

Protection of Medical Personnel and Other Voluntary Staff in Armed Conflict

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Abstract

When an armed conflict occurs, the Red Cross crew are at work, rescuing the victims of the attacks. The whole world is also at alert, keeping vigil, monitoring the wellbeing of the victims. But there is a great vacuum in the scenario. No one cares to know the effects of the armed conflicts on the health care workers themselves or on their beneficiaries and their facilities/services. Once, their services are guaranteed and the health of the victims are improving, the issue of their own health is neglected. This article departs from the general trend by looking into the condition of health care workers during the armed conflict, the effects of the armed conflict on their health and also on their work and their beneficiaries. The article adopts a right based approach to this issue of neglect, it concludes that such neglect is a violation of international humanitarian and human rights law and recommends different ways by which these set of persons can be better protected in a situation of armed conflicts.

Keywords: Humanitarian law, human right law, Armed Conflict, Medical Personnel, volunteers.

1.0. Introduction

Attacks on health care workers, health facilities/services and beneficiaries violate international humanitarian and human rights law. The consequences of such attacks extend beyond the immediate victims - the beneficiaries of the health services. A fundamental general principle of international humanitarian law which is applicable in all armed conflicts is that the wounded, sick, and shipwrecked shall be collected and cared for. To give effect to that rule, all parties to all armed conflicts are expected to respect and protect Attacks on health care workers, health facilities/services and beneficiaries violate international humanitarian and human rights law. The consequences of such attacks extend beyond the immediate victims - the beneficiaries of the health services. Primarily, children and their mothers, suffer the effects of the preventable illnesses that occur as a result of the interruption in much-needed health services. With regards to infectious diseases, the consequences can affect large number of people.

Medical personnel, other voluntary staffs, health-care facilities, medical vehicles, together with the wounded and the sick reaching health-care services are being attacked during war and other armed conflicts frequently. Attacks on these set of people provoke far-reaching secondary consequences as health-care professionals flee their posts, hospitals close, and vaccination campaigns come to a halt. These knock-on effects leave entire communities without access to adequate services. Despite these, violence (actual and threatened) against patients and healthcare workers and facilities is one of the most crucial yet overlooked humanitarian issues of today.

Health facilities and workers are often among victims of emergencies, disasters and other casualties. It should be noted that these attacks have become a feature of armed conflict despite their prohibition by the laws of war. It has in fact been stated that attacks on health workers and facilities have become a feature of modern war; they are not simply committed by rogue countries or forces.

This paper therefore discusses the various forms of attack on medical personnel and other voluntary staffs and examines ways by which these set of persons can be better protected in armed conflicts.

2.0. Definition of Terms

In order to have a good focus on the issue of discourse it is necessary to make a clear definition of terms that will be used in the course of this paper.

Medical personnel - The term refers to those persons assigned, by a Party to the conflict, exclusively to the medical purposes enumerated under sub-paragraph (e) or to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either permanent or temporary. The term includes:

- (a) medical personnel of a Party to the conflict, whether military or civilian, including those described in the First and Second Conventions, and those assigned to civil defence organizations;
- (b) medical personnel of national Red Cross (Red Crescent, Red Lion and Sun) Societies and other national voluntary aid societies duly recognized and authorized by a Party to the conflict;
- (c) medical personnel of medical units or medical transports described in Article 9, paragraph 2.

Voluntary staff – these include staff and volunteers of the International Red Cross and Red Crescent Movement involved in delivering health care; and first aiders.

Violence - means violent behaviour that is intended to hurt or kill somebody while violent is defined as involving or caused by physical force that is intended to hurt or kill somebody. Violence, according to the definition adopted by the World Health Organisation (WHO) is the intentional use of physical force or power – threatened or actual – against oneself, another person, or against a group or community that results in or has the likelihood to result in injury or death, psychological harm, mal-development or deprivation.

Armed conflict – this is a state of open hostility between two nations, or between a nation and an aggressive force. A state of armed conflict may exist without a formal declaration of war by either side. It is also a military action taken under Article 42 of the United Nations Charter.

Armed conflict exists whenever there is resort to armed force between two or more States; non-international armed conflicts are protracted armed confrontations occurring between governmental armed forces and the forces of one or more-armed groups, or between such groups arising on the territory of a State party to the Geneva Conventions of 1949.

3.0. Violence Against Medical Functions

The acts which constitute violence against medical functions have been categorized into five. The categories include:

3.1. Attacks on wounded and sick individuals

Attacks on or interference with patients is separate from attacks on and interference with medical facilities or personnel. This form of attack includes denial of impartial care to wounded civilians, assaults on patients within medical facilities, denial of access to health facilities, unreasonable obstructions of travel for medical care at checkpoints, discrimination, and interruption of medical care.

3.2. Attacks on medical facilities

Attacks on or interference with medical facilities includes shelling, shooting, looting, bombing, deprivation of water or electricity, intrusion, encirclement, and other forms of assaults.

3.3. Attacks on medical transports

Obstruction of or assaults on medical transport, such as ambulances, and obstruction of free transport of medical equipment and supplies. Other forms of obstruction of humanitarian relief, such as blockage of aid convoys, were excluded.

3.4. Improper use of facilities or emblems

The misuse of medical facilities and personnel for purposes inconsistent with the Geneva Conventions, including military use of civilian health facilities, use of patients or medical personnel as human shields, and misuse of the Red Cross emblem, though not a form of attack per se, can lead to attack.

3.5. Attacks on medical personnel

Attacks on or interference with medical personnel in their efforts to provide ethical care to patients includes arrests, detention, assaults, torture, harassment, invasion of medical officers, kidnapping, killing, intimidation, threats, robbery, prosecution for providing medical care, and disruption of training programmes.

It should also be noted that the targets for which attacks were most frequently reported were medical personnel and facilities as violations targeting wounded and sick individuals, proper use of medical facilities or emblems, and medical transport were less frequently reported. This paper focuses on attacks on medical personnel and voluntary staff.

4.0. Acts of Violence or Attacks on Medical Workers and Volunteers

Attacks on medical workers and facilities appears to be part of generalised violence directed towards civilians as a means of achieving a political goal. For example, medical workers, clinics, and hospitals were among many civilian targets in Bosnia, Chechnya, Kosovo, Rwanda, El Salvador, and Sierra Leone. In some cases, destabilization tactics included targeted attacks on physicians as community leaders or elites. Instances of this include the murder and kidnapping of physicians in Iraq, and by assaults on Muslim medical professionals in Bosnia.

It was also discovered in the same study that certain attacks on medical personnel are specifically designed to gain a military advantage. For instance, interference with medical functions in Kosovo, Nepal, Chechnya, East Timor, and Colombia seemed to be motivated, at least partly, to prevent enemy combatants from receiving care and re-entering battle and with the military objective to force civilians to leave. As stated by the ICRC's chief war surgeon Marco Balzan, preventing access to health care can become part of the warfare strategy and this has dire consequences for civilians and wounded combatants.

Another discovery was the fact that medical workers are arrested, detained, prosecuted, and sometimes tortured or executed for known or alleged provision of medical services to wounded enemy combatants, as occurred in Colombia, the Philippines, El Salvador, Nepal, Kosovo, Chechnya, and East Timor. Such actions are sometimes specifically authorised under local anti-terrorism law, despite the fact that the practice violates international humanitarian law and medical ethics. These practices are part of a larger trend in which countries' anti-terrorism practices deem the provision of medical care to alleged terrorists to be a violation of criminal law or the basis for denial of political asylum.

In addition, incidences of armed entry into medical facilities by armed groups so as to intimidate health-care personnel among other reasons can also be said to be an act of violence against medical personnel and other voluntary staffs.

In a study carried out by the ICRC, it was discovered that in nine per cent (9%) of the incidents of violence against medical functions recorded, health personnel were either killed or injured. In many more incidents, they had faced intimidation, harassment and other forms of violence which includes the use of explosives by State armed forces during active hostilities, kidnapping from their places of work by non-State armed groups, the killing of expatriates by non-State armed groups. It was also discovered that a larger percentage of health care personnel had been arrested and removed from medical facilities.

It should be noted, that reports on medical attacks on medical personnel and medical functions in general has been intermittent as no organization has embraced regular and systematic reporting of such attacks. This could be said to be due to the fact such attacks or violations are not being investigated. Indeed, in human rights reports published yearly, no category exists to record attacks on medical functions. Moreover, specific investigations of these violations show that such attacks do occur.

5.0. Effects of Acts of Violence

Acts of violence against medical personnel and other voluntary staff in armed conflict have been shown to cause death and injury, and also aggravate the suffering of populations that have been devastated by war and deprived of medical workers and facilities.

In addition, such actions disrupt health-care in a variety of ways. In fact, it may become difficult, even impossible, to provide adequate health care for the wounded and the sick. For example, an independent ICRC surgical hospital would normally treat approximately two thousand wounded people per year. One serious security incident can close such a hospital, drastically reducing if not eliminating surgical services for the wounded.

This is precisely what happened when six ICRC nurses were killed by unidentified gunmen in the ICRC hospital in Novye Atagi, Chechnya, on 17 December 1996. The tragedy provoked the withdrawal of the ICRC from the hospital and extended beyond the needless death of those Red Cross health-care workers to the thousands of wounded people who, as a result of that incident, lost access to essential surgical services. This type of an attack has been said to have an indirect and a multiplier effect. This was the case when a suicide bombing targeting Somali government ministers at a graduation ceremony in the capital, Mogadishu, in December 2009, killed dozens of people, including some of those graduating as doctors, depriving the war-torn country of desperately needed skills. It was said that there will never be records of the tens of thousands of patients these doctors might have treated in their lifetimes but now cannot.

There are however situations when medical personnel are insecure to move around and as such they are unable to reach those who need their services. For instance, in the Democratic Republic of the Congo, it is estimated that 40,000 deaths per month are due to diseases that are easily treatable and the stated reason for these people not receiving the necessary treatment is insecurity arising from armed conflict. The situation is not different in Afghanistan and Pakistan where polio eradication is hampered by insecurity and so hundreds of thousands of children cannot be vaccinated against polio.

Attacks on medical personnel and other voluntary staff are the most devastating out of all the attacks on medical functions. This is because in the absence of these persons, medical facilities including the hospital building and drugs become useless whereas medical personnel may still be able to do something positive as regards the wounded if any of the other medical functions is absent.

Furthermore, effects of such attacks have long term repercussion on the community where the attacks take place. The impact is beyond the immediate loss of life. They prevent future access to medical care and products.

6.0. Legal Framework for the Protection of Medical Personnel and Others

International legal standards for the protection of health workers in armed conflict have been in place for 150 years. It should however be noted that the present standards derive from international humanitarian law, human rights law, and medical ethics; and include the Geneva Conventions of 1949 alongside the two Additional Protocols to the Geneva Conventions which are made in 1977. Together, these standards offer protection in both international armed conflicts and non-international armed conflicts an example of which is civil war.

The Geneva Conventions make provision for the protection of medical personnel and voluntary staffs in armed conflict. The Conventions were sponsored by the International Committee of the Red Cross (ICRC) and the fundamental international agreements in the Conventions are inspired by respect for human personality and dignity.

Detailed rules that are designed to safeguard respect and protection for medical personnel and other voluntary staffs amidst others during armed conflict are contained in International humanitarian law (IHL). These rules bind both State armed forces and non-State armed groups. International human rights laws (IHRL) applies only in situations of violence other than armed conflict and it is less precise than IHL because it does not enshrine specific protection for medical personnel.

Another difference between IHL and IHRL is that IHL rules applies to all parties in armed conflict while IHRL rules apply to States exclusively as it cannot be conclusively said that IHRL binds non-State armed groups.

Without prejudice to the distinction between IHL and IHRL, it is worthy to note that ICRC, the leading authority on the Geneva Conventions, has interpreted these requirements to be customary international law, and therefore binding on states and other combatants irrespective of whether the parties have ratified the conventions and protocols. Violations can amount to war crimes to the extent that they are “willfully causing great suffering or serious injury to body or health”. Thus, non-State armed groups are expected to respect medical personnel, other voluntary staffs and medical facilities under the applicable international criminal and domestic law. In fact, they are to provide all feasible medical care in life-threatening circumstances.

The rules safeguarding medical functions during armed conflict as deduced from IHL and IHRL can be said to be the following:

1. All possible measures shall be taken to provide health care on a non-discriminatory basis to the wounded and sick.
2. All possible measures shall be taken to search for, collect and evacuate the wounded and sick in a non-discriminatory manner.
3. The wounded and sick and health-care personnel shall not be attacked, arbitrarily deprived of their lives, or ill-treated. The use of force against health-care personnel is justified in exceptional circumstances only.
4. Access to health-care facilities shall not be arbitrarily denied or limited.
5. Health-care personnel shall not be hindered in the performance of their exclusive medical tasks nor shall they be harassed for simply assisting the wounded and sick.
6. The wounded and sick, and health-care personnel and facilities must also be protected against interference by third parties.

The first two rules will not be discussed as they are not particularly relating to the protection of medical personnel and other voluntary staffs. It should however be noted that adherence to other rules is for the safeguard of the first, i.e. the provision of health care on a non-discriminating basis to the wounded and sick.

6.1. The use of force against health-care personnel is justified in exceptional circumstances only

Under the IHL rules, medical personnel (civilian or military) pursuing their exclusively humanitarian task may not be attacked or harmed as they have the right to be respected and protected.

Article 24 to 26 of the Geneva Convention, provides for the protection of medical personnel and personal aid societies. It further provides that medical personnel shall be respected and protected in all circumstances. The implication being that, when medical personnel fall into the hands of the enemy party, they shall be free to pursue their duties. There is however a proviso that if they commit, outside their humanitarian work, acts harmful to the enemy, they may be attacked or harmed but even then, the parties have obligations to provide a warning before an attack. There are some acts which are not deemed to be “acts harmful to the enemy” and medical personnel will still be covered when they carry out those acts.

Under the rules of IHRL, States have the obligation not to subject medical personnel, amidst others, to arbitrary deprivation of life and State agents can only use force against medical personnel where it is absolutely necessary to defend a person to an imminent threat to life or limb. To my mind, medical personnel cannot pose such a threat warranting the use of force against them. This is because they understand the obligation they have to preserve lives and may not put themselves in a position that will threaten others; they may however use light arms to defend themselves.

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

The IHL rule that imposes the obligation to respect medical personnel performing their exclusively medical duties includes not arbitrarily preventing the passage of health-care personnel and supplies. The author is of opinion that the total impact of the inability of medical personnel to move around cannot be assessed as we may know the number of persons that they could have attended to if they were unhindered in their movement. Thus, it can be seen that this obligation is derived from the fundamental duty to respect, protect and care for the wounded

and the sick.

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

The IHL rules impose the obligation to respect medical personnel who are performing exclusively medical duties. This obligation includes refraining from arbitrarily interfering with those duties so as to allow the wounded and sick to be treated. Thus, they have the right not to be punished for discharging their responsibilities in accordance with accepted standards of health care; and not to be compelled to act in a manner contrary to the law and/or health-care ethics.

Based on this, parties to a conflict shall not molest, harass, mistreat or punish medical personnel for performing activities which are compatible with medical ethics or for seeking to fulfil their ethical duties to patients.

They shall also not compel them to perform activities which are contrary to medical ethics or to refrain from performing acts required by medical ethics. It is on this basis that it is said that they shall not to be compelled to give information about wounded and sick people beyond what is required by domestic law or in terms of notification of infectious diseases and that the rules would preclude practices such as armed takeovers of hospitals by armed forces or groups who harass, intimidate or arrest health-care professionals.

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

The IHL rules also provide that parties to a conflict have the duty to ensure that medical personnel and facilities together with the wounded and the sick are respected by third persons; they are also expected to take measures to assist medical personnel in the performance of their duties. They can help them by removing the wounded and sick from the scene of combat and sheltering them, ensuring the delivery of medical supplies by providing a vehicle.

7.0. Recommendations

In order to effectively protect medical personnel and other voluntary staffs in armed conflict, it will be essential for all parties to the conflict to have a sound knowledge of IHL. This is because the widespread knowledge of IHL will contribute to the promotion of humanitarian ideals and it will also foster the spirit of peace among nations.

It can thus be said that medical personnel and other voluntary staffs should be well versed in IHL as it affects them and ensure that they do not go outside the protection guaranteed them by the law. Other parties to conflict should also be aware of the rights accorded to medical personnel and other voluntary staffs and should, at all times, protect and promote those rights.

To this end, Resolution 21 of 1977 provides that signatory States should take all appropriate measures to ensure that knowledge of international humanitarian law applicable in armed conflicts, and of the fundamental principles on which that law is based, is effectively disseminated. The conference further resolves that the authorities concerned should:

- (i) decide to teach IHL to the armed forces and appropriate authorities in a manner suited to national circumstances;
- (ii) publish materials that will assist in teaching IHL and circulate appropriate information for the dissemination of the Geneva Conventions and the Protocols;
- (iii) Organize seminars and courses on IHL;
- (iv) Intensify the teaching of IHL in universities especially in the faculties of law, political science and medicine;
- (v) Recommend to educational authorities the introduction of courses on the principles of IHL in secondary and similar schools;
- (vi) Invite the ICRC to participate actively in the effort to disseminate knowledge of IHL;
- (vii) Urge National Red Cross, Red Crescent and Red Lion and Sun Societies to offer their service to the authorities in their own countries with a view to the effective dissemination of knowledge of IHL.

It should be noted that except for the work of the ICRC, no international organisation or consortium assumes responsibility for strategies to protect medical personnel and other voluntary staffs in armed conflict. It is on this note that it is recommended that international organisations or consortiums like the World Health Organisation (WHO) should also take responsibility in the protection of medical personnel in conflict.

In 2009, WHO launched an initiative to make hospitals safe in emergencies, but the programme does not involve tracking of attacks on or interference with medical facilities and workers during conflict, or a strategy to restrict such acts through protective measures. With this initiative, the WHO took a major step toward the protection of health workers, health facilities, health transports, and patients during armed conflicts when it

passed a resolution on the WHO's role in humanitarian emergencies and included language calling on the WHO's director general which states:

to provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies, in coordination with other relevant United Nations bodies, the International Committee of the Red Cross, and intergovernmental and nongovernmental organizations, avoiding duplication of efforts.

It has also been discovered that there is no systematic reporting of assaults or violence on medical personnel and other voluntary staffs in armed conflict; and no comprehensive review of the scope of the problem has been done for more than 15 years. This is in contrast with the fact that governments and international organisations have tracked civilian mortality, attacks on journalist and the effect of weapons in conflicts and have developed protection strategies from this information.

It is on this basis that it is being recommended that appropriate authorities should ensure that there is comprehensive and routine data collection after attacks on medical personnel as this will help in identifying the scope, origins and causes of such violations. The information can also be used to deter violations, generate effective strategies to prevent violations, raise global awareness of the extent of violations, reinforce legal requirements to prohibit such attacks and galvanise action by the international community. Therefore, human rights organisations should expand their documentation of attacks on medical personnel and other voluntary staffs and also establish a separate category to record such attacks.

Governments and non-state actors need to make a more robust commitment to compliance. Such a commitment includes more intensive and consistent training of military forces in the medically related requirements of the Geneva Conventions, full investigation of all alleged violations and making the perpetrators accountable for their actions. Also, actors in conflict should also note that the violation of the rules of IHL by one party is not a justification for violations by the other. In addition, countries should ensure that respect for medical ethics is incorporated into their customary international humanitarian law and also reject the notion that departure from medical ethics is permissible to advance national security.

Furthermore, health workers and health programmes should never be used as cover for military action. Such actions provide an easy excuse for those who wish to perpetrate violence against civilians and potentially undermine community confidence in health services. It could cost more lives in the long run. This was the case when CIA used polio immunisation programme as a covert mechanism to gather intelligence about Osama bin Laden's compound in Pakistan and this has led many to perceive health care initiatives as threats.

This has led to the targeting of anti-polio health workers. In December 2012, gunmen allegedly from the Pakistani Taliban killed nine anti-polio workers, leading the United Nations to suspend the polio eradication program in the area. Two weeks later, on New Year's Day 2013, seven community development workers in Pakistan were killed, also due to their association with anti-polio work. On February 8, 2013, suspected members of the militant Islamist group, *Boko Haram*, killed nine healthcare workers in Nigeria. Also, Taliban commanders, asserting that the immunization program is a cover for U.S. espionage, have banned anti-polio work and have justified killing health care workers in areas of Pakistan under Taliban control as legitimate measures to coerce the United States to end drone strikes in the country.

In addition, the ICRC's suggestions that in conflict zones, armed forces should refrain from attacking health-care facilities, personnel and vehicles, blockades which prevent delivery of necessary medical items and the evacuation of sick and wounded people, should be lifted and investigations into incidents of violence against health care and accountability for attacks that violate international humanitarian law, should be investigated.

8.0. Conclusion

In spite of the passage of UN Security Council Resolution 2286 of 3rd May, 2016, incidences of violence against health care facilities and personnel, takes place weekly. The ICRC between May 2016 and May 2018, recorded over one thousand, two hundred (1200) attacks against health care facilities or personnel, in sixteen (16) countries. These attacks include, threats, kidnapping, and killings.

The rights accorded to medical personnel and other voluntary staff as it has been said earlier, help in fulfilling the overall purpose of having medical personnel around during armed conflict. That is, the fundamental duty to respect, protect and care for the wounded and the sick. When the rights of medical personnel cannot be guaranteed, thousands of wounded people will lose access to essential medical and surgical services and the fundamental principle underlying the coming into existence of ICRC, Geneva Conventions and other IHL and IHRL will not be achieved. Thus, when medical personnel and other voluntary staff are not well protected in armed conflict, health care cannot be adequately delivered. This is because the protection of medical personnel and other voluntary staffs is not all about saving their lives but most importantly ensuring the continuation of health care during and after a crisis.

In order to safeguard the fundamental principles underlying IHL, actors in armed conflict should ensure that

the rights of medical personnel and other voluntary staffs are well protected. States should also make strategic plans to safeguard the lives of medical personnel and voluntary staff in armed conflict.

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