and establishing communication protocols between the various checkpoints that might exist on the routes to medical establishments – including to provide advance notice of transports and patients in transit.

Context permitting, these procedures these should be applied so that searches and other measures of control are not carried out multiple times.

Ideally, belligerents should develop these procedures in coordination with actors providing medical care in their areas of operations. Efficient channels of communication are essential to their functioning.

4.1.1.3.4 Entry by armed and security forces into healthcare facilities

Another type of military operations are those to apprehend people receiving medical care. These are not prohibited, but – like all entry by armed and security forces in healthcare facilities – should only occur in exceptional circumstances, and be conducted in a manner that takes account of the risks these can pose to patients and healthcare providers and the potential damage to medical facilities and disruptions to their operations.

If possible, arrests should be conducted outside healthcare facilities, once patients have been discharged. If entry into facilities cannot be avoided, the timing, nature, duration and scope of the operation must, to the extent possible, take into account the routine and duties of the facility; and the rules regulating the use of force must be adjusted to take into account the context in which such operations are being conducted.

Consideration should be given to adopting standard, specific operating procedures for such operations; and to requiring higher-level prior authorization and the involvement of a legal adviser.

4.1.2 Looting

> [In April 2025] dozens of armed men stormed the MSF hospital and office in Ulang, Upper Nile state[South Sudan], threatened staff, and looted vital medical supplies and equipment. At the time, more than 100 patients were admitted and receiving critical treatment, including trauma care, maternity services and paediatric care. All were forced to flee when armed men entered the facility and began looting room by room … The incident forced MSF to suspend services, leaving the area without a functioning health facility, halting vital efforts to treat cholera patients and control the ongoing outbreak.[63]

While some of the rules protecting medical care are not absolute prohibitions, or are subject to feasibility, the prohibition on looting is absolute.[64] Despite this, according to the ICRC Health Care in Danger Study, looting of medicines and medical equipment is possibly the most common form of violence committed against healthcare facilities.[65] It can leave facilities without the resources necessary to continue operations, depriving communities of medical care.

63 Médecins Sans Frontières (2026), *Medical Care in the Crosshairs*, p. 36, https://www.msf.org/medical-care-crosshairs.
64 Article 28 Hague Regulations of 1907, and Article 33 GC IV.
65 International Committee of the Red Cross (2011): *Health Care in Danger: Making the Case*, Geneva: ICRC, p. 9, https://elearning.icrc.org/healthcareindanger-2015/en/pdf/chapitre1/Making_the_case.pdf.

4.2 Specific protection of medical facilities and transports

> On 14 March 2025, three loitering munitions struck a hospital in Zolochiv, Kharkiv region. The same facility was struck again on 27 March 2025 by two loitering munitions. On 19 March 2025, at least five loitering munitions struck a hospital in Krasnopillia, Sumy region. Both hospitals were damaged, the Krasnopillia hospital significantly so. The repeated strikes against the two hospitals suggest that they may have been attacked deliberately.[66]

IHL grants additional specific protection to medical facilities and transports that meet certain conditions. These can be military or civilian.

4.2.1 What are 'medical facilities'?

IHL treaties use the expression 'medical units', but this paper uses the term 'medical facilities' as more current. Article 8(e) AP I defines 'medical units' as:

> establishments and other units, whether military or civilian, organized for medical purposes, namely the search for, collection, transportation, diagnosis or treatment – including first-aid treatment – of the wounded, sick and shipwrecked, or for the prevention of disease … Medical units may be fixed or mobile, permanent or temporary.

It is generally accepted that this definition reflects customary international law, and that it also applies in non-international armed conflicts. Most aspects are clear and uncontroversial, including the range of medical services that may be provided.[67] Two elements warrant closer attention:

4.2.1.1 Organized for medical purposes

The Fourth Geneva Convention requires civilian hospitals to be 'organized for medical purposes'.[68] Factors that indicate such organization include the existence of staff – medical, technical and administrative – and medical equipment and supplies.

This does not exclude the possibility that facilities serving other purposes in peacetime, like schools or churches, are turned into medical facilities during a conflict, including on a temporary basis, to respond to needs. If this occurs, the use for medical purposes must be exclusive: for example, if a school has been converted into an emergency hospital, classes may no longer be held in it.

The requirement also means that locations used spontaneously to provide medical treatment, like apartments in areas of active hostilities, do not fall within the definition. In any event, they would not have been 'recognized and authorized', as discussed below. While not entitled to specific protection, such facilities nonetheless benefit from general protection under IHL as civilian objects, albeit recognizing that belligerents may not be aware of their presence and activities.

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66 Office of the United Nations High Commissioner for Human Rights (2025), *Report on the Human Rights Situation in Ukraine, 1 December 2024–31 May 2025*, para. 26, https://ukraine.ohchr.org/en/Report-on-the-Human-Rights-Situation-in-Ukraine-1-December-2024-31-May-2025.
67 Article 8(e) AP I provides an indicative list: hospitals and other similar units, blood transfusion centres, preventive medicine centres and institutes, medical depots and the medical and pharmaceutical stores of such units.
68 Article 18 GC IV.

4.2.1.2 Recognized and authorized by a party to the conflict

As far as civilian medical facilities are concerned, they must fall within one of three categories.[69] The first two are of greatest relevance in contemporary conflicts: the facilities must either belong to a party to the conflict; or be recognized and authorized by the competent authority of a party to the conflict.[70]

Like the requirement that medical personnel be 'assigned', this requirement establishes a continuing link between the facilities entitled to specific protection and a party to the conflict. The rationale is the same: requiring that states retain some control over facilities entitled to specific protection, to ensure they are used exclusively for medical purposes, as well as a responsibility to prevent abuse. If it functioned as envisaged, the system could also serve as an arrangement for reporting allegations of abuse and requiring corrective measures.[71]

The first category – 'belonging' to a party to the conflict – covers state medical facilities.[72] The party to the conflict is itself responsible for their administration and for preventing abuse of the specific protection.

The second – facilities 'recognized and authorized' by the competent authority of parties to the conflict – covers a range of facilities, including those of national Red Cross/Crescent societies of parties to the conflict or third states, or of humanitarian organizations or private commercial actors, provided these have been 'recognized and authorized'.

4.2.1.2.1 How has the requirement been applied in practice?

IHL treaties do not specify who the 'competent authority' is, or the procedures and criteria for recognizing and authorizing medical facilities. The expectation was that states would adopt domestic legislation to give effect to these provisions.[73]

The requirement that medical facilities be recognized and authorized is clearly stated in Additional Protocol I and repeated in numerous military manuals. It is also a prerequisite for entitlement to display the protective emblem – a separate set of rules. Even so, there appears to be limited awareness of what this requirement means in practice. It is different from, and distinct to, the consent to conduct relief operations required by Article 70 AP I. It is unclear how the requirement applies to facilities operated by humanitarian organizations. Often, specialized medical organizations operate on the basis of a memorandum of understanding with ministries of health. Arguably, this constitutes the recognition and authorization required by Article 12 AP I. As far as non-international armed conflicts are

69 Article 8(e) AP I, read in conjunction with Article 12 AP I.
70 The third category comprises facilities 'authorized in conformity with Article 9(2) AP I or Article 27 GC I'. It is not in current use.
71 Article 18(2) GC IV required belligerents to issue civilian hospitals with a certificate confirming that the premises were not being used to commit, outside their humanitarian duties, acts harmful to the enemy. As this was issued in peacetime, it could not attest the continued proper use of the facilities during conflict.
72 Military medical facilities are part of states' armed forces, so inevitably 'belong' to a party to the conflict. Consequently, it was not necessary to mention them in Article 12 AP I.
73 Bothe, M. and Janssen, K. (1986), 'The implementation of international humanitarian law at the national level: Issues in the protection of wounded and sick', *International Review of the Red Cross*, 26(253), pp. 189–99, https://international-review.icrc.org/articles/issues-protection-wounded-and-sick.

concerned, it is generally agreed that the definition of medical units in Article 8(e) AP I also applies to such conflicts, as does the requirement that medical facilities belong to or be recognized and authorized by a party to the conflict'.[74]

Recognition by state authorities continues to cover authorized medical facilities that end up in areas under the control of organized armed groups. As far as organized armed groups are concerned, an implicit reference to their entitlement to recognize and authorize medical facilities can be found in Article 12 AP II on authorization of the use of the distinctive emblem.

IHL treaties clearly make specific protection of particular medical facilities conditional on those facilities belonging to or being recognized and authorized by a party to the conflict. Despite this, it has been difficult to identify any significant practice. In parallel, states appear to have been willing to extend some aspects of specific protection as a matter of policy to *all* healthcare facilities, regardless of recognition and authorization.

Such a policy benefits the protection of medical care. However, the treaty rules established a system of checks and balances, whereby the party granting authorization had a continuing responsibility to minimize the risk of abuse of medical facilities, to prevent abuse, to respond to allegations of abuse, and to put an end to them. This important dimension has been lost. In fact, in many conflicts it is the very party with the responsibility for playing this role, or groups affiliated with them, that are abusing the protection afforded to medical facilities.

4.2.2 What are 'medical transports'?

Article 8(e) AP I defines 'medical transports' as:

> any means of transportation, whether military or civilian, permanent or temporary, assigned exclusively to medical transportation and under the control of a competent authority of a Party to the conflict.[75]

It is generally accepted that this definition reflects international customary law, and that it also applies in non-international armed conflicts. Most elements are clear and uncontroversial. Two aspects warrant closer attention:

4.2.2.1 Exclusively assigned

Vehicles must be assigned exclusively to medical transportation. They must only contain the wounded and sick, medical personnel, equipment or supplies, and, during such assignment, may not be used for any other purpose. The assignment can be permanent (i.e. for the duration of the conflict) or temporary.

4.2.2.2 Under the control of a competent authority of a party to the conflict

Transports must be under the control of a competent authority of a party to the conflict. This requirement aims to ensure that specific protection is extended only to vehicles that meet the relevant conditions, and that they are not used for improper purposes. Control must be exercised both at the time of assignation of the vehicle and, importantly, throughout its operation.

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74 Sandoz, Swinarski and Zimmermann (eds) (1987), *ICRC Commentary to the APs*, para. 4712, fn 7.
75 This paper only addresses medical transports on land.

IHL treaties do not specify who the competent authorities should be. For military medical transports they will be the relevant branch of the armed forces. For civilian medical transports it is left to states decide which authority is responsible for exercising this control. It is likely to be the same as those that recognize and authorize medical facilities.

While organized armed groups also appear entitled to assign medical transports, it has not been possible to find examples. Nor was it possible to find examples of how the relevant state and organized armed groups authorities exercised their oversight roles during armed conflicts.

4.2.3 What does specific protection entail?

> Several doctors and healthcare workers [in Ethiopia] said that … the seizure and attacks on ambulances by warring parties further prevented the ability of doctors to receive patients and for civilians to obtain care. One doctor in West Gojjam Zone said that the hospital's ambulance was essentially "non-operational". He said:
>
>> The numbers of patients have decreased because people are afraid of being accused as Fano. The ambulance drivers are not willing to fetch patients, they fear that the Ethiopian military may stop them an accuse them of transporting Fano. They worry if the Fano stops them, they will get accused of transporting the military.[76]

Medical facilities and transports must be respected and protected.[77] The obligation to respect refers to prohibited conduct, and the obligation to protect requires positive measures. For some conduct, it can be difficult, artificial and unnecessary to separate these two aspects. The underlying objective is to ensure that the operations of medical facilities and transports are not intentionally and unduly impeded.

4.2.3.1 The obligation to respect

IHL treaties give two specific examples of prohibited conduct: directing attacks against medical facilities and vehicles;[78] and using medical facilities and vehicles in an attempt to shield military objectives from attack.[79]

The obligation to respect also covers conduct that is prohibited or regulated by other rules of IHL, such as the prohibition on looting,[80] and unlawfully requisitioning medical facilities in situations of occupation.[81] Other restrictions are found in the general rules regulating the conduct of military operations. Most notably, expected damage to civilian medical facilities and vehicles must be taken into account in proportionality assessments; and all feasible precautions must be taken to avoid and, in any event, minimize, their incidental damage. More generally, in the conduct of military operations constant care must be taken to spare them.

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76 Human Rights Watch (2024), *"If the Soldier Dies, It's on You": Attacks on Medical Care in Ethiopia's Amhara Conflict*, p. 46.
77 Articles 19 GC I, 18 GC IV, 12 and 21 AP I and 11 AP II. In international armed conflicts, medical benefit from the same protections as mobile medical units.
78 Articles 12 and 21 AP I and 11 AP II.
79 Article 12 AP I. Article 11 AP II does not include this prohibition.
80 Article 33(2) GC IV.
81 Articles 57 GC IV and 14 AP I.

Article 12(4) AP I requires a specific precautionary measure: whenever possible, belligerents must ensure that medical facilities are sited so that attacks against military objectives do not imperil them.[82] Although this is framed in terms of the location of medical facilities, the converse is as relevant: military objectives should not be placed in the proximity of medical facilities.

Medical facilities and vehicles may not be used in an attempt to shield military objectives from attack.[83] Belligerents must not abuse their specific protection to obtain a military advantage – i.e. counting on their enemy to refrain from attacks that could damage them. The prohibition covers only the deliberate placement of military objectives within or in the proximity of medical facilities or vehicles with the intent of preventing attacks against these objectives.

Such intention may be difficult to infer, but systematic conduct may be indicative. In any case, the obligation to respect medical facilities and vehicles also prohibits conduct that amounts to 'acts harmful to the enemy' that would lead to the loss of their specific protection – like storing military equipment – or that would turn them into military objectives. This prohibition also covers situations where it is not possible to infer an intention of shielding military objectives.

If one party violates the prohibition on using medical facilities and vehicles to shield military objectives, or uses them to carry out acts harmful to the enemy, this does not release its opponent from its own obligations to respect the facilities and vehicles and to take all feasible precautions to spare them.

Belligerents must not intentionally prevent medical facilities from operating – for instance by intentionally denying them essential supplies such as electricity or water. Intentionally 'switching off' electricity or water is different from situations when such supplies are interrupted in the course of military operations. Those situations are governed by the general rules regulating the conduct of hostilities. For example, when planning an attack on a military objective, proportionality assessments must include the expected consequences of damage to the electricity and water infrastructure on medical facilities' ability to operate. If the damage to the infrastructure occurs as a result of military operations other than attacks, all feasible precautions should have been taken to minimize the impact on civilian objects, including civilian medical facilities.

4.2.3.2 The obligation to protect

The obligation to protect medical facilities and medical vehicles requires belligerents and other relevant parties to take feasible measures to facilitate their operations and, as a minimum, not to intentionally and unduly impede them.

IHL does not specify measures that must be taken. They can include measures that facilitate the provision of goods and services necessary to the operations of medical facilities and transports. Examples include refraining, to the extent possible, from conducting military operations in the vicinity of medical facilities, as these can

82 See also Article 19 GC I.
83 Article 12(4) AP I.

impair the ability of the wounded and sick, medical supplies, personnel and vehicles to reach the facilities; and keeping access roads open or, when if this is not possible, facilitating the operation of alternative routes.

As far as the supply of medicines and equipment and the movement of medical vehicles are concerned, the rules regulating humanitarian relief operations can provide guidance. Belligerents must allow the rapid and unimpeded passage of medical consignments and medical vehicles, but are entitled to adopt measures of control. These include conducting searches or requiring the use of particular routes. Any such technical arrangement must be applied in a manner that ensures as swift and efficient a passage as is possible.

While the obligation to respect medical facilities and vehicles sets out absolute prohibitions, the obligation to protect them is an obligation of means. Belligerents and other relevant actors, like neighbouring states, must take the measures that are feasible in the circumstances.

Context is important. The belligerent with control over the territory where medical facilities are located is likely to be in a position to take more significant measures to facilitate their work. However, its opponent may also have a role to play – for example by facilitating the passage of medical supplies and equipment.

The obligations of occupying powers are more onerous. To the fullest extent of the means available to them, and with the cooperation of national and local authorities, they must ensure and maintain medical and hospital establishments and services, as well as public health and hygiene in the occupied territory.[84]

The obligation applies to *all* medical facilities and vehicles – those belonging to, or recognized and authorized by one party, and those belonging to, or recognized and authorized by, its opponent. Inevitably, a party is likely to take more significant measures to protect its own facilities, including from the effect of hostilities. This includes important preparedness measures taken before the outbreak of conflict.

4.2.3.3 Measures by medical care providers

It is belligerents who have the primary responsibility for ensuring respect for the rules protecting medical care. However, the actors who operate medical facilities and vehicles also have an important role to play. For example, they can adopt internal measures regulating key aspects of their operations to minimize the risk that medical facilities and vehicles will be used to conduct acts harmful to the enemy, as well as to minimize the risk of allegations of such use. Possible measures may include prohibiting bringing weapons into medical facilities or transports. Depending on the context, prohibitions could extend to communication devices. Limits could also be set on the number of family members who may accompany patients.

In many contexts, medical organizations share the coordinates of their facilities with belligerents to facilitate the identification of those facilities. Experience has shown that the coordinates should indicate the entire perimeter of the premises rather than a single central spot. Information may also be provided on the specific markings used to identify medical premises and transports.

84 Article 56 GC IV.

Certain organizations strive to conclude written agreements with all parties involved in hostilities in particular contexts. These agreements set out the shared understanding of their obligations, and of the measures they will take to give effect to them, and identify focal points for liaising on their implementation. For example, in Afghanistan in 2016 and 2017, MSF concluded separate agreements with the Taliban and with the Ministry of Foreign Affairs on measures to be implemented by the National Defense and Security Forces.

MSF's experience indicates that even where it is not ultimately possible to conclude such an agreement, the process of negotiation can be extremely valuable, as it allows in-depth discussion of likely problematic areas, and of good practices to attempt to address them. It also allows the identification of key interlocutors to engage with if problems arise.

While many of the measures addressed in such agreements, and adopted in the internal regulations of medical organizations, are also relevant for state hospitals, in practice the latter may face pressure from state armed and security forces that make it harder for them to resist conduct that can put the facilities and patients at risk.

4.2.3.4 The limits of specific protection – not absolute immunity

The obligation to respect and protect medical facilities and transports does not grant them 'absolute immunity' from any type of damage; nor does it prohibit all conduct that could affect their capacity to operate.

For example, not all incidental damage to medical facilities or vehicles caused by an attack directed against a military objective in their vicinity is prohibited. Such damage must be assessed in accordance with the ordinary rules on proportionality – with due weight being given to the functions carried out by the facilities and vehicles.

Belligerents may, furthermore, lawfully respond to hostilities directed at them from within medical facilities, provided the requisite warning has been given and remained unheeded. Nonetheless, in returning fire in such circumstances, heightened precautions must be taken to minimize risks to the wounded and sick, healthcare providers and the medical facilities themselves.

Similarly, it is not prohibited to carry out operations within medical facilities to detain enemy combatants receiving medical treatment or other persons in relation to the conflict. When conducting such operations, belligerents must take all feasible measures to minimize their adverse impact on the wounded and sick, healthcare providers and the medical facilities. 'Feasible' should be understood as that which is practicable or practically possible, taking into account all circumstances ruling at the time, including humanitarian and military considerations.[85] In view of the disruptions and dangers they pose, military doctrine should indicate that such operations should be exceptional and should require higher-level authorization.

85 See, for example, UK Declaration on ratification of Additional Protocol I, 28 January 1998, https://ihl-databases.icrc.org/en/ihl-treaties/api-1977/state-parties/gb.

Similarly, although searching medical vehicles or requiring them to take particular routes is not prohibited, such conduct must not constitute intentional and unwarranted interference with their capacity to operate. Moreover, it must take into account the imperative of moving the wounded and sick as swiftly as possible to medical facilities where they can be treated.

4.2.4 Loss of specific protection

> We have made the decision to resume our core activities at Nasser hospital after continuously engaging with Gaza's Ministry of Health and assessing the situation. We have determined that the concrete actions taken by the relevant authorities have allowed the minimum conditions required for our teams to work safely and in line with our working principles.
>
> Since the suspension of our non-critical activities … our teams have seen clear and marked improvements in the situation.
>
> We had originally made the difficult decision to suspend all non-critical medical activities on 20 January 2026 after MSF staff witnessed a series of incidents. These included the presence of masked armed men, and others engaging in intimidation and carrying out arbitrary arrests of patients, as well as one incident that involved the suspected movement of weapons, all of which are completely unacceptable, and which we raised to the relevant authorities.
>
> We have now resumed activities. This decision reflects both the gravity of needs and concrete improvements in how the facility is being managed, including measures to restrict the entry of weapons and armed individuals.[86]

Medical facilities and vehicles lose specific protection if, outside their humanitarian functions, they are used to commit acts harmful to the enemy.[87] Importantly, specific protection ceases only after a warning has been given, setting whenever appropriate a reasonable time-limit for putting an end to the harmful conduct, and where this has remained unheeded. Allegations of such use are frequently contested.

4.2.4.1 Acts harmful to the enemy

IHL treaties do not define or provide examples of acts harmful to the enemy, but they do give examples of acts that are *not* considered harmful to the enemy: equipping facility personnel with light individual weapons for their own defence or for that of the wounded and sick; guarding facilities with sentries – as could be necessary to prevent looting, for example; the presence of small arms and ammunition taken from the wounded and sick, and not yet handed to the proper service; or the presence of combatants receiving treatment.[88]

Acts harmful to the enemy comprise any use of the facility or vehicle for military purposes. Examples include: conducting combat action from the facilities or vehicles; using them to shelter or transport able-bodied combatants; using them to store or move arms, ammunition or other military equipment; using them for confining or moving hostages; or using them for military observation and information gathering. Other harmful acts include locating access points to tunnel systems

86 Médecins Sans Frontières (2026), 'MSF resumes core activities at Nasser hospital', 17 April 2026, https://www.msf.org/msf-resumes-core-activities-nasser-hospital.
87 Articles 21 GC I, 19 GC IV, 13 AP I; and, in slightly different words, Article 11(2) AP II.
88 Article 13(2) AP I. See also Articles 22 GC I and 19 GC IV.

used by fighters in the medical facilities; or using medical vehicles to gather tactical intelligence – such as information on the presence of troops – and conveying it to a party to the conflict, or to hinder military operations.

It is generally considered that 'acts harmful to the enemy' is a broader concept than conduct that results in a civilian object becoming a military objective. The latter requires the object to make an effective contribution to miliary action by virtue of its nature, location, purpose or use; its destruction in the circumstances at the time must offer a definite military advantage.[89]

The notion of 'acts harmful to the enemy' covers not just the infliction of direct harm on enemy forces – by firing at them from medical facilities, for instance – but also conduct that is intended to interfere with military operations directly or indirectly, or that has this effect.

One important consequence of this difference in scope is that not all acts harmful to the enemy turn a medical facility or vehicle into a military objective. For example, tapping into the facilities' electricity and telecommunications networks and using them in tunnels under the facilities is an act harmful to the enemy, but probably not of a nature that would turn the relevant parts of the facilities into military objectives.

Moreover, not all operations by a belligerent within a medical facility constitute acts harmful to the enemy that can lead to loss of specific protection. For example, entering facilities to arrest combatants or others who are receiving treatment would not have this effect; but operations to capture able-bodied fighters sheltering in the facilities would.

In addition to being harmful to the enemy, the acts in question must occur *outside* the 'humanitarian functions' of the facilities or vehicles. Activities that could be harmful to the enemy but that fall *within* medical facilities' humanitarian functions include, most obviously, providing medical care to wounded and sick combatants; or instances when electronic equipment used in medical facilities interferes with military communications systems. As regards medical vehicles, there may be circumstances when their legitimate use impedes military operations, for example if a vehicle temporarily shields a military objective, or blocks the passage of military vehicles. Whether such conduct is outside the humanitarian function must be determined on a case-by-case basis, according to whether the adverse impact on the enemy's military operation was deliberate or incidental to the movement of the vehicle.

4.2.4.2 Warnings

Even if acts harmful to the enemy have been committed, specific protection is only lost once a warning has been issued and has remained unheeded.[90]

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89 Article 52(2) AP I. This view is not unanimous. The argument has been made that specific protection is only lost when medical facilities are *used* to commit hostile acts, while the definition of military objectives also covers situation where objects make an effective contribution to miliary action by virtue of their location or purpose. On this view, the possible grounds for loss of protection are in fact narrower.
90 Articles 21 GC I, 19 GC IV, 13 AP I and 11(2) AP II.

The general rules of IHL regulating conduct of hostilities require warnings of *attacks* that may affect the civilian population, unless circumstances do not permit.[91] The obligation in relation to medical facilities and vehicles is broader. A warning is required for *any* action that could undermine their specific protection. But not every operation has this effect. For example, entering medical facilities to arrest patients is not incompatible with specific protection and so does not require a warning.

Although the requirement to give a warning is framed in absolute terms in IHL treaties, some military manuals state that the obligation does not apply when troops are responding to fire from medical facilities.

The purpose of the warning is to draw attention to the conduct in question, so that it can be investigated and – if the claim proves to be well-founded – ended. The warning must identify the alleged conduct in sufficient detail for it to be investigated. Referring in general terms to the conduct of 'acts harmful to the enemy' or 'military operations' in the facilities is not sufficient. The warning should provide information on the location of the conduct, and when it occurs, as this could help identify the actors responsible for it – for example, which military units are present in the area.

IHL treaties do not specify who warnings must be issued to. A number of different actors can play a role in taking the necessary remedial action: the management of the medical facility; the state authorities that have 'authorized' the facility and that retain responsibility for ensuring it meets the criteria for specific protection – frequently the ministry of health; and the party to the conflict that is carrying out the harmful acts.

Who the most appropriate party is depends on the circumstances. There may be instances when the management of the medical facility can put an end to the conduct in question – for example, by requiring able-bodied combatants to leave the premises.

In Yemen, for example, a belligerent informed a medical organization that members of an armed group had gathered in the vicinity of one of the organization's facilities. The managers of the facility contacted the members of the group and persuaded them to relocate, explaining that their mere presence in such proximity to the hospital was putting it at risk. Key to success in this instance were the organization's channels of communication with both sides, and the receipt of information on the presence of the group. The fact that the group was not deliberately using the facilities to shield themselves contributed to their willingness to relocate.[92]

In other instances, the management of the medical facility may simply be unable to terminate the hostile acts, much as they would like to. An example might be where forces are using the premises or the affiliated vehicles to store weapons or conduct military operations. In theory, if these are the forces of the belligerent to which the medical facilities belong or that has authorized them, the entity that issued the authorization should be able to liaise with its military counterpart requesting the conduct to be terminated. In practice, if the conduct is intentional, it is unlikely

91 Article 57(2)(c) AP I.
92 Contribution made during expert meeting hosted by Chatham House, October 2025.

that the health ministry would be able to demand its termination. The position is even more complicated in practice if it is enemy forces – including organized armed groups – that are responsible.

For medical vehicles, similarly, warnings can be issued to different actors who might be able to take the necessary remedial action. They include: the managers of the entity with which the vehicles are affiliated – a medical facility or a private organization; the party that has assigned the vehicles and has a continuing obligation to control them; and the party to the conflict carrying out the harmful acts.

The contents of the warnings issued to different actors do not need to be the same. For example, warnings to managers of the medical facilities should be as detailed as possible, to allow them to investigate the situation. It is acceptable to send to the belligerent responsible for the conduct a more generic warning, to avoid sharing information that could reveal the extent of the intelligence at the disposal of its opponent and its sources, or to maintain some tactical element of surprise should the warning remain unheeded and operations have to be conducted to end the hostile acts.

A warning must be issued even if the party giving it considers that there is little likelihood that the harmful acts will be terminated. For maximum effectiveness, the warning should be issued to all of these actors – including the management of the medical facilities, who are the ones most directly affected.

IHL treaties do not specify the modalities for issuing warnings. What matters is that they are effective in conveying the information to the actors in a position to end the conduct, or who would be affected by loss of specific protection. Warnings can be communicated by whatever channels exist – such as email, phone call, text message, radio, leaflets or social media, or a combination of any of these – in a language that is understood by the intended recipients.

Ideally, direct channels of communication should be established between belligerents conducting operations in particular areas and the managers of medical facilities, in order to enable constant exchange of information to minimize the adverse impact of military operations on the functioning of medical facilities. These channels can also be used to share allegations of harmful acts and to discuss how to address them. Such arrangements must allow the swift exchange of information, and must not constitute a bottleneck.

For example, the admission of numerous wounded combatants to a medical facility following a military engagement can give rise to a cluster of mobile phone signals that the opponent is tracking, suggesting that there is a communications unit in the facility. Dialogue with the belligerent relying on such methods to track enemies would allow the hospital managers to explain the circumstances.

Ideally channels of communication should also be established with government departments responsible for medical facilities. This may be difficult as they are likely to be those of the opponent. A neutral intermediary could play a role in facilitating exchanges.

Warnings must set, whenever appropriate, a 'reasonable' time limit for remedying the situation. What constitutes a reasonable time limit depends on the circumstances, and on the nature of the acts harmful to the enemy. For example, it is reasonable to give a longer deadline for the removal of weapons stashed in a hospital when there are no military operations in the area than is the case when responding to fire from within the premises.

In the case of medical vehicles, if an ambulance poses an immediate threat – for example, if it is being used to conduct an attack – the warning will be issued to the staff on the vehicle, and the time limit for ceasing the hostile act will be minimal. If the threat is not immediate – if a vehicle is transporting the wounded and weapons, for instance – it should be allowed to finish its journey.

The deadline must also give the relevant authorities sufficient time to verify the accusations and to attempt to put an end to the harmful acts. It is not necessary, however, for any response to continuing harmful acts to take place within a particular time of the issuing of the warning, provided the acts in question are still ongoing when the response is undertaken.

Some literature suggests that if it is not possible to end the hostile acts, the time limit should allow the evacuation of the facilities.[93] This option is not mentioned in the treaties. Such an approach suggests that evacuating medical facilities is the only option if the situation cannot be remedied. Most frequently this is not the case, as it is likely to be only part of a medical facility that loses specific protection. Moreover, in view of the difficulties of evacuating hospitals and the risk this poses to the well-being of patients, alternative responses should be considered that allow facilities to continue operating.

Although the obligation to issue a warning is very clear, and is set out in military manuals and doctrine, it has been extremely difficult to find instances when warnings have been issued in recent conflicts. None was reported as having been issued before attacks against medical facilities variously in Ukraine, Sudan, Yemen or Myanmar. The warnings made public in relation to Israel's operations in Gaza did not identify the purported harmful acts sufficiently clearly.

Far more frequent than warnings are allegations by belligerents that medical facilities are being used to carry out hostile acts. No arrangements exist for independent verification of such claims. Frequently it is the word of the belligerent – at times after an attack has been conducted – against that of affected medical personnel and patients. Such claims are sometimes addressed in accountability proceedings, but at that stage the harm has occurred. Solutions should be sought for investigating in real time allegations that harmful acts are being conducted. Neutral parties acceptable to all sides can play an important role in verifying allegations and in liaising with relevant parties to put an end to them.

93 See, for example, International Committee of the Red Cross (2025), *2025 Commentary on GC IV*, para. 1854, https://ihl-databases.icrc.org/en/ihl-treaties/gciv-1949/article-19/commentary/2025.

This is a role that could be played by third states in a role akin to that of protecting powers, or by an international body like the International Humanitarian Fact-Finding Commission. As always, the challenge is not establishing modalities for the activities of such a body – including in terms of confidentiality – but finding an entity that is acceptable to all parties.

4.2.5 Consequences of loss of specific protection

If, despite the warning, the acts harmful to the enemy continue, the medical facility or vehicle loses its specific protection and must be treated like any other civilian object. The general rules applicable are set out in section 4.1.

Importantly, loss of specific protection does not necessarily mean that attacks may be directed against a medical facility or vehicle. This is only permissible if the harmful act is of a nature that would turn them into military objectives. This will be the case only if they meet the relevant criteria: if 'by their nature, location, purpose or use' they make an effective contribution to military action, and 'their total or partial destruction, capture or neutralization, in the circumstances ruling at the time, offers a definite military advantage'.[94]

As always, it is necessary to identify precisely what becomes a military objective. Obviously, this depends on the nature of the conduct. There may be circumstances whereby an entire facility becomes a military objective – for example, if armed forces take over a hospital. In most cases, however, it will be the specific parts where the relevant conduct is occurring that become military objectives – for example, the rooms where weapons are hidden or where openings into tunnels used by combatants are located.

Even if a medical facility or a vehicle becomes a military objective, the rule of proportionality and the requirement to take constant care to spare civilians and civilian objects continue to apply. In applying these rules, consideration must be given to the function of the medical facility, if it continues to operate, or of the vehicle, and to the presence and activities of the wounded and sick and of medical personnel – who continue to benefit from specific protection even if the facilities or vehicle have lost it.

Thus, for example, if a vehicle is used to transport weapons, attacks against it must comply with the rule of proportionality. That is to say, the expected death or injury of civilians, such as the wounded and sick or medical personnel it may be transporting, and the damage to the vehicle, must not exceed the concrete and direct anticipated military advantage – in this example from seizing or from destroying the weapons.[95] Furthermore, in view of the often life-saving services provided by medical vehicles, operations against the vehicle in response to hostile acts should, to the extent possible, be conducted in a manner that minimizes adverse impact. If possible, searches should be conducted and weapons removed, rather than destroying the vehicle. As always, what is feasible depends on the prevailing circumstances.

94 Article 52(2) AP I.
95 Article 57(2)(b) AP I.

As regards an attack on a hospital of which a part has become a military objective, only a very limited military operation is likely ever to be lawful. This is in view of the foreseeable extent of the incidental harm that such an attack would be expected to cause, in terms of death and injury to the wounded and sick and medical personnel, and damage to the facility, with foreseeable longer-term consequences for the provision of medical care.

Once a facility or vehicle has lost its specific protection, the additional rules that flow from that protection no longer apply. The consequences are particularly significant as regards the obligation to *respect* the facilities or vehicles.

These include, first, the obligation to issue a warning. That said, the general rules regulating the conduct of hostilities require belligerents to give effective advance warning of *attacks* that may affect the civilian population, unless circumstances do not permit.[96]

Second, the obligation to respect medical facilities and medical vehicles prohibits using these in a manner that turns them into a military objective. Once specific protection is lost, this prohibition no longer applies, as 'ordinary' civilian objects do not benefit from it.

Third, the prohibition on using medical facilities or vehicles to shield military objectives from attack also no longer applies. The general rules regulating the conduct of hostilities prohibit using the presence of *civilians* for such purposes, but not civilian objects.[97]

4.2.6 Regaining specific protection

Treaty provisions do not specify whether, following a warning that remains unheeded, specific protection is lost temporarily or permanently. Arguably, medical facilities and vehicles should only lose specific protection temporarily, for the duration of the harmful act, in the same way that civilian objects can become military objectives by virtue of their use or location at a particular moment and then revert to being civilian objects once this use has ceased, or where the dynamics of hostilities is such that their location is no longer a factor that makes them a military objective.

This said, consideration should be given to the nature of the harmful acts, and in particular their frequency. If certain conduct occurs repeatedly – for instance, if able-bodied combatants repeatedly shelter in certain facilities, or if they are systematically used to hide weapons – this could be an indication that those responsible for the facilities are unable to prevent their misuse. In such circumstances, the various individual incidents could be considered as ongoing conduct, and some more significant measure could be required for specific protection to be reinstated. Similarly, if vehicles affiliated with a particular institution are systematically used to carry out harmful acts, such as transporting weapons or able-bodied fighters, this is likely to undermine trust in all the fleet and thus lead to increased movement restrictions and searches. These are likely to continue until the improper use ceases.

96 Article 57(2)(c) AP I.
97 Article 51(7) AP I.

There is a divergence of view as to whether following loss of specific protection a formal 're-authorization' of medical facilities by the relevant authorities is required. It has been suggested that, in such circumstances, the side that was harmed by the acts that led to loss of specific protection could be responsible for issuing the equivalent of an authorization. There have not been any instances when this has happened.[98]

If belligerents were to agree to the involvement of a neutral third party in verifying allegations that medical facilities are used to conduct harmful acts, this entity could also play a role in identifying the steps to be taken to prevent their recurrence, and in 'certifying' that specific protection can be reinstated.

4.3 Good practice

- States should adopt measures under their domestic law, clearly indicating who is responsible for recognizing and authorizing medical facilities and for assigning medical vehicles. The measures should clearly elaborate the role of the entity in preventing abuse and responding to allegations of abuse.
- Armed forces must ensure that their policies, doctrines and operating procedures clearly give effect to the protections afforded to medical facilities and transports. These should be flowed down into mission-specific operating procedures and instructions, and should be disseminated and included in training programmes. Specific issues to be addressed include:
  - The prohibition of directing attacks against medical facilities and vehicles. To facilitate compliance with this prohibition, armed forces should map the location of medical facilities in the areas where they intend to conduct military operations, and regularly update this information. Medical facilities should be placed on a 'no strike' list.
  - The obligation to take into account incidental damage to medical facilities and vehicles, and the death or injury of medical personnel and of the wounded and sick, when conducting proportionality assessments. This should also include the foreseeable longer-term consequences of interruptions in the services offered by the facilities and vehicles for the availability of medical care.
  - The obligation, in the conduct of military operations, to take constant care to spare medical facilities and vehicles – including by refraining from, to the extent feasible, carrying out operations in the proximity of medical facilities, or locating military assets in their vicinity.
  - The prohibition on using medical facilities and vehicles to shield military objectives.
  - The circumstances under which forces may enter medical facilities to detain persons receiving treatment, and the measures that should be taken to minimize the adverse impact of such operations on other patients, medical care providers and the functioning of the facilities.

98 Discussion at expert meeting hosted by Chatham House, March 2025.

- The potential requirement for higher-level authorization of attacks and military operations expected to cause damage to medical facilities, or to affect their operations.
- Measures to facilitate the expedited passage of medical supplies and equipment. Such measures should cover initial entry into the relevant country – for example, by agreeing expedited customs procedures, and lists of pre-approved items – as well as subsequent movement within the country. These could include procedures to expedite searches at checkpoints.
- For medical vehicles, arrangements to expedite passage through checkpoints. These could include, for example, establishing dedicated lanes or, if this is not feasible, giving priority to medical vehicles; ensuring communication between successive checkpoints to give notification of the arrival of medical vehicles; expedited search and identification procedures; ensuring curfews include exceptions for medical vehicles; and requiring a higher level of authority for denial of movements.

- States should adopt exceptions for medical supplies and equipment in international and domestic export controls, sanctions and other relevant measures.
- Armed forces should map the 'operational environment' relevant to the continued functioning of medical facilities, including: infrastructure on which medical facilities depend, such as electricity and water infrastructure; access and supply routes; and alternative healthcare facilities in the area. This mapping should be regularly updated.
- Armed forces should establish channels of communication and coordination with civilian medical authorities and humanitarian organizations that provide medical care in their areas of operations. This is essential for elaborating and implementing these measures in a context-specific manner, and for addressing problems that may arise as swiftly as possible.
- Procedures should be agreed for identifying medical vehicles by means of registration numbers, logos, call signs and identification of staff, along with procedures for notifying movements.
- Modalities should be agreed with civilian medical authorities and humanitarian organizations to address situations where armed forces consider that acts harmful to the enemy are being conducted within, or in close proximity to, medical facilities, or in the use of medical vehicles.
- Organized armed groups should elaborate and implement similar measures to all those outlined above.
- Armed forces and groups should develop guidance that identifies activities that must not be carried out within or in the vicinity of medical facilities, and acts that must not be carried out via medical vehicles, as these activities could lead to loss of specific protection or allegations thereof.

- Actors operating medical facilities should identify practical measures to minimize the risk that acts harmful to the enemy will be conducted in the facilities. These can include: procedures for controlling admission; rules restricting weapons and the number of family members or visitors; and conducting routine checks of the perimeters. These measures can be set out in internal regulations for personnel, with relevant parts displayed at the entrance of the facilities.
- Armed forces and groups should require their personnel to follow any regulations adopted by medical facilities regarding armed entries, including respecting no-weapons restrictions.
- Organizations operating medical facilities could conclude written agreements with belligerents identifying the measures both sides will take to avoid the conduct of acts harmful to the enemy and to convey and address allegations of harmful acts.
- Channels of communication should be established between belligerents and the managers of medical facilities in the areas where they are conducting operations, and with relevant government departments, to enable a constant exchange of information to minimize the adverse impact of military operations on the functioning of medical facilities. These channels can also be used to raise concerns about possible acts harmful to the enemy and to address such allegations.

05 The distinctive emblem

Following a series of attacks by the Taliban directed against medical vehicles and personnel, Danish ISAF forces in Afghanistan recommended that medical personnel should not display the distinctive emblem. In these extraordinary circumstances, it was considered that medical personnel and the wounded and sick were better protected by not displaying the distinctive emblem.[99]

To give effect to the protections afforded to medical facilities, transports and personnel, it is important for them to be identifiable. The distinctive emblem – a red cross, red crescent or red crystal on a white ground – plays this role.[100]

The emblem does not confer protection – that comes from IHL – but it assists belligerents to identify medical facilities, transports and personnel to facilitate compliance with their obligations towards them.

There is no *obligation* to use the emblem. People and objects are protected even if the emblem is not worn or displayed. At times, armed forces do not mark medical facilities, as this may disclose the position of camouflaged frontline units. More problematically, in certain recent conflicts armed forces and medical organizations have refrained from marking their facilities, vehicles and personnel as they feared that the emblem was attracting fire rather than discouraging it.

99 Defence Command Denmark (2020), *Military Manual on international law relevant to Danish armed forces in international operations*, p. 268.
100 This is one use of the distinctive emblem: 'protective use'. The use during armed conflicts as the visible sign of the specific protection granted to medical personnel and objects. A second use – 'indicative use' – is to identify people, equipment and activities affiliated with components of the International Red Cross and Red Crescent Movement without implying that they are entitled to specific protection.

Traditionally the emblem is displayed by physical markings: armlets, flags and markings on the sides and roofs of medical facilities and transports. In 1996 Annex I to AP I was amended to include light, radio and electronic identification signals. More recently, the ICRC launched an initiative to consider the technical feasibility of a digital emblem, to mark the digital infrastructure of medical facilities.[101]

5.1 Who/what is entitled to display the emblem?

Only the persons and objects entitled to *specific* protection under IHL are entitled to use the distinctive emblem: medical personnel, facilities and transports that meet the definitions in Additional Protocol I and that belong to or are recognized and authorized by a party to the conflict.[102] In addition, these persons and objects must also be authorized to use the emblem. This is a related but separate step, but it can occur at the same time as recognition and assignment. The same criteria apply in non-international armed conflicts.

The emblem must be used under the control of a competent authority.

5.2 Who authorizes use of the emblem?

This issue is not specifically addressed in IHL treaties. The ICRC *Study on the Use of the Emblems* recommends that for *military* facilities and personnel, responsibility to authorize the use of the emblem should be entrusted to a state military authority; while for *civilian* facilities and personnel, the responsible authority may be military or civilian.[103] Frequently these are, respectively, ministries of defence and of health.

In non-international armed conflicts, Article 12 AP II requires the distinctive emblem to be used 'under the direction of the competent authority concerned'. It is generally agreed that these are the authorities of the organized armed groups, which must play a similar role to states in authorizing and supervising the use of the emblem.[104]

There have been instances when medical facilities authorized by a state continued to use the emblem when organized armed groups gained control of the area where they were located, as when the Free Syrian Army held Aleppo in Syria.[105] But for this paper it was not possible to find examples of medical facilities, transports or personnel belonging to organized armed groups displaying the emblem, or of civilian facilities and personnel being authorized to do so by the competent authorities of the organized armed groups.

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101 https://www.icrc.org/en/article/icrc-digital-emblem-project.
102 Articles 39 GC I, 41 GC II, 18 GC IV, 18 AP I and 12 AP II.
103 International Committee of the Red Cross (2020), *ICRC Study on the Use of the Emblems: Operational and Commercial and Other Non-Operational Issues*, Geneva: ICRC, Question 6, https://www.icrc.org/en/publication/4057-study-use-emblems-operational-and-commercial-and-other-non-operational-issues.
104 Sandoz, Swinarski and Zimmermann (eds) (1987), *ICRC Commentary to the APs*, para. 4746; and *ICRC Study on the Use of the Emblems*, Question 6.
105 Contribution made during expert meeting hosted by Chatham House, October 2025.

5.3 Regulation and supervision of the use of the emblem

The use of the emblem must be regulated and supervised to avoid abuse. Abuse is understood as referring to improper use of the emblem, rather than unlawful conduct *against* facilities, objects and persons entitled to display the emblem.

States must adopt domestic measures to regulate the use of the emblem, including: defining which emblems are recognized and protected in that state; specifying the authorized users and uses; and identifying the national authorities entrusted with regulating and monitoring its use. Domestic measures must also be adopted for the prevention, suppression and punishment of misuse of the emblem, both in peacetime and during armed conflict.[106]

Measures that criminalize misuse can have a deterrent effect, but such legal proceedings address *past* violations. IHL also requires the use of the emblem to be supervised, including to prevent or put an end to abuse in real time during armed conflicts.

Use by the medical services of the armed forces is under the direction of the competent military authority.[107] Military authorities, and in practice the military commander, must exercise effective control to ensure the emblem is not used improperly. There have been instances when improper use has been sanctioned by the armed forces.[108]

Supervision of use of the emblem by civilian medical facilities, transports and personnel is not expressly addressed in IHL treaties. Guidance documents on the use of the emblem tend to focus on legal measures to respond to misuse of the emblem, but do not address practical measures to respond to misuse in real time.[109]

An expert consultation on the emblem convened by the International Red Cross and Red Crescent Movement in 2024 concluded that in most cases states have not identified with sufficient clarity which authority is responsible for authorizing use of the emblem and, equally importantly, for supervising its use in times of conflict.[110]

Since authorities of organized armed groups are entitled to authorize the use of the emblem, they also have a corresponding obligation to supervise its use.

Many states have adopted extensive domestic measures regulating the use of the emblem, and have expended considerable efforts in preventing improper use by unauthorized persons, such as pharmacies or businesses. Notably, however, the same attention has not been devoted to measures to prevent misuse of the

106 *ICRC Study on the Use of the Emblems*, Question 44.
107 Article 39 GC I.
108 Contribution made during expert meeting hosted by Chatham House, October 2025.
109 See, for example, International Committee of the Red Cross (2008), *National legislation on the use and protection of the emblem – Model law*, Article 8, https://www.icrc.org/en/document/national-legislation-use-and-protection-emblem-model-law.
110 International Committee of the Red Cross (2025), *Advancing Protection of Health Care: Expert Meeting on the Regulation and Perception of Distinctive Emblems and Other Signs and Symbols Used to Identify Health-care Facilities, Vehicles and Personnel, Oslo, 17–18 June 2024*, Geneva: ICRC, https://www.icrc.org/en/publication/advancing-protection-health-care-expert-meeting-regulation-and-perception-distinctive.

emblem during conflicts – a time when such misuse can put the facilities and the wounded and sick at risk. The consultations for the ICRC *Study on the Emblem* could not determine with clarity where responsibility for such supervision for civilian facilities lay, let alone find examples of the relevant government authorities actually intervening to end misuse.

As for other aspects of the rules of IHL protecting medical care, the rules on the emblem foresee a heightened protection, coupled with a responsibility to prevent and respond to misuse. Insufficient attention has been placed on this second aspect – even though improper use of the emblem undermines trust, genuine use and, ultimately, the protections afforded to the people and facilities that the emblem aims to protect.

5.4 Misuse of the emblem

Misuse of the distinctive emblem is prohibited.[111] This prohibition covers improper use and perfidious use.

The distinctive emblem may only be displayed by those authorized to do so, and to mark objects and persons entitled to specific protection. Improper use occurs when the emblem is used by persons, facilities or transports not authorized to do so, such as pharmacies or any commercial user. It also occurs when persons, facilities or transports that are entitled to display the emblem act or are used in a manner that leads to loss of their specific protection – for example, when vehicles displaying the emblem transport weapons, ammunition or able-bodied combatants.

Entitlement to specific protection is a condition for authorization to display the emblem. As discussed, the precise arrangements for granting of such authorization can vary. There may be instances when they expressly indicate that loss of specific protection automatically ends or suspends the entitlement to display the emblem. More frequently this is likely to be an implicit condition.

Loss of specific protection is often disputed. While displaying the emblem in such disputed circumstances can contribute to giving effect to the protections afforded to the wounded and sick, the party displaying it should act in good faith and cease using it if they are no longer entitled to do so. Respect for the emblem is based on trust, meaning that if the emblem is displayed after specific protection is lost, its value is undermined in the specific instance and in future.

Perfidious use of the emblem is a grave breach of Additional Protocol I when it has the purpose of killing, injuring or capturing an adversary and causes death or serious injury.[112] Use of facilities and objects displaying the emblem for 'defensive' purposes – such as hiding or moving weapons, military equipment or fighters – would not constitute perfidy.

111 Article 38 AP I.
112 Article 85(3) AP I. This expands the scope of perfidy in Article 37 AP I. References to perfidious or treacherous killing or injuring of the adversary in the ICC Statute include when this is done by using the distinctive emblem. Articles 8(2)(b)(xi) and 8(2)(e)(ix) ICC Statute.

Making improper use of 'the distinctive emblems of the Geneva Conventions' is a war crime in international armed conflicts under the Statute of the International Criminal Court (ICC), if that use results in death or serious personal injury.[113] The corresponding Elements of Crime clarify that the use of the emblem must have been for 'combatant purposes', i.e. 'purposes directly related to hostilities and not including medical, religious or similar activities'.[114]

5.5 Good practice

- Domestic measures regulating the use of the emblem should clearly indicate who the competent authorities are for authorizing and supervising its use in armed conflict.
- Actors with a particular role as regards the emblem should elaborate guidance setting out specific measures to be taken to supervise its use – with the aim of preventing and responding to misuse. This work should expand existing guidance and focus on concrete operational measures for immediate (i.e. real-time) response to allegations of abuse.
- Armed forces should elaborate regulations and guidance to prevent abuse of the emblem when it is displayed on military medical facilities, transports and personnel, as well as to supervise its use.
- Organized armed groups should elaborate and implement similar measures to all those outlined above.
- Civilian providers authorized to display the emblem should adopt internal regulations to prevent abuse and to supervise its use.
- If belligerents in a particular conflict agree on the involvement of a neutral body to address allegations of misuse of specific protections, this body could also play a role in putting an end to misuse of the emblem.

113 Article 8(2)(b)(vii) ICC Statute.
114 International Criminal Court (2013), *Elements of Crimes*, The Hague, International Criminal Court, p. 15, fn 42, https://www.icc-cpi.int/publications/core-legal-texts/elements-crimes.

06 Promoting compliance with the rules on medical care

A better shared understanding of the rules of IHL on medical care in armed conflict is an important foundation, but does not of itself translate into better protection. What is urgently needed is compliance.

Compliance with the rules of IHL concerned with medical care in armed conflict requires that belligerents and other actors take steps to respect – and ensure respect for –the law. Promoting compliance requires the adoption of measures to facilitate implementation of the law, and to prevent violations in the first place. It also requires measures of accountability if violations occur.

6.1 Prevention

6.1.1 States and organized armed groups

As far as prevention of violations is concerned, the preceding chapters have identified various measures that states can take, including, most notably, ensuring that the rules protecting medical care are integrated in military doctrine, policies, directives and operating procedures; and spelling out very clearly the prohibitions and the precautionary measures that must be taken when carrying out military

operations that can adversely impact the continuity of the provision of medical care. These measures should be elaborated in peacetime so that they can be disseminated and included in training programmes.

It is not just armed forces that have a role to play. Other ministries and departments also have specific responsibilities, in particular those that recognize and authorize medical facilities, assign medical personnel and supervise the use of the distinctive emblem. There must be clarity as to which ministries have this responsibility. They must adopt clear instructions indicating the measures that they expect to be taken by those operating the facilities and transports, and those overseeing medical personnel, to ensure their protected status is not abused.

Equally importantly – but apparently overlooked in practice – IHL assigns these authorities a key role in supervising the functioning of the facilities, and in intervening when third parties are abusing their protections. This role must be discharged.

The same holds true for the parts of government that are responsible for authorizing the use of the distinctive emblem. Their role in supervising its use in times of armed conflict, and in intervening in cases of alleged abuse, has also been overlooked in practice.

States have other responsibilities, too. For example, they should ensure that domestic law does not allow the punishment of those who provide medical assistance. This can be done by including safeguards in criminal law, including in counterterrorism measures, expressly excluding the provision of medical care from offences. When the adoption of exceptions in the law is not feasible, clear prosecutorial guidance to this effect should be issued and flowed down to those investigating alleged crimes.

Ideally, organized armed groups should adopt measures that have a similar effect.

6.1.2 Those operating medical establishments

Public authorities and organizations that operate medical establishments and transports should adopt internal policies and procedures that allow them to minimize the risk of abuse. They should also adopt procedures for reacting to misuse, should it occur.

6.1.3 The United Nations

The international community –in particular the UN system – has developed numerous tools and processes to promote compliance with IHL.

Despite the centrality of the protection of medical care to IHL, and its importance in assisting some of the most vulnerable in armed conflict, there are no dedicated work streams that focus on this topic. It is, however, considered in other mechanisms. In addition to the mechanisms mentioned below, a number of the fact-finding bodies established by the UN Human Rights Council have also addressed the protection of medical care.

6.1.3.1 Monitoring and Reporting Mechanism on children in armed conflict

Attacks on hospitals are one of the six grave violations monitored by the UN Monitoring and Reporting Mechanism on Grave Violations against Children in Situations of Armed Conflict. For monitoring and reporting purposes, this mechanism adopts a very broad definition of 'attacks' as acts that put at risk the integrity of hospitals and medical personnel, and children seeking medical care.[115]

The mechanism also foresees the listing, in the annual report of the secretary-general on children and armed conflict, of parties to a conflict that conduct recurrent attacks on hospitals, or recurrent attacks or threats 'against protected persons in relation to' hospitals.[116] Listed parties are required to develop and implement action plans, with the support of the UN, setting out concrete activities to stop and prevent future attacks on hospitals and protected persons. Since such action plans are confidential, it was not possible, when compiling this research paper, to determine whether they include measures to prevent attacks on hospitals; and, if so, what these are.

The Secretary General's 2025 report listed five states on this ground: Israel, Myanmar, Russia, Sudan and Syria. It also listed a number of armed groups: the Taliban and ISIL in Afghanistan, two groups in the Central African Republic (CAR), five in the Democratic Republic of the Congo (DRC), one in Haiti, and Al-Shabaab in Somalia.[117]

6.1.3.2 Security Council Resolution 2286 (2016)

In 2016 the Security Council unanimously adopted Resolution 2286, on the protection of the wounded and sick, and medical and humanitarian personnel. The resolution, co-sponsored by 84 states, was a strong reaffirmation of the rules protecting medical care in armed conflict.

The resolution is complemented by recommendations by the secretary-general on measures to prevent acts of violence against the wounded and sick, medical and humanitarian personnel, their transport and equipment, and health facilities; and to better ensure accountability and enhance their protection.[118]

Resolution 2286 requires the secretary-general to report annually on this issue. This has been done in the annual report on protection of civilians. While it is only possible to devote a limited section of that report to the topic, it is a valuable way of keeping it on the Security Council's agenda.

In Resolution 2286, the Security Council also expressed its intention to ensure that peace operations are mandated, 'where appropriate and on a case-by-case basis', to contribute to a secure environment to enable the delivery of medical assistance. To date, this has not happened.

115 Office of the Special Representative of the Secretary-General for Children and Armed Conflict (2014), *Protect schools + hospitals: Guidance note on Security Council Resolution 1998*, New York: United Nations, https://digitallibrary.un.org/record/4016099?v=pdf.
116 SCR 1998 (2011) OP 3.
117 United Nations Secretary-General (2025), *Children and armed conflict: Report of the Secretary-General*, A/79/878 S/2025/247, 17 June 2025, https://docs.un.org/en/S/2025/247.
118 United Nations Secretary-General (2016), 'Letter dated 18 August 2016 from the Secretary-General addressed to the President of the Security Council', S/2016/722, 18 August 2016, https://digitallibrary.un.org/record/839216?v=pdf.

6.1.3.3 Sanctions

Conducting attacks against hospitals is a basis for listing people and groups under the Security Council sanctions regimes in relation to Somalia, the DRC and South Sudan. CAR sanctions include the additional ground of attacks against medical personnel.[119]

Conduct violating the protections afforded to medical establishments and personnel is also implicitly covered in those sanctions regimes where violations of IHL more generally are a listing criterion: Sudan, Libya and Yemen.[120]

While sanctions can play a role in promoting compliance with IHL, consideration must also be given to their possible adverse impact on the continuity of provision of medical care. Sanctions should include safeguards authorizing otherwise prohibited conduct when this is necessary to conduct medical activities.

6.1.4 Geneva Call

The NGO Geneva Call works with organized armed groups to promote their compliance with IHL. One way it does this is by encouraging such groups to sign 'deeds of commitment' on specific aspects of IHL. These are public pledges by the groups to comply with key humanitarian norms.

In 2018 Geneva Call launched a deed of commitment for the protection of healthcare in armed conflict.[121] Five armed groups have signed this deed so far.

6.1.5 Data collection initiatives

In recent decades a number of initiatives have been launched to collect data on the impact of hostilities on the provision of medical care. They include the World Health Organization's (WHO) Surveillance System for Attacks on Health Care,[122] developed as part of the organization's Attacks on Health Care initiative;[123] and Insecurity Insight's programme of mapping and annual reporting.[124]

Both initiatives adopt very broad approaches as to what constitutes an 'attack'. For the Insecurity Insight system, for example, an attack is any act or threat of verbal or physical violence, or obstruction that interferes with the availability, access and delivery of curative or preventive health services carried out by an actor linked to the conflict.

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119 SCR 2293 (2016) OP 7 (e) (DRC); SCR 2521 (2020) OP 15(d) (South Sudan); and SCR 2399 (2018) OP 21(b) and SCR 2745 (2024) OP 5 (CAR).
120 SCR 1591 (2005) OP 3(c) (Sudan); SCR 2174 (2014) OP 4(a) and SCR 2213 (2015) OP 11(a) (Libya); and SCR 2140 (2014) OP 18(c) Yemen.
121 Geneva Call (2018), 'Deed of Commitment Under Geneva Call for the Protection of Health Care in Armed Conflict', https://www.genevacall.org/wp-content/uploads/2023/07/Official-DoC-Protecting-health-care-in-armed-conflict.pdf.
122 World Health Organization (2017), 'Surveillance System for Attacks on Health Care (SSA)', https://extranet.who.int/ssa/Index.aspx.
123 For further details of the initiative, see World Health Organization (2026), 'Stopping attacks on health care', https://www.who.int/activities/stopping-attacks-on-health-care.
124 Insecurity Insight (2022), 'Attacks on Health Care', https://insecurityinsight.org/projects/healthcare.

It is useful to have an idea of trends. But to address any problematic conduct, it must be identified accurately. The measures needed to prevent the recurrence of looting of medical supplies, for instance, are very different from those necessary to address disproportionate attacks or restrictions on the supply of medical goods and equipment.

6.1.6 Global Initiative to Galvanize Political Commitment to International Humanitarian Law

The protection of hospitals is one of the seven thematic workstreams in the Global Initiative to Galvanize Political Commitment to International Humanitarian Law, launched by the ICRC and six states (Brazil, China, France, Jordan, Kazakhstan and South Africa) in 2024.[125]

Under the initiative, states and experts will examine the main contours of the specific protection granted to hospitals under IHL, and address legal and operational challenges that threaten to undermine this protection. Recommendations from the consultations are due to be presented in late 2026.

6.2 Accountability

6.2.1 Criminal investigations

Violation of some of the rules specifically protecting medical establishments, transports and personnel are grave breaches and war crimes under the ICC Statute, including: directing attacks against hospitals and places where the sick and wounded are collected;[126] directing attacks against buildings, material, medical units and transports, and personnel using the distinctive emblems of the Geneva Conventions in conformity with international law;[127] making improper use of the distinctive emblems of the Geneva Conventions, resulting in death or serious personal injury;[128] and killing or wounding treacherously individuals belonging to the hostile nation or army.[129]

In addition, violations of the general rules regulating military operations, which include protection for medical establishments, transports and healthcare providers, constitute grave breaches and war crimes under the ICC Statute. These include: directing attacks against civilian objects;[130] launching an attack in the knowledge that it will cause incidental loss of life or injury to civilians or damage to civilian objects which would be clearly excessive in relation to the concrete and direct

125 International Committee of the Red Cross (2026), 'Global Initiative to Galvanize Political Commitment to International Humanitarian Law'; 'Humanity in war: A global initiative for humanitarian law', https://www.upholdhumanityinwar.org. As at mid-May 2026, 111 states had formally joined the initiative.
126 Articles 8(2)(b)(ix) and 8(2)(e)(iv) ICC Statute.
127 Articles 8(2)(b)(xxiv) and 8(2)(e)(ii) ICC Statute.
128 Article 8(2)(b)(vii) ICC Statute.
129 Articles 8(2)(b)(xi) and 8(2)(e)(ix) ICC Statute.
130 Article 8(2)(b)(ii) ICC Statute.

overall military advantage anticipated;[131] and destroying or seizing the enemy's property unless such destruction or seizure is imperatively demanded by the necessities of war.[132]

Despite such range of possible bases for prosecutions, and the apparent multitude of instances when the rules protecting medical care have been violated, there have been very few criminal investigations and prosecutions by domestic or international courts.

Attacks against hospitals were considered in two cases before the International Criminal Tribunal for the former Yugoslavia, but the court did not charge these as separate offences in either case.[133] So far, it is only the ICC trial chamber in *The Prosecutor v. Bosco Ntaganda* that has specifically addressed charges of conduct against medical facilities in any detail. The defendant was found guilty of pillage in relation to the looting of medicines and medical equipment from a hospital by soldiers; and for directing attacks against protected objects in relation to an attack against a healthcare facility.[134]

Several factors may have contributed to the paucity of case law. Among them are the challenges of investigating some of the violations, especially those relating to the conduct of hostilities. For example, determining whether a facility was directly targeted requires carrying out retrospective assessments of competing claims of whether the facility was used in a manner that led to loss of protection. In many instances, damage to medical facilities takes the form of incidental damage from attacks against military objectives, but the war crime of 'disproportionate attacks' is notoriously difficult to prosecute.

This does not explain the lack of investigation of violations of the absolute rules such as murder or ill treatment of healthcare providers, or looting of medical supplies, equipment and ambulances.

Domestic courts have not been more active. Two recent examples come from Ukraine: Ukrainian prosecutors are investigating a number of Russian attacks on medical facilities, including strikes against hospitals in Kherson and Kyiv.[135]

UN Security Council Resolution 2286 urged states to investigate violations of IHL relating to the protection of the wounded and sick, medical personnel and facilities. A decade on, medical care is simply not a priority area of investigation.

131 Article 8(2)(iv) ICC Statute.
132 Articles 8(2)(b)(xiii) and 8(e)(2)(e)(xii) ICC Statute.
133 International Criminal Tribunal for the former Yugoslavia (ICTY) *Prosecutor v. Dragomir Milosevic;* and ICTY *Prosecutor v. Stanislav Galić*.
134 International Criminal Court (2019), *The Prosecutor v. Bosco Ntaganda*, ICC-01/04-02/06, Judgment, 8 July 2019, https://www.icc-cpi.int/sites/default/files/CourtRecords/CR2019_03568.PDF.
135 Pustiva, V. (2023), 'Обстріл Херсона 24 грудня: російському командиру повідомлено про підозру' [Shelling of Kherson on 24 December : Russian commander informed of suspicion], Korrespondent.net, 18 May 2023, https://ua.korrespondent.net/ukraine/4590433-obstril-khersona-24-hrudnia-rosiiskomu-komandyru-povidomleno-pro-pidozru; Office of the Prosecutor General (2024), 'Повідомлення про підозру та повістки про виклик Кобилаша С.І. на 16.09.2024, 17.09.2024, 18.09.2024' [Notice of suspicion and summons to summon Kobylash S. I. on 16.09.2024, 17.09.2024, 18.09.2024], 10 September 2024, https://www.gp.gov.ua/ua/posts/povidomlennya-pro-pidozru-ta-povistki-pro-viklik-kobilasa-si-na-16092024-17092024-18092024-ukrayinskoyu-ta-pereklad-rosiiskoyu.

6.2.2 Administrative investigations

One key aspect of accountability that is frequently overlooked is armed forces' investigations of particular incidents or of systemic issues.[136] Investigations of possible violations of IHL are critical for the proper application of the law, and for discharging the obligation to ensure respect for IHL. While they will not inevitably lead to individual accountability, investigations can identify shortcomings in existing military policies and procedures, and should lead to their improvement.

A case in point is the US Department of Defense's investigation of the 2015 attack on an MSF hospital in Khunduz, Afghanistan, in which 42 MSF staff and patients were killed. This led the department to revise its targeting standard operating procedures,and to adopt administrative sanctions against some of the personnel involved in the attack.[137]

Administrative investigations can also lead to criminal investigations. At the time of writing, however, there have been no recent instances when such investigations have led to prosecutions for incidents relating to medical facilities or transports.

6.3 Humanitarian arrangements to facilitate the provision of medical care

In addition to measures to promote compliance with the law, practical arrangements can play an important role in facilitating the provision of medical care. These include mechanisms for notifying belligerents of the location of medical facilities and movements of transports; and arrangements like temporary cessations of hostilities and the establishment of humanitarian corridors. These can allow patients, healthcare personnel and medical supplies and equipment to reach medical establishments, and medical transports to operate. Evacuations can facilitate the movement of the wounded and sick from areas of active hostilities. More ambitiously, belligerents could agree the establishment of hospital zones.

These arrangements can enhance the security of the wounded and sick, facilitate their access to medical care and the functioning of medical facilities. With the notable exception of 'days of tranquillity' – i.e. temporary suspensions of hostilities to undertake specific tasks, frequently vaccinations – such arrangements have been established on very few occasions. For them to operate in a manner that is safe for the intended beneficiaries, the arrangements must be established by agreement between the warring parties. Reaching agreement has proved extremely difficult. As is the case for other issues addressed in this paper, an intermediary

136 Lubell, N., Pejic, J. and Simmons, C. (2019), *Guidelines on Investigating Violations of International Humanitarian Law: Law, Policy, and Good Practice*, Geneva Academy of International Humanitarian Law and Human Rights, and International Committee of the Red Cross (ICRC), https://www.icrc.org/sites/default/files/document/file_list/guidelines_on_investigating_violations_of_ihl_final.pdf.
137 US Department of Defense (2016), 'Department of Defense Press Briefing by Army General Joseph Votel, commander, U.S. Central Command', transcript, 29 April 2016, https://www.war.gov/News/Transcripts/Transcript/Article/746686/department-of-defense-press-briefing-by-army-general-joseph-votel-commander-us; Bouchet-Saulnier, F. and Whittall, J. (2018), 'An environment conducive to mistakes? Lessons learnt from the attack on the Médecins Sans Frontières hospital in Kunduz, Afghanistan', *International Review of the Red Cross*, 100(907-909), pp. 337–72, https://doi.org/10.1017/S1816383118000619.

can play a key role in facilitating agreement, but in most recent conflicts it has been impossible to find a party that is willing to assume this function and that is acceptable to all belligerents.[138]

6.4 Good practice

- Initiatives to track the adverse impact of military operations on medical care should identify the nature of the conduct in a specific manner, rather than referring to all conduct as 'attacks'.
- In setting the mandate of peace operations, the UN Security Council should incorporate contributing to a secure environment to enable the delivery of medical assistance, as called for in Resolution 2286.[139] The Department of Peace Operations should elaborate policies and practices for this aspect of peace operations.
- Armed forces should adopt minimum standards for the conduct of effective and independent investigations; and should conduct internal investigations following specific incidents when military operations have serious consequences on the capacity of medical facilities to operate, or where their impact on the continuity of medical care appears to be a systemic problem. The outcome of such investigations should indicate whether relevant doctrines and procedures must be amended.
- Armed forces should ensure their doctrines and procedures address the forces' roles in agreeing and implementing humanitarian arrangements for the benefit of the wounded and sick.
- Organized armed groups should elaborate and implement similar measures to the those outlined in the two preceding points.

138 See Gillard (2024), *Enhancing the security of civilians in conflict*.
139 SCR 2286 (2016) OP 10.

07 Conclusions

‘IHL is not enough – effective protection requires active engagement.’[140]

In the decade since the adoption of UN Security Council Resolution 2286, increased awareness of the impact of conflict on medical care has not equated with better protection on the ground. Shedding light on the extent of the problem is important, as is the expression of a political commitment to address it, but solutions lie in adopting and following practical measures to give effect to existing protections.

The preceding chapters have identified a number of concrete measures that can be taken by states, organized armed groups and other actors to promote compliance with the rules. It has to be recognized that armies and armed groups with no wish to comply with IHL will not be persuaded to take any such measures. Nevertheless, this chapter sets out five overarching conclusions.

7.1 Military doctrine to minimize impact on medical care

Some states are elaborating instruments to minimize civilian harm across all their military operations. Some are also preparing for war-fighting readiness, including adopting measures for complying with IHL in the event of armed conflict, bearing in mind that conflict may occur on their own territory as well as abroad.

As they do this, a key step to minimize the impact of military operations on continuity of, and access to, medical care is developing doctrine, policies and directives that identify in a granular way how healthcare systems can be impacted by military operations, and specific measures that can be taken to reduce this impact.

Central to this is a robust understanding of the ‘civilian environment’ in which operations will be conducted. In terms of medical care this includes:

140 Médecins Sans Frontières (2026), *Medical Care in the Crosshairs*, p. 14.

- Mapping the locations of medical facilities and assessing their capacity for the provision of medical care in the expected area of operations and in the immediate vicinity.
- Elaborating 'no strike' lists for medical facilities, and requiring heightened care for objects that provide essential services on which they depend.
- Determining the proximity of medical facilities to military objectives.
- Assessing the potential indirect impact on medical care of military operations – such as the disruption of essential utilities and access for patients caused by the interruption in the supply of electricity and water, or obstruction of supply routes.

The operational environment should be assessed both prior to, and at regular intervals during, operations.

Measures for minimizing the negative impact of military operations on civilian medical care include:

- Developing contingency plans to address the foreseeable disruption to the provision of civilian healthcare services, and to restore full service as soon as possible;
- Facilitating and/or implementing measures to restore healthcare services (medical support for facilities, engineering support for repair, etc.) after military operations.

Military medical personnel should be involved in the elaboration of these measures. And the measures should be refined for each theatre of operations, ideally on the basis of engagement with the civilian medical actors present.

7.2 Continuous communication and coordination

IHL's system of protection of medical care is to a great extent based on trust, but this trust has been eroded. Key to returning to a situation of respect during active hostilities is an effective channel of communication between belligerents and those operating medical facilities. But this is missing in most situations.

Representatives of medical organizations and of armed forces who participated in the consultations for this paper agreed that a key measure in ensuring continuity of medical care in armed conflict is the efficacy of channels of communication between belligerents and civilian healthcare providers.

In peacetime, engagement between states and representatives of medical organizations facilitates the elaboration of harm mitigation measures based on an accurate understanding of the civilian environment. It also enhances mutual understanding and, in turn, trust. Conducting joint exercises and training programmes in peacetime can play an important role in this regard.

Such civil–military coordination is essential in times of armed conflict. As discussed in preceding chapters, it allows agreement on procedures to minimize the impact of military operations on continuity of healthcare, and to address allegations of abuse.

Despite its evident value, in many contexts such engagement does not exist. While states engage with international medical organizations to authorize the latter's operations, this is often the extent of the contact. Most frequently, this occurs in state capitals at health ministry level. Channels of engagement are also necessary with military and security forces at all levels – central, regional and local.

Engagement is also necessary with organized armed groups. Yet, in many contexts it is this very engagement with such armed groups that has led states to punish healthcare providers.

Coordination with their military and civilian counterparts must be enshrined in the doctrines and policies of armed forces and healthcare providers.

7.3 Coherence across legal regimes

Realization of the protections of medical care in IHL can be undermined by restrictions in other bodies of law. This is particularly the case for domestic counterterrorism measures, frequently applied by states parties to non-international armed conflicts. These include broad prohibitions on the provision of any type of support to groups considered terrorist, and are frequently used to limit the operations of medical organizations.

The same concerted engagement between humanitarian actors and states that led to the inclusion of safeguards for humanitarian action in most sanctions regimes must now shift to criminal counterterrorism measures. Importantly, safeguards must expressly refer to medical care, which is not synonymous with humanitarian action.

7.4 Reinvigorating the supervisory measures foreseen by IHL

Until the adoption of Additional Protocol I, the protection afforded by IHL treaties to civilian objects was limited. In view of this, the extension of the specific protections initially granted to *military* medical facilities, transports and personnel to their civilian equivalents was significant. This protection was granted only to facilities and people under a degree of state control. The authorities overseeing them were responsible for supervising their operations, for preventing abuse of the protected status, and for putting instances of abuse to an end. The system of supervision generated trust in the system.

Additional Protocol I unintentionally changed these dynamics. The rules regulating the conduct of hostilities offered significant protection to *all* civilian objects, without a corresponding system of supervision. The extension of protection

to civilian medical facilities, transports and personnel is of course positive, but it diminished the incentive to adopt the control mechanisms that were the condition for entitlement to the specific protection of medical facilities.

The important system of authorization and supervision of medical facilities has been overlooked as a matter of law, and has fallen into disuse in practice. This is unfortunate. Many of the challenges faced by the organizations operating medical facilities relate to allegations of misuse. A system that contributes to preventing misuse, and that plays a role in mediating allegations of misuse, remains extremely valuable in upholding the system of trust that is essential to the functioning of the rules. While recognizing that at times the very actor that should be exercising this supervision is in fact the actor misusing the facilities, efforts should be made to revive this aspect of the rules, including in the preparedness measures currently being developed by some states.

7.5 Violations must have consequences

The entitlement to receive medical care in armed conflict is a cardinal principle of IHL. There is no gap in the rules protecting the wounded and sick, medical facilities and transports, and their violation constitutes war crimes. Yet there have been no consequences for even the most flagrant violations. In the past two decades, investigations by international and domestic tribunals can be counted on the fingers of one hand.

This disconnect between the letter of the law, the rhetoric condemning violations, and the reality of lack of accountability is unacceptable. Conduct impacting medical facilities and personnel is not intrinsically more difficult to investigate than other acts.

There is no reason why domestic and international tribunals are overlooking the range of offences that can deprive entire communities of life-saving services. Violations must have consequences for the perpetrators, not just the most vulnerable.

7.6 Final words

In recent times, it has often been asserted that the rules-based international order is a thing of the past. It has to be recognized, of course, that for civilians in many countries the current shift in the international order is not significant: they have suffered under the threat or actuality of unlawful and protracted armed conflict all their lives.

Is IHL immune from the change in the international order? It can surely be said that no model of a future world order is conceivable without fundamental humanitarian rules and principles protecting the most vulnerable in armed conflict. In the current global instability and the continuation of multiple armed conflicts, the rules of IHL are more important than ever.

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