40th Round Table on Current Issues of International Humanitarian Law

"The Additional Protocols 40 Years Later: New Conflicts, New Actors, New Perspectives"

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Advances in the protection of medical personnel, facilities and transports under the Additional Protocols and interpretative challenges on the fundamental obligations to respect and protect

The task assigned to me is to address the advances in the protection of medical personnel, units and transports under the two Additional Protocols. I will take the liberty to also pay attention to the flip side of the equation, namely where the Additional Protocols have *failed* to advance the protection of medical personnel, units and transports.

In so doing, I will focus on *legal* advances or the lack thereof. It might be needless to say, but nevertheless worthwhile to remind ourselves that more recent trends in the *actual* protection of medical personnel, units and transports on the ground suggests that we might have to speak about retrogressions rather than advances. The ICRC and other humanitarian organizations, the UN and the media have well documented this deplorable trend, which includes an increase in incidents of killing, injuring, kidnapping, harassing, intimidating, robbing, and arresting medical personnel for performing their medical duties; the, shelling, looting, forced entry, or other forceful interference with the running of health-care facilities (such as depriving them of electricity and water); and the attacks upon, theft of and interference with medical vehicles etc.[1] However, in light of these trends on the battlefield, it would seem as important as ever to remind ourselves of the advances that the Additional Protocols undoubtedly mark in the *legal* protection of medical personnel, units and transports. Indeed, since that protection in the Additional Protocols – much as any other aspect of them – 'supplements' the 1949 Geneva Conventions rather than replaces the protections contained in the latter, one could summarily describe *all* protective rules pertaining to medical personnel, units and transports in the Additional Protocols as legal advances. However, I will limit myself to identifying some which, in my view, are particularly significant, first in the area of medical personnel; secondly in the realm of medical units and transports; and thirdly, those that derive from the regulation of medical personnel, units and transports under the two Additional Protocols more broadly.

[1] Cf ICRC Health Care in Danger- The Issue, http://healthcareindanger.org/the-issue/.

Advances

A first significant development is the definitional precision and expansion in Additional Protocol I. As far as personnel is concerned, Geneva Convention I and II contained only rudimentary definitions.[2] In contrast, Additional Protocol I (art 8 (c)-(k) provides for rather detailed definitions of medical personnel. In addition to an increase in the precision, the definition in Additional Protocol I also marks a significant expansion in as much as it now includes civilian medical personnel of a party to the conflict and hence goes beyond the protection provided in accordance with Geneva Convention I and II, which only apply to medical personnel serving the armed forces, as well as going beyond article 20 Geneva Convention IV, which applies to the medical personnel of civilian hospitals. Simultaneously, the definition of medical personnel clarifies that persons assigned to the enumerated medical purposes, (eg search for, collection and treatment of the wounded, sick and shipwrecked, or the administration of medical units or to the operation and administration of medical transports) must be so 'exclusively', i.e. these must be their sole tasks.[3] The formal status of medical personnel – and the entitlement to the protection that this status entails – is nevertheless contingent on the assignment of a party to the armed conflict. This is especially relevant for civilian medical personnel. Persons engaged in the medical care of others, while not being members of the armed forces, may not automatically be assumed to also fulfil that task vis-à-vis the wounded and sick during armed conflicts.[4] This aspect of the definition – requiring the assignment of a party to the armed conflict - also entails that, although the civilian population and aid societies have the right to collect and care for the wounded and sick on their own initiative[5], they will not enjoy the protection of 'medical personnel' absent the official assignment of medical tasks by the competent authority. In its totality, the definition of medical personnel is clear and precise and as such certainly qualifies as an advance.

A further significant advance in relation to medical personnel in Additional Protocol I is its strengthening the protection of medical duties. While the matter will be addressed in more detail by my fellow panelist, suffice it to say that the relevant provisions of Additional Protocol I and Additional Protocol II[6] are filling an important gap left by the Geneva Conventions.

Turning from persons to objects, Additional Protocol I also contains detailed definitions of medical units, transportation, transports, vehicles, ships and craft, and aircraft, clarifies the distinction between permanent and temporary ones, and – mirroring the definition of medical personnel - also expands the definition of medical units and transports, to include military *and* civilian ones. Indeed, some of the rules address civilian medical units

[2] Cf arts 24-26 GC I, 36 GC II.

[3] *ICRC Commentary,* 125, para. 353.

[4] *Ibid*., para. 354.

[5] Cf. Article 17, para. 1, 2nd sentence, AP I; see also Kleffner, *Protection of the Wounded, Sick, and Shipwrecked",* in: D. Fleck (ed), The Handbook of International Humanitarian Law, 3rd ed., Oxford University Press (2013), p 328 Section 605.

[6] Article 16 AP I and 10 AP II.

exclusively, complementing the provisions of Geneva Convention I and II, and regulating the conditions for granting protection[7] and the discontinuance of such a protection on account of such medical units being used to commit acts harmful to the enemy. The latter by and large replicates the conditions in Geneva Convention I. I will not expand on this latter issue, since the notion of 'acts harmful to the enemy' will be addressed by Laurent Gisel shortly.

For situations of belligerent occupation, Additional Protocol I also subjects the requisitioning of civilian medical units to stricter conditions than is foreseen for civilian hospitals in Article 57 Geneva Convention IV. The latter provides that requisitioning of civilian hospitals is permissible, provided it is done temporarily and is urgently necessary for the care of the military wounded and sick, on the condition that suitable arrangements are made in due time for the care and treatment of the patients and for the need of the civilian population for hospital accommodation, while prohibiting an occupying power from requisitioning material and stores of civilian hospitals so long as they are necessary for the needs of the civilian population. In contrast, Article 14 of Additional Protocol I sets forth a duty of the Occupying Power to ensure that the medical needs of the civilian population in occupied territory continue to be satisfied and a general prohibition to requisition civilian medical units, their equipment, their *matériel* or the services of their personnel, so long as these resources are necessary for the provision of adequate medical services for the civilian population and for the continuing medical care of any wounded and sick already under treatment. Compliance with that general duty and prohibition is not the only condition for lawful requisitioning in situations of belligerent occupation. Rather, additional conditions must be fulfilled[8].

As far as medical transports are concerned, a very important area in which Additional Protocol I not only develops or refines pre-existing rules, but establishes genuinely new rules is the area of medical aircraft. As such, it breaks the deadlock that had surrounded several issues and had prevented the drafters of the 1949 Geneva Conventions to address the issue in any detail and which resulted in the very rudimentary regulation in the Geneva Conventions[9], which in turn proceeded from a very embryonic provision in the 1929 Geneva Convention[10], and subjected all activity of medical aircraft to the agreement of the belligerent states and – in the case of flights over the territory of neutral states – to the additional agreement of the latter. Additional Protocol I now provides for a set of rules, some of which can be reconciled with the pre-existing rules in the Geneva Conventions (for example the obligation to mark medical aircraft). However, others are in clear conflict. These conflicting provisions hence replace the relevant provisions of the Geneva Conventions in the relations between Parties to the Protocol. More specifically, Article 25 of Additional Protocol I, specifies that medical aircraft in areas not controlled by an adverse party is to be

[7] Art 12 (2) AP I.

[8] These conditions are necessity and the making of immediate arrangements to ensure that the medical needs of the civilian population, as well as those of any wounded and sick under treatment who are affected by the requisition, continue to be satisfied.

[9] Arts 36/37 GC I, 39/40 GC II and 22 GC IV

[10] Art 19 of the 1929 Geneva Convention.

respected and protected also if there is *no* agreement with that adverse party. Nor does Article 26 (1) on medical aircraft in contact or similar zones, strictly require an agreement, although it recognizes that protection for medical aircraft in such areas can be fully effective only by prior agreement between the Parties to the conflict. This increase in the legal protection of medical aircraft is counterbalanced by new rules setting forth certain restrictions on their operations (Art 28), including the prohibitions to use them to acquire any military advantage, to collect or transmit intelligence data etc (Art 28) and provisions on landing and inspection of medical aircraft (Art 30). It is noteworthy that the loosening of the agreement requirement in Additional Protocol I seems to have since informed a further process of customary law, which extends the regulation for contact or similar zones to medical aircraft in areas controlled by an adverse Party, as expressed in the Harvard Air and Missile Warfare Manual.[11] Such a process further underlines the importance of the rules in Additional Protocol I, which marked an important step in developing a regulatory framework that strikes an adequate balance between military concerns and humanitarian considerations.

Beyond the aforementioned advances in the specific area of medical personnel, on the one hand, and medical units and transports, on the other hand, three more developments that apply to medical personnel, units and transports more broadly are worth pointing out. First, Additional Protocol I extends the prohibition of reprisals – that is otherwise contained in the Geneva Conventions[12] - against all of the aforementioned persons and objects, including civilian medical personnel and civilian medical units and transports. This is particularly significant in light of the fact that the prohibition of reprisals against individual civilians, the civilian population and civilian objects[13] have proven to be less than uncontroversial, even amongst states parties to the Additional Protocols, some of whom have entered reservations. No such reservations have been entered in relation to Article Additional Protocol I, which sets forth the prohibition of reprisals against medical personnel, units and transports.

Secondly, Additional Protocol I criminalizes acts 'described as grave breaches in the Conventions as grave breaches … if committed … against … medical … personnel, medical units or medical transports which are under the control of the adverse Party and are protected by this Protocol.'[14] These acts hence become subject to the grave breaches regime, with its duty to extradite or prosecute, command responsibility and other ensuing obligations set forth in both the Conventions and Additional Protocol I.

Thirdly, some of the rules of Additional Protocol I that pertain to medical personnel, units and transports survived the melt down – or, as some would say 'simplification' - of Additional Protocol II and hence also apply in non-international armed conflict that reach the

[11] Rule 78 (a).
[12] In casu Article 46 of GC I
[13] Cf Arts 51 (6) AP I; 52 (1) of AP I.
[14] Article 85 (2) AP I.

required threshold. This holds true for the general obligations to respect and protect medical personnel and medical units and transports, and certain aspects of the protection of medical duties.

Mentioning Additional Protocol II seems an appropriate moment to transition from the advances of the Additional Protocols to some of those **areas in which the Additional Protocols have *failed to advance* the legal protection of medical personnel, facilities and transports.** Again, I will be selective and only point out some of those that I consider to be particularly significant.

First, Additional Protocol II does not contain any definitions similar to those contained in Article 8 of Additional Protocol I. Accordingly, neither the notion of medical personnel nor the one of medical units or transports – much as any other notion in the realm of the protection of the wounded, sick and shipwrecked – is clarified. The solution of choice to fill the resulting definitional gap is to simply transpose the definitions from Additional Protocol I and apply them by analogy. Yet, such an exercise needs to be approached with a certain degree of caution. To extend the definition in Additional Protocol I, which covers both military and civilian medical personnel, to also apply in non-international armed conflicts would import the continued conceptual obscurity that surrounds the notion of 'civilian' in non-international armed conflicts. Admittedly, this issue is irrelevant as far as the legal protection is concerned, since importing the definition from Additional Protocol I would mean that both military and civilian medical personnel have to be respected and protected in all circumstances in any event. However, the point here is the conceptual one that notions that are well established in the law of international armed conflict are not necessarily fitting or can be replicated in the law of non-international armed conflict. Indeed, this problem was already recognized during the negotiations at the Diplomatic Conference leading to the adoption of the Additional Protocols. When the issue of defining medical personnel arose in the context of Additional Protocol II, the idiosyncracies of non-international armed conflict, and more specifically the fact that one of the parties is a non-state organized armed group, was noted as warranting certain departures from the definitions in Additional Protocol I.[15]

Secondly, as is well known, Additional Protocol II does not contain any criminalization – be it of violations of the rules pertaining to the protection of medical personnel, units or transports or violations of any other of its rules. In that respect, the Rome Statute of the International Criminal Court has filled an important gap in the law of non-international

[15] See ICRC Customary Law Study, Commentary p 83: Eg, the term "Red Cross or Red Crescent organisations" was used in the draft definition of medical personnel in AP II order "to cover not only assistance provided on the Government side but also already existing Red Cross groups or branches on the side opposing the Government and even improvised organizations which had come into existence only during the conflict". It should be noted in this respect that the term "Red Cross (Red Crescent, Red Lion and Sun) organizations" is also used in Article 18 of Additional Protocol II. Secondly, the drafting committee had deemed it necessary to specify that aid societies other than Red Cross organisations must be located within the territory of the State where the armed conflict is taking place "in order to avoid the situation of an obscure private group from outside the country establishing itself as an aid society within the territory and being recognized by the rebels".

armed conflict, in as much as it now contains the war crimes of 'Intentionally directing attacks against buildings, material, medical units and transport, and personnel using the distinctive emblems of the Geneva Conventions in conformity with international law (Art 8(2)(e)(ii) ICC Statute) and 'Intentionally directing attacks against buildings dedicated to (amongst other), hospitals and places where the sick and wounded are collected, provided they are not military objectives' (Art 8 (2)(e)(iv) ICC Statute). Indeed, the corresponding war crimes in international armed conflict mark a further development if compared to the grave breach contained in Article 85 (2) of Additional Protocol I to which I alluded previously. Be that as it may – Additional Protocol II does not contain any criminalization.

Thirdly, no prohibition of reprisals corresponding to Article 20 of Additional Protocol I has found its way into Additional Protocol II. Back during the days of the Diplomatic Conference, a suggestion to include specific prohibitions of reprisals in non-international armed conflicts was rejected. However, it is by no way certain what to make of that rejection. The ICRC has deduced from the opinions expressed by at least some states during the Diplomatic Conference, in combination with some other material, a customary rule prohibiting parties to non-international armed conflicts to resort to belligerent reprisals and to other countermeasures against persons who do not or who have ceased to take a direct part in hostilities.[16] In fact, one of the arguments in support of such a rule is that '[t]here is insufficient evidence that the very concept of lawful reprisal in non-international armed conflict has ever materialised in international law'. That statement comes very close to saying that the lack of a rule permitting reprisals in non-international armed conflict means that states are legally barred from resorting to reprisals.
Others have taken the absence of a prohibition in Additional Protocol II – or for that matter in any other area of the conventional law of non-international armed conflict - and state practice and *opinio juris* to suggest that reprisals are permissible in non-international armed conflict, under certain conditions. This is not the place to enter into a debate, which essentially would boil down to asking whether the Lotus-principle is still good law. Suffice it to say that we could have that debate to no small measure because Additional Protocol II is silent on the issue of belligerent reprisals, including on belligerent reprisal against medical personnel, units and transports, rather than settling the issue.

To conclude, the Additional Protocols have advanced the protection of medical personnel, facilities and transports in several respects. However, some of the pertinent issues remain unaddressed, especially in the law of non-international armed conflicts as regulated by Additional Protocol II.

[16] Cf Rule 148 of the ICRC Customary Law Study.