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Ne tirez pas sur l'ambulance : Protégez la mission médicale

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AMBULANCE

PRÉFACE

Alain Berset, Président de la Confédération, chef du Département fédéral de l'intérieur DFI

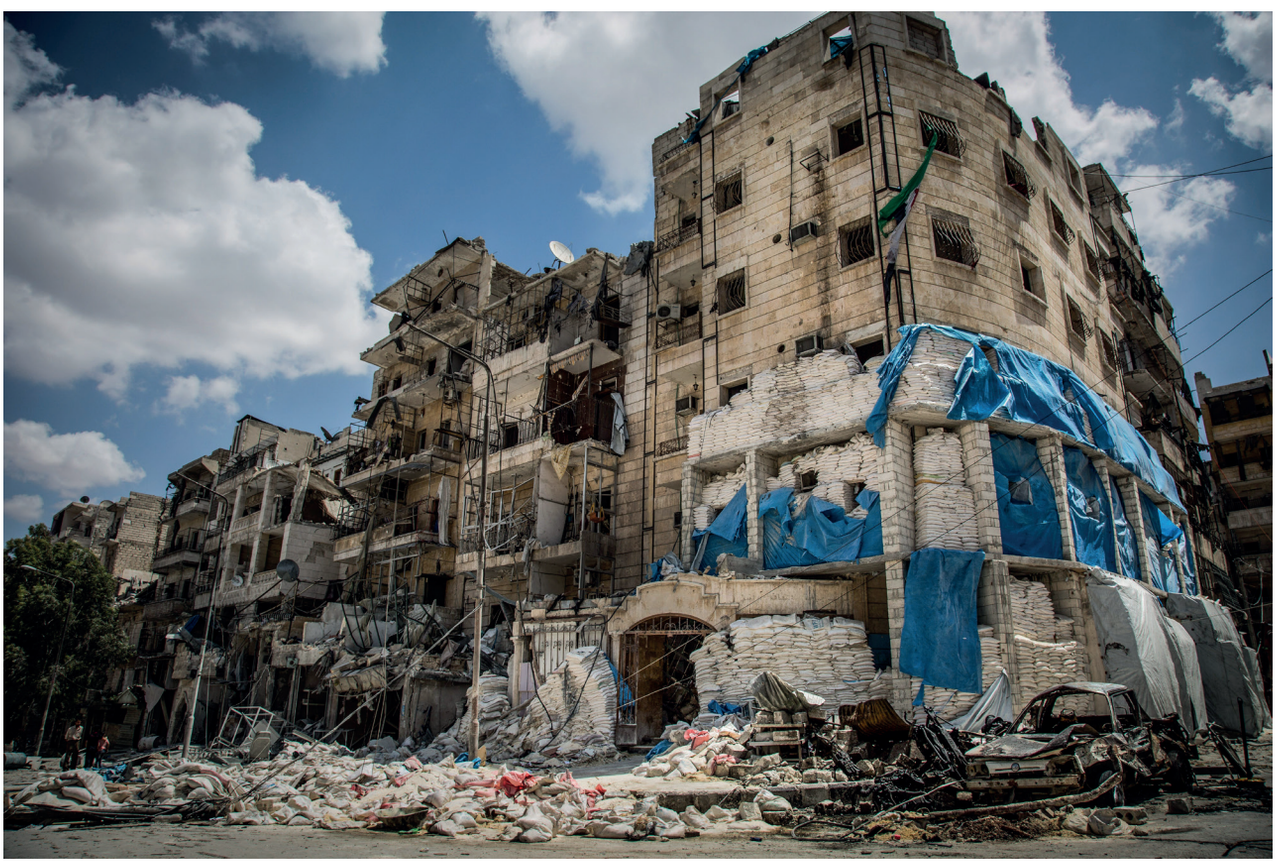
Cette édition de Politorbis est consacrée à un phénomène d'une gravité extrême. Ces dernières années, les attaques contre les missions médicales se sont multipliées. La violence contre le personnel médical et contre les structures sanitaires est intolérable. Tout doit être entrepris pour protéger la mission médicale.

Des normes internationales contraignantes existent et elles s'appliquent à toutes les parties à un conflit armé. Le droit international humanitaire établit des règles protégeant les malades et les blessés en temps de conflit armé. Quant aux droits de l'homme, ils prévoient une protection des soins de santé en tout temps, y compris dans les situations de crise et de troubles internes. Toute violence à l'encontre des missions médicales est donc prohibée par le droit international. Pourtant, ces normes sont régulièrement bafouées et les auteurs de violations impunis.

Face à l'ampleur des crises actuelles, la Suisse s'est engagée pour défendre et renforcer la protection des missions médicales. Elle agit sur le terrain et sur la scène internationale. Elle a ainsi créé et co-préside avec le Canada un groupe informel d'Etats qui se consacrent au suivi et à la mise en œuvre de la résolution 2286 à Genève. Elle soutient aussi financièrement le projet « Attacks on Health Care » mis en œuvre par l'OMS dans le cadre de son Programme de gestion des situations d'urgence sanitaire. Ce projet vise à collecter les données sur les attaques au plan mondial et à en analyser l'impact. La Suisse s'engage également pour que le droit soit respecté par toutes les parties impliquées dans des conflits armés, y compris par les groupes armés, et pour que les violations ne restent pas impunies.

Si la paix ne peut être assurée dans nombre de régions, nous nous devons pour le moins de respecter nos valeurs et principes humanitaires en accordant une protection au personnel de santé qui apporte secours et soins aux victimes de conflits. Avec le concours de tous les leviers et instruments dont elle dispose, la Suisse participe à cet effort qui s'inscrit dans la tradition de son engagement pour le respect du droit international humanitaire et des droits de l'homme.

Les contributions de cette édition de Politorbis nous aident à saisir l'ampleur du problème et à approfondir notre réflexion. Il nous incombe à tous de faire en sorte que nous ne cédions pas à l'indifférence face aux actes de violence à l'encontre des missions médicales.



East Aleppo
PHOTO: ALMASRI Karam

INTRODUCTION

Manuel Bessler[1]

Hôpitaux bombardés délibérément, convois de secours pris pour cible, civils fuyant les zones de guerre dans le viseur de combattants, personnel soignant et patients persécutés. Face à la brutalité croissante des conflits armés, le respect du droit international humanitaire est plus important que jamais. Les conflits modernes vont-ils anéantir certaines des valeurs universelles comme la protection des blessés et des malades lors de conflits armés? Comment protéger les patients, le personnel médical et les hôpitaux aujourd'hui ? C'est le type de questions très actuelles qui sont abordées dans ce numéro de Politorbis.

Quand j'étais jeune délégué au CICR, au début de ma carrière, la protection de l'emblème de la Croix-Rouge et du Croissant-Rouge ainsi que des structures sanitaires en général, était une donnée bien établie et universellement reconnue. Basée sur les Conventions de Genève, cette protection était acceptée et il semblait peu envisageable de remettre ces acquis humanitaires fondamentaux en question.

Les violations du droit international humanitaire (DIH) commises par des armées officielles ainsi que par des groupes armés non étatiques sont devenues récurrentes dans de nombreux pays, comme en Syrie, au Yémen, en Lybie, en République Centrafricaine, en Irak, au Pakistan, en Palestine, en Ukraine, au Soudan du Sud et au Soudan, pour ne citer que quelques pays concernés.

Jusqu'il y a peu, hôpitaux et écoles pouvaient légitimement être considérés comme des lieux suffisamment sûrs, y compris dans un contexte de conflit armé; aujourd'hui, ce sont des cibles. De même, les organisations humanitaires se trouvent confrontées à des obstacles et risques aggravés lorsqu'elles veulent établir un accès rapide et sans entraves aux populations dans le besoin. Les conséquences de ce climat d'insécurité sont graves: l'action humanitaire souvent ne va pas à ceux qui sont les plus nécessiteux, les plus vulnérables; nous nous trouvons contraints de la déployer là où elle reste possible sans mettre immédiatement en péril la vie et l'intégrité physique de nos équipes.

CICR, OMS, MSF, Handicap International : entre constat et révolte

Le CICR est directement concerné par ce thème, non seulement à cause de sa mission de servir les populations civiles et les personnes hors de combat en temps de conflits armés et à cause de la vie de ses collaborateurs mise en danger sur le terrain, mais aussi en vertu de son rôle de gardien du DIH. La dégradation de la protection médicale est principalement due au fait que les conflits se prolongent et que les hostilités se déroulent généralement dans des environnements urbains où la population civile et les infrastructures civiles deviennent des cibles de plus en plus fréquemment. La prolifération et la fragmentation d'acteurs armés ainsi que l'explosion du nombre de déplacés à l'intérieur de leur pays et à travers des frontières, compliquent encore la donne.

En 2008, le CICR a commandité une étude sur la violence contre les installations de santé dans 16 pays. Les résultats ont révélé une situation grave et encouragé le CICR à s'engager dans une lutte déterminée en faveur de la protection de la mission médicale. Sur la base d'innombrables ateliers et autres conférences, le CICR a lancé son initiative « Health Care In Danger » (HCID) en 2011[2]. Consolidé par de vastes consultations, le CICR a élaboré un document qui recense pas moins de 150 recommandations.

Le CICR est donc devenu un acteur incontournable qui joue un rôle central sur cette question. Il engage des moyens considérables à cet effet et fédère un nombre impressionnant d'acteurs concernés par cette problématique, y compris des militaires et des groupes armés non-étatiques. L'engagement résolu de l'institution et de son président qui sillonne le monde inlassablement et encourage ses équipes sur les terrains les plus dangereux est à la hauteur de l'enjeu : garantir la protection de la mission médicale.

L'OMS est également un acteur incontournable, notamment de par son mandat très spécifique. Avant l'implication de l'OMS sur cette question, il n'existait pas une base de données fiable et complète recensant les attaques sur la mission médicale. Le CICR et MSF, tout comme d'autres, collectent certes des données sur la question, mais essentiellement sur les attaques les impactant directement. La fameuse

1 Délégué du Conseil fédéral à l'aide humanitaire, Chef du Corps suisse d'aide humanitaire et Vice-Directeur de la Direction du développement et de la coopération (DDC)

2 ICRC, Health Care in Danger: A Sixteen Country Study, Geneva, 2011

Ecole de santé publique de l'Université de John Hopkins à Baltimore s'est par exemple aussi lancée dans cet exercice en 2017[3]. Des tentatives régionales ont vu le jour, comme l'ONG Union of Medical Care and Relief Organisation qui fait ce travail de recensement pour son propre compte en Syrie[4].

L'organisation la mieux placée pour procéder à cet exercice complexe de manière systématique est sans conteste l'OMS. Soutenue par plusieurs pays, l'OMS a lancé un projet nommé "Attacks on Health Care", que l'Aide humanitaire de la Suisse cofinance. Le Dr. Rudi Coninx, Chef a.i. de l'Humanitarian policy and Guidance à l'OMS dirige ce travail et en présente ici le cadre et les objectifs principaux.

En tant que responsable des questions de sécurité chez MSF, François Delfosse est bien placé pour parler de la protection de la question médicale, d'autant qu'il a été le témoin direct de graves attaques d'infrastructures sanitaires de MSF dans divers pays. L'attaque très médiatisée de l'hôpital de Kunduz par l'armée américaine en Afghanistan en octobre 2014 a marqué un tournant dans la prise en compte de ce phénomène au plan mondial. 42 personnes ont été tuées à cette occasion, dont 14 collaborateurs de MSF. A la suite de l'enlèvement de 5 de ses expatriés en Syrie en 2014, MSF s'est retiré des zones contrôlées par le groupe Etat Islamique (EI). Ces événements ont conduit MSF à revoir ses modalités d'intervention en profondeur. La sécurité a encore accru son importance et une stratégie de « déconfliction » définie comme un processus de négociation avec tous les opérateurs armés visant à éviter les interférences mutuelles, à prévenir les incidents en assurant le respect de l'espace médical et humanitaire par tous les acteurs concernés, y compris ceux désignés comme « terroristes » si nécessaire, est désormais appliquée lors de chaque intervention.

MSF est un opinion-leader qui jouit d'un large soutien dans la société civile et qui joue un rôle de premier plan dans la prise de conscience de l'opinion publique internationale sur la protection de la mission médicale comme sur d'autres thèmes. On se souvient de l'opération spectaculaire où l'hôpital de Genève était illuminé pour illustrer à quoi ressemble un hôpital bombardé et en feu. MSF a aussi réalisé un film de réalité virtuelle utilisé comme outil de plaidoyer destiné à sensibiliser les spectateurs à l'ignominie que représente l'attaque d'un hôpital. L'effet est saisissant.

MSF est ainsi devenu un acteur incontournable quand la protection médicale est évoquée au niveau international et participe à toutes les réunions consacrées à ce thème au même titre que les Etats. Comme l'article très documenté de François Delfosse l'illustre pleinement, MSF poursuit dans sa voie pionnière et militante.

Dans un vibrant plaidoyer dénonçant l'utilisation des armes explosives contre les populations civiles dans le conflit syrien, la responsable de Handicap International Suisse montre les ravages souvent irréversibles causés par ce type de bombes. L'intérêt de ce cri du cœur tient surtout au fait que les données rapportées sont le résultat d'une étude très fouillée qui vient de paraître et qui dépeint les conséquences de la destruction des hôpitaux et autres infrastructures en reproduisant des témoignages particulièrement saisissants. Elle constitue l'analyse la plus approfondie et la plus documentée menée à ce jour sur les destructions qu'a connu ce pays ravagé par la guerre.

La Suisse s'engage

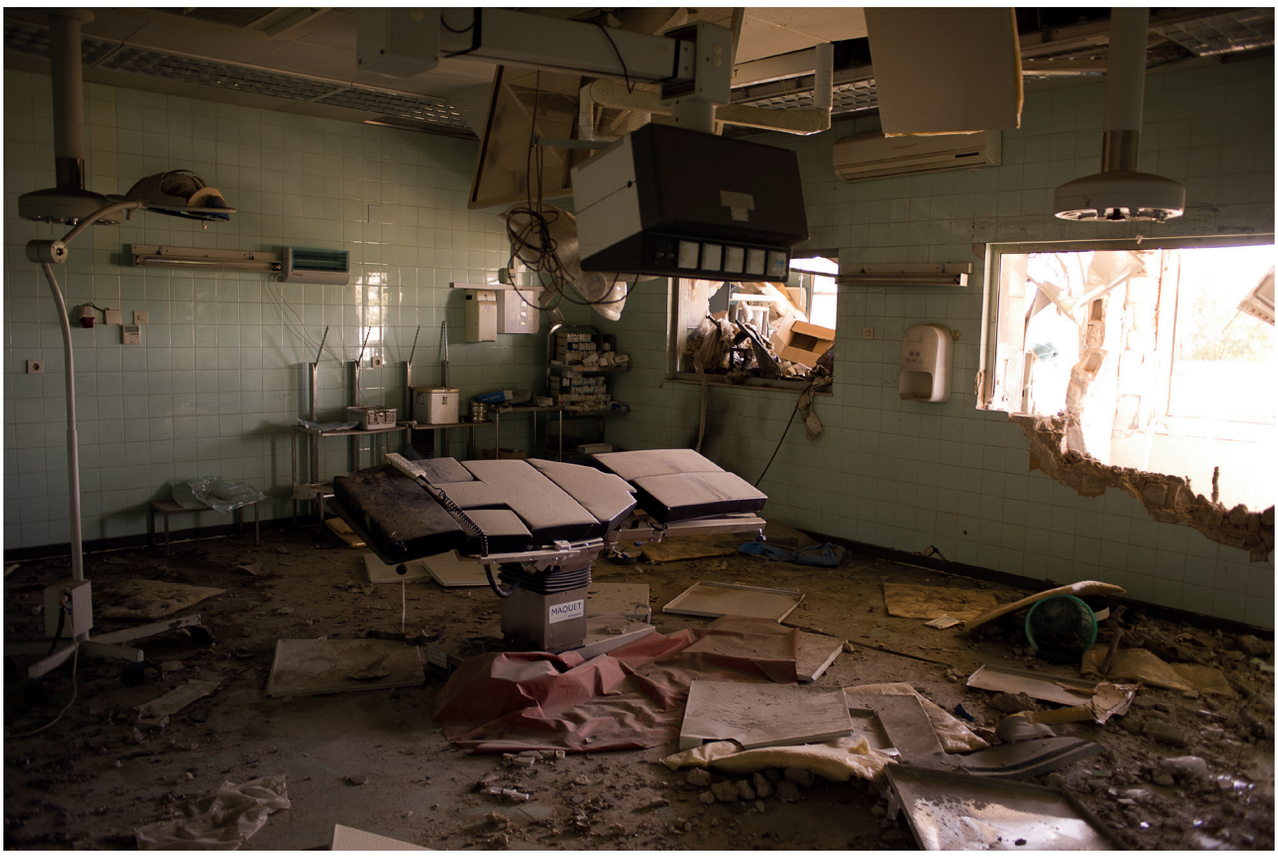
L'article d'Oliver Hoehne montre comment la Mission de la Suisse auprès des organisations internationales à Genève a joué un rôle décisif dans l'avancement de la cause de la protection de la mission médicale. La Mission Suisse à Genève a multiplié les initiatives, les débats, les ateliers et autres rencontres formelles et informelles qui ont contribué à créer un climat favorable à la promotion de la mise en œuvre de la Résolution 2286 du Conseil de Sécurité.

C'est à juste titre que l'article relève l'importance de l'existence d'un « hub humanitaire » très dense à Genève, sur lequel la Mission de la Suisse à Genève s'est largement appuyé pour enraciner son action et faire aboutir ses initiatives, en collaboration avec la Mission du Canada et d'autres missions permanentes.

Même si le vote unanime des Nations Unies en 2016 en faveur de la Résolution 2286 est considéré par les

3 John Hopkins, Impunity Must end: Attacks on health in 23 countries in Conflict in 2016, Baltimore, MD, 2016

4 L'ONG « Union of Medical Care and Relief Organizations » (UMCRO) publie un document intitulé Syria Monthly Hospitals Report qui fait le décompte des informations disponibles chaque mois sur les attaques des missions médicales en Syrie.



Lybia, Sirte, Ibn Sina Hospital. The hospital came under fire and most of the buildings attached to it were destroyed. The main operating room and most of the windows were also destroyed
Photo: GRECO, Annibale

observateurs comme un succès majeur du multilatéralisme, il n'a pourtant pas été suivi d'effet notable sur le terrain. Cela a été relevé par les participants au Side-Event que j'ai dirigé au Palais des Nations à Genève dans le cadre du segment humanitaire du Conseil économique et social (ECOSOC) au mois de juin 2017.

Entre droit et morale

C'est avec raison qu'une large section de ce numéro de Politorbis est consacrée aux questions juridiques liées à la protection de la mission médicale. La contribution captivante de Jonathan Cuénoud montre les enjeux qui sous-tendent les débats juridiques actuels concernant la protection de la mission médicale. J. Cuénoud commence par rappeler qui et quoi bénéficient de la protection octroyée par le DIH (les personnes hors de combat, soit les civils, les blessés et malades, les prisonniers, le personnel sanitaire, ainsi que les biens et objets civils et sanitaires) et il précise que les dispositions relatives à la mission médicale sont aujourd'hui largement reconnues comme des règles coutumières. Elles s'imposent donc, dit-il, « à toutes les parties en conflits, qu'ils soient internationaux ou non-internationaux ainsi qu'aux Etats qui ne seraient pas parties aux traités pertinents ». Ensuite, J. Cuénoud traite des difficultés d'interprétation liées à la perte de protection spécifique de la mission médicale et à la notion d' «actes nuisibles à l'ennemi » qui n'est pas clairement définie en DIH.

Il aborde également le rôle complémentaire joué par les droits de l'homme et affirme que les règles de protection octroyées par le DIH sont en quelque sorte au service du droit international des droits de l'homme et plus particulièrement du droit à la santé et du droit à la vie dont jouit toute personne.

Dustin A. Lewis, Naz K. Modirzadeh et Gabriella Blum de la Harvard Law School examinent cette problématique dans leur ouvrage Medical Care in Armed Conflicts : International Humanitarian Law and State Responses to Terrorism paru en septembre 2015[5]. Le texte reproduit ici est un résumé de cette

5 Disponible sur SSRN: https://ssrn.com/abstract=2657036

recherche soutenue par le DFAE (Division Sécurité humaine de la Direction politique). Les auteurs affirment que l'amalgame qui est parfois fait entre le DIH et le cadre juridique applicable à la lutte contre le terrorisme peut avoir des répercussions négatives sur la protection de la mission médicale. En réprimant par exemple des médecins qui soignent des personnes listées comme terroristes, les Etats enfreignent le DIH.

Daniel Messelken poursuit ses recherches sur les questions d'éthique militaire depuis de nombreuses années au centre d'éthique de l'Université de Zürich qu'il dirige. Il montre dans son article la situation ambigüe dans laquelle se trouve un médecin militaire loyal envers sa hiérarchie et tenu aussi à respecter les impératifs d'assistance médicale neutre envers tous ceux qui nécessitent des soins. C'est la question éthique qui est posée et qu'il est difficile pour un individu de résoudre aisément dans les situations de conflit de rôle auxquelles il est confronté, comme il le montre à l'aide de nombreux exemples. La réflexion sur les dilemmes éthiques qui est entamée ici doit être approfondie et intégrée dans la pratique, car les militaires sont évidemment au cœur des conflits et de leur gestion, et partant, de la protection de la mission médicale. Ils ont un rôle à jouer dont le contenu reste encore largement à définir.

Pour conclure, je voudrais remercier tous ceux qui ont prêté leur concours à la réalisation de ce numéro de Politorbis, tous les auteurs, mais aussi la division Afrique de l'Aide humanitaire de la Suisse et particulièrement Pierre Maurer qui en a eu l'idée et qui en a assuré la réalisation.

Part 1: **Protection de la mission médicale : entre constat et révolte**

The ICRC at the heart of the Medical Protection

Peter Maurer[1]

"To help, without asking whom".
Henry Dunant

The protection of the medical mission, a matter of life or death

3 August 2017, Gambo, Central African Republic. Around 50 people flock to the local health center seeking refuge. The security situation in the area has deteriorated greatly and fearing for their safety, women, men and children gather in what they believe is a sanctuary for life. They find death instead. Armed men enter the health center shooting indiscriminately at them. Around 50 people, including medical personnel, along with six Red Cross volunteers are killed. Sadly, this is not a one-off type of event.

Similar tragedies are taking place in many other parts of the world, and not only in countries ravaged by armed conflict. Incidents of violence against health care are consistently documented[2] in Afghanistan, Central African Republic, Iraq, the Occupied Palestinian Territories, South Sudan, Syria, Yemen but also in El Salvador, Pakistan and Nigeria, just to name a few. This violence can take many forms, some more visible such as the bombing of hospitals, other less visible but equally serious in their humanitarian consequences, such as threats and attacks directed against medical personnel, or the holding up of ambulances at check-points.

The ICRC gathered information on incidents of violence against health-care providers in 11 countries affected by conflict between January 2012 and December 2014; with our data showing that national health-care providers were by far the most affected[3]. The data indicated the wide extent of the problem and the serious challenges that this violence poses to the local health system. In a country like Afghanistan, where in 2014 there were on average three physicians per 10'000 inhabitants (for example, compared to 41 physicians in Switzerland[4]), the loss of a skilled health care professional will be acutely felt. Most of these incidents don't make the headlines, but their contribution to the erosion of national health systems, and in many cases to their collapse, is significant.

Yemen is a tragic example of a country where the health system has suffered enormously from the conflict, including from direct attacks and severe restrictions placed on access to health care. Between March 2015, when the civil war in Yemen intensified, until March 2017, the ICRC gathered more than 160 cases of violent incidents against health care. At the time of writing, only 45% of the country's already fragile health infrastructure is functioning partly as a result of this violence, as well as the restrictions on the imports of fuel and other essential goods such as medical supplies.

At the end of 2015, the ICRC had sounded the alarm bell that less than 30% of medicines and medical provisions were entering the country. This shortage caused the price of medicine to skyrocket, beyond the reach of average citizens. In the worst affected areas, doctors were unable to save the lives of their patients due to the absence of critical drugs and vital equipment. The UN estimates that on average 20 people were dying every day from treatable wounds and curable illnesses. Then the cholera crisis arrived. I visited Yemen in July 2017, at perhaps the peak of the outbreak, and saw the impact that this preventable disease is having on the lives of so many; and

1 Peter Maurer is ICRC President

2 See for example, ICRC, Health Care in Danger: Violent Incidents Affecting the Delivery of Health Care, January 2012 to December 2014, available at https://www.icrc.org/en/download/file/6417/health_care_in_danger_-_violent_incident_reports.pdf ; World Health Organisation (WHO), Attacks on Health Care, available at: http://www.who.int/entity/hac/techguidance/attacksreport.pdf?ua=1, as well as Dashboard on January-March 2017 incidents, available at: http://www.who.int/entity/emergencies/attacks-on-health-care/attacks_dashboard_2017_Q1_updated-June2017.pdf?ua=1; Safeguarding Health in Conflict coalition, No protection, no respect. Health workers and health facilities under attack 2015 and early 2016, available at http://reliefweb.int/sites/reliefweb.int/files/resources/SHCC2016final.pdf; Watchlist on children and armed conflict, Every Day Things are Getting Worse. The Impact on Children of Attacks on Health Care in Yemen, available at http://watchlist.org/publications/every-day-things-getting-worse-impact-children-attacks-health-care-yemen/

3 ICRC, Health Care in Danger: Violent Incidents Affecting the Delivery of Health Care, January 2012 to December 2014. See above note 2

4 Global health workforce statistics are available through the WHO Global Health Observatory at: http://apps.who.int/gho/data/node.main.HWF?lang=en&showonly=HWF

how the destruction of essential social infrastructure, like water and sanitation services, creates breeding grounds for disease. By August 2017, more than half a million Yemeni people were believed to have been infected and cholera had claimed more than 2'000 lives. None of the above were inevitable consequenes of war.

The ICRC has worked for more than 150 years assisting and protecting victims of armed conflict and other situations of violence. ICRC's own existence, together with modern International Humanitarian Law (IHL) originate from the indignation over the fate of wounded and sick soldiers abandoned on the battlefield and the concern to provide them, without distinction, with adequate care. The universal ratification of the four Geneva Conventions of 1949 embodies the States parties' aspiration to balance military necessity with humanitarian concerns and regulate the conduct of hostilities in a way that could have the least possible impact on civilians. And it was in large part thanks to the efforts of a group of committed Swiss citizens that international consensus was reached on a rejection of the idea of "victory by any means" on the enemy. Access to health care and its safe delivery, particularly during armed conflict, when health care is needed the most[5], is a fundamental concern. However, the evolution of warfare[6] has made it one of the most pressing humanitarian issues of the world today.

Evolution of warfare and the protection of health care

The evolution of warfare in recent decades is characterized by the protracted nature of a number of contemporary armed conflicts, including Syria and Yemen, Afghanistan, South Sudan, the Central African Republic, Somalia, Libya or the Democratic Republic of the Congo. The long duration of wars results in essential services, including vital health care services, becoming increasingly limited for affected populations. These consequences are exacerbated by the fact that many of these wars are fought in urban areas. There, for example, substantial and long-term civilian suffering is caused by the use of explosive weapons with a wide impact area. Civilians within the vicinity of an explosion are likely to be killed or

Libya, Sirte, Hospital, Neonatal Intensive Care Unit. Damaged incubators.
Photo: LIOHN, André

injured by the blast and fragmentation effects of such weapons or harmed by the collapse of buildings. But they can also suffer from the reverberating effects of the damage caused by these weapons when they hit essential infrastructure, such as hospitals, schools, power plants and sanitation systems, or when the weapons lay as unexploded ordnance that persists as a threat to civilians until it is removed. These consequences have been widely documented in different contexts, such as Iraq, Lebanon, Afghanistan and Somalia[7].

Modern armed conflicts are also increasingly fought through proxies and armed groups operating among the population. The multiplication and fragmentation of parties to armed conflicts brings additional challenges. On the State side, we note the number of foreign interventions in ongoing armed conflicts, in support of State or non-State parties. On the non-State side, the armed groups participating in military confrontations frequently split or multiply. These dynamics can increase the number of frontlines and the potential for civilians to be caught up in the fighting, including the risk of destruction or damage to essential infrastructure, such as health-care facilities. They also create challenges for humanitarians and health-care providers to gain an accurate understanding on the nature of parties involved and support provided, impacting on their capacity to negotiate access, security guarantees, and engage meaningfully on protection issues and respect for in-

5 Pierre Perrin, War and Public Health, ICRC, Geneva, 1996.

6 On the evolution of warfare see Volume 97, No. 900 of the International Review of the Red Cross, 2015.

7 See for example, ICRC, 'Somalia: war wounded in Mogadishu referral hospitals reach new peak', 27 January 2011, available at: http://www.icrc.org/eng/resources/documents/news-footage/somalia-tvnews-2011-01-27.htm

ternational humanitarian law, including in relation to the provision of health care.

The Health Care in Danger Initiative

In 2008, the ICRC carried out an initial study on violence against health care in 16 countries where the ICRC was present due to an armed conflict or violence. From 1 July 2008 to 31 December 2010, 1,342 reports detailing 655 separate incidents of violence or threats of violence affecting health-care providers were collected from a variety of sources and processed. The results of this study[8] were presented to the 31st International Conference of the Red Cross and Red Crescent Movement[9] in 2011, building the case for the adoption of Resolution 5 "Health Care in Danger"[10].

Besides reiterating the responsibility of States to respect relevant international humanitarian law and applicable international human rights law, Resolution 5 of the 31st International Conference gave a specific mandate to the ICRC "to initiate consultations with experts from States, the International Federation, National Societies and other actors in the health-care sector, with a view to formulating practical recommendations for making the delivery of health care safer in situations covered in the present Resolution, and to report to the 32nd International Conference in 2015 on the progress made".

The ambitious objectives of the initiative, notably safeguarding people's access to health care and ensuring its safe delivery in armed conflict or other emergencies, revolved around three main streams of work:

- the mobilization of National Red Cross and Red Crescent Societies and other humanitarian and health organizations, such as Médecins Sans Frontières, the World Medical Association, the International Council of Nurses and the health services of the armed forces;
- building on the experience of the International Red Cross and Red Crescent Movement and relevant actors and work together to identify recommendations and practical measures to prevent, and mitigate the effects of, this violence; and
- working both at global and national levels to ensure the implementation of those recommendations and concrete measures.

Between 2012 and 2014, the Red Cross and Red Crescent Movement, in close partnership with certain States and other stakeholders, organized a global consultation process with practitioners and experts from around the world. In parallel, a global communication campaign was also launched to raise awareness and mobilize the general public around the human cost of this violence and promote action.

The "priority themes" for consultation were identified based on the Movement's operational experience in humanitarian settings safeguarding health care and its safe delivery. Ten thematic workshops were held around the world, attended by experts from a wide range of institutions, organizations and groups, including hospital managers, doctors, nurses, pharmacists, ambulance drivers, first aiders, first responders, scholars, religious leaders, Movement staff and volunteers, military officers, government officials. Some had lived through conflict; others had advocated for people needing health care; still others had contributed to developing measures for preventing or responding to violence against health care in armed conflict or other emergencies, or had worked to improve health-care systems' resilience to crisis. These consultations offered participants a forum to discuss the diverse aspects of violence, share their knowledge on different practices to tackle it and work together to identify recommendations and practical measures to make access to, and delivery of, health care safer.

In London (April 2012) and Cairo (December 2012), representatives of the medical community discussed the importance of health-care ethics and the responsibilities of health personnel. In workshops in Oslo (December 2012) and Teheran (February 2013), members of the International Red Cross and Red Crescent

8 ICRC, Health Care in Danger : A Sixteen-Country Study, available at: https://www.icrc.org/eng/assets/files/reports/report-hcid-16-country-study-2011-08-10.pdf?__hstc=163349155.fe1c9eda00f12d65b671905ee92e0d9b.1501077401980.1503482717842.1503499968350.13&__hssc=163349155.1.1503499968350&__hsfp=4277793560

9 Since it was first held in 1867, the International Conference of the Red Cross and Red Crescent, gathering the States signatories of the Geneva Conventions, members of the International Red Cross and Red Crescent Movement, and observers, has been a unique forum for discussing issues of humanitarian concerns as well as explore new challenges and trends as observed in contemporary armed conflicts.

10 The text of Resolution 5 "Health Care in Danger" is available at: https://www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm

Movement proposed several measures to improve the security and access to victims by their volunteers while strengthening their role as advocates for victims to authorities and other relevant stakeholders. The workshop in Toluca, Mexico (May 2013) focused on practical issues relating to the security of ambulance services in crisis situations. In Ottawa (September 2013) and Pretoria (April 2014), the workshops identified measures to improve the security of health care facilities, while the incorporation into domestic legislation of States' obligations under international law with regard to safeguarding access to and delivery of health care was discussed in Brussels in January 2014.
A number of bilateral consultations also took place in several countries with military experts and a workshop was held in Sydney in December 2013 to identify good operational practices and guidelines within the States' armed forces, which can contribute to protect health services and improve access to health care during armed conflicts and other emergencies. Moreover, between April 2013 and October 2014, 36 armed groups agreed to be approached by the ICRC and to discuss their challenges in respect and protection, but also in accessing to health care.

This global consultation process resulted in more than 150 recommendations, which serve as the basis for the International Red Cross and Red Crescent Movement's humanitarian diplomacy work, and shape the operational response to the challenges posed by attacks and violence against health-care providers. Another outcome was the development of tools and guidelines adapted to specific stakeholders, such as a guide on "The responsibilities of health-care personnel working in armed conflicts and other emergencies", or a security survey to assess the degree of vulnerability of health-care facilities. The HCID initiative's current phase now focuses on the promotion and implementation of the recommendations resulting from the global consultation process.

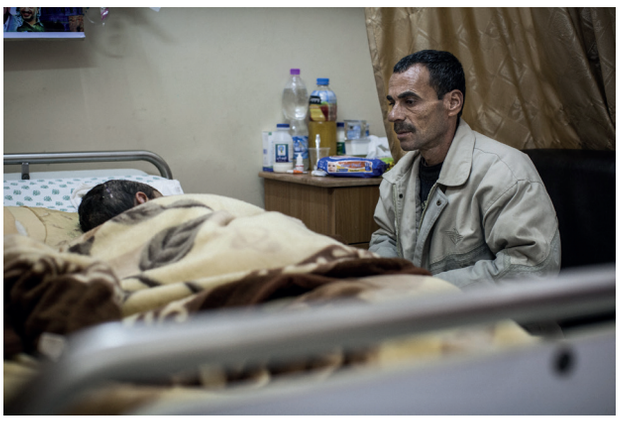
Progress at the global level

In October 2014, the African Union (AU) members of the AU Peace and Security Council adopted a common Declaration on HCID. The Declaration promotes the implementation of some Health Care in Danger recommendations, particularly from the Brussels workshop on domestic normative frameworks and Sydney workshop on military practice, by the African Union and its Member States, including within the framework of consolidation of an African Union Standby Force for peace support operations.

The 69th session of the United Nations General Assembly in December 2014 marked another important milestone for the humanitarian diplomacy initiated by the ICRC on the basis of the recommendations issued from the 2012-2014 global consultation process. During this session, the General Assembly adopted four resolutions[11] which paved the way for a stronger international commitment towards ensuring safer access to health care. In all four resolutions, emphasis is placed on the issue of violence against health care, recognizing the seriousness of this problem and its immediate and long-term impact, in particular in terms of loss of life and human suffering; weakening and deteriorating health systems; obstacles to health development. The resolutions called on states to protect the delivery of health care; to strengthen the resilience of national health systems; to take appropriate measures to prevent and tackle violence against health care; and to prevent and address violence against health-care providers. The HCID initiative was explicitly mentioned in the main humanitarian resolution (Strengthening of the Coordination of Emergency Humanitarian Assistance of the United Nations) and in the resolution on the status of the Additional Protocols to the Geneva Conventions, in recognition of the efforts of the International Red Cross and Red Crescent Movement on this issue.

A number of the initiative's recommendations are incorporated in these resolutions, such as those relative to the strengthening of domestic normative

11 Resolution A/RES/69/120 on the Status of the Protocols Additional to the Geneva Conventions of 1949: http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/120; Resolution A/RES/69/132 on Global Health and Foreign Policy, presented by the Global Health and Foreign Policy Initiative (GHFPI). The GHFPI was established in 2007 and reunites seven States; Norway, Brazil, France, Indonesia, Senegal, South Africa, and Thailand. These States decided to focus on the coherence between health and foreign policy, and the possibility to use health to create closer cooperation between countries. The group presents a resolution to the General Assembly every year: http://www.un.org/Docs/journal/asp/ws.asp?m=A/69/405; Resolution A/RES/69/133 "Safety and Security of the Humanitarian Personnel and Protection of United Nations personnel": http://www.un.org/Docs/journal/asp/ws.asp?m=A/69/L.33; Resolution A/RES/69/135 "Strengthening of the coordination of humanitarian and disaster relief assistance of the United Nations, including special economic assistance: Strengthening of the coordination of emergency humanitarian assistance of the United Nations": http://www.un.org/ga/search/view_doc.asp?symbol=A/69/L.40



Gaza City, Shifa hospital. A man worried about his 10-year-old son who suffered head injuries during the hostilities. It took him one hour to find him buried in the rubble of their damaged home. / Photo: GRECO, Annibale,

frameworks and the importance of respecting medical ethics; the establishment of national systems for the collection of data on violence affecting health care delivery; training and awareness-raising among health personnel, public officials and the general public; appropriate identification of health personnel, facilities and medical transports.

In December 2015, the 32nd International Conference of the Red Cross and Red Crescent shifted focus, with the adoption of Resolution 4 "Health Care in Danger: Continuing to protect the delivery of health care together"[12]. While highlighting the serious humanitarian short and long-term consequences of violence against health care, Resolution 4 sets out a clear road map for the protection of health-care providers. Measures are called for in a variety of areas that invoke the recommendations of the HCID global consultation process.

These measures range from:

- development and amendments to domestic legislation;
- procedures and practices of State armed forces and security forces;
- enhancing contextualized understanding of the nature of violence affecting healthcare delivery;
- enhancing the understanding of legal and ethical responsibilities of health-care personnel;
- enhancing the secure functioning of health-care facilities ; and
- enhancing risk management and overall security of ambulance and emergency health-care services, including those of National Societies.

In addition, an emphasis is put on the need for investigations by States in the aftermath of attacks against health-care personnel and facilities to prevent such incidents in the future, ensure accountability and address the plight of victims.

Another significant aspect highlighted in this Resolution is the importance of cooperation between relevant stakeholders to tackle the different factors that may contribute to the lack of respect and protection of health care services and thus prevent incidents. Resolution 4 calls for continued cooperation between States, the International Red Cross and Red Crescent Movement, the health-care community and other concerned stakeholders to implement concrete and locally adapted practical measures to prevent and address violence against patients, health-care personnel, facilities and medical transports. It calls, for example, on the International Red Cross and Red Crescent Movement to continue supporting and strengthening the capacities of local health-care providers, bearing in mind that they are often among the ones most affected by violence and therefore require specific attention.

Finally, on 3 May 2016, the UN Security Council (UNSC) adopted a landmark resolution, S/RES/2286 (2016), calling on States to respect IHL and implement measures for the protection of health workers working in armed conflict. It also requested the UN Secretary-General to include in all relevant country and thematic reports specific developments on the subject, and to 'promptly' submit recommendations enhancing the protection of the sick and wounded, as well as medical personnel, assets and facilities, and the accountability for those who attack them.

These recommendations[13] "set out practical measures that all States should implement to prevent acts of violence, attacks and threats against medical care in armed conflict, enhance the protection of medical care and ensure the documentation of acts of violence, attacks and threats against medical care, as well as accountability and redress"[14]. Here again, the measures outlined the recommendations developed during the HCID global consultation process, with

12 The text of the resolution is available at : http://rcrcconference.org/wp-content/uploads/sites/3/2015/04/32IC-AR-HCiD-_EN.pdf

13 The text of the letter is available at http://reliefweb.int/report/world/recommendations-un-sg-submitted-pursuant-para-13-sc-resolution-2286-2016-measures

14 S/2016/722, Letter dated 18 August 2016 from the Secretary-General and addressed to the President of the Security Council, para 5.

specific reference, among others, to strengthening domestic legal frameworks, safeguarding medical ethics, promoting the exchange of experiences and practice.

Although these two resolutions were a welcome development, it is sad to observe that they came a few months after the bombing of an MSF-supported hospital in Kunduz, Afghanistan, killed 42 people, including patients and medical staff, generating public outcry and causing the suspension of MSF operations in the area. Over one year after their adoption, much remains to be done on the implementation of the recommendations of the resolutions to avoid incidents such as Kunduz and the several other attacks which have since taken place in Central African Republic, South Sudan, Yemen, Syria, Afghanistan and elsewhere.

Moving from resolutions to action

Promising developments however exist. Since the HCID initiative was launched in December 2011, the ICRC has witnessed and supported the implementation of a number of positive measures at national level for the protection of health-care services both by States and non-state actors. In Liberia, for example, the National Army has integrated in its training manual recommendations and measures which would allow the development of operational practices safeguarding the delivery of health care, ranging from ensuring better coordination with the army medical services, to the establishment of priority criteria for the passage of ambulances at check-points.

In the Gaza Strip, the ICRC has worked with the Ministry of Health and local religious leaders in a campaign to decrease the influx of civilians accompanying patients into the emergency departments of medical facilities. Overcrowding in these services, particularly in times of crisis, results detrimental to the quality of care and security of personnel and patients.

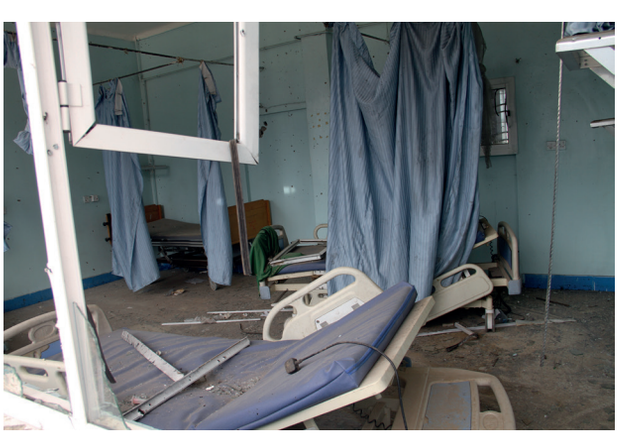
In Nigeria, efforts have focused on removing ambiguities in the interpretation of domestic legislation and aligning it with medical ethics in the specific context of reporting obligations of medical staff to authorities concerning gunshot wounds.

Following a pledge on the protection of health care supported by Peru's national IHL commission "CONADIH", taken in the framework of the 32nd International Conference, the Peruvian Ministry of Health and the Peruvian Red Cross adopted the "Health primer on the Rights and Responsibilities for the Health Personnel" that was elaborated in 2015 with the technical support of the ICRC. Peru is now discussing the inclusion of the protection of health care in the objectives of the Peruvian National Human Rights Plan 2017-2021.

In Lebanon, the ICRC is currently conducting a dialogue on the protection of the medical mission with the main armed factions active in Ein El Helwa refugee camp, and the majority of these groups have acceded to a unilateral declaration on the protection of health-care personnel and facilities, and the rights of weapon wounded and sick persons to access proper treatment.

Beside these positive examples and the increasing attention brought to the issue of violence against health care and the protection of patients and health workers in conflict zones on the global agenda, some priority areas deserve immediate attention.

Several organisations and think tanks have embarked on data collection and analysis of violence against health care. However, there is a need for a more consistent approach and methodology to be developed. The mandate and leadership of the World Health Organisation can surely play an important role. In order to understand the local and national patterns of violence against health care and their impact, and in turn enact relevant policy and legislative changes, States require data gathered in a rigorous and systematic manner. Greater evidence would enrich advocacy arguments about the impact



Yemen, Taiz city, Al-Thawra hospital. The three patients who had been laying in this room were pulled out of their beds when the shelling started. / Photo: AL ABSI, Wael

of violence against health care beyond its immediate human cost. Improved evidence on the public health concerns and other socio-economic consequences of violence against health care will increase pressure on actors responsible of these attacks to justify their policies and their actions. Previous successful campaigns have proved that "raising the political cost" (of violence) is usually necessary in order to generate a change in general attitudes about means and methods of warfare, and the political and diplomatic momentum necessary to improve humanitarian standards for civilian protection in armed conflict.

There remains a pressing need for scattered initiatives at national level to be regrouped, given coherence and supported under national plans of action to prevent and address violence against health care. This would ensure that efforts are integrated into public health plans, that their implementation is monitored and measured against indicators, which might well be relevant in the framework of the Sustainable Development Goals, and that sufficient resources are allocated.

The WHO Global Strategy on human resources for health (Global Workforce Strategy) resolution, adopted in May 2016 is an encouraging step in the right direction. The resolution places the issue of preventing and addressing violence against health-care providers squarely within ongoing WHO efforts to increase the availability of health-care professionals by 2030, and within WHO technical expertise to offer advice on good practices in health-related issues to governments. Links are also made with the health-related Sustainable Development Goals, which will of course be reached with more difficulty when health-care personnel and facilities are less available due to violence against them in conflict or other emergencies.

States must focus much more on the behaviour and attitudes of weapons bearers, on respecting IHL, and on increasing accountability for those that carry out attacks against health care. We need more organized exchanges on best practices to improve the passive protection of facilities and patients, and on changing knowledge, attitudes and behaviour in weapons bearers.

Finally, a collective effort to maintain the issue as a top priority on global and national agendas is critical. This effort calls for humanitarian and health organisations, but not only, to work together to reject the "normalization" of this violence and reiterate that attacks against health care are not an inevitable consequence of war and must be prevented.

The Role of the World Health Organization (WHO) in protecting the Medical Mission

Dr. Rudi Coninx OMS[1]

It is a sad reality that health care workers providing care in the most difficult situations come under attack themselves. To add to the tragedy, this happens at precisely the time when their patients need them most. In the last three years, since WHO began collecting data on such attacks, some 896 hospitals and health care centers have been attacked, 1,331 health care workers have been killed and 2,052 injured. This is probably an underestimation as not all such attacks are reported or registered.

The worst hit is Syria. More than half the health facilities in the country have been at least partially damaged, and the nearly two-thirds of health workers have died or fled since the beginning of the crisis. Half the health facilities in Yemen are not functioning any more. Such attacks deprive people of urgently needed care, endanger health care providers, undermine health systems and long term public health goals, and add to the deterioration in the health and wellbeing of affected populations.

The number of attacks does not appear to be decreasing, despite declarations and resolutions made at the United Nations General Assembly (e.g. 2015 UN General Assembly Resolution 69/132 on Global Health and Foreign policy, and Security Council Resolution UNSC 2286 (2016) on Healthcare in Armed Conflict), and despite efforts by the international community to remind all parties of their responsibilities in this matter.

WHO is committed to using its expertise, moral authority and convening power towards stopping these attacks. In August 2015, WHO established a staff position in its emergency department dedicated to working on this important issue in collaboration with concerned internal and external actors and adopted a plan of action, with generous support of the Swiss Agency for Development and Cooperation (SDC), for the next three years.

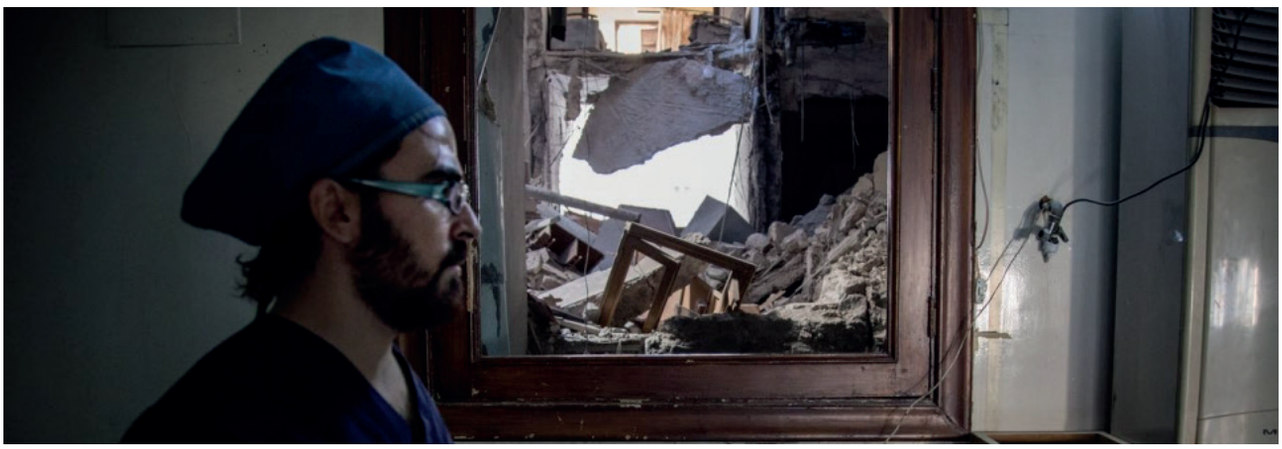
In July 2016, WHO launched its WHO Health Emergencies Programme (WHE) with attacks on health care as a priority issue. In October 2016, the WHE Directors from headquarters and the six regional offices gathered with the WHO representatives of the 17 countries with the largest emergency-affected populations, marking the first three-level WHE meeting since its establishment. Demonstrating the importance of the issue of attacks on health care, one of the three days of this meeting was dedicated to the way forward with concrete decisions on data collection, advocacy and the identification and promotion of best practices to reduce risk of attacks and strengthen resilience and care for victims after attacks.

In order to address the problem, WHO has taken a trifold approach: gather the evidence, advocate for attacks to end, and promote good practices.

- **Evidence**. In order to understand the extent and the nature of the problem, we need to have data. At present, there is no single global database where data on attacks are compiled. There is no agreement on what data to collect and no agreed upon method to collect the data. To address this gap, the World Health Assembly, in resolution WHA 65.20, tasked WHO with developing a methodology to systematically collect data on attacks on health care workers, health facilities, ambulances and patients. This method has now been developed and will be rolled out in countries. The method for data gathering will be made available allowing everyone to report into a centralized database. WHO will then make the information and analysis available, allowing researchers as well as advocacy groups to use the same evidence.

- **Advocacy**. WHO's advocacy efforts aim to build a commitment for action and create momentum for change, making the protection of health care in fragile settings a political and development priority for decision makers and their constituents. Attacks on health care are a clear violation of International Humanitarian Law. They are

1 Chief a.i., Humanitarian Policy & Guidance, Emergency Operations, WHO Health Emergencies Programme



Syria, Aleppo, Dr. Abu Wasim, one of the seven surgeons in Aleppo at that time, is next to a damaged room on the upper floors of a hospital in Aleppo-Syria, which was hit by an air strike in mid-October 2016, Sinjar Hospital. / PHOTO: ALMASRI Karam

also a violation of the Right to Health, enshrined in the WHO Constitution, and endorsed by the WHO Member States. Attacks deprive people of urgently needed health care, and they undermine our long term health development goals.

WHO aims to re-establish the principle of sanctity of health care, which is undermined by attacks on health facilities, personnel and transports, especially when the perpetrators remain unaccountable.

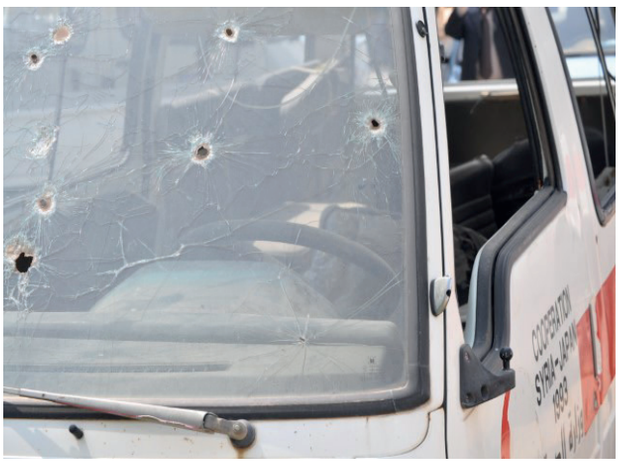
WHO's global leadership in the field of health, its technical expertise and political capital will be brought to bear on this problem to help Member States progressively achieve the right to health. Member States have spoken often to defend the right to health. Resolutions of the World Health Assembly reinforce WHO's strong position against violence in health care settings. These include resolution 46.39 in 1993, resolution 55.13 in 2002, resolution 64.10 in 2011, and resolution 65.20 in 2012. WHO and its constituent Member States have organized numerous side events to draw attention to the problem of attacks on health care workers, at World Health Assembly meetings and side events, during the United Nations General Assembly or the ECOSOC Humanitarian Affairs Segment, at side events for the World Humanitarian Day or during the Human Rights Council: in May 2015 at the 68th World Health Assembly, the then Director-General of WHO, Dr Margaret Chan, stood together with the Emergency Relief Coordinator, the President of the ICRC and concerned Member States to urge for collective action to stop attacks on health care. She repeated this appeal at a side event during the United Nations General Assembly. In May 2016 at the 69th World Health Assembly, the Director-General again stood together with Member States, the President of the ICRC and the International President of Médecins Sans Frontières to call for collective action to stop attacks on health care. In 2017, the current Director General, Dr Tedros Adhanom Gebreyesus, repeated his support for this project at the World Humanitarian Day event in Geneva.

- **Promote good practices.** It is difficult to make evidence-based recommendations if we do not know the nature and the full extent of the problem or its impact on health. It is therefore all the more important to document the consequences of attacks on the health care system and on the health of people in the community.

  The short-term consequences of such violence are evident: patients are deprived of the care they need, at the time they need it most. Health personnel are prevented from providing services, often lifesaving, leading to avoidable deaths. Attacks stop essential public health services from being provided, leading to the spread of disease and even epidemics, as we have witnessed with the resurgence of polio cases in Syria in 2013, or with the spread of cholera in Yemen today. The long-term consequences of attacks are even less known, and it is time to study the impact on chronic diseases, nowadays the leading cause of death in many countries where conflicts take place, and on the health system as a whole. Hard-won gains in reducing child mortality, improving maternal health

and fighting diseases such as polio can be undone in mere minutes. The impact of medical personnel departing, or being killed, health-care facilities closing or being destroyed is not well studied, but in the long term the cost of training new health care workers and building new health structures is enormous. Without these additional investments, we will not be able to achieve Universal Health Care, or the Sustainable Development Goals.

We also know little about the impact of the measures that are currently recommended: how effective are they, are they situation specific or are they universal. WHO will link up with academic institutions and partners to critically evaluate best practices and promote the ones with proven efficacy.



Syria, a shot Ambulance vehicle / PHOTO: WHO

WHO recognizes that the magnitude of this problem requires greater leveraging of its global leadership and outreach, including as Health Cluster Lead Agency, and its expertise in setting norms and making available authoritative information. WHO realizes it can leverage its convening power and the commitment of Member States and partners to implement the best practices to reduce attacks and mitigate their consequences to health service delivery.
Ultimately, WHO seeks to ensure that health workers everywhere can provide health care in a safe and protected environment and that patients can receive the health care they need when they need it; WHO seeks to ensure that health workers are protected, resilient, and equipped with knowledge and resources. It envisions a world where parties to conflict understand and uphold their responsibilities under International Humanitarian Law, where healthcare delivery is not disrupted by attacks and where all forms of violence against health care stop.

WHO's work on stopping attacks on health care builds on, and reinforces the work already underway by ICRC (Health Care in Danger), MSF (Medical Care under Fire), Safeguarding Health in Conflict Coalition, UNICEF (including through the application of the Monitoring and Reporting Mechanism of the Office of the Representative of the Secretary-General for Children and Armed Conflict (SGOCAC) which investigates attacks on schools and hospitals), OHCHR (Office of the United Nations High Commissioner for Human Rights), non-governmental organizations, academic institutions, and many others to optimize our collective effectiveness in bringing change. WHO will reach out to the World Medical Association, the international Council of Nurses and the International Committee of Military Medicine and many others to bring together a coalition of the willing.

When in May 2016 the United Nations' Security Council unanimously adopted Resolution 2286, sending a strong message around the world that health care must be protected during conflict, WHO supported the Resolution and commended the countries, including Canada and Switzerland, and the organizations, most notably MSF and ICRC, which tirelessly championed this resolution.

Security Council resolution 2286 encourages Member States to apply it, as well as the recommendations already made in ICRC's Health Care in Danger project, and other actions. It refers specifically to the actions that WHO plans to undertake in its current project: gather and consolidate comparable data; establish national registries; document the health consequences of attacks to health care delivery and public health; establish national legislation to uphold International Humanitarian Law; implement risk reduction measures, including through WHO's Safe Hospitals Programme; engage communities in protecting health care; inform emergency response plans with security risk analysis; promote and apply ethical principles in health care delivery and speak out and advocate with zero-tolerance.

Looking forward

WHO welcomes the creation of the informal group of States, set up by Switzerland and Canada, to galvanize the efforts of permanent missions in Geneva in support of existing efforts by States and humanitarian actors to implement Resolution 2286.

Through its Attacks on Health Care project, WHO's expected outcome is to minimize disruptions to health care delivery resulting from attacks during emergencies. WHO will collect and share robust data to demonstrate the extent and nature of attacks that are taking place and their devastating impacts on those affected. WHO will then be able to catalyze the collective advocacy of key stakeholders in order to identify, promote and apply concrete measures to reduce the likelihood of attacks and strengthen the resilience of health systems and populations after attacks. Working with these stakeholders to raise public awareness will in turn encourage Member States to recognize the political as well as human impacts of attacks and to cease their occurrence over time. Ultimately, no health workers should have to lose their life for saving others.

Médecins Sans Frontières on Attacks on Hospitals and the Protection of Health Care in Time of Conflict

François Delfosse[1]

"*The doctor of your enemy is not your enemy*"
Dr Joanne Liu, International President of Médecins Sans Frontières[2]

A reality check

"*It is evident that hospitals are not safe from bombings in Idlib at the moment, and this is outrageous.* […] *The fighting parties, and their political and financial backers, must stand by the many commitments they have made in UN Assembly and Security Council resolutions*" said Brice de le Vigne, MSF Director of Operations in a statement[3] that followed an attack against hospitals in a Syrian war zone where healthcare has been near-annihilated by Syrian and Russian armed forces. The Hama Central/Sham hospital, supported by MSF, was hit by an airstrike Tuesday 26th of September 2017, putting it out of service. Three other hospitals were hit and put out of service on the 19th in Idlib governorate, and two hospitals in the district of Jisr al-Shugur were evacuated on the night of the 27th out of fear of being bombed.

In Yemen, the number of air strikes in the first six months of 2017 totaled 5,676, according to a report by the Protection Cluster in Yemen[4], led by the United Nations High Commission for Refugees (UNHCR). The total number of air strikes in 2016 was reportedly 3,936. This escalation in air strikes is concomitant with what the World Health Organisation qualify as the "world's worst cholera outbreak[5]".

The war has destroyed much Yemeni infrastructure, including hospitals, schools and roads, with reports of both sides targeting health-care facilities and workers. And in Yemen like in many other conflicts, barriers to access healthcare take many forms, obstruction to care, refusal of access on security grounds, attacks against hospitals, arrest of patients and/or staff inside medical facilities.
But while the specifics of attacks and incidents vary, the end result is similar: the "medical space" that we need to establish in order to do our work is compromised and medical staff, patients, caretakers are killed or injured, facilities stop functioning, and civilians are deprived of care. In Yemen today, only 45% of health care facilities are fully functional, with remaining medical staff no longer paid and overwhelmed.

The tragic humanitarian crisis endlessly unfolding in Yemen is a striking example of the consequences of modern warfare on population, beyond death, injuries and displacement: "*Across the Middle East and Africa, outbreaks of infection have occurred as a direct effect of war, compounded by food and water shortages, displacement, and damage to infrastructure and health services. Nowhere is this web of interconnections more clear than in the cholera epidemic in Yemen*" states a recent editorial in The Lancet Infectious Diseases[6]. Several factors resulting directly from the effects of war drove the spread of cholera, not the least ones being yet again the near-annihilation of the health care system by a US- and UK-backed Saudi-led coalition which conducts the vast majority of air strikes on Yemen, together with the heavy restrictions on essential drugs importation enforced by the latter.

This dire picture raises legitimate questions, and two years after the bombing of an MSF hospital in Kunduz, Afghanistan – a turning point for our organisation which should not overshadow other numerous similar incidents[7] –, one and a half year after the adoption of UNSC Resolution 2286 (2016)[8], one can

1 Project Manager "Attacks against Hospitals". Formerly MSF Security Advisor and MSF Head of Mission in the Middle East.

2 http://www.msf.org/en/article/syria-statement-dr-joanne-liu-international-president-m%C3%A9decins-sans-fronti%C3%A8res

3 http://www.msf.org/en/article/syria-healthcare-being-annihilated-amid-intensified-bombings-syria%E2%80%99s-north-west

4 https://reliefweb.int/sites/reliefweb.int/files/resources/protection_cluster_yemen_situation_update_august_2017.pdf

5 http://www.aljazeera.com/news/2017/06/yemen-faces-world-worst-cholera-outbreak-170625041932829.html

6 Cholera in Yemen: war, hunger, disease…and heroics / The Lancet Infectious Diseases , Volume 17, Issue 8, 781 - http://www.thelancet.com/journals/laninf/article/PIIS1473-3099%2817%2930406-1/fulltext

7 http://sudanreeves.org/2015/10/08/msf-the-kunduz-afghanistan-hospital-attack-and-msf-in-sudan-october-8-2015/

8 On May 3, 2016, the United Nations Security Council unanimously adopted Resolution 2286 (2016) on healthcare in armed conflict. It was a record-breaking resolution, co-sponsored by more than eighty UN Member States. http://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/2286%282016%29

legitimately wonder where we stand with the protection of "the wounded and sick, medical and humanitarian personnel engaged exclusively in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities".

Trend setting ?

From a warfare historical perspective, deliberate or accidental targeting of health services is nothing new. But the memory and recording of attacks against medical facilities is incomplete at best, nonexistent in many cases. We know there were attacks against hospitals in Afghanistan in the 80s or in Vietnam for instance. But it is only in May 2016 that the WHO published for the first time ever a report on attacks against medical services and providers for the years 2014 and 2015[9].

Hence it remains difficult to speak of trends as we lack historical perspectives when looking more than a few years back. But actually, historical patterns and trends do not really matter; and as far as MSF is concerned, we should focus on our epoch, a post-UNSC Resolution 2286 world if we may say. How this world looks like? Blurred and biased. All of the above highlights todays and future challenge ahead, in face of a blatant lack of political will, not lacking hypocrisy though, from the side of coalition leaders and members but also their enablers. We are witnessing an abyss between commitments and the lack of action to stop attacks or to stop continued action supporting or enabling attacks. Though each attack is different, repetition of attacks risks creating an insupportable new norm, and we must ensure that today conduct of warfare as we witness it in Syria or Yemen does not set the trend for present and future conflicts. We must oppose the shift in the conduct of hostilities.

To be clear, MSF, as an emergency medical organisation, is not an anti-militarist or pacifist organisation. Humanitarian action asks: "Who needs help because of this war?" instead of "Who is right in this war?" and our humanitarian project is simple and limited: to help people survive the devastations of war, save lives, alleviate suffering, delivering humanitarian action "here and now". It is not to bring war to an end, to promote democracy, economic development, or peace. But "*even war has rules*"[10] and help people survive the devastation of war is also done through advocating for the respect of International Humanitarian Law that seek to limit the effects of armed conflict, to protect people who are not or are no longer participating in hostilities and to restrict the means and methods of warfare[11].

From international commitment to domestic practices: Fifty shades of grey

One can only be puzzled by the fact that the main contributor State to the UN Humanitarian Fund for Yemen in 2016[12] covering nearly 50% of the total with a USD 53.3 million contribution has made 10 times more amount in arms sales to Saudi Arabia. As stated by Rasha Mohamed, a Yemeni Researcher for Amnesty International, "*aid with one hand, missiles with the other*" [13].

But to be fair to the "blamed and shamed" State, on the 10th of July 2017 the UK High Court rejected[14] a legal challenge by Campaign Against Arms Trade (CAAT[15]) that UK arms sales to Saudi Arabia for use in the conflict in Yemen were illegal. Instead, the Court ruled that the Government was "*rationally entitled*" to conclude there does not exist a clear risk that UK arms sold to Saudi Arabia might be used in the commission of a serious violation of international Humanitarian Law in the Yemen conflict, despite e.g. the extensive bombing of the whole Saada governorate, declared "military zone" in May 2015, resulting in the destruction of dozens of hospitals, including three MSF supported hospitals Haydan, Razeh and Abs. According to a Human Right Watch statement, "*the landmark legal case, brought by Campaign Against Arms Trade, tried to establish that the UK government is breaking its own arms export licensing criteria by selling weapons to Riyadh, given the repeated international humanitarian law (IHL) violations the Saud-led coalition has committed during its military campaign in Yemen.*

9 http://www.who.int/hac/techguidance/attacksreport.pdf

10 http://www.msf.org/en/article/afghanistan-enough-even-war-has-rules

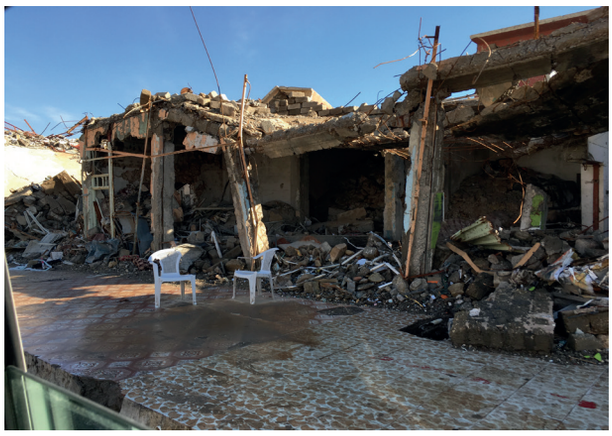
11 https://www.icrc.org/en/war-and-law

12 http://www.unocha.org/sites/unocha/files/2016_YHF_Annual%20Report_Final.pdf

13 http://www.independent.co.uk/voices/saudi-arabia-arms-sales-yemen-war-uk-government-us-donald-trump-obama-aid-a7643066.html

14 https://www.judiciary.gov.uk/wp-content/uploads/2017/07/r-oao-campaign-against-arms-trade-v-ssfit-and-others1.pdf

15 https://www.caat.org.uk/



Iraq, Sinjar Hospital. / PHOTO ALMASRI Karam

Had the High Court ruled in favour of Campaign Against Arms Trade, it was hoped that UK arms sales to Saudi Arabia would have been suspended – at least temporarily – and thereby help to pressure Riyadh to end its unlawful attacks in Yemen. […] Monday's ruling is terrible news for Yemen's civilians. But the Court's approach also involved some significant omissions[16]", raising concerns about the UK's current system of arms transfer control[17].

As reminded by ICRC, "*States have committed to making their arms transfer decisions subject to respect for international humanitarian law (IHL) and international human rights law. Steps must now be taken to ensure that these criteria are applied in practice*"[18].

Here again, it is about filling the gap between international laws and domestic laws and actual practices.

16 https://www.hrw.org/news/2017/07/11/yemen-suffering-hands-saudi-arabia-and-uk-profiting

17 https://www.saferworld.org.uk/resources/news-and-analysis/post/727-reflections-on-the-uk-high-court-decision-on-arms-sales-to-saudi-arabia

18 https://shop.icrc.org/decisions-en-matiere-de-transferts-d-039-armes-application-des-criteres-fondes-sur-le-droit-international-humanitaire-758.html?___store=default. Recalling their obligation to respect and ensure respect for international humanitarian law, States strengthen controls on the transfer of weapons so that they do not end up in the hands of those who may be expected to use them to violate international humanitarian law. 31st International Conference of the Red Cross and Red Crescent, Resolution 2: 4-year action plan for the implementation of international humanitarian law, Annex 1: Action plan for implementing international humanitarian law, Objective 5: Arms transfers (adopted by consensus on 1 December 2011)

Frontline negotiation

This brings us back to our operational theaters, where a set of international rules seeks to limit the effects of armed conflict. We know the basics of IHL regarding the conduct of hostilities: among others, the principles of distinction between civilians and combatants, the necessary precaution and proportionality in attacks, the different protected status (combatant, wounded out of combat, medical personnel, etc…).

Today those basic principles are disrespected in many countries by a wide range of actors, and despite international laws, despite de-confliction mechanisms, despite the UNSC Resolution 2286, the reality we witness in conflict zone is a medical mission regularly under attack, while it should be systematically protected.

In too many occurrences, threats to provision of healthcare come not from insurgent group, but from government, and we do believe that states bear a greater responsibility, and must demonstrate exemplarity in respect of IHL. But in reality, inconsistency prevails and we face a dangerous lack of clarity, with unilateral interpretation of IHL by State military forces, security forces, intelligence and counterterrorism forces. In particular, there's an urgent need to address the blurring of lines between IHL and Counter Terrorism-legislation leading to the criminalization and attacks of medical care when considered as "material support to terrorism". This was expressed in the most blatant way in the case of Kunduz bombing when Afghan officials justified the attack on MSF trauma center because it was treating wounded Taliban. "*They give them medicine; they transport and treat their injured*," the commander of the Afghan quick-reaction force in Kunduz told a New York Times journalist[19], going further by stating that "[MSF hospital] *existence is a big problem for us.* […] T*hat hospital is in the service of the Taliban.* […] *If they make it a hundred times, we'll destroy it a hundred times*."

As distorted such a position may sound, it is illustrative of the risk attached to the blurring of lines mentioned above, as well as of the discrepancy de facto existing between States' respective interna-

19 http://www.nytimes.com/2016/05/22/magazine/doctors-with-enemies-did-afghan-forces-target-the-msf-hospital.html?_r=0

tional commitments and their actual translation into domestic law and practices.

When it comes to practices, MSF responsibility is to define the most appropriate engagement and negotiation strategy to be developed and deployed in our operational contexts, in coherence and complementarity with the security strategy decided by the operational line, aiming at efficiently mitigate the risk of being targeted by reducing our vulnerability to attack and impact of such attacks on our operations, staff and beneficiaries.

In order to achieve this, it was utterly important to capture the MSF's experience while engaging with the US Government (USG) and Afghan stakeholders following the US military attack of the MSF Kunduz Trauma Center, so to identify several lessons learnt which can be useful for MSF operations elsewhere, in particular in counter-terrorism contexts.

Kunduz case-study and lessons learnt

Following the attack on Kunduz in the "fog of war", MSF asked for investigation by the IHFFC[20], engaged in an in-depth internal review of the incident and refused the mistake explanation made by the USG as stated in the USA AR. 15-6 report partially declassified (721 out of 3000 pages are publically released as well as released to MSF[21]).

This report stated that "*the comprehensive investigation concluded that this tragic incident was caused by a combination of human errors, compounded by process and equipment failures. Fatigue and high operational tempo also contributed to the incident. These factors contributed to "the fog of war", which is the uncertainty often encountered during combat operations*".

Beyond the so-called "fog of war", we do consider that human errors were wrong understanding and implementation of IHL, compounded by legal and procedural mistakes, the misuse of self-defense rationale – where an entire city has been declared a hostile zone – and no precaution and proportionality assessment has been done, nor reference to and use of the No-Strike List which included MSF Trauma Center.

20 International Humanitarian Fact-Finding Commission http://www.ihffc.org/index.asp?Language=EN&page=home

21 Summary of the Airstrike on the MSF Trauma Center in Kunduz, Afghanistan on October 3, 2015; Investigation and Follow-on Actions. Available at: https://publicintelligence.net/centcom-kunduz-hospital-attack/

Post-Kunduz Capitalization : Engagement with the US and Afghan stakeholders, lessons learnt. March 2016[22].

After an initial phase of public confrontation, the elaboration of MSF's internal review and the call for the IHFFC investigation, MSF entered into a year-long period of negotiations characterized by the prioritization of bilateral engagement with the US government and Afghan stakeholders, leading to key outcomes such as the signature by GoA and Taliban of a Humanitarian Memorandum of Understanding or the US Secretary of Defense (DoD) Statement of Principles[23] that recall the principles related to the protection of medical mission and requiring DoD personnel to adhere to them.

MSF now benefits from a set of negotiated and written agreements on very concrete operational subjects that can be useful for other MSF theatres of operations:

Clarification of channels of communication for de-confliction purposes; establishment of a "hotline" for major security incidents; use of internationally-recognized logo for day and night aerial hospital identification (use of the red crescent emblem with night vision glue tape); MSF locations and GPS coordinates sharing modalities; definition of the circumstances in which domestic law enforcement measures apply inside an MSF facility; establishment of warning mechanism when an MSF facility is deemed to be used outside of its medical function.

It is important to outline on this point that the US military informed MSF through official correspondence that "*in some cases however, IHL recognizes that a warning prior to the use of force in self-defense against enemy belligerents within an MSF facility that hast lost its protection may not be feasible or appropriate*"[24]. Given US military vague interpretation of "self-defense" situations and the recurrent "fog of war" in US counter-terrorism military activities, this can clearly limit the warning mechanism.

In addition, while the US Secretary of Defense Statement of Principle reaffirms the protected status of the medical care provided by impartial humanitarian actors, as well as the wounded and sick, there were some points of divergence between MSF and the US that remain and could not be modified on the final document. Those remaining concerns for MSF are:

A) Search and Capture:
The right to search and capture wounded and sick of the enemy inside hospital poses a threat to the neutrality of the structure and may result in deterring the population from seeking care. The US claim that this right exists under the article 12 of the 1949 Geneva Convention ignores the more recent International Humanitarian Law provisions from the two 1977 additional protocols[25], which more clearly recognizes the protections of the wounded and sick. Any search and capture operation within a protected medical structure – MSF or otherwise – could have detrimental impact on care of the patient as well as having the effect of undermining the war-affected population's perception of the facility as a protected neutral site that provides safe access to health care.

B) Criminalization of Medical Care:
MSF is concerned that the following language below -included in the final version of the "Statement of Principles"- allows the criminalization of medical staff who treat wounded and sick according to medical ethics when a State has not accepted the services of impartial humanitarian organization.

"Where a State has accepted the services of an impartial humanitarian organization, it must not regard such services, including the provision of medical care, as unlawful and subject to punishment."

As an example, the government of Syria has never granted MSF the permission to operate inside the country and through domestic legislation has criminalized the provision of medical care to opposition forces or populations in opposition-controlled areas, regardless of whether or not they are considered wounded or sick.

Given the above, it would be interesting for MSF to engage on similar processes with other key militaries worldwide in order to get a more nuanced view on their interpretations of the IHL, in particular regarding those legal grey zones when it comes to the protection of medical care during armed conflict and that has concrete implications for MSF work. However relevant and fruitful this negotiation process was, this was reactive and ad hoc, and too often a dangerous lack of clarity prevails and challenges the relevance of de-confliction measures, such as sharing GPS coordinates of medical facilities, which is typically the case in Syria. This is not merely theoretical; as a matter of fact, several critical incidents occurred in Yemen and Afghanistan, while de-confliction measures – defined as a process of avoiding mutual interference and preventing incidents – were enforced.
De-conflicting with military operators seems theoretically and legally right but not always efficient to improve the security of MSF teams and patients.

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22 Andrés Romero, internal MSF report : Post-Kunduz Capitalization : Engagement with the US and Afghan stakeholders, lessons learnt. March 2016.

23 https://www.defense.gov/Portals/1/Documents/pubs/Principle-Promulgation-Memo.pdf

24 Official correspondence. USFOR-A, Resolute Support letter to MSF in Afghanistan, November 7th, 2016.

25 The United States have not signed the two additional protocols to the Geneva Convention.

As demonstrated with the post-Kunduz process, MSF responds to threats and violent incidents with two prevailing approaches:

The "normative approach" invokes IHL and the principle of the sanctity of medical space[26]. This approach first and foremost reaffirms existing laws, seeking their application to specific circumstances and advocating for the respect of the medical mission, like through the adoption and operationalization of the UNSC Resolution 2286 (2016).

But when confronted with direct risk of attack, the normative approach does not protect us, therefore requiring a more "pragmatic approach", which sees transgression of standards and laws during conflicts as inevitable, and therefore presupposes the need to negotiate (and renegotiate) the acceptance of our medical space in specific context. To that end, MSF must and will continue engaging with all warring parties, including Non State Armed Group (NSAG), as was the case in Afghanistan with the Taliban representatives seeking the signature of a humanitarian MoU. If States are serious about protecting the medical mission, they have to agree that humanitarian organisations like MSF have to be in contact with all groups, even if considered as enemy.

The UNSC Resolution 2286 (2016), a breakthrough, falling short?

Ingenuity aside, MSF has to advocate for the respect of IHL but we believe that more need to be done, through the operationalization of the UNSC Resolution 2286. As stated by the ICRC president, this resolution is "*a solid foundation on which to make progress* [but] *more must be done*". He recommended strengthening national legislation to improve access to health care, emphasizing also the critical importance of Member States establishing national data-collection systems to gather information about patients and health facilities.

Indeed, it was a record-breaking resolution, adopted at unanimity by the UNSC based on a draft proposed by Egypt, New Zealand, Spain and Uruguay, and co-sponsored by more than eighty UN Member States.

The resolution addresses acts of violence, attacks, and threats against "the wounded and sick, medical and humanitarian personnel engaged exclusively in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities" on the basis of the International legal framework (applicable international human rights law, IHL, Geneva Conventions and their Additional Protocols 1977 and 2005).

The text of the resolution does answer MSF main concerns toward IHL language and limitations, representing some improvements compared to the existing IHL framework and shall serve for further leverage on the protection of the medical services in situations of armed conflict.

Some of the 2286 topics that are of special interest to MSF:

Protection of medical and humanitarian personnel: The resolution is going beyond IHL terminology regarding definition and protection of medical personnel and medical unit. By referring to "medical and humanitarian personnel engaged exclusively in medical duties" rather than "person assigned by a party to the conflict exclusively to the medical purpose" in the Geneva Conventions, healthcare personnel such as MSF staff who act in an independent and impartial manner, benefits of a protected status even if not assigned and controlled by the parties to the conflict.

International versus non-international armed conflicts: It makes no difference between international and non-international armed conflict neither to civilian or military medical facilities. The principles referred to in the resolution can be used to simplify legal protection regime of health care facilities.
National staff: By referring to locally recruited medical and humanitarian personnel, it is the first mention of a "protective status" for national staff engaged by foreign organization, if exclusively engaged in medical duties (local staff being assigned by foreign humanitarian organization and not by a party to the conflict, they were not directly covered by restrictive definition of IHL).

Non-criminalization of health personnel: The resolution expanded beyond domestic law to preserve the autonomy of the doctor to act in the patient best interest under medical ethic and IHL framework

26 Duroch F et al. Medical Care Under Fire: An analysis of MSF's experience of violence and insecurity in the field. Internal MSF report on the findings of the Medical care Under Fire Project, March 2016.

(non-punishment of personnel for carrying out medical activities compatible with medical ethics).

Humanitarian access: The resolution does not reaffirm state sovereignty and the obligation of state consent for humanitarian medical assistance but refers to the obligation of all parties to the conflict to facilitate safe and unimpeded passage for medical/humanitarian personnel exclusively engaged in medical duties to all people in need , consistent with international humanitarian law.

The resolution does not limit itself to prohibition of intentional attack on the Medical Mission but expands on other acts of violence, indiscriminate attacks and threats and to obliges to verify that military objectives are not civilians, nor subject to special protection.

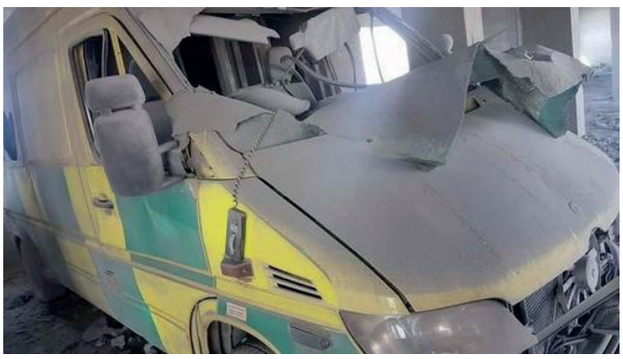
Identification: The protection of the Medical Mission is not linked to the use of the distinctive emblems (under the Geneva Convention, i.e. red cross/ crescent) but its use enhanced its protection.

Legal framework – Rules of Engagement – Military manuals: It requests States to implement practical and effective measures of prevention of attacks on the Medical Mission through the development of domestic legal frameworks and to ensure that armed and security forces are taking it into account in the conduct of war.

Accountability: It calls on States to conduct "in an independent manner, full, prompt, impartial and effective investigations within their jurisdiction", therefore refusing international mechanism for investigation and accountability.

Ending impunity: It emphasizes States' responsibility to ensure perpetrators of violations of International Humanitarian Law are brought to justice and, in the case of war crimes, their prosecution in the international criminal justice system.

Reporting: The resolution includes a robust reporting mechanism of obstruction to the delivery of medical assistance, acts of violence and threats against the Medical Mission, but also remedial actions taken to prevent similar incidents and action taken to identify and hold accountable those responsible of such acts through UN Secretary General country-specific reports and other relevant thematic reports on the protection of civilians and a yearly briefing to the SC on the implementation of the resolution.



Syria, Hama, Sham Hospital, Damage to one of the hospital's ambulances. Hama Central/ Sham hospital in southern Idlib governorate, was a major referral facility for the region. PHOTO: ALMASRI Karam

2286 Operationalization: The UN Secretary General Recommendations

Furthermore, the resolution called on the UN Secretary General to provide recommendations[27] on measures to enhance the protection of and prevent acts of violence against the patients, health personnel and the Medical Mission. The recommendations have been submitted "*pursuant to para 13 of SC resolution 2286 (2016), on measures to prevent acts of violence, attacks and threats against the wounded and sick, medical personnel and humanitarian personnel*"[28]. This document, and its endorsement by States, is essential to translate the resolution into sustained action in terms of compliance of parties to their obligations under IHL, improved data collection, accountability procedures, etc…

The adoption of the recommendations could contribute to make the violation of the Medical Mission in conflict zones an absolute red-line for States that are parties to a conflict. In that respect, the recommendations address two aspects key to MSF security: the national legal approach and the transcription of the principles in what is called "operational precautionary measures" (e.g. Rules of Engagement, military manuals, tactical directives, Standard Operating Procedures,…). For example:

- Recommendation 2-c and Recommendation 3 allow first aid organizations to operate "in line with medical ethic without incurring sanctions or pun-

27 https://documents-dds-ny.un.org/doc/UNDOC/GEN/N16/262/55/pdf/N1626255.pdf?OpenElement

28 https://reliefweb.int/report/world/recommendations-un-sg-submitted-pursuant-para-13-sc-resolution-2286-2016-measures

ishment for doing so". If transcribed in national laws, it would clarify grey zones such as health care as a support to terrorism or search and capture acts in hospitals as part of anti-terrorist legislation.
- Recommendation 9 is about "operational precautionary measures". Ensuring that some of the key States involved in conflict/international coalition review and update their military directives would be a critically useful step.
- In addition, Recommendation 11 on independent investigations, enlarge the type of jurisdiction that was limited to national jurisdiction in the resolution 2286 (2016), to international fact-finding missions.

We oppose the shift in the conduct of hostilities witnessed in several international and non-international armed conflicts and their specific rational (Counter-Terrorism operations; efforts to deprive enemy-controlled territories of infrastructure; making life for civilians unbearable); we need to reaffirm IHL norms as an effective practice, and seek for domestic translations of IHL into Domestic Law and War Manuals. To that end, States should pro-actively facilitate dialogue between humanitarian actors and military apparatus sharing the same operational field. We need to bridge the gap between humanitarian and military understanding(s) of IHL.

Ultimately, what MSF wants is for medical care to be exempt from all definitions of "material support" and "complicity to terrorism". National laws need clear and explicit exemptions for medical and humanitarian activities.

Resolution 2286 and its recommendations remains a tool allowing addressing the issue of protection of the Medical Mission. But a year and half after, the content of the resolution and SG's recommendations remains largely rhetoric and little has been done by States to concretely translate the resolution into action.

The Role of Permanent Missions in Promoting the Protection of the Medical Mission

Oliver Hoehne[1]

United Nations Security Council Resolution 2286 is a significant achievement at the multilateral level. Tabled by five non-permanent members from all geographic regions and adopted unanimously, it calls for further efforts and additional measures to better protect medical facilities and personnel. Taken together with key resolutions from the United Nations General Assembly, the World Health Assembly, ECOSOC's Humanitarian Affairs Segment, and the International Conference of the Red Cross and Red Crescent, these texts reaffirm the continued relevance of international law – including international humanitarian law and international human rights law – and send out a strong political signal at the highest multilateral level on the need to comply with international law. However, since Resolution 2286 was adopted in May 2016, health-care facilities and personnel have continued to suffer from attacks, which, in addition to causing injury, death and destruction, deprive vast parts of the population of health care and carry dire long-term consequences for communities. The challenge today therefore clearly lies in implementation.

Resolution 2286 contains a range of specific recommendations. These include, inter alia: adhering to relevant international treaties; ensuring that medical ethics are protected both legally and practically; promoting regular cooperation and sharing of best practices; exerting influence to ensure respect of the law and national implementation of international law through norms and standards; and raising awareness of the law and fostering a culture of respect. Also of paramount importance are provisions relating to education and training for weapon bearers, including the principle of providing medical assistance to the enemy; incorporating precautionary measures and the principles of distinction and proportionality into all military operations; the need for full, prompt, impartial and effective investigations if incidents occur; and accountability.

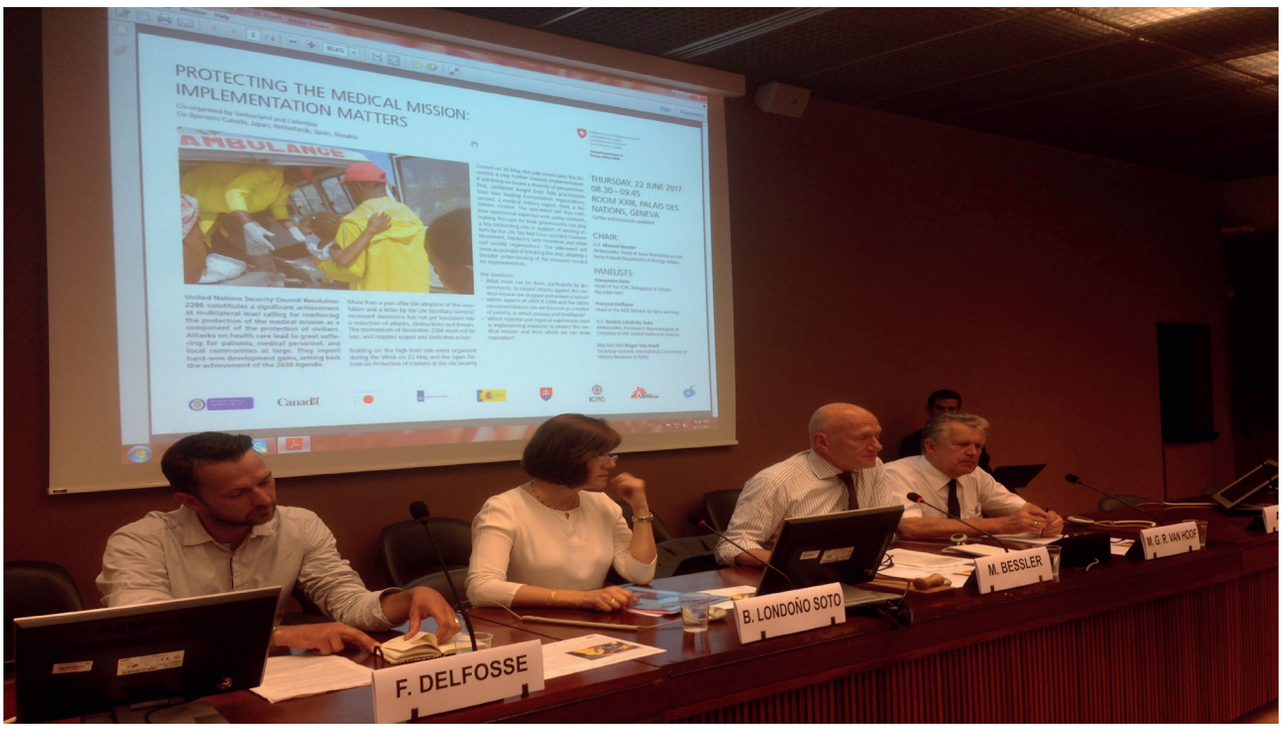
Many of these aspects resonate with Geneva. As a humanitarian, health and human rights hub, it is uniquely placed to combine operational expertise with policy outreach in order to ensure that the obligation to safeguard health-care services is met. Much is already happening, such as the Health Care in Danger initiative by the International Committee of the Red Cross (ICRC), the Attacks on Health Care programme by the World Health Organization (WHO), as well as advocacy and research by leading civil society organizations such as the #NotATarget campaign by Médecins Sans Frontières (MSF). These organizations were key partners in drafting Resolution 2286. It is therefore not surprising that Geneva, through these and other agencies, carries an important supportive function in implementing the resolution. But what does this mean for permanent missions in Geneva?

Three Roles for Permanent Missions

First, permanent missions can play a key connecting role in sharing information between New York, Geneva and respective capitals, as well as with operational agencies. One might be led to assume that in today's hyperconnected world, information is already being shared abundantly. Yet many diplomatic missions in Geneva confirmed a distinct need for improved sharing of information on the issue of the protection of the medical mission in the triangle between capitals, New York and Geneva, particularly information that is accompanied by comment and analysis, pointing the way for concrete measures. This allows shedding light on the specific question of the medical mission in a wider context of the protection of civilians. The simultaneous presence of the International Red Cross and Red Crescent Movement and key United Nations agencies as well as numerous civil society organisations in Geneva, all of them working with beneficiaries on a daily basis and thus with a precious picture of field realities, offers fertile ground for this.

In singling out the protection of the medical mission, care is being taken not to create the impression of a hierarchisation of constituencies within the realm of the protection of civilians in armed conflict. At-

1 Deputy Head of the Multilateral Division, Permanent Mission of Switzerland to the United Nations Office and Other Organizations in Geneva



Geneva, Ambassador Bessler chairs the ECOSOC HAS meeting co-organized by Switzerland and Columbia, discussing the implementation of Resolution 2286
PHOTO: HOEHNE Oliver

tacks on hospitals, the looting of medical supplies or undue delaying of ambulances at checkpoints are not more important than other aspects of the protection of civilians, including those covered by dedicated processes, such as children in armed conflict or schools. Rather, working on this issue points out a specific need to address the protection of the medical mission and to promote dedicated implementation measures, over a given period of time, maintaining the momentum of Resolution 2286 and other texts, including a resolution of the 32nd International Conference of the Red Cross and Red Crescent of December 2015, on whose implementation States are expected to report.

Second, permanent missions can enhance the knowledge base and widen the cercle of those willing to implement the resolution, by discussing and sharing good practices, promoting the need for national action, and suggesting outreach to parliaments, national medical associations, and other fora and processes that may be of relevance. Without a precise understanding of the issue at hand and its multifaceted dimensions, implementation at national level will remain hampered and incomplete and governments may remain at the stage of supporting the importance of the issue without taking actual steps towards effective change. While not operational on the ground, permanent missions in Geneva can make a useful contribution as they already reach out to a variety of actors ranging from other States, humanitarian and other agencies, to civil society and academia in their daily work and can use these channels and networks to reach a deeper understanding of the nature, implications, existing experiences and opportunities offered by Resolution 2286 as well as the letter of the UN Secretary-General dated 18 August 2016. Several issues of particular relevance to Geneva contained in the resolution and the letter merit such a discussion, for example medical ethics, exchanges of information and national multi-stakeholder fora, training for military personnel and members of armed non-state actors, or data collection, analysis and reporting.

Third, by involving both diplomatic staff working on humanitarian affairs and those working on health, human rights and other matters, permanent missions can enhance their own, more holistic understanding of the measures needed. This is a prerequisite for sustainable health care which involves not only humanitarian, but also development, human rights and peacebuilding work. Thus, the medical mission provides a concrete entry point for the often mentioned "breaking the silos" or the "humanitarian-development nexus" debate: It helps diplomatic

missions to increase both internal communication and understanding of institutional dynamics and developments, as well as to publicly position themselves more consistently to transversal challenges such as attacks on the medical mission. It also opens up doors for a variety of events and processes where a discussion of the protection of the medical mission is relevant, yet would otherwise, without such connections, not take place.

An informal group to promote implementation

In order to act on the idea of a reinforced role of permanent missions in Geneva in support of existing efforts by States and humanitarian actors to implement Resolution 2286, Switzerland together with Canada set up an informal group of States. The group is composed of States from across all geographic regions, reflecting the diversity of the range of original penholders of the resolution, as well as the ICRC, WHO and MSF as standing observers. It offers an additional and dedicated avenue for discussion and action, parallel to, and in support of, existing efforts. With a focus on State action, the group offers the possibility for States to take over particular tasks or work streams alone or jointly with others. In regular meetings usually at technical level, the group has identified three fields of action for which it aims to develop concrete action, namely mobilization and advocacy, data collection, and preparedness and prevention.

Action under the first field of action has so far encompassed a presentation on national practice in the context of the Universal Meeting of National International Humanitarian Law Committees, a statement at the Healthcare Workforce Summit, a statement at the presentation of the report of the Special Representative of the Secretary-General for Children and Armed Conflict, as well as two side-events described in more detail below. Under the second field of action, engagement with actors collecting and disseminating information on the impact of attacks and on replicable data collection models and methods is currently foreseen. Under the third field of action, efforts are ongoing to examine amongst others the non-criminalization of medical practitioners and the sharing of good practices in relation to contingency planning and the application of existing International Humanitarian Law in the development of Standard Operating Procedures and Rule of Engagement.

The informal group of States on UN Security Council Resolution 2286 was instrumental in the organization of a side-event at the World Health Assembly in May 2017, entitled "Attacks on health care - Where do we stand one year after the adoption of UNSC resolution 2286?" and co-chaired by the Health Ministers of Switzerland and Canada, respectively, with attendance of the President of MSF and of senior representatives of both ICRC and WHO. This side-event pointedly highlighted the urgent need for action, confirmed the global nature of the phenomenon of attacks on health care, and sent a strong political signal of support to the resolution and the subsequent letter by the UN Secretary-General.

The informal group then organized a complementary side-event at the Humanitarian Affairs Segment of ECOSOC in June 2017, taking the discussion a step further towards implementation by bringing on board a diversity of perspectives ranging from field practitioners to a medical military expert to that of a diplomatic mission. In combining operational expertise with policy outreach, it made the case for how governments can play a key connecting role in support of existing efforts by the UN, the Red Cross and Red Crescent Movement, Médecins Sans Frontières and other civil society organizations. Participants pointed out that both a normative approach, focusing on advocacy, the respect of International Humanitarian Law and a restatement of applicable norms, as well as pragmatic measures were needed. The non-criminalization of principled humanitarian action, the importance of further work within the UN Security Council, as well as the need to involve Ministries beyond Foreign Affairs, including Defence, were also mentioned. Concrete implementation examples include the revision of national legislation, improved data collection, and sharing of good practices. The creation of multi-stakeholder mechanisms was discussed, such as a national roundtable or consultation committee, to gradually create trust among civilian, military and humanitarian actors and to provide a space for dialogue on the protection of the medical mission. Such endeavours take time, but may ultimately lead to a joint insight into the shared vulnerabilities of all when the medical mission is under attack, and based on that, promote tangible improvements on the ground.

Of particular relevance was the inclusion of a military medicine perspective, often missing in such debates, which brought concrete suggestions in terms

of the inclusion of specific situations in military trainings, for instance the control of ambulances at check points. Rules of engagement and Standard Operating Procedures may also need to be reviewed and clear reporting lines established so as to avoid undue political considerations in situations of a tension between intended military action and legal or ethical considerations. Participants also pointed out measures to improve communication between humanitarian actors and military or armed groups, such as hot lines, non-strike lists and additional visual marking of medical facilities in the aim of reducing the risk of attacks on the medical mission.

The way ahead

Looking ahead, it appears essential for Permanent Missions in Geneva and elsewhere to remain engaged on this issue along the lines of mobilization and advocacy, data collection, and preparedness and prevention. Fora and processes relating to humanitarian affairs, to health, to human rights and further aspects, whether originating in the United Nations, the Red Cross and Red Crescent Movement or elsewhere, can be used to transmit ever more precise messages and recommendations on the implementation of Resolution 2286. The Human Rights Council plays an important role in promoting accountability and upholding the rule of law. As a further step, it may be worthwhile considering a series of closed-door multi-stakeholder discussions of certain aspects of the resolution and the letter, with a published but non attributed outcome document spelling out elements for implementation grounded in actual experience and research. Such discussions carry the potential of constituting a community of diplomats attentive and knowledgeable on this issue, and a helpful partner to humanitarian and other actors. Once diplomats rotate out of Geneva, they can carry their exposure on the protection of the medical mission with them to their next posting.

Furthermore, regional groups, organizations and gatherings constitute promising avenues for outreach to further States. As was pointed out at the above-mentioned side-events, the current debate in Geneva can benefit from more diversity.

In addition to broadening the range of countries involved and the venues used to discuss the medical mission, promising steps have been undertaken in terms of reaching out to other constituencies. After the initial outreach bringing together humanitarian, health and human rights staff of permanent missions, precious insight was gathered at various events at ECOSOC's Humanitarian Affairs Segment on the military perspective. The avenue of civil-military coordination and mutual learning from respective vantage points both globally as well as at national and regional levels merits further action. Another constituency absent from initial discussions on the medical mission is the legislative branch of government. The potential of the Interparliamentary Union, regional bodies and national parliaments for effective implementation of measures to better protect the medical mission is evident, and should be further explored, as could be the corporate sector, media and religious constituencies. In all these efforts, care must be taken that the outcome relates to advocacy and not merely communication, and that the focus remains firmly anchored in the promotion of national action to implement the resolution.

Finally, it may be worth examinig if the format of the informal group in Geneva could be replicated in field locations, depending on contextual realities, to promote exchange of information and maintaining of the momentum in a diversity of geographic settings. This may include discussions in States with international military or peacekeeping engagements; those directly or indirectly affected by attacks on the medical mission; those with influence on actors potentially involved in such attacks; as well as donor governments and those with functions in regional networks.

It is a long way from New York's Security Council Chamber to the field locations where ambulances are unduly delayed, where nurses, doctors and patients are attacked and where already scarce health infrastructures are destroyed. If Geneva through its organizations and its Permanent Missions can be a multiplier, relay and hub for reflection, exchange and action, it may contribute its share to a world with less attacks, better knowledge, and stronger accountability. As we aspire for better protection of civilians, the ultimate proof of effectiveness of any measure and effort remains a tangible improvement of the situation on the ground.

Syrie: Bombarder des civils, ce n'est pas la guerre mais un crime!

Petra Schroeter[1]

Chaque jour, 90 civils dans le monde sont victimes des armes explosives: bombardements aveugles, tirs de mortiers ou d'obus. Il est temps de les protéger! Avec sa campagne de mobilisation «Stop Bombing Civilians», Handicap International appelle à l'arrêt immédiat des bombardements contre les civils et au respect du Droit humanitaire international. La population syrienne paie un lourd tribut à une guerre qui dure depuis plus de six ans.

L'emploi d'armes explosives (mines antipersonnel, bombes à sous-munitions, missiles, roquettes, obus, bombes aériennes), dont certaines sont interdites par des traités internationaux, a significativement augmenté ces quatre dernières années.

Ces armes sont utilisées en zones peuplées dans la majorité des conflits actuels, par les forces du gouvernement ou des acteurs non gouvernementaux. Les pays les plus affectés en 2016 sont l'Irak, la Syrie, le Pakistan, l'Afghanistan, le Yémen et la Turquie[2].

Tous les jours, ce sont 90 civils qui sont tués et blessés par des armes explosives dans le monde. Lorsqu'elles sont utilisées dans des zones densément peuplées, 92% des victimes sont des civils dont de nombreux enfants.

Quand elles ne tuent pas, ces armes barbares blessent et mutilent, forcent les déplacements, détruisent les infrastructures civiles et empêchent de fournir l'aide humanitaire. Un pourcentage élevé de ces armes n'explose pas à l'impact, ce qui représente une menace longtemps après la fin des combats. De plus, elles constituent un obstacle à la reconstruction du pays et plongent la population dans une extrême pauvreté.

L'utilisation d'armes explosives est devenu systématique dans les conflits actuels comme si en situation de conflit, bombarder de façon indiscriminée les civils était considéré comme acceptable, voire normal. Leur recours massif dans les zones urbaines montre une absence totale de considération pour la vie des civils.

Cela va à l'encontre du Droit international humanitaire qui précise que toutes les précautions doivent être prises pour épargner la population et les biens à caractère civil. Toute attaque doit ainsi respecter le principe de distinction entre civils et combattants. Ces principes fondamentaux doivent être fermement défendus et appliqués.

La population syrienne prise pour cible

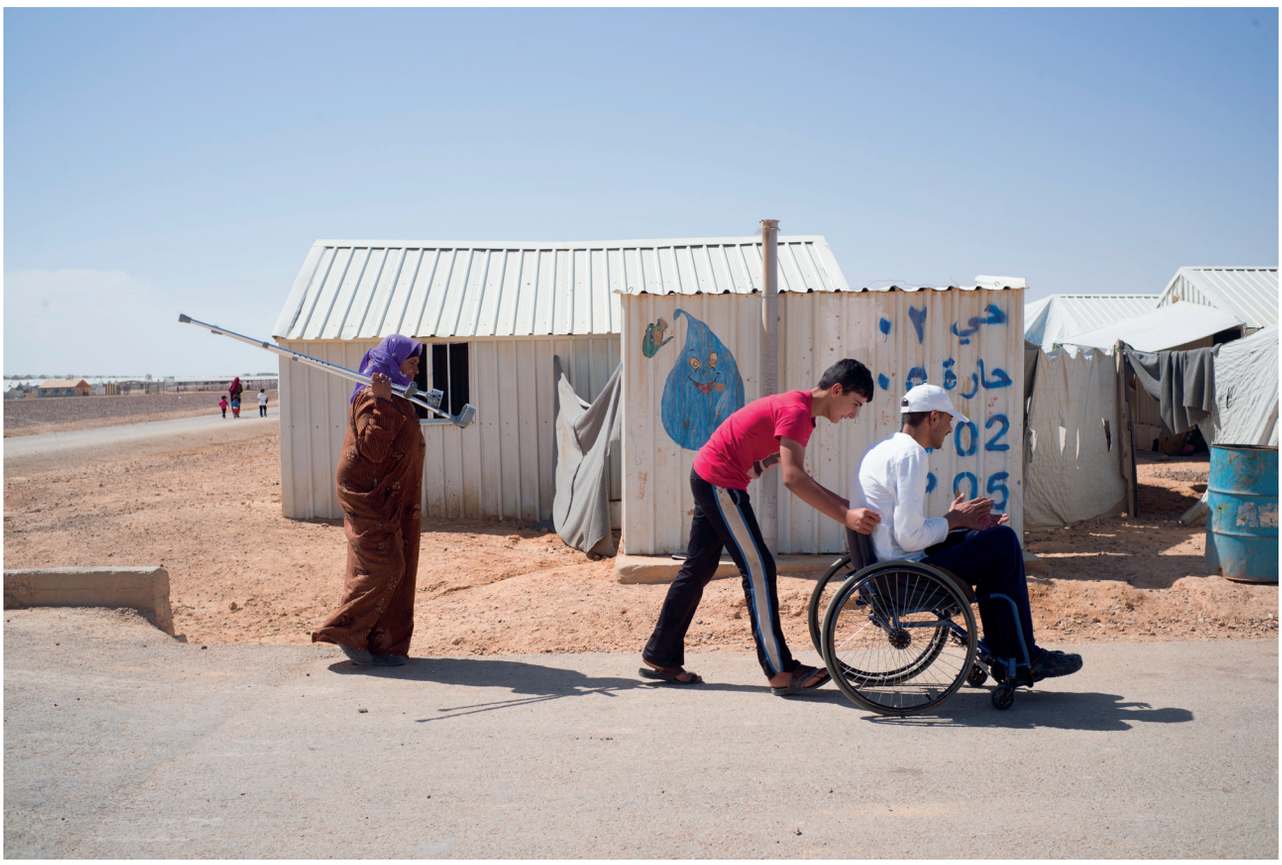
La guerre en Syrie et la crise qu'elle engendre dans toute la région s'imposent comme une catastrophe humanitaire d'une ampleur inégalée depuis la seconde guerre mondiale, tant par le nombre de personnes déplacées et que par le nombre de pays touchés.

Le bilan humain est si démesuré qu'il donne le vertige: plus de 400'000 morts et près de 2 millions de blessés. Toute une génération souffrira des séquelles sur le long terme et des décennies seront nécessaires pour remettre le pays debout une fois le conflit terminé.

Les bombardements et pilonnages d'une intensité inouïe sur la population civile sont devenus la règle. En Syrie, 90% des bombardements se font dans des zones peuplées. Ils ont atteint un seuil épouvantable en 2016, avec des effets dévastateurs sur les Syriens et les infrastructures essentielles du pays, anéantissant les tissus social et économique, etc. Un chiffre est particulièrement révoltant: 85% des victimes sont des civils.

1 Directrice de Handicap International Suisse

2 Action on armed violence, 2011-2014: The impact of explosive weapons. Lien: http://aoav.org.uk/explosive-weapon-survey



Jordan, Camp Azraq Mohammed
PHOTO: FOHLEN C. / Handicap International

Blessures physiques et souffrance psychique

Le rapport «*Syria, A Mutilated Future*»[3] met en évidence les conséquences dévastatrices des bombardements sur la population syrienne. En raison de leurs effets de souffle et de fragmentation, les armes explosives tuent et causent des blessures complexes, graves et invalidantes qui requièrent un accès immédiat à des soins médicaux adéquats et à une chirurgie traumatologique appropriée[4]. Selon le rapport, 15% des victimes recensées ont dû être amputées, 47% des blessés souffrent de fractures simples ou complexes, et 80% sont traumatisées et en grande détresse psychologique.

Le manque d'accès aux soins aggrave les effets des armes explosives sur les blessés. L'absence de services médicaux adaptés - en raison de l'effondrement du système de santé en Syrie ou de l'incapacité des structures médicales à répondre aux besoins des réfugiés blessés dans les pays limitrophes - a des conséquences graves sur les patients: séquelles avec douleurs à vie, amputation, déformation du membre touché, handicap voire décès.

Déplacements massifs de populations

L'utilisation intensive des armes explosives en zones peuplées est l'une des causes premières du déplacement en masse des Syriens. La moitié de la population est déplacée, soit 11 millions de personnes. Parmi eux, 5 millions se sont résolus à trouver refuge dans les pays voisins (Liban, Jordanie et Irak), où bon nombre peine à trouver de quoi se nourrir et se loger.

Le rapport «*Everywhere the bombing followed us*»[5] montre que la population est forcée de fuir à de nombreuses reprises, jusqu'à 10 fois, avant de trouver un

3 Syria a mutilated future, mai 2016. Lien: http://bit.ly/2g70vdK

4 L'utilisation d'armes explosives en Syrie: un héritage mortel, mai 2015. Lien: http://bit.ly/1UPJMqf

5 Everywhere the bombing followed us, octobre 2017. Lien: http://bit.ly/2ya68N2

refuge sûr. Ces déplacements multiples sont la cause de situations de grande précarité et d'une grave détresse psychique.

Amira, 44 ans, vivait dans un village de la région d'Alep, où elle était enseignante. De 2012 à 2015, elle a été témoin des bombardements dans son village avant de pouvoir fuir, d'abord en Turquie puis au Liban en 2016. Un de ses fils a été tué lors d'un bombardement et elle vit maintenant seule avec son plus jeune fils, âgé de 13 ans. Elle souffre de dépression et est toujours sous médication. Elle raconte: *«Lorsque les bombardements commençaient, il n'y avait qu'une chose à faire: fuir et se cacher. Nous étions comme des chiens, tremblants et terrifiés. Le monde entier tremblait avec moi. Les gens couraient de gauche à droite, et se heurtaient les uns aux autres dans un état de chaos et de peur; même les animaux couraient. A chaque fois que les bombardements s'intensifient, les gens s'échappent; c'est la même chose dans toutes les villes. Nous étions continuellement contraints de nous réinstaller quelque part et de migrer. Pour les Syriens, la vie et la mort sont sur la route. Ceux qui n'ont pas quitté la Syrie sont déplacés à l'intérieur du pays, des milliers de fois. Il n'y a pas d'endroit sûr, pas de perspective d'avenir.»*

Bombardements et pilonnages sont la première cause de leur départ forcé dans et de leur ville de résidence (36 %), après les violences armées (25%) et la montée de la criminalité à l'intérieur du pays (23%). Etre personnellement blessé ou avoir un proche tué par un bombardement, la destruction des résidences, celle des infrastructures publiques, notamment la détérioration des services de santé, l'effondrement des moyens de subsistance, principalement dans les zones péri-urbaine, sont à l'origine du déplacement forcé et en masse de la population syrienne.

Paupérisation et traumatisme

Le rapport met également en avant la paupérisation des populations, qui ont souvent tout perdu à cause des bombardements: 44 % des personnes affirment avoir perdu leurs moyens de subsistance (bétails, commerces, etc.). Les personnes déplacées ont perdu une partie de leurs biens et de leurs moyens de subsistance à plusieurs reprises, à chaque fois qu'elles étaient victimes ou exposées à de nouvelles violences et forcées de se déplacer à nouveau.

Sara, 35 ans, vient d'une ville près de Daraa. De 2012 à 2015, sa famille a été forçée de fuir de ville en ville en Syrie. En 2016, elle trouve finalement refuge au Liban. *«Notre maison a été détruite. Nous avons tout perdu. Nous n'avons pas eu le temps de rassembler nos affaires, alors nous n'avons rien pu sauver. Nous n'avons pas fui en voiture. Les voitures étaient des cibles de bombardements et de tirs, c'était trop dangereux. Alors nous avons marché. Dès que nous avons commencé à fuir, notre vie est devenue très différente. Nous n'avions pas toujours de quoi manger ou boire. Il nous arrivait de ne rien manger pendant plusieurs jours.»*

Perte du domicile, des sources de revenus, appauvrissement brutal, perte des repères liée aux déplacements forcés, déscolarisation des enfants, dépendance nouvelle à l'aide caritative…, sont les conséquences dramatiques des bombardements massifs en Syrie. Elles s'accompagnent souvent d'un fort sentiment de perte de dignité exprimé par les personnes interviewées.

Amira l'enseignante de 44 ans, en parle en ces termes: *«La migration forcée est une humiliation. Le besoin est humiliant; vivre dans une communauté qui n'est pas la vôtre est également humiliant. Nous avons un dicton populaire qui dit: ceux qui quittent leur maison perdent leur valeur.»*

Après les risques physiques (50 % des réponses), la destruction du domicile et des infrastructures publiques (36 %), les conséquences psychologiques comme la peur, le stress, la détresse sont mentionnées comme étant des conséquences directes liées à l'utilisation des armes explosives en Syrie (35 %). Les destructions provoquées par les bombardements ont un impact spécifique sur les femmes, se traduisant par une plus grande vulnérabilité face au chaos social engendré par ces bombardements, l'effondrement de leurs moyens de défense, de leur intégrité physique, et une plus grande vulnérabilité aux actes criminels.

Destruction des infrastructures civiles

En 2016, les bombardements et pilonnages ont atteint un niveau terrifiant avec 36 000 attaques impliquant des armes explosives[6]. Les habitations des villes et des villages, les infrastructures civiles essentielles telles que les hôpitaux, les écoles, les systèmes d'électricité et d'approvisionnement en eau, les champs… et les routes ou systèmes de transport: tout est dé-

6 Source International NGO Safety Organisation (INSO)

truit. Entre juin et décembre 2016, la bataille d'Alep illustre cette utilisation massive des armes explosives en zones peuplées, avec un nombre de victimes multiplié par trois en 2016.

Amira d'un village de la région d'Alep raconte: «*Les bombes aériennes, les roquettes, les missiles tirés à l'épaule, les mortiers, les pistolets antiaériens, cela venait de partout, tout autour de nous. À chaque fois, nous avions l'impression que nous, les civils, nous étions au milieu de tout cela, pris au milieu de la guerre, sans nul part où aller. Nous vivions dans le suspense, attendant dans la peur que quelqu'un ne meure dans un bombardement, d'un accident par mine ou d'une maladie. Ou alors ils mourraient parce que nous n'avions pas de médecins et pas d'hôpitaux où aller: plusieurs femmes sont mortes en couche et plusieurs enfants sont morts parce qu'il n'y avait pas d'hôpitaux à proximité où les emmener.*»

Depuis le début du conflit en Syrie en 2011, plus de 450 structures de santé ont subi des attaques et plus de 750 personnels médicaux ont été tués[7]. Pour la seule année 2016, environ 200 attaques sur des centres de santé ont été recensées dans le pays par l'Organisation mondiale de la santé. Les hôpitaux sont régulièrement ciblés, directement ou indirectement, causant à chaque fois des morts, des blessés et des destructions.

Layal, 23 ans, vient de la région située à l'Est de Damas. Femme au foyer, elle vivait avec son mari, tailleur, et son fils avant d'être blessée par un tir d'artillerie. «*L'hôpital où j'étais soignée était loin d'être l'un des hôpitaux les mieux équipés. Je dirais que c'était plutôt un dispensaire. Le personnel était capable de faire des opérations d'urgence mais ils leur manquait l'équipement dont j'avais besoin. Aussi, c'était un endroit effrayant. Il a subi de nombreux tirs d'artillerie. Les bombes ne pouvaient pas nous atteindre car nous étions tous au sous-sol mais, vous savez, nous ne nous sentions pas en sécurité malgré tout. Nous savions que l'hôpital était une cible. Tous les hôpitaux le sont.*»

Un hôpital soutenu par Handicap International dans le Gouvernorat de Deraa dans le Sud de la Syrie a été indirectement touché par un bombardement en février dernier. Plusieurs membres du personnel ont été blessés et le bâtiment a été partiellement détruit. Ce nouveau bombardement touchant un hôpital témoigne d'un mépris absolu pour la vie des civils.

D'après l'Unicef, plus de 80 écoles ont été attaquées en 2016. Au total depuis le début du conflit, ce sont plus de 7 000 établissements scolaires qui ne peuvent plus être utilisés parce qu'ils sont détruits ou endommagés, servent d'abris à des familles déplacées ou sont utilisés par des forces armées.

Amira, enseignante vivant dans la région d'Alep, se rappelle: «*Lorsque l'école n'était pas fermée, de nombreux enfants restaient quand même à la maison parce qu'il aurait été trop dangereux pour eux de marcher jusque là-bas. Même pendant les cours, nous ne nous sentions pas en sécurité. J'étais l'un des rares professeurs restant dans le village. Pendant un certain temps, les personnes déplacées dormaient dans les écoles. Les deux écoles dans lesquelles j'ai travaillé ont été bombardées. Beaucoup de personnes sont mortes lors de ces bombardements. En dehors de l'école, là où les enfants jouaient, il y avait toutes sortes d'armes non-explosées et, à l'extérieur de la ville, il y avait des mines partout.*»

Une pollution durable par les restes explosifs

Lors d'une attaque, un pourcentage variable des armes n'explose pas à l'impact, représentant une menace mortelle durable pour les survivants longtemps après les combats. La présence de restes explosifs de guerre rend périlleux le retour des populations dans leurs quartiers une fois l'attaque passée ou le conflit terminé. Elle entrave toute reprise sociale et économique des pays et des régions après un conflit.

Les dégâts dans les villes, à l'instar de Kobané, sont terribles. Les frappes aériennes et les combats au sol ont détruit près de 80% de la ville, avec un niveau de contamination par les restes explosifs de guerre d'une extrême diversité et densité.

Sara, 35 ans, dont la famille a été forçée, durant trois ans, à fuir de ville en ville en Syrie, raconte: «*Les mines étaient partout, surtout autour des villes, des villages, des groupes de maisons et des bâtiments agricoles. Il y avait des mines dans les champs, dans les vergers et sur les bords des routes. Beaucoup ont été tués par les mines. Afin de les éviter pendant notre fuite, nous marchions dans les traces de pas, de voitures, de camions ou de tracteurs. Nous marchions en ligne, des centaines de personnes distantes de 5 à 10 mètres, une file qui s'étendait si loin qu'on en voyait pas la fin. Mais cela ne*

7 Source UOSSM (Union of Medical Care and Relief Organizations).

fonctionnait pas toujours. Quand quelqu'un marchait sur une mine et mourrait, nous devions abandonner les corps sur place, sans interrompre notre marche trop longtemps et enterrer un corps était bien trop risqué.»

Dans son rapport «*Utilisation d'armes explosives en Syrie: un héritage mortel*»[8], Handicap International alerte sur le niveau élevé de pollution par ces armes dans tout le pays. Plus de 5 millions de Syriens vivent dans des zones hautement contaminées, parmi eux plus de 2 millions d'enfants. La présence de restes explosifs de guerre sur le territoire syrien a atteint une telle concentration, en raison de l'intensité des bombardements, que les opérations de dépollution prendront au moins trente ans.

Une campagne pour dire STOP aux bombardements des civils

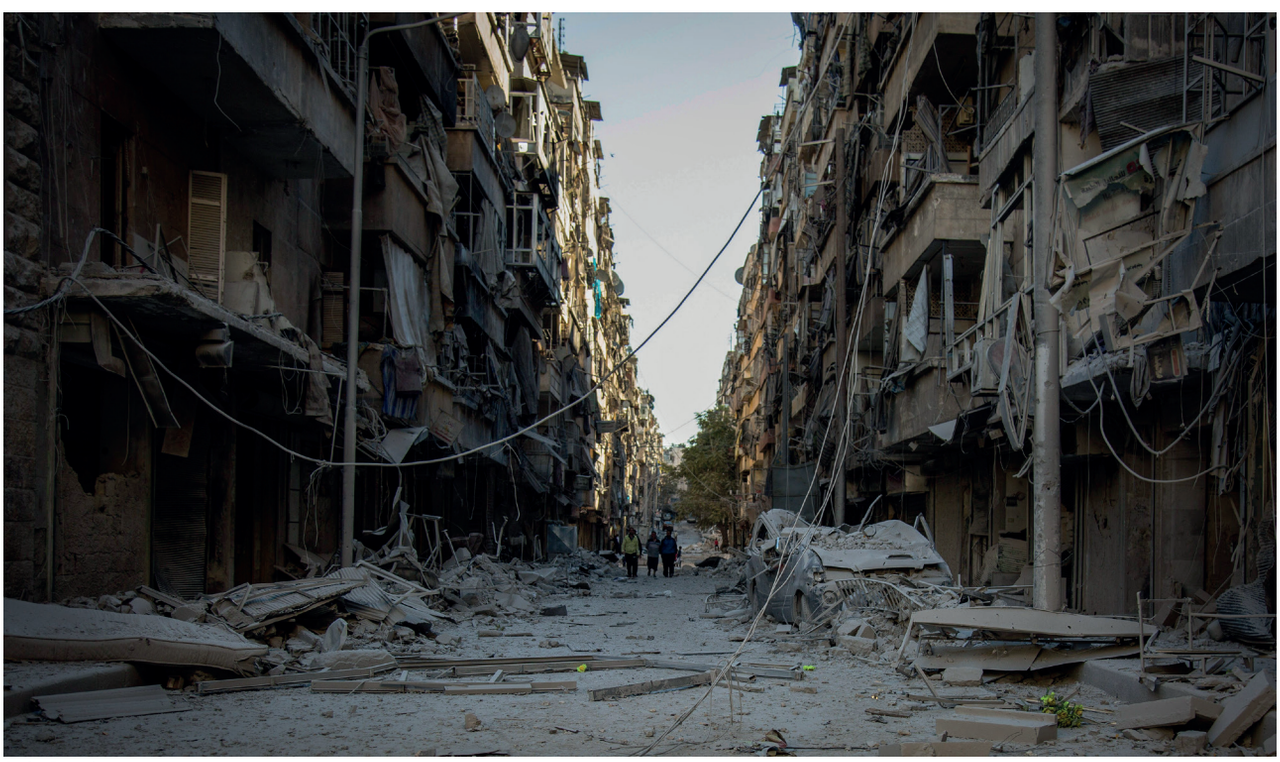
Cet usage massif d'armes explosives en zones peuplées et sur les infrastructures civiles est une pratique qui viole le Droit International Humanitaire (DIH). Ce dernier impose de protéger les civils lors de conflits, de les distinguer des combattants lors d'attaques et de permettre de leur acheminer de l'aide. Un impératif humanitaire qui ne semble jamais avoir été pris en compte dans cette guerre.

Les parties aux conflits doivent tout mettre en œuvre pour épargner la vie des civils. Il n'est pas acceptable que des hôpitaux ou des structures de santé soient atteints par ces bombardements, empêchant l'accès à des soins vitaux à des civils plongés au cœur des combats. La communauté internationale doit condamner avec davantage de force ces attaques et peser de tout son poids pour les faire cesser.

C'est pour dénoncer et mettre fin à ces pratiques inadmissibles que Handicap International a lancé la campagne de mobilisation citoyenne «**Stop Bombing Civilians**». Elle cherche à alerter l'opinion publique et les Etats sur les effets dévastateurs pour les civils de l'utilisation des armes explosives en zones peuplées.

Handicap International œuvre au sein de la coalition INEW (**International Network on Explosive Weapons**) à l'élaboration d'une déclaration politique visant à mettre fin à l'utilisation des armes explosives en zones peuplées, afin d'amener les Etats à s'engager contre cette pratique barbare et à y mettre fin. Car bombarder les civils ce n'est pas la guerre, c'est un crime!

8 Utilisation d'armes explosives en Syrie: un héritage mortel. Analyse de la contamination par les armes en Syrie, mai 2015. Lien : http://bit.ly/1QEaCzT



Syria, East Aleppo
PHOTO: ALMASRI Karam

Part 2: **Protection de la mission médicale : entre droit et morale**

La protection juridique de la mission médicale

Jonathan Cuénoud[1]

Introduction

Protéger les blessés et les malades dans les conflits armés est la raison même de la naissance du Mouvement international de la Croix-Rouge et du Croissant-Rouge et du droit international humanitaire (DIH) il y a plus de 150 ans. Cette protection n'a cessé de guider le DIH tout au long de son développement. La notion de « mission médicale » regroupe l'ensemble du dispositif et des activités sanitaires et médicales destinées, en période de conflit armé, aux blessés et malades. L'Organisation mondiale de la santé (OMS) a dénombré en 2016, 302 attaques contre la mission médicale ayant résulté en 418 morts et 561 blessés dans 20 pays et territoires[2]. Certaines parties en conflit en ont fait une tactique de guerre. Nous verrons que le DIH octroie une protection dite spécifique, complète et très détaillée, à la mission médicale. Les droits de l'homme viennent ajouter une strate complémentaire de protection qui vient préciser certaines règles du DIH. Les deux corps de droit offrent des règles de protection complémentaires et synergiques à la mission médicale.

La protection spécifique de la mission médicale octroyée par le droit international humanitaire (DIH)

La toute première Convention de Genève de 1864 comportait déjà des protections spécifiques pour les blessés et malades, ainsi que pour le personnel de santé, les unités sanitaires et les transports sanitaires. Les principes les plus importants de cette Convention sont les suivants:

- les belligérants ont l'obligation de recueillir et de soigner les militaires blessés ou malades quel que soit le pays auquel ils appartiennent ;
- le personnel sanitaire, ses établissements et ses véhicules doivent être reconnus comme neutres et par conséquent, être protégés et respectés par les belligérants ;
- le signe distinctif de la croix rouge sur fond blanc symbolise cette neutralité et cette protection.

Ces règles n'ont cessé de se développer pour s'adapter à la réalité des conflits. Ces principes furent donc maintenus, étendus et précisés dans les versions ultérieures des Conventions de Genève adoptés par la suite en 1906, en 1929 et finalement en 1949. Nous verrons qu'en 1977, les Protocoles additionnels aux Conventions de Genève sont également venus développer les Conventions de Genève en élargissant leur protection. Ils ont en outre unifié la protection prévue par les Conventions de Genève pour les blessés et malades, le personnel sanitaire, les unités sanitaires, les moyens de transport sanitaire, le matériel sanitaire civil ou appartenant aux forces armées en regroupant les dispositions pertinentes sous le titre de « mission médicale »[3]. Les règles relatives à la protection de la mission médicale se trouvant dans différents instruments juridiques réglementant différents aspects de sa protection, ce développement n'est pas des moindres. Les dispositions relatives à la protection de la mission médicale sont aujourd'hui largement reconnues comme des règles coutumières. Elles s'imposent donc à toutes les parties en conflits, qu'ils soient internationaux ou non-internationaux ainsi qu'aux Etats qui ne seraient pas parties aux traités pertinents.

Les bénéficiaires de la protection spécifique

Ces dispositions prévoient un régime de protection dit « spécifique » de la mission médicale aux personnes et objets qui sont affectées, par une partie à un conflit, exclusivement à des fonctions médicales. « De par l'exclusivité de cette fonction, ils bénéficient d'une protection spécifique contre les attaques, les

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2 http://www.who.int/emergencies/attacks-on-health-care/attacks_dashboard_2016_updated-June2017.pdf?ua=1

3 Art. 8-31 PAI et 7-12 PAII.

Ukraine, Donetsk, Kievsky Rion District, Hospital 21. An operating block which doesn't have any windows left and that has been covered by bags of sand.
PHOTO: GRANIER-DEFERRE Capucine

atteintes ou d'autres ingérences dans leurs missions pendant la conduite des hostilités »[4]. Ce privilège se manifeste par le port de l'emblème – la croix rouge, le croissant rouge ou le cristal rouge[5]. Les autres personnes (ou objets), même si elles prodiguent des soins de santé, bénéficieront – s'il s'agit de civils – « seulement » de la protection octroyée en leur qualité de civils. Nous nous concentrerons ici uniquement sur les dispositions liées à la protection spécifique et commencerons par en analyser les bénéficiaires.

Les blessés et les malades

Les 1ère et 2ème Conventions de Genève de 1949 sont entièrement consacrées à la protection des blessés, malades, naufragés et des services d'assistance nécessaires pour leur venir en aide. Les combattants deviennent des « personnes protégées » au sens des Conventions de Genève dès lors qu'ils sont blessés, malades ou naufragés et dans la mesure où ils s'abstiennent de tout acte d'hostilité[6]. La Convention de Genève IV et le Protocole additionnel I élargissent cette protection aux blessés, malades et naufragés civils qui, encore une fois, s'abstiennent de tout acte d'hostilité[7].

Le personnel sanitaire

Les soins nécessaires ne peuvent être prodigués que dans la mesure où les personnes qui en ont la charge sont également protégées contre les attaques. C'est donc dans cet esprit que les Conventions de Genève I et II octroie protection au personnel sanitaire militaire exclusivement affecté à cette tâche qui doit être autorisé à remplir ses fonctions sanitaires. Le Protocole additionnel I élargit cette protection au person-

4 Rapport du CICR, Le droit international humanitaire et les défis posés par les conflits armés contemporains (32IC/15/11), Genève, octobre 2015, P. 38.

5 Le lion-et-soleil-rouge mentionné dans les Conventions de Genève et leurs Protocoles additionnels n'est aujourd'hui utilisé par aucun Etat.

6 Voir la définition des personnes protégées aux art. 13 des CGI et II.

7 Voir art. 16 CGIV et 8 (a) et (b) PAI.

nel civil et aux sociétés de secours qui remplissent les conditions requises par les Conventions de Genève[8]. Les Conventions de Genève I et IV protègent de manière similaire les civils qui apportent spontanément des soins aux combattants ou civils malades et blessés[9]. En résumé, jouissent donc de la protection spécifique :

- le personnel sanitaire militaire (permanent ou temporaire)[10] ;
- le personnel sanitaire civil désigné par une partie au conflit[11] ;
- le personnel sanitaire mis à la disposition d'une partie au conflit par des Etats tiers ou des organisations humanitaires[12] ;
- le personnel d'une Société de la Croix-Rouge ou du Croissant-Rouge reconnue et spécifiquement accréditée par une partie au conflit[13] ;
- les civils qui apportent spontanément des soins aux combattants ou civils malades et blessés[14].

Les biens et objets sanitaires

Le DIH protège également, de manière très détaillée, les unités sanitaires[15], les moyens de transport sanitaire[16] et le matériel sanitaire. Tout comme le personnel sanitaire, ces biens doivent être respectés et protégés par les belligérants. Ils ne peuvent pas faire l'objet d'attaques. Ici aussi, le Protocole additionnel I est venu développer la protection prévue par les Conventions de Genève en l'élargissant aux unités sanitaires et aux moyens de transport sanitaire civils[17].

8 Art. 26-27 CGI, 25 et 36 CGIV, 9 § 2 PAI.

9 Art. 18 CGI et 20 § 1 CGIV.

10 Art. 24-25 CGI et 36-37 CGII.

11 Art. 20 CG IV et 8 PAI.

12 Art. 8 PAI.

13 Art. 26 CGI, 24 CGIV, 8 PAI.

14 Art. 18 CGI et 20 § 1 CGIV. En l'absence de définition de la notion de "personnel médicale" dans le PAII, celle-ci doit être comprise de la même manière dans les conflits armés non-internationaux qu'internationaux. Voir le commentaire de l'art. 9 PAII.

15 Art. 19-23 CGI, 18 CGIV, 8 (e) et 12-14 PAI. Voir art. 8 (e) pour une définition complète. Cette notion couvre notamment les hôpitaux et autres unités similaires.

16 Art. 35-37 CGI, 38-40 CGII, 12-22 CGIV, 8 (g) et 21-31 PAI. Voir art. 8 (g) pour une définition complète.

17 Art. 8 (e), (f), (g) et 15 PAI. En l'absence de définition des notions d'unités et moyens de transport sanitaires dans le PAII, celle-ci doit être comprise de la même manière dans les conflits armés non-internationaux qu'internationaux. Voir le commentaire de l'art.11 § 1 PAII.

Nous noterons que du côté du volet pénal, le Statut de Rome stipule que, tant dans les conflits armés internationaux que non-internationaux, sera considéré comme crime de guerre, «le fait de diriger intentionnellement des attaques contre les bâtiments, le matériel, les unités et les moyens de transport sanitaires, et le personnel utilisant, conformément au droit international, les signes distinctifs prévus par les Conventions de Genève »[18].

Résolution 2286 du Conseil de sécurité : Un nouvel élargissement de la protection spécifique ?

Le 3 mai 2016, le Conseil de sécurité a adopté à l'unanimité la résolution 2286[19]. Il s'agit de la première résolution entièrement dédiée à la question du respect de la mission médicale dans les conflits armés. Il est intéressant de noter que cette résolution semble mettre sur un pied d'égalité les agents humanitaires dont l'activité est d'ordre exclusivement médical, leurs moyens de transport et leur matériel et le personnel médical tel que défini par le DIH. Il est donc permis de se demander si la résolution 2286 vient ici élargir la protection octroyée par le DIH. Il y a toutefois lieu de rappeler que la résolution 2286 ne semble pas avoir été adoptée sous la forme d'une décision «contraignante»[20].

La perte de la protection spécifique

Comme nous l'avons vu, le DIH offre une protection spécifique à des catégories de personnes et de biens, militaires et civils, qu'une autorité compétente affecte exclusivement à des missions sanitaires[21]. Cette protection spécifique tombe au moment de la commission d'un « acte nuisible à l'ennemi », « en dehors de leur fonction humanitaire » [22]. La perte de la protection spécifique n'entraine toutefois pas automatiquement la perte de la protection générale octroyée aux civils et aux biens civils. Pour qu'une attaque

18 Art. 8 § 2, let. b, ch. xxiv et 8 § 2 let. e, ch. ii du statut de Rome

19 Elle est issue de l'effort de cinq Etats-membres (au moment de l'adoption) du Conseil de sécurité : Egypte, Japon, Nouvelle-Zélande, Espagne et Uruguay.

20 L'autorité sous laquelle elle a été adoptée, chapitre 7 ou 8, est laissée ouverte et le texte même de la résolution ne contient pas le terme « décide ».

21 Cette protection se manifeste par le port d'un des emblèmes distinctifs (la croix rouge, le croissant rouge ou le cristal rouge).

22 Art. 21 CGI, 34 CGII, 13 § 1 PAI. Ces conditions sont cumulatives. Voir à cet égard le commentaire de l'articl 21 CGI de 2016 du CICR, § 1844.

contre un bien sanitaire se justifie, encore faut-il que le bien en question soit devenu un objectif militaire, c'est-à-dire qu'il doit, de par son utilisation apporter une contribution effective à l'action militaire[23] ou que la personne en question prenne une part directe aux hostilités. Les principes de proportionnalité et de précautions continuent de s'appliquer[24].

Le DIH ne définit ni ne dresse de liste exhaustive des « actes nuisibles à l'ennemi ». Il énumère toutefois un certain nombre de scénarios non constitutifs de ce type d'actes :

- le fait que le personnel de l'unité soit doté d'armes légères individuelles pour sa propre défense ou pour celle des blessés et des malades dont il a la charge ;
- le fait que l'unité soit gardée par un piquet, des sentinelles ou une escorte ;
- le fait que se trouvent dans l'unité des armes portatives et des munitions retirées aux blessés et aux malades et n'ayant pas encore été versées au service compétent ;
- le fait que des membres des forces armées ou autres combattants se trouvent dans ces unités pour des raisons médicales[25].

Les commentaires des Protocoles additionnels indiquent quant à eux que les actes suivants seront constitutifs d' « actes nuisibles à l'ennemi » : le fait d'utiliser des structures médicales pour abriter des combattants ou d'y entreposer des armes ou des munitions, d'y installer un poste d'observation militaire, couvrir des opérations militaires ; le fait de transporter des troupes valides, des armes ou des munitions; ou encore le fait de tirer sur un objectif militaire au combat[26]. La protection ne pourra, même dans ces cas, cesser avant qu'un avertissement ait été donné et qu'un un délai raisonnable soit resté sans effet[27]. Le but est ici de permettre à ceux qui sont en train de commettre un acte nuisible à l'ennemi de mettre fin à leur conduite ou du moins de permettre l'évacuation des blessés et malades[28].

23 Art. 52 § 2 PAI.

24 Breitegger A., Le cadre juridique applicable à l'insécurité et à la violence touchant les soins de santé dans les conflits armés et autres situations d'urgence dans Revue internationale de la Croix-Rouge, Volume 95 Sélection française 2013 / 1 et 2, pp. 76-77.

25 Art. 13 § 2 PAI.

26 Voir les commentaires des articles 21 et 23 PAI.

27 Art. 13 § 1 PAI.

28 Voir les commentaires des articles 13 PAI et 11 PAII.

On retiendra donc que contrairement à ce que certaines parties engagées dans des conflits armés ont pu récemment affirmer, le fait qu'un hôpital abrite des combattants blessés pour leur prodiguer des soins médicaux ne lui fait pas perdre sa protection spécifique. Comme nous l'avons vu, là est tout l'objectif de la protection spécifique octroyée à la mission médicale par le DIH. Les parties en conflit devraient par ailleurs renoncer à toute utilisation à des fins militaires des établissements et services sanitaires. Cette utilisation comporte en effet des risques pour la vie et la santé du personnel sanitaire et de leurs patients et « sape le rôle et l'image des hôpitaux en tant qu'espace sécurisé permettant l'accès à des soins de santé »[29]. Il est en effet primordial pour les parties en conflit de pouvoir avoir confiance dans le fait qu'aucun acte qui pourrait leur nuire ne sera commis par le personnel sanitaire ou depuis une structure sanitaire.

L'obligation de soigner sans discrimination

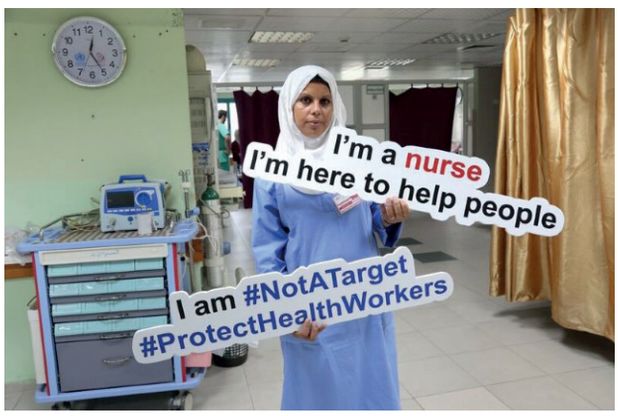
En plus des règles de protection, le DIH consacre l'obligation positive de soigner les blessés, malades et naufragés sans discrimination[30]. Comme nous l'avons vu, tous les blessés, malades et naufragés, qu'ils soient civils ou militaires, et qu'ils aient ou non pris part au conflit armé, doivent être respectés et protégés, et ce à quelque partie qu'ils appartiennent[31]. Selon le DIH, ils doivent se voir fournir, dans la mesure du possible et dans les délais les plus brefs, les soins médicaux que leur état exige[32]. Ces soins doivent être prodigués sans aucune distinction de caractère défavorable fondée sur des critères autres que médicaux. Aucune distinction ne doit donc être faite entre militaires et civils, alliés et ennemis. Sont considérées comme des distinctions de caractère défavorable, celles qui portent sur le sexe,

29 Rapport du Rapporteur spécial sur le droit qu'a toute personne de jouir du meilleur état de santé physique et mentale, 9 août 2013, A/68/297, p. 11.

30 Pour ce qui est des conflits armé internationaux, ce principe est consacré par les articles 12 §§ 2, 3 et 15 § 1 CGI, 12 §§ 2, 3 et 18 § 1 CGII, 16 § 1 CGIV, 10 PAI. Pour les conflits armés non-internationaux, cette règle se base sur l'article 3 commun aux quatre CG qui stipule que « [l]es blessés et malades seront recueillis et soignés ». Les articles 7 et 8 PAII détaillent davantage cette règle. Voir règle 110 du droit international humanitaire coutumier.

31 Etude sur le droit international humanitaire coutumier, règle 110,

32 Etude sur le droit international humanitaire coutumier, règle 110.



Occupied Palestinian Territory, Nurse, joining the #NotATarget campaign
PHOTO: WHO

la race, la nationalité, la religion, les opinions politiques ou tout autre critère analogue. Le DIH et le droit international des droits de l'homme partagent le même objectif[33]. Le droit à la vie, consacré par l'art. 6 § 1 du Pacte international relatif aux droits civils et politiques, prévoit l'obligation de prendre des mesures positives visant notamment à accélérer la fourniture de soins de santé à l'égard de personnes dont la vie est en danger[34]. Le droit à la santé, consacré à l'article 12 du Pacte international relatif aux droits économiques, sociaux et culturels, forme toutefois la base la plus claire pour ce qui est de l'obligation de faciliter et fournir les soins de santé[35]. Le droit à la santé est constitué de quatre composantes : disponibilité, accessibilité, acceptabilité, qualité[36].

L'obligation de soigner sans discrimination a pour double-corollaire : 1) l'interdiction de refuser ou de limiter l'accès aux structures médicales de façon arbitraire, 2) l'interdiction de toute entrave à l'accomplissement des tâches du personnel sanitaire.

L'interdiction de refuser ou de limiter l'accès aux structures médicales de façon arbitraire

Selon le DIH, il est donc interdit de porter atteinte au bon fonctionnement et au ravitaillement des structures médicales[37]. Il incombe en outre aux belligérants de favoriser le libre passage de tout envoi de secours humanitaires (ex : médicaments, matériel sanitaire) de caractère humanitaire et impartial et conduits sans aucune distinction de caractère défavorable, afin d'en permettre l'accès aux victimes[38]. Nous ne rentrerons ici pas dans le détail des dispositions du DIH applicable aux situations d'occupation mais il est à noter que celles-ci sont plus exigeantes et visent à préserver le système de santé public préexistant.

Le droit à la santé prévoit notamment la création des conditions propres à assurer à tous des services médicaux et une aide médicale, obligation qui implique d'assurer un accès rapide et sans aucune discrimination aux services médicaux essentiels[39]. Selon le droit à la santé, les installations, biens et services en matière de santé doivent être accessibles à tous, en particulier aux groupe de populations les plus vulnérables ou marginalisés, et ce sans discrimination fondée notamment sur la race, la couleur, le sexe, la langue, la religion, l'opinion politique ou tout autre opinion, l'origine nationale ou sociale[40]. Dans ce sens, refuser de soigner des personnes blessées lors d'un conflit ou bien réserver un traitement préférentiel aux personnes de même allégeance constitue une atteinte au droit à la santé[41]. Le refus délibéré de fournir des soins de santé peut également constituer une violation du droit à la vie voire même un crime contre l'humanité[42].

33 Breitegger A., op. cit., p. 66.

34 Casier F., Les règles du droit international humanitaire et du droit international des droits de l'homme pertinentes pour la protection des soins de santé et leur accès aux victimes, p. 9, disponible sur : http://www.ismllw-be.org/session/2013-12-05-CASIER%20F%20Texte%20Final.pdf

35 Articles 2 § 2 et 12 du Pacte international relatif aux droits économiques sociaux et culturels.

36 Voir pour plus de détails : Comité des droits économiques, sociaux et culturels, Observation générale n°14 « Le droit au meilleur état de santé susceptible d'être atteint », UN Doc. E/C.12/2000/4, 11 août 2000.

37 Commentaire de l'article 12, §1, du Protocole additionnel I de 1977, § 517.

38 Art. 23 CGIV, 70 PAI, 18 § 2 PAI, règle 55 du droit international humanitaire coutumier.

39 Comité des droits économiques, sociaux et culturels, Observation générale n°14 « Le droit au meilleur état de santé susceptible d'être atteint », UN Doc. E/C.12/2000/4, 11 août 2000, § 28.

40 Ibid., §§ 12 et 18.

41 Rapport du Rapporteur spécial sur le droit qu'à toute personne de jouir du meilleur état de santé physique et mentale, 9 août 2013, A/68/297, p. 7.

42 Pour plus de détails, voir A. Breitegger, op. cit., p. 69.

L'interdiction de toute entrave à l'accomplissement des tâches du personnel sanitaire

De manière générale, l'obligation de respecter les membres du personnel sanitaire implique aussi le devoir de ne pas perturber arbitrairement leur travail afin que les blessés et malades puissent recevoir les soins nécessaires[43]. Le DIH prévoit également que nul ne sera puni pour avoir exercé une activité de caractère médical conforme à la déontologie, quels qu'aient été les circonstances ou les bénéficiaires[44]. Ce principe est de nature coutumière[45] et a été réaffirmé dans la résolution 2286 du Conseil de sécurité adoptée en mai 2016. En outre, les personnes exerçant une activité de caractère médical ne peuvent être contraintes d'accomplir des actes contraires à la déontologie médicale ou aux autres règles médicales qui protègent les blessés et les malades, ou aux dispositions prévues par les conventions de droit international humanitaire, ni de s'abstenir d'accomplir des actes exigés par ces règles[46]. Cet aspect est particulièrement important et doit être réaffirmé à l'heure où les Etats renforcent leur arsenal de mesures pour lutter contre le terrorisme. Certains Etats ont en effet adopté des mesures restreignant ou criminalisant la fourniture de soins médicaux dans des zones contrôlées par des groupes armés considérés comme terroristes ou directement aux membres de ces dits groupes. Ces mesures peuvent avoir une application inappropriée à la fourniture des soins médicaux alors même que les règles du DIH susmentionnées trouvent application. Elles peuvent non seulement dissuader le personnel sanitaire de fournir de soins par craintes de poursuites judiciaires mais également les personnes blessées suite à une participation directe aux hostilités d'accéder aux établissements et services sanitaires[47]. Des docteurs at autres travailleurs sanitaires ont été arrêtés, inculpés et condamnés pour le simple fait d'avoir respecté le caractère impartial exigé par leur profession.

Une telle criminalisation entraine également violation du droit à la santé, droit qui implique l'obligation négative de ne pas faire arbitrairement obstruction aux soins de santé[48].

Conclusion

Le DIH et les droits de l'homme partagent le même objectif pour ce qui est de la protection de la mission médicale. Ils offrent des protections complémentaires et synergiques. Le DIH offre une protection spécifique complète et détaillée à des catégories de personnes et de biens sur la base de leur statut ou de leur fonction. La protection spécifique octroyée par le DIH est plus précise que celle octroyée par les droits de l'homme qui est plus « générale »[49]. Les règles du DIH sont en quelque sorte au service du droit international des droits de l'homme et plus particulièrement du droit à la santé et à la vie dont jouit toute personne[50]. Les mesures positives que les Etats[51] doivent prendre afin de faciliter l'accès aux soins de santé sur une base non discriminatoire sont, elles, plus précisément décrites par les droits de l'homme et en particulier le droit à la santé que par le DIH. Les attaques contre le personnel de santé, les unités et matériels sanitaires, de même que les restrictions aux services de santé peuvent donc non seulement constituer des violations du DIH mais également du droit à la vie et du droit à la santé. Cette complémentarité entre le DIH et le droit international des droits de l'homme apporte non seulement une meilleure protection dans les conflits armés mais garantit l'accès à des mécanismes supplémentaires de responsabilisation pour les Etats et de réparations pour les victimes.

43 Casier F., op. cit., p. 16.

44 Art. 16 § 1 PAI et 10 § 1 PAII.

45 Etude sur le droit international humanitaire coutumier, règle 26.

46 Art. 16 § 2 PAI et 10 § 2 PAII.

47 Rapport du Rapporteur spécial sur le droit qu'à toute personne de jouir du meilleur état de santé physique et mentale, 9 août 2013, A/68/297, pp. 7 et 8. Voir note de Naz Modirzadeh dans le présent numéro.

48 Comité des droits économiques, sociaux et culturels, Observation générale n°14 « Le droit au meilleur état de santé susceptible d'être atteint », UN Doc. E/C.12/2000/4, 11 août 2000, §§ 33 et 43.

49 Le DIH peut donc être ici considéré comme la lex specialis. Voir : Breitegger A., op. cit., pp. 51 et 52.

50 Cet article ne nous a pas permis d'entrer dans le détail des mesures prévues par le droit à la vie.

51 Cet article ne nous a pas permis de rentrer dans le débat de l'applicabilité des du droit international des droits de l'homme aux groupe armés non-étatiques. Nous noterons ici simplement qu'il est de plus en plus reconnu que les groupes armés non-étatiques qui atteignent un certain degré d'organisation et de contrôle territorial sont non seulement liés par le DIH mais devraient également respecter les droits de l'homme. Voir pour plus de détails le Rapport du Rapporteur spécial sur le droit qu'à toute personne de jouir du meilleur état de santé physique et mentale, 9 août 2013, A/68/297, pp. 20-22.

Humanity in the Midst of Armed Conflict: Military Doctors' Ethical Obligations

Daniel Messelken[1]

During wars and armed conflict, the destruction of buildings, infrastructure, and the natural environment on one hand, and the suffering, mutilation, or death of combatants and civilians on the other, are omnipresent. The consequences of war, particularly the unbearable fate of the injured, have been described by Henri Dunant in his book *A Memory of Solferino*.[2] His powerful testimony of the agony and suffering of some 40,000 wounded and dying soldiers on a nineteenth century battlefield has inspired the Red Cross movement and paved the way for the Geneva Conventions.

Health care providers (HCPs) can play an important role in armed conflicts, since it is through their knowledge and efforts regarding medical care that they may relieve the suffering of (some of) the injured. Armies have had doctors accompany them at all times so that their soldiers can receive medical treatment if they are wounded in battle. However, doctors and other HCPs working within military medical services do not have an easy role to play. They find themselves in a unique and demanding position: as medical personnel, they strive to offer the best care to their patients without taking into account patients' nationality, sex, rank, or any other nonmedical criteria. As members of the armed forces, they are part of the military hierarchy and expected to support the military missions they are sent into – missions that are all but neutral in most cases. This can lead to situations with conflicting obligations (either real or perceived) when, for example, during armed conflict, the different obligations from military and medical ethics associated with the two roles are irreconcilable.[3] To put it more bluntly, the doctors' charge to relieve suffering and to care for all patients equally can prove difficult in the face of military necessity. The closer medical personnel are working "embedded" with their combatant comrades, the more their medical role will be blurred with the military role and the distinction become unclear. Military commanders may perceive medical care as an additional asset available to them and disregard the duty of HCPs to provide impartial medical care.

In this short article, we will first illustrate the ethically challenging work of military HCPs with some examples before introducing the legal and ethical obligations to which HCPs are bound. We will conclude that, to avoid a blurring of the different military and medical roles with distinct ethical obligations, it is necessary to clearly separate the medical and military functions in reality.

Examples of ethical challenges for HCPs during armed conflict

Let us illustrate the challenging (dual) role of military HCPs by looking at some ethically difficult situations and problematic issues.[4] I would like to briefly

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2 Dunant, Henri. 1986. A memory of Solferino. Geneva: ICRC.

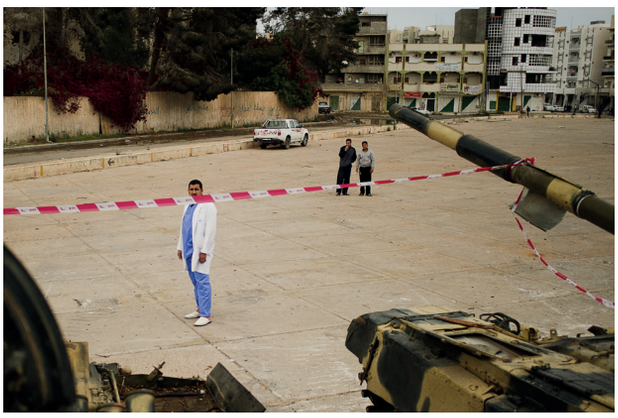
3 On the notion of dual obligations (or dual loyalties) in the military context see for example Allhoff, F. (2008) (ed.): Physicians at war – the dual-loyalties challenge. Dordrecht: Springer.

4 For an overview: Nathanson, Vivienne. 2013. "Medical ethics in peacetime and wartime: the case for a better understanding". International Review of the Red Cross, 95, 189-213.
The ZH Center for Military Medical Ethics in cooperation with the ICMM and other partners has started a collection of scenarios in military medical ethics. It offers a list of ethically difficult situations encountered by military HCPs. It can be accessed via https://scenarios.militarymedicalethics.ch/.

mention three areas that regularly provoke ethical problems during deployment.[5]

First, during missions abroad, military HCPs usually operate in a situation with scarce resources (both of supply and of personnel). Due to resource limitations, HCPs cannot provide the same level of care as in civilian settings and are forced to triage patients, i.e., they can only admit selected patients to their facilities. Consequently, they need selection and admission criteria, and the military environment and chain of command sometimes try to influence the rules of medical eligibility by either imposing nonmedical criteria or by simply demanding the prioritized treatment of some patients for strategic (and thus nonmedical) reasons. Thus, not only are resources scarce, but HCPs see themselves confronted with external pressure regarding how and for whom the resources should be used. Other issues related to scarce resources include offering different standards of care, acting beyond one's own competences (e.g., treating children when no pediatrician is available), and providing suboptimal care. In fact, many ethical issues faced by (military) HCPs would not be present if medical resources were abundant or at least sufficient.

A second area of ethical challenges for military HCPs arises when medicine becomes an instrument for nonmedical purposes. On one hand, this can happen in so-called "winning hearts and minds" campaigns, when medical care is provided to a population with the intention to gain acceptance or support for the military.[6] Medical care thus becomes a means to an end, which itself has nothing to do with medicine. On the other hand, the issue of complicity in abuse of medicine can arise when medicine or the trust usually placed in physicians is abused to achieve nonmedical aims such as gaining intelligence. The suspected use of a vaccination campaign to gain



Lybia, Misrata front line. A doctor looking for people in need of evacuation.
PHOTO: LIOHN, André

widespread DNA information as a tactic to identify the whereabouts of Osama bin Laden is an example.[7] Misusing existing medical intelligence, such as a detainee's condition or phobias, is another one. A last and particularly striking example of abusing medical knowledge is when HCPs are employed to medically monitor detainees in order to guarantee their survival of illegal interrogation methods.

Third, when treating members of enemy forces, local allied military personnel, or local civilians, military HCPs can be confronted with different cultural environments and norms. Simple language barriers, different understandings of the reasons for an illness, or distrust in unknown medical methods could be named as some examples.

Now that we have introduced some of the real-world challenges of military HCPs, the following section looks into the legal framework that guides the provision of health care during armed conflict, namely international humanitarian law (IHL).

5 Some of the ethical issues presented in this article are, in a similar way, also encountered by humanitarian HCPs (namely resource scarcity and intercultural issues). We will however restrict our discussion to military HCPs. For an overview on ethical issues of humanitarian health care see for example Slim, Hugo. 2015. Humanitarian ethics: a guide to the morality of aid in war and disaster. New York: Oxford University Press. Or the Humanitarian Health Ethics Research Group (http://humanitarianhealthethics.net/ [accessed September 29, 2017]).

6 Eagan Chamberlin, Sheena M. 2015. "Ethical Issues in Civilian Medical Assistance Programs." In Proceedings of the 4th ICMM Workshop on Military Medical Ethics, edited by Daniel Messelken and David Winkler. Bern, pp. 47-65.

7 Eckenwiler, Lisa et al. 2015. "Counterterrorism policies and practices: health and values at stake." Bulletin of the World Health Organization 93 (10): 737-738.

Protection of the wounded and of the medical role in IHL[8]

Today's IHL "recognizes death, injury and destruction as an inevitable side-effect of armed conflict, but aims to prevent human suffering where it is unnecessary and to alleviate it where it cannot be prevented."[9] HCPs can significantly contribute to this aim of upholding the principle of humanity in the midst of armed conflict. This is why HCPs are granted a special status and are protected under IHL – albeit indirectly. The reason why the protection granted to HCPs can be described as indirectly justified is because the protection is established to benefit the actual victims of violence in armed conflict, namely the wounded and sick. Common Article 3 of the Geneva Conventions states, "[p]ersons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction […]."[10] The protection of the wounded and sick would, however, be inefficient if those who care for them were not protected as well. HCPs would be unable to fulfill their role and provide medical assistance if they could be legitimately attacked during armed conflict in the same way as combatants. Thus, as "a natural consequence of the requirements designed to assure respect and protection for the victims of armed conflicts,"[11] HCPs working on the battlefield to aid the wounded and sick benefit from the same protection and must be respected as well.

The principle of humanity, which is at the basis of the protection and addressed in Common Article 3, according to the most recent ICRC commentary on the Convention, is "not merely a recommendation or a moral appeal," but in fact "an obligation of the Parties to the conflict under international law."[12] Therefore, protecting and respecting the work of HCPs in armed conflict can be interpreted as a legal obligation. In IHL, we can thus find a clear distinction between combatants and those not involved in the hostilities, and we can also interpret this as what has been labeled as "an explicit separation of the healing role from the wounding role."[13] Doctors and HCPs in general, according to IHL, should act according to their medical role and its associated duties only. They are, as Annas puts it, "Physician First, Last, Always."[14]

The clear assignment and the commitment expected of HCPs in regard to the medical role becomes even more evident when we look into the specific IHL regulations for HCPs. In the Geneva Conventions, within their Additional Protocols as well as in the recent comprehensive ICRC study on international customary humanitarian law, HCPs are explicitly given the freedom to perform their duties autonomously within the framework of their professional ethics, namely medical or health care ethics. In the first Additional Protocol, it is stipulated that "under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom."[15] Anyone who provides ethically acceptable medical treatment to any other person can do so without having to fear legal prosecution, and the HCP shall not be sanctioned otherwise. The more modern customary law study reiterates this regulation by stating in its rule 26 that "[p]unishing a person for performing medical duties compatible with medical ethics or compelling a person engaged in medical activities to perform acts contrary to medical ethics is prohibited."[16] Doctors and HCPs shall

8 For an introduction to IHL, see for example Melzer, Nils. 2016. International Humanitarian Law: A Comprehensive Introduction, Geneva, ICRC. https://www.icrc.org/en/publication/4231-international-humanitarian-law-comprehensive-introduction

9 Ibid., pp. 133f.

10 Common Article 3, The Geneva Conventions of 12 August 1949, Geneva: ICRC, pp. 35f. https://shop.icrc.org/les-conventions-de-geneve-du-12-aout-2259.html [accessed on September 27, 2017]

11 Baccino-Astrada, A. 1982. Manual on the Rights and Duties of Medical Personnel in Armed Conflicts, Geneva, ICRC, p. 31. See also for a more recent account of this argument: Melzer, N. 2016. Op cit., pp. 137.

12 Comment to Art 3, §552. Commentary of 2016 on the First Geneva Convention. Online Publication: ICRC. https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=59F6CDFA490736C1C1257F7D004BA0EC

13 Sidel, Victor W. 2004. "Warfare (II. Medicine and War)" In: Post, S. G. (ed.) Encyclopedia of Bioethics. New York: MacMillan, p. 2562.

14 Annas, George J. 2008. "Military Medical Ethics — Physician First, Last, Always". New England Journal of Medicine, 359, 1087-1090.

15 AP 1, Art. 16. Protocols Additional to the Geneva Conventions of 12 August 1949. Geneva: ICRC, p. 19. https://shop.icrc.org/les-protocoles-additionnels-aux-conventions-de-geneve-du-12-aout-1949.html

16 Henckaerts, J.-M. & Doswald-Beck, L. 2005. Customary international humanitarian law. Cambridge: Cambridge University Press, p. 86.

thus be free to perform their duties without restrictions and according to what is ethically expected from them as medical professionals, be it in peacetime or during armed conflicts.[17]

To summarize this small glimpse into the provisions of IHL, we can thus retain that IHL aims at upholding a minimum of humanity even during armed conflict. Humanity is a "principe essentiel"[18] of IHL and acts as a counterweight to the logic of military necessity, which dominates much of what happens during armed conflict. IHL tries to uphold humanity by inter alia, protecting the victims of war or violent conflict, and by extending this protection to those who work, in the midst of conflict, to relieve some of the suffering, namely HCPs. To aid them and allow their humanitarian work, IHL creates protected spaces and permits HCPs to carry on with their work according to the ethical standards of their profession.

Iraq, Nineveh, Western Mosul, Mosul General Hospital. Portrait of a child at the Hospital
PHOTO: IBRAHIM Sherkhan

17 In another recent publication, I interpret the impartial activities of health care providers during war as a "remainder and prospect of peace" that uphold the sphere of peace during war. See Messelken, D. 2017. "Medical Care During War: A Remainder and Prospect of Peace". In: The Nature of Peace and the Morality of Armed Conflict, edited by F. Demont-Biaggi. Palgrave Macmillan.

18 Pictet, Jean. 1979. Commentaire des principes fondamentaux de la Croix-Rouge. Geneva: Institut Henry Dunant, p. 17.

Ethical principles of health care applicable in armed conflict

Although IHL, as we have just learned, mentions medical ethics and explicitly requires HCPs to act accordingly, it remains unclear to which provisions of medical ethics IHL actually refers.[19] The ICRC, in a small brochure for HCPs working in armed conflict, has distilled "three pillars of health care ethics," namely "respect for the autonomy and dignity of the individual; maintaining confidentiality; and ensuring genuine and valid consent for any procedure."[20] Even though this is a very concise summary of what is usually meant by medical ethics, it is worth looking a bit deeper into the question as to what IHL could mean by referring to "medical ethics." To approach an answer to this question, we may refer to several sources that can all claim to contribute to a comprehensive picture: general ethics, regulations specifically designed for health care in armed conflict, and mainstream medical ethics.

First, we can base the ethical obligations of military HCPs on general ethical principles. The principles of humanity and of respect for human dignity can be mentioned among these general ethical principles. Usually, we also assume a general duty to help or rescue others who are in need of help if we can provide that support without posing too much of a risk or too high cost on the rescuer's part. Someone, for example, who sees a child drowning in a small pond is expected to save the child even if this comes at some cost for him (as long as the rescuer does not have to risk his own life).[21] This general duty can become more stringent if the rescuer has additional competences or capabilities that make the success of the life-saving support more likely – doctors certainly have some of these competences.[22]

19 See for example Mehring, S. 2015. First do no harm: medical ethics in international humanitarian law. Leiden; Boston: Brill Nijhoff, pp. 27-48.

20 ICRC 2012. Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflicts and Other Emergencies. Geneva: ICRC.

21 Saving a drowning child in a "shallow pond" is the famous example used in Singer, P. 1972. "Famine, affluence, and morality". Philosophy and Public Affairs, 1, pp. 229–243.

22 For an overview on the discussion regarding the duty to care, see Messelken, Daniel. 2018. "On the duty to care during epidemics". In: Ethical Challenges for Military Health Care Personnel: dealing with epidemics, edited by D. Messelken and D. Winkler. London: Routldedge, pp. 144-163.

Second, what is meant by (peacetime or ordinary) medical ethics can be deduced from mainstream theories or documents regarding medical ethics. Namely, we can refer to the World Medical Association's (WMA) medical ethics manual[23], which can be considered to also broadly overlap with the principles of the mainstream account of academic medical ethics. According to the WMA manual, doctors and health care personnel should abide by the following ethical standards:

- Remain impartial, treat all patients according to medical needs only, and do not discriminate
- Respect the patient's dignity
- Act in the patient's best interest
- Maintain patient confidentiality and keep medical information secret (unless there is imminent danger for others, e.g., a highly infectious disease)
- Avoid inflicting harm on patients
- Treat individuals and groups fairly and distribute scarce resources in a fair manner

The mainstream account of (bio-) medical ethics with its four well-known principles of patient autonomy, non-maleficence, beneficence, and justice imposes very similar ethical obligations on those working in the health care sector. [24] It is thus safe to assume that current interpretations of what IHL refers to by "medical ethics" could start from these approaches.

Lastly, yet no less important, a few documents and regulations exist that have been designed to provide ethical guidance to HCPs working in armed-conflict scenarios and emergencies. Even if they are rather short, these documents are particularly relevant, as they have been formulated explicitly for an application in the difficult circumstances of armed conflict. The two most relevant documents are the (1) WMA Havana declaration of 1956 (last revision in 2012)[25] and the (2) Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies.[26] The latter document was developed under the lead of the ICRC and has been endorsed by a number of important international organizations such as the World Health Organization (WHO), the WMA, and the International Committee of Military Medicine (ICMM).[27] Similar to the earlier WMA Havana declaration, the 2016 ICRC document states in its first principle that "[e]thical principles of health care do not change in times of armed conflict and other emergencies and are the same as the ethical principles of health care in times of peace." It thus postulates prominently that ethical principles to which HCPs are bound are independent from contexts and circumstances.[28] Both documents, in their main bodies, restate the well-known main principles from "ordinary" medical ethics, such as respecting the patient's dignity, respecting patients' autonomy and acting in their best interest, keeping medical secrets, and distributing resources and medical care without discrimination and according to medical needs only. With all of this taken together, we can reiterate that (military) HCPs working in the context of an armed conflict or even in the heat of the battlefield should respect the same ethical principles as their civilian counterparts. The circumstances can be exceptional, and the application of the principles can take this context into account, but their essence does not change. Doctors and HCPs are there to provide medical assistance to the best of their knowledge, impartially, in a fair manner, and without exhibiting any discrimination.

With regard to an application of the medical ethics principles to the problematic issues of military HCPs introduced earlier in this article, one would come to the following recommendations based on our account of medical ethics: Scarce resources should be distributed according to medical needs only and in a manner to benefit the interests of a maximum number of possible patients, independently of their ori-

23 World Medical Association. 2015. Medical Ethics Manual. 3rd edition. https://www.wma.net/what-we-do/education/medical-ethics-manual/

24 Beauchamp, T. L. & Childress, J. F. 2009. Principles of biomedical ethics, Oxford, Oxford University Press.

25 WMA Regulations in Times of Armed Conflict and Other Situations of Violence (Havana Declaration). https://www.wma.net/policies-post/wma-regulations-in-times-of-armed-conflict-and-other-situations-of-violence/

26 Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies. https://www.icrc.org/en/download/file/21341/icrc_ethical_principles.pdf

27 The document has also been positively received by the Committee of the Chiefs of Military Medical Services in NATO (COMEDS). It is envisaged to use it as standard-relating document within NATO medical doctrine.

28 An almost identical statement can be found in the WMA's Havana declaration.

gin, rank, sex, etc. In other words, (military) HCPs must be allowed to make triage decisions according to medical criteria with no interference. Similarly, the abuse of medicine is ethically unacceptable and must be prevented; HCPs must refrain from participating in any action that uses medicine as a means to further a nonmedical end. Medical care should always be provided without precondition, without distinction, and with the aim of alleviating suffering. The primary role to which military doctors are ethically and legally bound, we can summarize, is that of a physician.

Outlook

In this article, we have tried to show how the role of military HCPs is ethically challenging. They are bound to medical ethics with the aim of upholding a minimum of humanity in the midst of armed conflict, despite being a part of a military organization and wearing its uniform. The independence of medical personnel and their primary obligation to medical ethics can be a challenge during the exercise of the mixed roles that military doctors have to fulfill. Being part of the military hierarchy and nevertheless acting impartially to treat all wounded equally is certainly not an easy task.

In addition, a blurring of the military and medical roles puts the ultimate responsibility on the individual military doctor to weigh the roles against each other. Those with little experience or those working in combat situations may tend to perceive themselves (primarily or even exclusively) as soldiers and neglect their ethical and legal obligations to remain impartial. Group dynamics in small units can amplify this tendency. It is therefore important to clearly separate the healing and fighting roles to avoid confusion and mixed obligations. Embedding medical personnel into combatant forces or transferring medical tasks to combatants is counterproductive to the aim of a clear distinction. This is certainly one reason why IHL requires to distinguish the roles of combatants and HCPs and also stipulates the geographic separation of their activities whenever possible. In addition, IHL makes it very clear that no justification is required for HCPs to act in accordance with health care ethics. Instead, a strong justification is required if they are to deviate from this role. Recently, the UN Security Council has reiterated this position by "stressing the need to uphold their [the HCP's] respective professional codes of ethics."[29]
To reach this aim, it is important that the special role of military doctors with their ethical obligations and legal restrictions is broadly recognized among all members of the military, including combatant forces. The role of the HCP and its restrictions must also be systematically taken into account in operational planning. Only then can we respect and protect medical personnel and their independent, neutral medical duty in accordance with the principle of humanity.

Further reading

- Gross, Michael L. & Carrick, Don (eds.) 2013. *Military Medical Ethics for the 21st Century, Farnham: Ashgate.*

- ICRC 2012. *Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflicts and Other Emergencies, Geneva, ICRC.* https://shop.icrc.org/les-soins-de-sante-en-danger-les-responsabilites-des-personnels-de-sante-a-l-oeuvre-dans-des-conflits-armes-et-d-autres-situations-d-urgence-1171.html [accessed September 28, 2017]

- World Medical Association 2015. Toolkit for Doctors Working in Situations of Violence. Geneva. https://www.wma.net/wp-content/uploads/2016/11/HCiD-toolkit-for-Doctors-2015.pdf [accessed September 28, 2017]

- BMA Medical Ethics Committee and Armed Forces Committee. *Ethical decision-making for doctors in the armed forces: a tool kit, London, BMA.* https://www.bma.org.uk/advice/employment/ethics/armed-forces-ethics-toolkit [accessed September 28, 2017]

- United Nations. 2016. Security Council Resolution 2286 (2016), Strongly Condemning Attacks against Medical Facilities, Personnel in Conflict Situations. http://www.un.org/press/en/2016/sc12347.doc.htm [accessed September 30, 2017].

29 UN Security Council. 2016. Resolution 2286 (2016). Adopted by the Security Council at its 7685th meeting, on 3 May 2016. New York. http://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/2286(2016)

Medical Care in Armed Conflict: International Humanitarian Law and State Responses to Terrorism

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The global fight against terrorism has taken a turn that threatens to erode a foundational ethic of international humanitarian law (IHL): the protection of medical care for all wounded combatants, whether friend or foe. At the same time, aggressive state responses to terrorism illuminate how IHL medical-care protections, while extensive, are often fragmented and non-comprehensive. In short, contemporary counterterrorism policies contradict some of these IHL protections and expose the weakness of key others.

In 1864, states agreed to a pioneering IHL treaty on medical care. It required that the wounded and sick combatants of the warring states who are rendered *hors de combat* (out of the battle) be protected and cared for. Over time, those safeguards were extended to all wounded fighters *hors de combat* of all parties in all armed conflicts. Of course, protections for the wounded would be largely meaningless without access to medical personnel and supplies. So IHL also shields those engaged in medical care and the means they employ to do so. States thereby struck a balance—part practical, part moral—to keep medical care for the wounded and sick above the conflict.

None of these IHL protections is weakened for an enemy if she is defined as a terrorist. For instance, under IHL no wounded fighter may be denied medical care due to a terrorist designation.

Yet as part of their response to terrorist threats, some states attack medical caregivers or abuse, withhold, prevent, or punish medical care. Attacks directed at health-care facilities in terrorist-controlled areas and the use of health-care professionals in the abusive treatment of alleged terrorists have been widely condemned. So, too, have denials of medicine to populations under the control of terrorist groups.

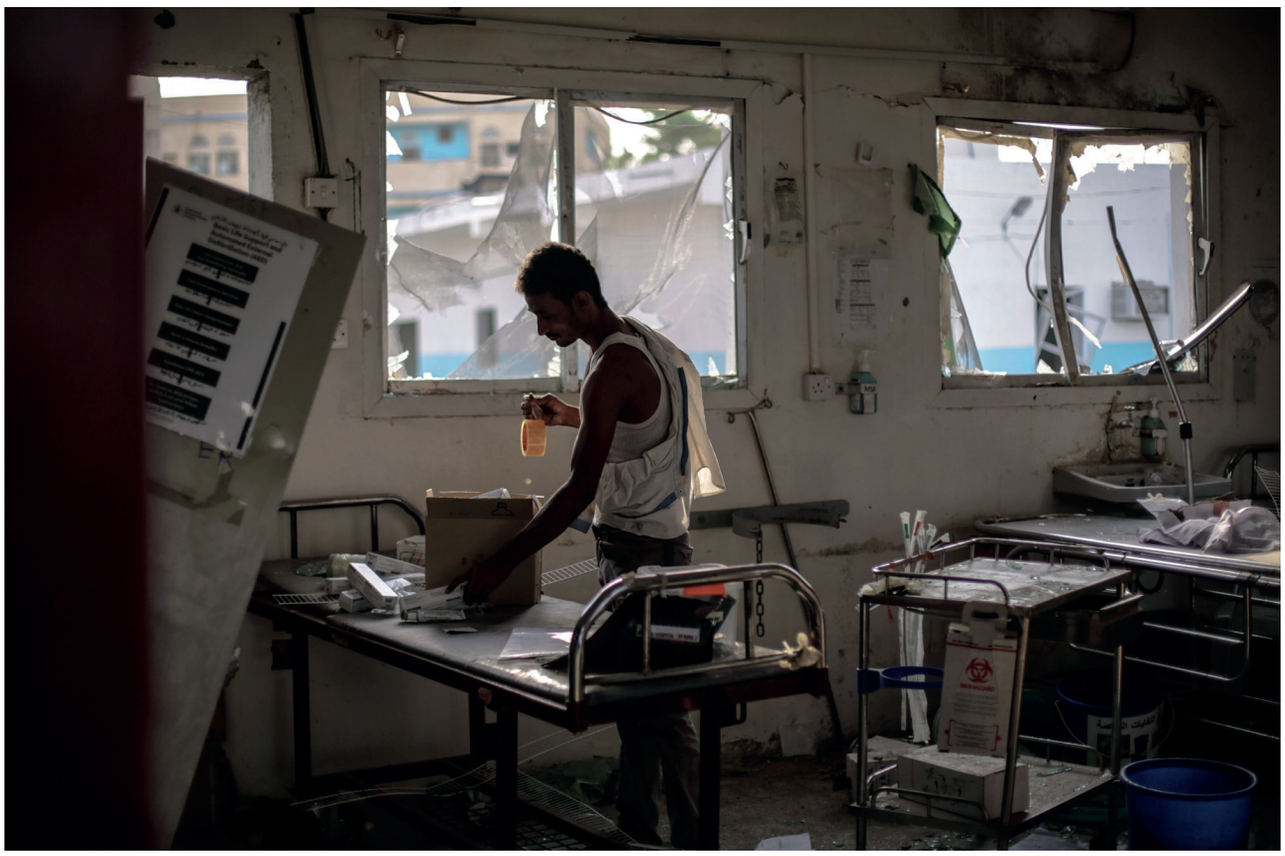
Our inquiry focuses on another element: how, often with the legal force and political backing of the United Nations Security Council, states penalize—during wartime (as well as peacetime)—diverse forms of support, sometimes including medical care, to terrorist organizations. These responses to terrorism reject two of the premises underlying the IHL protections for medical care.

First, counterterrorism policies recast medical care as a form of illegitimate support to the enemy. In comparison, according to the International Committee of the Red Cross (ICRC), the "dominant idea behind" the First Geneva Convention of 1949 is that "medical treatment, *even where given to enemies*, is *always legitimate*, and does not constitute a hostile act. *Medical personnel are placed above the conflict*." Amid swelling concern, in 2011, the ICRC called for states to exclude from anti-terrorism legislations activities that are exclusively humanitarian and impartial in character and that are conducted without adverse distinction. Otherwise, prohibitions of medical services to persons rendered *hors de combat* as support to terrorism would "call into question the very idea behind the creation of the ICRC—and subsequently of National Red Cross and Red Crescent Societies—over 150 years ago."

Second, counterterrorism policies reject the corollary proposition that a terrorist organization may assign a medical corps to work under its authority. Thus, domestic anti-terrorism legislations often prohibit medical caregivers from acting under the direction and control of terrorist groups. In comparison, the IHL system of protection of medical care hinges partly on mutual trust between the warring parties. The display of the Geneva Conventions' distinctive emblems is perhaps the most visible manifestation of that trust. Displaying those emblems notifies the

1 This article is the executive summary of an extensive research by HLS / PILAC: Lewis, Dustin A. and Modirzadeh, Naz K. and Blum, Gabriella, Medical Care in Armed Conflict: International Humanitarian Law and State Responses to Terrorism (September 8, 2015). Harvard Law School Program on International Law and Armed Conflict (HLS PILAC), September 2015. Available at SSRN: https://ssrn.com/abstract=2657036

2 The Program on International Law and Armed Conflict of the Harvard Law School is a strategic partner of the Human Security Division / Political Directorate / FDFA.



Yemen, Hajjah, Abs Hospital, Airstrike aftermath
PHOTO: SHAIF Rawan

opposing side that the personnel and objects bearing them claim to benefit from special protections. IHL requires the warring parties—including organized armed groups—to safeguard that trust by overseeing and controlling their own medical personnel, transports, and units.

As we demonstrate, however, IHL's own commitment to these premises remains incomplete and creates fault lines in the protective landscape. State responses to terrorism exacerbate these fault lines. And counterterrorism policies threaten to further weaken these ethical norms.

These are not mere abstract concerns. Across recent and current armed conflicts, state responses to terrorism have cast a spotlight on the scope and implementation of IHL protections for medical care:

- During its internal armed conflict, Peru prosecuted physicians in part for providing medical assistance to members of Sendero Luminoso (the Shining Path);
- Colombia penalized a medical professional who managed the longer-term specialized care of members of the Fuerzas Armadas Revolucionarias de Colombia (the Revolutionary Armed Forces of Colombia);
- Syria detained physicians who gave medical care to wounded opposition fighters designated as terrorists, and it attacked health-care facilities in terrorist-controlled areas;
- The United States prosecuted an American physician for agreeing to be an "on call" doctor for wounded members of al-Qaeda the next time that doctor travelled to Saudi Arabia; it penalized a different American for seeking to travel to Iraq and Syria to provide medical care to wounded members of the Islamic State of Iraq and al-Sham (ISIS) and in hospitals in ISIS-held territory; and it prosecuted a Canadian in part for providing English lessons in an al-Qaeda clinic in Afghanistan to assist nurses in reading medicine labels; and
- Australia and the United Kingdom are evaluating whether to penalize, upon their return, medics who have reportedly provided medical care in ISIS-held territory—including, potentially, to members of ISIS.

Over the last quarter-century, terrorists and other non-state actors have controlled access to civilian populations in a variety of armed conflicts. Consider Afghanistan, Chechnya, Colombia, Gaza, Iraq, Lebanon, Mali, Nepal, Nigeria, Pakistan, Peru, the Philippines, Somalia, Syria, and Yemen (among others). The number and effects of terrorist attacks are reportedly increasing around the world. And states are designating more organized armed groups as terrorists. We therefore expect that these questions will become more salient and more urgent in a growing number of theaters.

The surge in armed conflicts involving terrorism has brought to the fore the general question of medical care in armed conflict and the particular legal protections afforded to those providing such care to terrorists. Against this background, we evaluate IHL protections for wartime medical assistance concerning terrorists. Through that lens, we expose gaps and weaknesses in IHL. We also examine tensions between IHL and state responses to terrorism more broadly.

While those responses to terrorism highlight fault lines in the IHL landscape of medical-care measures, these ruptures are not new. But they are increasingly noticeable as terrorism is more frequently conceptualized as forming part of armed conflicts and as more states undertake aggressive responses to terrorist threats.

Part of the problem in the normative framework is that not all IHL medical-care measures are universally applicable to all armed conflicts. The oldest fault line is the disparate extent to which the legal regime protects medical care in the two types of armed conflict recognized under IHL: international armed conflicts (IACs) and non-international armed conflicts (NIACs). Traditionally, IHL imposed many more medical-care obligations in IACs than in NIACs. In the 1970s, states attempted to create a more uniform and comprehensive regime. Those efforts met success insofar as states opted into the resulting treaties flattening many of those distinctions. But because numerous states did not contract into the new treaties, those efforts simultaneously exacerbated the fragmentation between states and across conflicts. Over all, selective participation in the legal regime has led to significant variance in states' medical-care obligations.

Meanwhile, an array of medical-care rules has crystallized into customary IHL (which binds all states, regardless of whether the state is a party to a relevant treaty). But a number of important customary IHL medical-care rules identified by the ICRC in a pioneering study lack, in our view, sufficient evidence of states' buy-in. Nor do developments in international human rights law and international criminal law fully resolve the fragmentation or fill the gaps in the IHL protections for medical care.

Furthermore, even the most extensive IAC and NIAC treaties do not exhaustively protect all facets of medical care. To date, for instance, under IHL states have not regulated the capture and retention of medical personnel in NIAC. Nor have they addressed independent caregivers seeking to travel to conflict areas to treat the wounded and sick in terrorist-controlled territory where civilian needs are often greatest.

Against the backdrop of this fragmented protective landscape, states are taking more aggressive approaches to preventing, intercepting, and punishing terrorism. The U.N. Security Council has been a key driver of these responses, requiring member states to take more and broader steps to obviate terrorist threats. Yet so far, the Council has not required that, in doing so, states fully exempt impartial wartime medical care, even in circumstances that would render such care protected under IHL. Rather, the Council seems to consider providing medical assistance and supplies to al-Qaeda and its associates as at least a partial ground for designating those who facilitate such care as terrorists themselves.

The overall result today is unsatisfactory. By prosecuting physicians for supporting terrorists in armed conflicts, some states are likely violating their IHL treaty obligations. But in certain other instances where states intentionally curtail medical care there is no clear IHL violation. Both those *actual IHL violations* and the *lack of clear IHL violations*, we think, are cause for concern. The former represent failures to implement the legal regime. And the latter highlights the non-comprehensiveness—or, at least, the indeterminateness and variability—of the normative framework.

At first glimpse, the legal protections for medical care to an ISIS fighter or a member of the Shining Path may attract little sympathy. But those safeguards represent a fundamental thread that ties the

larger tapestry of IHL protections together. Pulling that thread risks unraveling the broader wartime international law protective regime—a regime that aims, however imperfectly to date, to cover not only terrorists but all wounded people in armed conflict: military and civilian, terrorist and non-terrorist alike.

We first introduce some key concepts and sketch the relationship between the laws of armed conflict and state responses to terrorism. Then we trace the long history of the development of international legal protections for impartial medical assistance in armed conflict. We next illuminate the two major sets of IHL protections for impartial wartime medical care concerning terrorists: first, the entitlement to and the protection of medical care for the wounded and sick; and second, the most salient aspects of the corollary protections for medical caregivers, transports, units, and supplies.

We then discuss—alongside a broader analysis of the relationship between the laws of armed conflict and responses to terrorism—how states are attempting to prevent, disrupt, and punish terrorist threats. We focus on the relatively recent ascendance of the globally oriented anti-terrorism regime emanating from the U.N. Security Council. We also highlight the domestic jurisprudence of three states—Colombia, Peru, and the United States of America—where legal proceedings concerning wartime medical care to terrorists have been instituted.

We conclude by emphasizing that the Security Council's move to legislate global counterterrorism measures has occurred without due consideration—at least due public consideration—of the potential impact on the foundational ethic of IHL entailed in impartial medical care. Nor, in implementing those Council obligations and in devising their own additional anti-terrorism measures, have states sufficiently and publicly evaluated the potential consequences for that foundational ethic. Without duly considering what may be lost, these responses to terrorism risk unwittingly eroding a normative pillar of IHL.

Kunduz Hospital after the Attack
PHOTO: QUILTY Andrew

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37	**L'Asie** **Quelles évolutions et quelles conséquences pour la Suisse?** (1/2005)	• Etat des lieux, une perspective régionale • L'Asie du Sud • L'Asie du Sud-Est • L'Extrême-Orient • Politique asiatique de la Suisse, une approche thématique • Politique économique extérieure de la Suisse: Priorités en Asie • Entwicklungszusammenarbeit und Armutsbekämpfung in Asien

		• La politique de coopération économique au développement en Asie • Frieden, Menschenrechte und Migration – das Engagement des EDA in Asien • Politique culturelle du DFAE en Asie • Herausforderungen für die schweizerische Umweltaussenpolitik am Beispiel der Region Asien
38	**Processus de Barcelone** (2/2005)	• La Méditerranée comme espace invente • Die Bedeutung des Mittelmeerraumes und des Barcelona-Prozesses aus Schweizer Perspektive • 10 ans après Barcelone, où en est le partenariat euro-méditerranéen? • The Euro-Mediterranean Partnership in the run-up to the 10th anniversary of the Barcelona Declaration • Partenariat Euro-méditerranéen ou Partenariat euro-arabe? • Promoting Political and Economic Reform in the Mediterranean and Middle East • L'avenir politique du partenariat euro-méditerranéen: l'Erope face aux dilemmas démocratiques • Barcelone +10: l'immigration comme risque transnational
39	**Globale öffentliche Güter – die Globalisierung gestalten** (3/2005)	• Through the lens of global public goods: Managing global risks in the national interest • Gesundheit als globales öffentliches Gut: eine politische Herausforderung im 21. Jahrhundert • Internationale Finanzstabilität: Nutzen und Beitrag aus der Sicht der Schweiz • Globale öffentliche Güter und das internationale Umweltregime • Globale Gemeinschaftsgüter aus entwicklungspolitischer Sicht • Globale öffentliche Güter und die multilaterale Reformagenda des Millennium +5-Gipfels • The International Task Force on Global Public Goods • Globale öffentliche Güter und die Schweizer Aussenpolitik
40	**Die Schweiz als Schutzmacht** (01/2006)	• Protecting powers in a changing world • Die Vertretung fremder Interessen als Ausgangspunkt für weitergehende Friedensinitiativen • Kleine Schritte, langer Atem Handlungsspielräume und Strategien der Schutzmachttätigkeit im Zweiten Weltkrieg am Beispiel der „Fesselungsaffäre" • Une occasion risquée pour la diplomatie suissen Protection des intérêts étrangers et bons offices en Inde et au Pakistan (1971-1976) • Annexe: Liste des intérêts étrangers représentés par la Suisse depuis la fin de la Seconde Guerre mondiale
41	**Südamerika – Teil des Westens, Teil des Südens** (02/2006)	• Der Linksruck in Südamerika • Die soziale Problematik Lateinamerikas: Ihre Entwicklungsrelevanz • Brésil-Amérique du Sud – partenariat ou Leadership? • Die Schweiz und Südamerika: Herausforderungen, Interessen und Instrumente • Brasilien – Partner für die nachhaltige Entwicklung, Perspektiven für brasilianisches Bio-Ethanol in der Schweiz • La décentralisation dans les Andes ou l'art d'accompagner un processus • Vers une politique scientifique et technologique bilatérale • Coopération scientifique et développement: Diversité et disparités-l'Amérique du Sud à l'aube du XXIe siècle • Argentinienschweizer in der Krise – ein kritischer Rückblick • Stagnierende Entwicklung – zunehmende Auswanderung: Migration als Überlebensstrategie in Südamerika
42	**The Fragile States Debate –** Considering ways and means to achieve stronger statehood (01/2007)	• The International Debate • Seeking out the State: Fragile States and International Governance • Assessing Fragility: Theory, Evidence and Policy • Failed state or failed debate? Multiple Somali political orders within and beyond the nationstate • Sharing the spoils: the reinvigoration of Congo's political system • Administering Babylon – on the crooked ways of state building and state formation • Since when has Afghanistan been a "Failed State"? • Switzerland and Fragile Contexts • Fragile Statehood – Current Situation and Guidelines for Switzerland's Involvement

43	**Islam et politique dans les Balkans occidentaux** **(**02/2007)	• Entre nationalisme laïc et instrumentalisation des institutions religieuses islamiques • Fin de l'hégémonie du S.D.A. et ancrage institutionnel du néo-salafisme • Bibliographie sélective
44	**La politique étrangère de la Suisse : permanences, ruptures et défis 1945 – 1964** (01/2008)	• De la neutralité «fictive» à la politique de neutralité comme atout dans la conduite de la politique étrangère • Partizipation oder Alleingang?Die UNO-Beitrittsfrage aus der Sicht Max Petitpierres (1945-1961) • La Suisse et la conférence des Nations Unies sur les relations diplomatiques • Die Guten Dienste als Kompensationsstrategie zur Nicht-Mitgliedschaft bei der UNO • L'accord italo-suisse de 1964: une rupture dans la politique migratoire suisse • Die Diplomatischen Dokumente der Schweiz (DDS) und die Datenbank DoDiS
45	**Power sharing** **The Swiss experience** (02/2008)	• Sharing History • Sharing State and Identity • Sharing Territory • Sharing Rule • Sharing Democracy • Sharing Language and Religion • Sharing Justice • Sharing Wealth and Income • Sharing Security • Sharing the Future
46	**Efficacité de l'aide:** **Bilan et perspective** (01/2009)	• Efficacité de l'aide et querelles de méthodes: l'émergence de la 'Déclaration de Paris' et ses conséquences • Wirksamkeit: Aktualität und Herausforderungen eines alten Anspruchs der Entwicklungspolitik • Country Ownership and Aid Effectiveness: why we all talk about it and mean different things • Die Wirkung der Entwicklungszusammenarbeit im ultilateralen System • Public Private Partnerships und Wirksamkeit der Entwicklungszusammenarbeit • Der Bedeutungszuwachs von Public Private Development Partnerships • Can Coherent, Coordinated and Complementary Approaches to Dealing with Fragile State Yield Better Outcomes? • The Prospects of Colombia and Latin America concerning the Paris Declaration • Coopération au développement triangulaire et politique étrangère: simple avatar de la coopération bilatérale ou nouvel instrument pour une coopération publique «globale»? • Von Paris nach Accra – und darüber hinaus Lehren aus der Aid Effectiveness Debatte aus der Sicht der Zivilgesellschaft • Opportunities and Challenges for EU Development Cooperation after the Accra High-Level Forum • Aid Effectiveness after Accra: What's next?
47	**Genocide Prevention** (02/2009)	• Today's conversation about Genocide Prevention • Emerging paradigms in Genocide Prevention • Genocide Prevention in Historical Perspective • What is Genocide? • What are the Gaps in the Convention? • How to Prevent Genocide? • Options for the Prevention and Mitigation of Genocide: Strategies and Examples for Policy-Makers • Why the Responsibility to Protect (R2P) as a Doctrine or (Emerging) Norm to Prevent Genocide and Other Massive Human Rights Violations is on the Decline: The Role of Principles, Pragmatism and the Shifting Patterns of International Relations • Risks, Early Warning and Management of Atrocities and Genocide: Lessons from Statistical Research • How to Use Global Risk Assessments to Anticipate and Prevent Genocide • Prevention of Genocide: De-mystifying an Awesome Mandate • Prevention of Genocide: The role of the International Criminal Court • Transitional Justice and Prevention • Seeding the Forest: The Role of Transnational Action in the Development of Meaningful International Cooperation and Leadership to Prevent Genocide • Religion and the Prevention of Genocide and Mass Atrocity • The Systematic Violations of Human Rights in Latin America: The need to consider the concepts of genocide and crimes against humanity from the "Latin American margin"

		• Genocide Prevention and Cambodian Civil Society • A Reflection from the United States: Advancing Genocide Prevention Through a High-Level Task Force • The construction of a global architecture for the prevention of genocide and mass atrocities • The regional fora: a contribution to genocide prevention from a decentralized perspective
48	**La situation des femmes dans le monde arabe** (01/2010)	• « La situation des femmes dans le monde arabe » • La violence domestique à l'égard des femmes dans la société palestinienne • Les femmes dans les professions de la santé en Jordanie • « Dernier voyage à Marrakech » ou Comment moraliser le genre dans une chronique judiciaire • « Féminisme d'État Tunisien »: 50 ans plus tard, la situation des Tunisiennes • La longue marche des femmes marocaines. De Akhawât as-safâ' à la Caravane des droits • Le parcours militant d'une femme kurde de Syrie. De la cause kurde à la défense des droits des femmes • Les représentations des femmes dans le discours nationaliste palestinien autour de la commémoration du cinquantenaire de la Nakba • Représentations de la place des femmes musulmanes dans l'Islam en Suisse romande
49	**Swiss Science Diplomacy** (02/2010)	• Genèse et première croissance du réseau des conseillers scientifiques suisses (1958-1990) • Le réseau suisse des conseillers scientifiques et technologiques de 1990 à la création de swissnex • Gedanken eines Zeitzeugen zum Start des Wissenschaftsrates von 1958 • Douze années japonaises: 1986-1998 • La nouvelle diplomatie scientifique de la Suisse et le modèle swissnex: l'exemple de Boston après 10 ans • La Suisse scientifique dans le monde du 21ème siècle: maintenir le cap ! • Science Diplomacy Networks
50	**Dealing with the Past** (03/2010)	• A Conceptual Framework for Dealing with the Past • A normative conception of Transitional Justice • The right to know: a key factor in combating impunity • Rule of law and international, national justice mechanisms • Reparation programs: Patterns, Tendencies, and Challenges • The role of Security Sector Reform in Dealing with the Past • Dealing with the Past in peace mediation • Pursuing Peace in an Era of International Justice • Transitional Justice and Conflict Transformation in Conversation • Reflection on the role of the victims during transitional justice processes in Latin America • Archives against Amnesia • Business in armed conflict zones: how to avoid complicity and comply with international standards • Masculinity and Transitional Justice: An Exploratory Essay • The application of Forensic anthropology to the investigation into cases of political violence • Dealing with the past: The forensic-led approach to the missing persons issue in Kosovo • A Holistic Approach to Dealing with the Past in the Balkans • West and Central Africa : an African voice on Dealing with the Past • Dealing with the Past in DRC: the path followed? • Challenges in implementing the peace agreement in Nepal: Dealing with the Impasse • Switzerland, the Third Reich, Apartheid, Remembrance and Historical Research. Certainties, Questions, Controversies and Work on the Past
51	**Un Kosovo unitaire divisé** (01/2011)	• Définitions constitutionnelles du Kosovo • Les prérogatives de l'Etat au Kosovo dans la pratique • Approche • Environnement humain au Nord du Kosovo • Grille d'analyse, hypothèses et concepts • Géographie • Populations : descriptions et chiffres • La division au quotidien

51	**Un Kosovo unitaire divisé** (01/2011)	• Economie • Niveaux de vie • Perceptions • Institutions • Trois niveaux de blocages • Etat de droit : quel droit ? • Institutions locales • Efficacité des institutions ? • Les institutions vues par les citoyens • Organisations internationales • MINUK, OSCE, KFOR • EULEX • ICO / EUSR • Le facilitateur de l'UE pour le Nord du Kosovo • Stratégies et discours • Absence de dialogue – politique du fait accompli • Discours inachevés • Stratégie de Belgrade • Stratégie de Pristina • Du partage à la partition ? • Implications d'une partition pour le Kosovo • Dialogue et coopération régionale
52	**Religion in Conflict Transformation** (02/2011)	• Religion in Conflict Transformation in a Nutshell • When Religions and Worldviews Meet: Swiss Experiences and Contributions • Introduction to the Conference "When Religions and Worldviews Meet" • Competing Political Science Perspectives on the Role of Religion in Conflict • Transforming Conflicts with Religious Dimensions: Using the Cultural-Linguistic Model • Culture-sensitive Process Design: Overcoming Ethical and Methodological Dilemmas • Transforming Religious-Political Conflicts: Decoding-Recoding Positions and Goals • Creating Shifts: Using Arts in Conflicts with Religious Dimensions • Diapraxis: Towards Joint Ownership and Co-citizenship interviewed by Damiano A Sguaitamatti • Diapraxis in Different Contexts: a Brief Discussion with Rasmussen • Bridging Worlds: Culturally Balanced Co-Mediation • Connecting Evangelical Christians and Conservative Muslims • Tajikistan: Diapraxis between the Secular Government and Political Islamic Actors • Swiss Egyptian NGO Dialogue as an Example of "Dialogue through Practice" (Diapraxis) • Communities Defeat Terrorism–Counter-Terrorism Defeats Communities, The Experience of an Islamic Center in London after 9/11
53	**« Révoltes arabes : regards croisés sur le Moyen-Orient »** (01/2012)	• Révoltes arabes : Regards croisés sur le Moyen-Orient • La position géopolitique de l'Asie antérieure • Les révoltes arabes : réflexions et perspectives après un an de mobilisation • Printemps arabe et droit public • Le cas syrien • The Arab Gulf Monarchies: A Region spared by the 'Arab Spring'? • La France dans le piège du printemps arabe
54	**Tenth Anniversary of the International Criminal Court: the Challenges of Complementarity** (02/2012)	• Ten Years after the Birth of the International Criminal Court, the Challenges of Complementarity • We built the greatest Monument. Our Monument is not made of Stone. It is the Verdict itself. • Looking Toward a Universal International Criminal Court: a Comprehensive Approach • What does complementarity commit us to? • Justice and Peace, the Role of the ICC • Towards a Stronger Commitment by the UN Security Council to the International Criminal Court • Where do we stand on universal jurisdiction? Proposed points for further reflexion and debate • Challenges in prosecuting under universal jurisdiction • Commissions of Inquiry : Lessons Learned and Good Practices • Towards the Creation of a New Political Community • The Fate of the Truth and Reconciliation Commission in the Federal Republic of Yugoslavia-Serbia

		• When Politics Hinder Truth: Reflecting on the Legacy of the Commission for Truth and Friendship • On Writing History and Forging Identity • Colombia and the Victims of Violence and Armed Conflict • Historical Memory as a Means of Community Resistance • How We Perceive the Past : Bosnia and Herzegovina, 17 Years On • Regional Approach to Healing the Wounds of the Past • Challenges in Dealing with the Past in Kosovo : From Territorial Administration to Supervised Independence and Beyond • Setting up Mechanisms for Transitional Justice in Burundi : Between Hope and Fear • « My Papa Is There » • Transitional Justice Mechanisms to Address Impunity in Nepal • Nepal: Better no Truth Commission than a Truth Commission Manipulated • Spain and the Basque Conflict : From one Model of Transition to Another • Moving to a new Social Truth • Peace and Coexistence • EUSKAL MEMORIA : Recovering the Memories of a Rejected People • France and the Resolution of the Basque Conflict • Democracy and the Past
55	**L'eau – ça ne coule pas toujours de source** **Complexité des enjeux et diversité des situations** **(01/2013)**	• L'Eau douce est au centre du développement de l'humanité, la Suisse est concernée • Empreinte hydrique: la Suisse et la crise globale de l'eau • S'engager sur le front de la crise globale de l'eau au service des plus pauvres: un défi que doivent relever les entrepreneurs des Greentec suisses • Le partenariat innovant de la Haute Ecole de l'Arc Jurassien dans l'acquisition des données pour l'eau et l'agriculture : les nouvelles technologies participatives au service du développement • Se laver les mains avec du savon, une des clés de la santé publique mondiale • De l'or bleu en Asie Centrale • Ukraine: quand la décentralisation passe par l'eau • Noël à Mindanao • La contribution de la coopération économique du SECO au défi de la Gestion des réseaux d'eau urbains • Diplomatie de l'eau: l'exemple du Moyen-Orient • Le centime de l'eau: la solidarité de toute une ville !
	La diplomatie suisse en action pour protéger des intérêts étrangers (01/2014)	• Swiss Diplomacy in Action: Protective Power Mandates • Aperçu historique sur la représentation des intérêts étrangers par la Suisse et sur les activités de Walter Stucki en France • Du mandat suisse de puissance protectrice des Etats-Unis en Iran • Le mandat suisse de puissance protectrice Russie-Géorgie : négociations avec la Russie et établissement de la section des intérêts géorgiens à Moscou • Questions et réponses lors du débat du 15 décembre 2011 • Documents et photographies
57	**Switzerland and** **Internet governance:** **Issues, actors, and challenges** (02/2014)	• The evolution of Internet governance • WHY is Internet governance important for Switzerland? • What are the Internet governance issues? • What are the seven Internet governance baskets? • WHO are the main players? • HOW is Internet governance debated? • WHERE is Internet governance currently debated? • Foreseeable scenarios • Recommendations
58	**Bei Not und Krise im Ausland** Konsularischer Schutz und Krisenmanagement der Schweiz im 21. Jahrhundert **En cas de détresse et de crise à l'étranger** La protection consulaire et la gestiondes crises de la Suisse au 21ème siècle (03/2014)	• „Plane Gut. Reise gut" Der konsularische Schutz der Schweiz • « Départ réfléchi. Voyage réussi » La protection consulaire de la Suisse • Das Krisenmanagement-Zentrum des EDA – Heute und in Zukunft • Le Centre de gestion des crises du DFAE – Aujourd'hui et demain • « Responsable moi ? » La perception de la notion de responsabilité individuelle chez le citoyen suisse se rendant à l'étranger • « Un indien averti en vaut deux » Le point sur l'aventure psychologique des voyageurs

58	**Bei Not und Krise im Ausland** Konsularischer Schutz und Krisenmanagement der Schweiz im 21. Jahrhundert **En cas de détresse et de crise à l'étranger** La protection consulaire et la gestion des crises de la Suisse au 21ème siècle (03/2014)	• „Ich denke immer wieder daran!» Langfristige Verarbeitung von schwerwiegenden Ereignissen • Abseits der Normalrouten Reisealltag eines Afrikakorrespondenten • Konfrontiert mit dem Ungewissen Zwischen institutioneller Pflicht und Eigenverantwortung am Beispiel einer Mitarbeiterin von Mission 21 in der Republik Südsudan • Das kollektive Gedenken zur Bewältigung von Katastrophen • Luxor – 1997 • Drei Tage, die eine Ewigkeit waren • Halifax – 1998 • SR 111 • Thailand – 2004 • Tsunami im indischen Ozean / Tsunami dans l'océan indien • Rückblick vom damaligen Missionschef der Schweizer Botschaft in Bangkok • Rückschau eines Detachierten der Schweizer Botschaft zur Situation im Unglücksgebiet in Thailand • Détachement pour la coordination des interventions dans la zone de Phuket • Learing by doing an der Tsunami-Hotline • Liban – 2006 • « Evacuez ! » • Guerre Hezbollah / Israël • Haiti - 2010 • Im Kriseneinsatz nach dem Erdbeben in Haiti • À la recherche de concitoyens • Evakuation von Kindern • Fukushima - 2011 • Erdbeben, Tsunami, nukleare Verstrahlung • Organisation der Verwaltung / Organisation administrative • Das Krisenmanagement des EDA im Zeitraum 2002 bis 2006 • Das Krisenmanagement des EDA, die Entwicklung bis 2010 • Création du Centre de gestion des crises Multiplication des crises et des défis • Die Konsularische Direktion Konsequente Weiterführung eines Erfolgsmodells • Umsetzungsinstrumente / Instruments de mise en oeuvre • Im Büro fühle ich mich am sichersten Reisehinweise des EDA • Es ist wahrscheinlich, dass das Unwahrscheinliche geschieht Die Entwicklung der Hotline und Helpline EDA • Missions KEP : un témoignage Synergies d'actions Collaboration entre l'Aide humanitaire et le Centre de gestion des crise (KMZ) • Zusammenarbeit in Krisen, eine Notwendigkeit Zusammenarbeit des Eidgenössischen Departements für auswärtige Angelegenheiten mit dem Bundesamt für Bevölkerungsschutz • Protection consulaire : le dynamisme indispensable d'une institution millénaire
59	**Réflexions autour du pétrole au Moyen-Orient** (01/2015)	• A Middle Eastern "Rubik's Cube": Solution Problems Reflections on the First Stage of the Arab Spring • What the Drop in oil prices holds for the Middle East, Russia and beyond? • Pétrole - Moyen-Orient, Irak et Kurdistan irakien : état des lieux et évolution • Petrole et geopolitique au Kurdistan irakien • Vers une indépendance kurde en Irak ? Le Kurdistan et l'évolution de ses relations avec la Turquie • Rente, fédéralisme et transition en Irak : démocratie ou nouvel ordre autoritaire ? • Le Moyen-Orient au cœur des enjeux énergétiques de la Chine • Avec le négoce des matières premières, la Suisse joue sa réputation
60	**The Caucasus Conflicts: Frozen and Shelved ?** (02/2015)	• Abkhazia: Regulations for Trade with Disputed Statehood • Conflict and Peace in South Ossetia – from a Local Perspective • History Dialogue between Georgians and Abkhaz: How Can Working with the Past Pave New Ways? • Bridging Gaps in Civilian Peacebuilding in the Nagorny Karabakh Context • Armenia: An Interior View • Stability without Peace in Chechnya • The Role of the Chairmanship in the OSCE Engagement in the South Caucasus • The Work of the OSCE High-Level Planning Group

		• Mediating Ambiguity – Contrasting the Mediation Perspectives of the Belgrade-Pristina Dialogue and the Geneva International Discussions • Neither War Nor Peace in Georgia: Geneva Discussions Seen from a UN Angle • The EUMM's Work in Georgia
61	**Schweizer Partnerschaft mit der NATO** 20 Jahre Schweizer Teilnahme an der Partnerschaft für den Frieden (01/2016)	• 20 Jahre PfP: Geschichte und Rückblick der Schweizer Erfahrungen • Adolf Ogi: „Die Partnerschaft für den Frieden ist vielleicht der beste Deal, den wir je erhalten haben" • 20 Jahre Schweizer Beteiligung an der Partnerschaft für den Frieden mit der NATO • Behutsame Schritte in die Partnerschaft für den Frieden - Überlegungen eines aussenstehenden Beobachters • Die Schweiz und die NATO vor der Partnerschaft für den Frieden,1949-1995 • Aktueller Stand der Beziehungen • Partnerschaft für den Frieden: sicherheitspolitische Einbettung • Aussenpolitische Bedeutung der Partnerschaft für den Frieden • Le rôle de la Mission suisse auprès de l'OTAN • Der Beitrag der Genfer Zentren zur Partnerschaft für den Frieden • Praktische Aspekte der Schweizer Teilnahme an der PfP und die Rolle der PfP angesichts aktueller Herausforderungen • Entwicklung der Partnerschaft und ihre Bedeutung für die Schweizer Armee • Le Partenariat pour la Paix: tout bénéfice pour les Forces aériennes • Praktischer Nutzen der Partnerschaft für die Schweizer Armee • Utilité de l'interopérabilité • Nutzen der Partnerschaft für die einsatzorientierte Ausbildung in der Friedensförderung • armasuisse und die Partnerschaft für den Frieden • Einsatz der SOG im Rahmen von «Partnership for Peace» • Les défis du PPP • Die PfP aus Sicht anderer europäischer Staaten • 20 Years of Austrian Partnership with NATO – Record and Outlook • Finnish view of NATO Partnership • Ausblick: Wie entwickelt sich die PfP in der Zukunft? • Rethinking NATO's Partnerships for the new security environment • PfP, Multipolarity and the Challenges in the Middle East and North Africa • Die Schweiz und der Wandel der NATO-Partnerschaftspolitik, 1996-2016
62	**Der Bund und die Auslandschweizerinnen und -schweizer** La Confédération et les Suissesses et Suisses de l'étranger (02/2016)	• Die Tätigkeit des Bundes für eine starke Verbindung der Auslandschweizerinnen und Auslandschweizer zur Heimat • Invitation à la decouverte des Suissesses et Suisses de l'étranger • Mobility to and from Switzerland • La construction de la Cinquième Suisse au cœur de l'internationalisation de l'économie • Aktuelle Entwicklungstendenzen des Profils der Auswanderinnen und Auswanderer aus der Schweiz • Die Aus- und Rückwanderungsberatung des EDA • Stagiaires: Auslandschweizerinnen und Auslandschweizer auf Zeit • Gelebte Mobilität in der beruflichen Grundbildung im Technologiekonzern Bühler • Schweizer (Berufs-)Bildung im Kontext internationaler Mobilität • Neue Wege für das Studium im Ausland • Que fait concrètement le SECO pour aider les Suisses de l'étranger ? • Les 50 ans de l'article constitutionnel sur les Suisses de l'étranger • Immatriculation hier, annonce aujourd'hui – un exemple de lien entre le citoyen à l'étranger et les autorités de la patrie • eVERA – à l'heure des services consulaires en ligne • La Cinquième Suisse, maillon important du réseau de contacts de notre diplomatie • Lyon - Depuis 2010 • Sydney - Zweimal Nationalfeiertag 2015 • Kairo - „Revolution" 2011 • Los Angeles - 2010 bis 2013 • Bangkok - 2009 bis 2015 • New York - de 2010 à 2014 • Mailand-Abidjan-Wellington - 2005 bis 2016 • Seoul - 2012 bis 2016 • Hong Kong - 2014 bis 2015 • Die Schweizer Revue zwischen Leistungsauftrag und Sparvorgaben • Swissinfo.ch – der Link zur Heimat • Der Bund und die Ausübung der politischen Rechte aus dem Ausland • Die Sozialhilfe für Auslandschweizer und Auslandschweizerinnen

62	**Der Bund und die Auslandschweizerinnen und -schweizer** La Confédération et les Suissesses et Suisses de l'étranger (02/2016)	• Der Zugang zur Sozialvorsorge des Bundes für Auslandschweizerinnen und Auslandschweizer • Haben Schweizer Banken etwas gegen Auslandschweizerinnen und Auslandschweizer als Kunden? • Der Schweizerverein Helvetia: Ein Stück Heimat in Hamburg • Die Plattform in einer Region ausserhalb der Metropolen: Der Schweizerverein Jütland und Fünen • Das Swiss Institute, New York • Pro Ticino, l'associazione che riunisce i ticiniesi fuori cantone … in rete • Vous avez dit OSE? • Die ASO und die Jugend • Schweizerschulen im Ausland • Erinnerungen an die Schweizer Schule Rom • Portrait d'une école suisse à l'étranger : le Colegio Helvetia de Bogota • Mit zwei Kulturen aufzuwachsen bringt viele Erfahrungen und erweitert den Horizont • Die Schweizerschule Bangkok und ihr Patronatskanton Luzern • Von der Schweiz nach Mexiko und wieder zurück
63	**Die Auslandschweizergemeinschaft: Profil – Netze – Partnerschaften** **La communauté des Suisses de l'étranger : profil – réseaux – partenariats** (03/2016)	• Internationale Wanderungen von Schweizer Staatsangehörigen • Schweizerinnen und Schweizer in der Volksrepublik China: jung, mobil und auf der Suche nach Herausforderung • Les habitants suisses des régions françaises limitrophes de la Suisse • Südbaden und die Schweizer – einkaufen ja, wohnen nein? • Zuwanderung von Schweizerinnen und Schweizern: eine deutsche • Perspektive • Auslandschweizer sind mehrheitlich Doppelbürger – Grund und mögliche Folgen • Chancen und Schwierigkeiten der Doppelbürgerschaft in Frankreich • Wenn Statistiken an ihre Grenzen stossen – das Beispiel der Schweizerinnen und Schweizer in Israel • Integration und Assimilation in fremden Ländern • Kästen und Interview: Beispiel Thailand • «Migration in den Herkunftsstaat der Vorfahren»: Das Beispiel von Personen schweizerischer Abstammung aus Argentinien • La Cinquième Suisse, maillon important du réseau de contacts de notre diplomatie • Die Partnerschaften des Bundes
64	**In Support of Federalism Debates** (01/2017)	• What is federalism, what are federations? • What are origins, rationales and determinants of federal systems? • What are 'alternatives' to federalism? • Federalism in contexts of peace-statebuilding and democratic transitions • Federalism debates as part of peace negotiations, national dialogue and constitutionk making • Common issue: who shall participate? • On dynamics of debates on substance and possibilities to manage them • How to demarcate federal units? • How to distribute powers and resources? • What to consider when establishing the second chamber of parliament? • How much importance shall federalism give to ethnic diversity? • Shall federal units have their own Constitution? • Do federal units have a right to self-determination? • When do federations fail? • What aspects of the federal design determine how centralized or non-centralized a federation is? • Selected literature • List of tables and figures • Questions on Federalism