This collection of contributions made by renowned international experts and practitioners addresses the new challenges in the field of IHL application that emerge from the outbreak of pandemics and large-scale diseases in armed conflict scenarios.

The 44th Round Table on current issues of humanitarian law focused on some of the most topical, legal and operational military issues generated by pandemics, particularly when they overlap with other humanitarian emergencies in areas of the world already affected by international and/or non-international armed conflicts. More precisely, the contributing experts stressed the dramatic impact on civilians of the misuse made by both governments and non-state armed groups of the restrictive measures related to the sanitary crisis, often implemented to exercise control over populations and territories at the expense of the most vulnerable categories of civilians in terms of human rights violations and limitations on their legal protection.

The Round Table provided a forum to discuss relevant topics related to conflict management during pandemics, the implications of the healthcare crisis in the application of IHL, the difficulties in guaranteeing the protection of civilians and health workers, delivering humanitarian aid and safeguarding humanitarian access.

The International Institute of Humanitarian Law is an independent, non-profit humanitarian organisation founded in 1970. Its headquarters are situated in Villa Ormond, Sanremo (Italy). Its main objective is the promotion and dissemination of international humanitarian law, human rights, refugee law and migration law. Thanks to its longstanding experience and its internationally acknowledged academic standards, the International Institute of Humanitarian Law is considered to be a centre of excellence and has developed close cooperation with the most important international organisations.
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Pandemics, Armed Conflict and International Humanitarian Law

44th Round Table on Current Issues of International Humanitarian Law (Online, 6, 8, 13, 15 September 2021)

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The International Institute of Humanitarian Law would like to thank Ms. Sara Zuecco and Mr. Edoardo Gimigliano, who contributed to the realization of the work and Ms. Shirley Morren, who was involved in the painstaking task of proofreading and editing.

Cover image: Zamboanga, jail. The ICRC delivers cleaning and hygiene items to one of the most overcrowded jails in the country in an effort to fight the COVID-19 pandemic. The ICRC also donates electronic tablets that will be used to help the detainees maintain contact with their family during the lockdown, since visits are suspended. Photographer: M.A. Guiroy/ICRC

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Preface

While negatively influencing the standard of living of the world population, the Covid-19 pandemic impacted lives globally to different extents. The outbreak indeed led to the increase of socio-economic inequalities and the deterioration of national healthcare systems worldwide. Against this background, the areas experiencing situations of violence and armed conflict certainly were the most severely affected by such a threat, particularly due to their already weakened state capacities.

The pre-existing situation of fragile infrastructures and unstable governance in armed conflict scenarios disclosed diversified legal and operational obstacles because of the overlapping crises. In several cases, for instance, the coronavirus emergency and its management were converted into shortcuts to the establishment of more intense territorial control and rights deprivation by both state and non-state armed groups. In these difficult contexts, the humanitarian response had to be reshaped in order to guarantee the easiest access possible to basic aid and healthcare to the civilian population.

On 6, 8, 13 and 15 September 2021, the 44th edition of the Sanremo Round Table on current issues of international humanitarian law was held online in the form of a webinar series, for the second consecutive year due to the Covid-19 restrictions. Nonetheless, this online version of the Round Table was able to reach more than 1,200 international experts and practitioners from the humanitarian, military, academia, and civil society sectors, connecting from all over the world.

The 44th Sanremo Round Table, jointly organised with the International Committee of the Red Cross, focused on “Pandemics, Armed Conflict and International Humanitarian Law”, and addressed several issues related to conflict management, protection of civilians and health workers, as well as the deliverability of humanitarian relief operations endangered at different levels by the sanitary crisis and the consequent state of emergency declared by the local public and/or military authorities.

Such proceedings are meant to reaffirm once again the role of the Sanremo Institute in the analysis and interpretation of the crucial issues of international humanitarian law, with the ultimate purpose of continuing to contribute to the dissemination of the fundamental principles and provisions of IHL, as well as to foster their application.

I take the occasion, therefore, to warmly thank all those who contributed and participated to the event, with the conviction that the Sanremo Round Table and the present proceedings will represent the pathway through which
the universally known “humanitarian dialogue in the Spirit of Sanremo” will positively impact the awareness, fulfilment, promotion and respect of international humanitarian law and international human rights law.

_Edoardo GREPPI_

President of the International Institute of Humanitarian Law
Opening session
Introduction

Edoardo GREPPI
President, International Institute of Humanitarian Law (IIHL)

Excellencies, Distinguished Guests, Ladies and Gentlemen,

As President of the International Institute of Humanitarian Law, I would like to welcome you to this 44th annual Sanremo Round Table organised by the Institute in co-operation with the International Committee of the Red Cross and with the support of the Italian Ministry of Foreign Affairs, and the Commune of San Remo. The Round Table is the keynote event of the Institute’s calendar as you know and provides a unique opportunity for academics, military, humanitarian actors and other interested parties to discuss critical issues in International Humanitarian Law. Sadly, as last year the pandemic means that we have to hold this Round Table online but we all hope that this time next year we will be back in Sanremo.

The Pandemic has affected absolutely all aspects of life for all the citizens of the world and as such we thought it appropriate to examine its effects on armed conflict and those unfortunate enough to be impacted by armed conflict. As is traditional for the Round Table this will be looked at from a 360° perspective examining the legal and operational challenges and difficulties that have been faced by those involved in armed conflict, those adversely affected by it and the humanitarian actors who have strived to minimise the consequences of armed conflict on those who find themselves adversely affected. I am indebted to the ICRC, Dr Durham and her staff, for all the assistance they have given the Institute staff in realising this project. Today and over the following three sessions I am sure we will have productive discussion in the well know ‘Spirit of Sanremo’. We are fortunate to have so many well-qualified and excellent speakers appearing on the panels and I would also like to thank them.

We will start after introductory remarks today with a question-and-answer session with the Force Commander of MINUSMA Lt Gen Dennis Gyllensporre.

It is now my pleasure to give the floor to Dr Helen Durham, Director of International Law and Policy at the ICRC for her introductory remarks.
Helen DURHAM  
Director of International Law and Policy, International Committee of the Red Cross (ICRC)  

Excellencies, Ladies and Gentlemen, Professor Greppi,  
It is a distinct pleasure for me to join you, Edoardo, in opening this 44th Sanremo Roundtable on current issues of international humanitarian law.  

It is now about 18 months that the Covid-19 pandemic has affected the lives of all of us in so many ways. For our dear community of legal and operational experts at the Sanremo Roundtable, it is the second time that we have to convene online. And while I dearly miss the opportunity to see you, our expert speakers and all participants in person in beautiful Sanremo, I am delighted to welcome a diverse audience online. It is great to see people from all parts of the world joining us virtually, including those for whom travel to Sanremo might not have been an option.  

The pandemic has affected everyone, everywhere, in one way or another – but it has not affected all of us equally. The ICRC operates in over 90 countries around the world, many of which are affected by armed conflict and other situations of violence.  

Over the past year and a half, we have seen that people and communities affected by armed conflict have been among the hardest hit. Think about:  
- displaced persons who are now living in congested camps;  
- detainees, especially those in overcrowded places of detention;  
- women, men and children who have been deprived of their livelihoods and access to basic services by the combination of armed conflict and the economic consequences of the pandemic;  
- or persons living in places outside governmental control, for whom access to vaccines, for instance, is a particular challenge.  

Throughout the pandemic, the ICRC has worked relentlessly with all parties to armed conflicts – States and non-State armed groups – to ensure that these peoples’ needs are not forgotten and that parties to the conflict live up to their obligations under international humanitarian law. And indeed, international humanitarian law sets out important provisions to address some of the protection challenges raised by the pandemic, ranging from the protection of medical personnel and facilities to a well-established framework for humanitarian operations during armed conflict, which must be respected even in times of a pandemic.  

We are very happy to convene experts from the humanitarian, military, government, academia and civil society sectors at this Roundtable to explore
some of the legal and operational challenges posed by the intersection of armed conflicts and the pandemic.

I wish all of us an insightful, interactive and engaging conference in the virtual spirit of Sanremo.
Key-note Messages

Alberto BLANCHERI
Mayor of Sanremo

Distinguished Guests of the Sanremo Round Table,
I am very honored to welcome you to this 44th edition of the Sanremo Round Table on current issues of IHL, on behalf of the Municipality of Sanremo and the whole City Council.

We are living in challenging times. The impact of Covid-19 on our lives does not need to be explained to anyone, as we have all witnessed its effects on our daily life for quite a long time now.

Considering this, I would like to say how glad and proud I am to see that, even during these uncertain times, the Sanremo Institute has been able to shape its flagship event – which traditionally took place, since 1970 every September in the city of Sanremo – to an online format, to keep up its mission of disseminating international humanitarian law and fostering the international scientific debate.

The chosen topic “Pandemics, armed conflict and international humanitarian law” could not have been timelier. When sanitary emergencies are combined with armed conflicts, natural disasters and other humanitarian crises, the negative consequences on civilian populations inevitably multiply, indiscriminately threatening all its fringes both directly and indirectly.

The participation of experts and practitioners from academic, humanitarian, and military circles from all over the world is proof of the prestigious reputation of this event organized by the Institute in collaboration with the International Committee of the Red Cross, which strongly contributes to the international projection of the City of Sanremo and its ambitious vocation to be recognized among the main international cities of peace.

Let me now thank the Institute, the International Committee of the Red Cross and all the institutions involved in the organisation of this important webinar series, with the very strong hope to be able to host you next year in Sanremo, our beautiful city.

I wish you a fruitful Round Table and good health to you and your families.
Benedetto DELLA VEDOVA
Undersecretary of State, Italian Ministry of Foreign Affairs
and International Cooperation

Excellencies, Ladies and Gentlemen,

I am really pleased to participate in the Opening Session of this annual Round Table organized by the Sanremo International Institute of Humanitarian Law with the International Committee of the Red Cross.

The Italian Ministry of Foreign Affairs and International Cooperation has a longstanding and deep cooperation with the Institute. Last year we celebrated its 50th anniversary, which testified its enduring success. Since its establishment in 1970, it has played a pivotal role in the promotion and development of International Humanitarian Law, establishing itself as an international “centre of excellence”.

The Annual Roundtable represents a renowned forum that deserves growing attention. In this respect, the choice of the theme for this edition – focused on the application of International Humanitarian Law during the pandemic – proves once again the Institute’s ability to grasp evolving challenges and to adapt to changing times.

Notwithstanding the appeal for a global cease-fire launched by the UN Secretary General in May 2020, guns have not been silenced and armed conflicts have continued to rage around the world even during the Covid-19 pandemic, when the international community should have been concentrating on redoubling its efforts to save lives around the world.

When coupled with other global concerns, including armed conflicts, the Covid-19 pandemic has been a threat-multiplier, exacerbating and aggravating pre-existing humanitarian needs and vulnerabilities.

This is even more true in already fragile and unsafe environments, particularly in war-torn countries, where people very often already suffered from a limited access to health systems and other basic services.

Let me mention some of the additional challenges caused by the pandemic on persons living in areas affected by armed conflicts that see us strongly committed:

1. First of all, the pandemic had a devastating impact on access to education for children living in conflict-affected areas, thus further depriving them of the possibility to build a better, brighter, and more inclusive future. This is why Italy continues to undertake a number of initiatives in this respect, including promoting the widest possible support to the Safe Schools Declaration, and supporting all other initiatives aimed at putting an end to the worst forms of violations of the rights of children during armed conflicts.
2. In war-ravaged countries, not only poor health systems tend to collapse, but the pandemic makes it even more crucial to protect healthcare facilities and health personnel in order to ensure unimpeded, fast and safe access to adequate medical assistance. Unfortunately, five years after the consensual adoption of the Security Council Resolution 2286 on the “protection of medical personnel and facilities in armed conflicts”, attacks on hospitals, frontline medical personnel and humanitarian convoys continue unabated.

3. Another challenge made even more complicated by the pandemic is the access to humanitarian assistance. It is of the utmost importance that all parties involved in armed conflicts allow and facilitate rapid and unhindered passage of humanitarian relief for civilians in need.

Italy is firmly committed to the protection of civilian population and the most vulnerable categories during armed conflicts. We have ratified both the Additional Protocols to the 1949 Geneva Conventions, and we play an active role in supporting the promotion and the implementation of international humanitarian law, including by means of diplomatic initiatives to urge reluctant States to join the relevant international instruments.

We are also committed to promoting accountability for violations of international humanitarian law and, in this perspective, we ensure our strong support to international justice and accountability mechanisms, including the work and the independence of the International Criminal Court as a fundamental actor in the global fight against impunity.

In conclusion, let me thank once again the Sanremo Institute, and in particular Professor Greppi and Professor Pocar, whose expertise brilliantly lead the Institute, for continuing to raise the attention on serious challenges to international humanitarian law as well as on emerging trends linked to contemporary forms of armed conflicts, including the role of non-state armed groups and the protection of civilians living in areas beyond state control.

I can ensure that Italy will continue calling for a renewed and firmer commitment of the international community to the respect of international humanitarian law by all actors involved in armed conflicts, made even more crucial by the exacerbated context of the pandemic. Thank you.
Esperanza MARTINEZ  
Head of Covid-19 Crisis Team, ICRC

When looking back at the past 18 months, we can see three dominant and intersecting themes: the Covid-19 pandemic, armed conflict, and international humanitarian law.

Areas affected by armed conflict are at the sharp end of risks associated with infectious diseases. By one estimate, over 70% of epidemics in the three decades preceding 2009 originated in countries where conflict and violence have crippled health systems\(^1\). Moreover, containing viral spreads in these contexts is much harder for a number of reasons, such as insecurity, weakened health and sanitation infrastructure, or a decimated healthcare workforce.

If in addition we consider that there are around 100 armed conflicts involving 60 states and more than 100 non-state armed groups raging in the world today\(^2\), it becomes clear that the threat to overall public health is significant.

Delving into the Covid-19 pandemic, it is evident that vaccines play a critical role if we are going to regain some sense of normalcy worldwide. However, vaccines are not enough. We also need to ensure they make it into peoples’ arms, that individuals and communities are in fact vaccinated.

To ensure equitable access both to Covid-19 and routine vaccines we need to work both at the macro and the local level.

At a macro level, we need to scale-up the supply of Covid-19 vaccine doses and continue investing in national health systems. At local level, existing capacities and resources need to be strengthened, local supply chains need to be established or maintained, health care workers need to be trained.

As more vaccines against Covid-19 start to arrive in countries at war, how do we ensure that doses reach the local level and that people turn up and get vaccinated?

First, parties to conflict must respect and protect healthcare staff and facilities, in accordance with their obligations under international humanitarian law.

Yet even though health care workers represent our first and last lines of defense, from February through December 2020, ICRC delegations in 42

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countries received close to 850 reports of violence against health care linked to Covid-19. Although not all cases involved weapon bearers – a significant level of harm was actually caused by civilians – it is the responsibility of parties to conflict to ensure a safe environment in which health care workers can perform their functions. It is their responsibility to protect them.

In countries affected by conflict and violence, law and policy must go hand in hand with the delivery of essential services to bring about meaningful change. For the ICRC, this means engaging with state armed forces and non-state armed groups around world to safeguard healthcare in armed conflict all along the continuum of care: from community health, to vaccination activities, to the delivery of intensive care in hospitals.

Second, where parties to armed conflicts are unable to fulfil their responsibility to provide for those in need, they must grant access to impartial humanitarian organisations.

In over 90 countries in which the ICRC operates, we are seeing first-hand how the pandemic has impacted people’s lives and livelihoods. And we are also witnessing how the secondary effects of Covid-19, such as poverty, lack of education and employment opportunities, are shattering people’s dignity and hope in the future. Humanitarian needs are increasing day by day.

If parties to armed conflicts, both States and non-State armed groups, are unable to ensure the basic needs of a population under their control, including medical needs, to the around 50 million people that the ICRC estimates live under the exclusive control of non-state armed groups, and to thousands of detainees held by parties to armed conflicts, then unhindered access must be granted to impartial humanitarian organizations.

In this sense, the ICRC is continuing its humanitarian activities and redoubling efforts to support vaccination. This includes supporting national vaccination plans, supporting National Red Cross and Red Crescent Societies in their vaccination efforts, and acting as a neutral intermediary to facilitate access for people in last mile and other hard-to-reach areas. Some of the places where are supporting these efforts are Iraq, Yemen, South Sudan, Myanmar, Colombia, Afghanistan, among others.

Third, genuine community engagement must be part-and-parcel of vaccination activities – because for vaccination to happen, people need to trust those administering the vaccines.

One of the painful lessons from the Ebola responses in West Africa is that forcing people to be vaccinated – providing ‘healthcare at gunpoint’ – doesn’t work. On the contrary, it only exacerbates vaccine hesitancy, stigma and attacks against health care workers. Moreover, it disincentivizes people from seeking other essential services.
Community engagement is, above all, about building trust through dialogue regarding how people perceive Covid-19 among the many other challenges they face. It is about promoting good information so communities can make informed choices for themselves. And for this to happen, States and non-State armed groups need to be involved.

To conclude, it is important to recall that examples of compliance with international humanitarian law rarely make the headlines. This, however, does not mean that they don’t happen. On the contrary, as a humanitarian organization working in places affected by armed conflict, we are witness to militaries avoiding targeting medical facilities, to soldiers waving ambulances with wounded and sick combatants through checkpoints, or to governments including communities not under their control, and detainees, in their vaccination plans. These examples give us hope. They illustrate that the intersection between pandemics and conflict can be navigated with tools at our disposal. And international humanitarian law is one of the most critical ones.
Mike RYAN  
Executive Director, World Health Organization (WHO)  

Ladies and Gentlemen, dear Colleagues, dear Friends,  

Allow me to start by thanking the International Committee of the Red Cross and the International Institute of Humanitarian Law for the opportunity and honor to speak to you today.  

The focus of this year’s Round Table is truly timely.  

Over the last 20 months, Covid-19 has tested all countries and all agencies and has revealed fractures and fragility in our systems. It has brought to light the painful fundamental weaknesses and inequities in all our societies.  

As we have all witnessed: its impact has been amplified in fragile and conflict-affected settings.  

70% of high impact epidemics occur in fragile, conflict-affected and vulnerable countries.  

We have all seen the destructive interaction between conflict and epidemics, be it during the Ebola outbreak in the Democratic Republic of Congo, or cholera outbreaks in Yemen.  

Epidemics and pandemics and conflicts are deeply interlinked.  

On the one hand, conflicts and humanitarian crisis provide the environment for pandemics to spread rapidly while undetected. People contract and transmit diseases more easily when they are displaced and live in precarious and overcrowded conditions caused by conflicts, without adequate food, shelter and clean water, and where health services and disease surveillance are barely existent.  

On the other hand, pandemics can further worsen weaknesses in basic social services, which may trigger or amplify conflicts. Lack of access to basic services, including health drives conflict, displacement and mass migration.  

Conflict has been on an upward trajectory since 2010 and experts estimate that two thirds of the world’s poor could live in contexts defined by fragility, conflict and violence.  

Pandemic response in settings of armed conflict is complex and challenging:  

1. In conflict settings, it has been challenging to obtain information on Covid-19 transmission and mortality, because detection and testing capacities are limited, and those who have the disease are most probably unable to seek the health care they need and may die in their homes undetected and uncared for, and potentially infecting their entire household;
2. pandemic disproportionately affect vulnerable populations already living in poverty, instability and conflicts, and Covid-19 was no exception. In 2021, 235 million people - 1 in 33 people worldwide - will need humanitarian assistance and protection. This is a significant increase from the 1 in 45 people a year ago, which was already the highest figure in decades;

3. conflict-affected countries are frequently faced with multiple concomitant disease outbreaks, adding challenges to Covid-19 detection and response and dividing limited resources;

4. Covid-19 has caused disruptions to the delivery of essential health services across the globe. This is particularly concerning in fragile and conflict-affected countries as they entered the pandemic with weak health systems. WHO’s most recent Pulse Survey covering the delivery of 63 services in the first quarter of 2021 in 25 countries with FCV settings show that 22 out of the 25 countries are reporting disruption to at least one of the services;

5. fear of the epidemics and access to basic health services are being used to empower, or curtail, human, civil and political rights of persons. They are being exploited as a political tools, a weapon of war or an opportunity for human rights violations, further isolation and stigmatization of marginalized groups, minorities, to stigmatize, to incite fear;

6. in addition, many frontline healthcare workers risk their lives in conflict-affected settings. Attacks affecting health facilities, transport and patients became more frequent after the onset of the Covid-19 pandemic. In 2021 alone, more than 600 incidents of attacks on healthcare were recorded across 14 countries and territories through the WHO Surveillance System on Attacks on Health Care, which caused over 200 lives lost this year.

We are all doing our best in the context of limited resources, limited political commitment and “short-termism” that has really hurt us over the last number of years.

For decades, people and communities have been left outside the health system, the social system, the economic system. How can we expect, that people in poor and conflict-affected communities will trust the system, if it only engages with them when there is a crisis and when their crisis has been going on for generations?

Covid-19 has already taught us many lessons:

- we learned that we need an end-to-end and all-of-government and all-of-society approach to global pandemic preparedness and response;
• we learned that we need to recommit to a comprehensive and coordinated response at all levels using all the tools at our disposal wisely, fairly and compassionately;
• we know that good governance is at the center of successful and effective outbreak response and that we need to strengthen national health systems and public health systems;
• we learned that, national and international systems need to leverage and empower local capacities to prevent, detect and respond to health threats. This is even more urgent in FCV setting where collapsed health systems kill;
• we learned that we need to engage and empower communities, as, ultimately, epidemics or pandemics begin and end in community.

A response at community level can only be successful when it can build on a social contract, on the community's collective knowledge and understanding and trust towards governance and information systems.

Over the last months we have not only struggled with an epidemic but also an “infodemic.”

People all over the world have found themselves in a forest of information overload and struggled to distinguish the trees of good information from the trees of misinformation.

There was no information deficit but what was missing was trust between people, between people and governments and between governments.

We can do better at information management and the dissemination of good information but unless we bridge the gap in trust, this effort it will be futile.

At the end of the day, information itself does not change behavior. Only if there is trust in the information source and trust that the information is in people’s best interest, they will act.

Finally, it is important that we know that we will not end the pandemic quickly. The emergence of variants is making eliminating the virus very difficult. But we can end the emergency, the public health crisis, the social crisis, the economic crisis, by increasing vaccination coverage.

And this means increasing access to vaccines everywhere – and especially in the most vulnerable settings of this world.

This will end the suffering, the deaths, the pressure on the health system and the cycle of lockdowns.

Apart from that, we also need to continue to intensify our tracking of the virus through expanded testing and tracing and break chains of transmission using targeted public health and social measures.
Health emergencies, epidemic and global pandemics such as Covid-19 are always a revealer of uncomfortable and inconvenient truths. We have ripped the bandages away from some very old wounds in our society. We are paying a heavy price for our lack of preparedness for lack of equity and their lack of access to the basic human rights of healthcare.

How we protect the most vulnerable people will be the defining issue of our generation. Business as usual will not get us there.

We will neither achieve the SDGs nor any form of global health security, if we will fail millions of people, families and communities in fragile countries, who need us more than ever.

We will fail, if we do not fundamentally change to the way we deliver services in fragile states.

Director-General Dr. Tedros has said many times that we are all in this together and that this is not over anywhere until it is over everywhere. One person matters, one life matters, the rights of any single individual matters and must be seen and protected in every way we possibly can.
Introductory Remarks
The Pandemic and IHL before the Institut de Droit International

Fausto POCAR
Honorary President, IIHL

The ongoing pandemic – a serious form of epidemic that has affected the entire world infecting a large number of people – has attracted the interest of lawyers in any area of law, including the most important and oldest academic institution dealing with international law, the \textit{Institut de droit international (International Law Institute)}, founded almost 150 years ago, in 1873. In an unusually short time, the \textit{Institut} has appointed last year a commission and a rapporteur – a Japanese scholar, professor Shynia Murase – and has discussed and adopted a Resolution on “Epidemics and International Law” a few days ago, during an online session ended last Friday September 3. It is a resolution that tries to clarify certain principles without going into many details, as it is the case for most of the Institute’s resolutions, but it may be worth making some brief remarks at the beginning of our Round Table, since this is the first event on pandemics after the adoption of that Resolution.

As the title of the Resolution is “Epidemics, Pandemics and International Law”, it was to be expected that IHL would not be a significant component of its text. As just mentioned, the Institute’s resolutions tend to state some general principles without going into a detailed description of their implications and of the measures requested for their implementation by States. One could even foresee that the generic reference to international law in the title might imply that no specific consideration at all would be given to IHL and that the text would confine to international law in peacetime. And indeed, the first draft simply mentioned IHL in an article (Article 7) dealing with the interrelationship among relevant rules of international law. Among them IHL was also mentioned, alongside international environmental law, trade and investment law, intellectual property law, transport law and international law on peace and security; additionally, IHL was not even severed from law on peace and security as if it had no independent standing and were a component of the latter. The recommendation was that in developing new rules relating to the protection of persons from epidemics, States should seek to avoid conflicts with these other relevant rules of international law: a somewhat weak recommendation which left open any solution as far as the priority that should be given the one or the other law in any given case.
The subsequent debate during the session lead to the result of singling out IHL, or better to add a distinct consideration of IHL, in a specific paragraph of the same provision, where it is affirmed that “IHL must be strictly observed when an international or non-international armed conflict occurs, including its humanitarian principles relevant to prevention, reduction and control of epidemics”. Although it is drafted in quite general terms, this special rule, which imposes on States to respect strictly IHL both in international and in non-international armed conflicts when an epidemic occurs, recognizes its priority with respect to other rules of international law.

This priority may look natural when States develop new rules relating to the protection of persons, because IHL – unlike other areas of law mentioned earlier – serves primarily a purpose of protection, in particular as far as the persons who do not participate in hostilities are concerned.

However, the reach of a reference to a strict observance of IHL may go beyond the simple and neutral application of IHL, which imposes on belligerents a number of obligations concerning health protection, like the ones not to attack hospitals and to avoid the risk of epidemics in detention facilities. A reference to a strict observance of IHL may also impose a general obligation to interpret and implement its rules and principles in a way that takes into account the specific situation of an epidemic or pandemic.

It is interesting to note in this regard that the 2nd paragraph of Article 7 refers to IHL not only in general, but also specifically to its humanitarian principles relevant to prevention, reduction and control of epidemics. This reference includes, it goes without saying, the several specific provisions in the Geneva Conventions that take into account epidemics and contagious diseases – Articles 12 and 24 of GC I, 29 and 30 of GC III, 56 and 91-92 of GC IV – on which I will not go more into details.

But, and even more importantly, the reference to humanitarian principles relevant to the prevention, reduction and control of epidemics entails relevant implications for the scope and application of the fundamental principles of IHL, including the basic principles concerning the conduct of hostilities – distinction, proportionality and precaution. In particular, it recalls the last two, as they imply an assessment of the damage that a military operation may cause in a situation in which the civilian population – and not only the civilian population – is going through because of an epidemic, even more a pandemic, which makes it more vulnerable in the case of ongoing hostilities.

It is not without relevance that SC Res 2439 (2018) called for an “immediate cessation of hostilities by all armed groups” in the Democratic Republic of Congo as they could jeopardize the response to the Ebola outbreak; and that later on the SC, referring to the current pandemic, adopted
Res 2532 (1 July 2020) calling for a general and immediate cessation of hostilities in all situations due to Covid-19. If, in the view of the SC, the seriousness of an epidemic may go until implying the cessation, or at least the suspension, of hostilities, the existence of the pandemic is clearly relevant for a stricter interpretation and application of the principles governing the conduct of hostilities.

I will not go further in these introductory remarks. The Round Table will have the opportunity to deal with all these themes and it is not for me now to develop them. My task was only to draw the attention to the Resolution just adopted by the *Institut de droit international* and to its possible implications for our debates.
Cross-interview

Legal and Operational Challenges arising in Armed Conflict in the Times of Pandemic

Chair: Edoardo GREPPI
President, International Institute of Humanitarian Law (IIHL)

Dennis GYLLENSPORRE
Lieutenant General, Force Commander, MINUSMA

Cordula DROEGE
Chief Legal Officer, ICRC

Edoardo GREPPI
At what point in 2020 did the pandemic start to affect the operation and what were the initial effects?

Dennis GYLLENSPORRE
Thank you excellences, ladies and gentlemen,
Mali is a country with experience of dealing with Ebola so the pandemic implications and awareness came quite early in the process and before the first case of Covid-19 was reported. For us, at the very beginning, the most important question was to assess the reputational risk of the United Nations, and one of our main focuses was to align ourselves with the government in terms of mitigating and preventing the entry of Covid-19 into Mali.

Edoardo GREPPI
What additional humanitarian consequences resulted from the pandemic that the ICRC observed in situations of armed conflict? What is the role of IHL in preparedness and response to pandemics in such contexts?

Cordula DROEGE
I think many of the consequences that we have seen were also evoked by some of the distinguished speakers at the beginning of this session. It is really the compounded effects of pandemic and conflicts, which is a double burden.

* The following text is based on the transcript of the recorded session. It has not been revised by Lieutenant General Dennis Gyllensporre and does not commit him with regard to the views expressed.
The conflict as such, of course, is already a multiple burden of violence which, in today’s world, is very often compounded by environmental degradation and climate change, desertification in some places and, basically, a pandemic in a situation of armed conflicts hits a system that is already weak in terms of health infrastructure, education, and economies. Situations of conflict are often situations of poverty and, of course, if you have additional restrictions due to a pandemic, then such circumstances hit those who are poorest the most.

At the same time, we also observed that the pandemic was not always at the forefront of the concerns of people experiencing armed conflicts or other hardships and, in some contexts, the discussion was, in a way, quite absent. Just to give you an example, our Regional Director for Africa was recently in the Democratic Republic of the Congo for 10 days and, on such occasion, the issue of Covid-19 did not even come up once with the interlocutors. Perhaps, as General Gyllensporre will mention later, in northern Mali we have a large number of cases of Malaria and the testing shows that Covid-19 cases are actually not very high. For the ICRC, this means that, on our operational focus, at least for the moment, we do not necessarily prioritize Covid-19 but we prioritize other main humanitarian needs of the population.

With regard to the role of IHL in preparedness, I would say two things. One is about the respect for all rules, or rather the fact that the disrespect for IHL rules is basically a root cause for the vulnerability of populations when the pandemic hits because the disrespect for those rules has already weakened the systems. The response to a pandemic requires human and material resources but when hospitals are bombed, when medical personnel has already fled or has been forced to leave, when populations have been forcibly displaced, when prisons are overcrowded, then, of course, the vulnerability to a pandemic is exacerbated. Respect for IHL in the first place, particularly respect for the rules on the conduct of hostilities and the sparing of infrastructure, would go a long way to help in preparedness against such an extra-shock as a pandemic. The second thing about IHL relates to the specific rules as IHL includes a number of explicit obligations for Parties to conflicts. First and foremost, IHL is full of rules obliging Parties to safeguard the health and hygiene of all populations under their control and this is, of course, the core obligation that goes a long way towards containing pandemics, and protecting persons deprived of liberty, rules in occupied territories, and rules concerning displaced populations. The second specific set of rules that are very important in IHL, and which we might come to talk about later, relates to all the rules protecting medical facilities and medical personnel. The third set of rules concerns the entire legal framework
concerning humanitarian access and the services of impartial humanitarian organizations in armed conflict situations.

Edoardo GREPPI

How did you and the force have to adapt your operations to take account of the pandemic and was there a stage when you had to take an operational pause?

Dennis GYLLENSPORRE

First of all, we did not take any operational pause but there were some constraints in our operations on both the strategic and the operational level.

At the strategic level, specifically when it came to establish a partnership between the UN Mission and the government on an action plan to curb the situation, which became stronger as we moved towards facing the consequent management of Covid-19 cases. This translated in the sharing of knowledge, equipment, and in providing resources to the government. From our point of view, it also translated in ensuring transparency with regards to the status within the Mission and the UN family on the number of cases that we had to mitigate while preventing rumours as well as misinformation with regards to our role in the country.

At the operational level, there were quite a number of issues that we had to deal with and, perhaps, the most obvious and important one regarded the civilian population. For a peacekeeper, the very core of his or her business, is to interact with the population, and here we were in a situation where we had to deal with some new aspects when protecting civilians within the framework of IHL. For a period of time, in practical terms, we stopped doing foot patrols to interact directly with the population, we obviously had to make sure that everybody had masks for protection, and we also stopped CIMIC projects as these could have been a venue as well as a source of misinformation and spread of suspicion with regards to the United Nations. On the operational side we also had to take into account the limitations of our forces in terms of the ability to be supported from the air. Air operations rely very much on logistics, and there was a significant degree of uncertainty as to whether we would be able to be supported by the supply chain. For us, it was a situation that also took place against a backdrop of a military coup so there were some additional restrictions applied to Mali for quite some time. We also worked quite a lot with New York and with the troop-contributing countries. In order to play it safe, many contingents had to stay on longer than expected and planned, and for quite some time, our personnel did not know when they would be able to re-join their families. This was quite an important issue for us to address. As a final line of operation, we
also had to take care of the personnel in terms of their safety and give attention to the procedures, including hygiene procedures and other procedures concerning traditions. We had Ramadan being celebrated during the Covid-19 situation so we had to issue guidance in order to mitigate and balance this against the traditions of the different contingents. All these aspects caused quite a hardship and the core of all was the leadership at all levels to make sure that discipline, morale and adherence to rules and regulations were present at all levels to make sure that we could limit the negative effects as much as possible.

**Edoardo GREPPI**

How does IHL address specific challenges that have arisen in the protection of wounded and sick people, including people infected with the coronavirus, and health-care professionals involved in the pandemic response?

**Cordula DROEGE**

I think I will echo a lot of what General Gyllensporre has already said about the issues of rumours and misinformation. Perhaps, to zoom in on the violence that we saw driven by fear and misperception and resulting from the stigmatization of patients and healthcare personnel, as my colleague Esperanza said at the beginning of this session, we have recorded 850 cases of violence. What we saw was really sick people denied care and attacked because they were seen as Covid-19 spreaders or healthcare personnel, hospitals, quarantine centres and vaccine centres sometimes attacked because entire communities disagreed with their work. We also saw some cyber-attacks against facilities, perhaps not much in conflict contexts, but we do know that healthcare facilities are particularly vulnerable to cyber-attacks.

Perhaps, something that differentiates the Covid-19 pandemic from other previous and historical pandemics, is the use of the internet and social media which is a sort of fertile ground for spreading rumours, misinformation, and serves as a platform for people to threaten particular groups and healthcare personnel. For us, the issue with such aspect is that it can easily spill over from the online to the real world, as it were, and pose direct physical danger.

The violence that we saw came mainly from the civilian population and, on the other hand it seems all the more important to stress that States and Parties to the conflict have obligations not only to refrain from attacking healthcare personnel, wounded and sick, but also to protect them in situations of armed conflicts. So, in that context and perhaps going a bit beyond what might be legally required, it certainly seems to us that what States and Parties to conflicts should do, is to present accurate information about both the virus
and protective measures to reduce the risk of infection and also to effectively address the stigma that is surrounding Covid-19 in order to well protect patients as well as healthcare personnel.

_Edoardo GREPPI_

What was the most important factor that affected your operations? For instance, we have mentioned the exchange of information. Was it a relevant factor?

_Dennis GYLLENSPORRE_

Information exchange was a key factor in terms of creating a common understanding of the situation both within the Mission and with our Malian partners. We had to pay a lot of attention to such issue, and I also think it is an aspect that we underestimated in the beginning as the key foundation to making informed decisions and getting the stakeholders on board is to have a good supply of credible information. As mentioned before, quite a lot of misinformation made this quite challenging in addition to getting the reports from the ground, and it is certainly an area that should be highlighted.

_Edoardo GREPPI_

What does IHL say on humanitarian access when a pandemic erupts on top of an armed conflict? How can we ensure a meaningful balance between public health and humanitarian imperatives?

_Cordula DROEGE_

IHL provides quite a precise framework regarding humanitarian access allowing for impartial humanitarian organizations to provide protection and assistance to populations in need in armed conflict. Ground rules provided by IHL really guide the dialogue between humanitarian actors and the authorities and, as you mentioned, strike the balance between health imperatives, military necessity and humanitarian action.

Measures undertaken by States to contain the spread of Covid-19, had to be quite severe particularly in the beginning, and implied restrictions on international travel, sometimes restrictions on freedom of movement of humanitarian workers, restrictions on import particularly of certain medical material and also other goods. All these aspects, of course, affected and hampered the delivery of humanitarian work by organizations, leaving some populations without support.

For IHL, impartial humanitarian organizations must seek and obtain consent from the authorities to deliver their activities, also in the context of Covid-19. However, the Parties to the conflict have an obligation to provide for the basic needs of the populations under their control so the consent to
humanitarian operations is not discretionary. Arguments based on the necessity to counter the spread of Covid-19 are not valid grounds to deny consent to humanitarian activities of impartial humanitarian organizations.

What States are entitled to do for IHL, of course, is to prescribe measures of control and other technical arrangements based on health considerations in order to regulate the humanitarian activities in territories under their control. However, such measures and arrangements, although they are legitimate, cannot, in practice, completely hamper or undermine humanitarian action. It is here where a meaningful balance between public health imperatives, military necessity and humanitarian considerations should be sought. To give you a couple of concrete examples, it was important, from our perspective, to benefit from waivers of movement restrictions based on public health in order to reach the population in need of our support. At the same time, measures that provided for our personnel to be medically vetted, not to be contagious, or to be sufficiently equipped to avoid spreading further the pandemic seemed to be appropriate and were completely justified. In such context, certain humanitarian activities such as food distributions were done in a phased manner in order to avoid a large congregation of people.

To summarize, there is the question of consent for people who are in need, where such consent has to be given if the basic needs are not met, and then, there is the question of finding the balance to impose public health measures.

*Edoardo GREPPI*

Was there any significant effect on MINUSMA detention operations and, if so which one? Were extra measures in place for those deprived of liberty because of the pandemic?

*Dennis GYLLENSPORRE*

We had detention activities going on, and we are still conducting detention operations. In terms of implications, we had to make sure that the same protocol we apply to our own personnel was also applied to detainees in order to ensure their safety and security with regards to Covid-19. Basically, this procedure is an addition to the regular procedures for detention to allow the detainees to be part of the Covid-19 protocol in the same way as any other UN personnel.

*Edoardo GREPPI*

In its operations, the ICRC is working with all Parties to armed conflicts. What has been the experience of the ICRC concerning the way NSAGs have handled the pandemic, and what particular challenges did that raise?
Cordula DROEGE

The ICRC is in contact with over 400 armed groups around the world. As you can imagine, such groups are very diverse, ranging from favela gangs to quasi-State authorities which *de facto* govern millions of people. These differences greatly affect the way they have responded to the Covid-19 pandemic. On the one hand, we have seen armed groups taking measures that are very similar to the responses of States to the pandemic as they imposed curfews, ordered the closure of most shops and governance institutions, and permitted only essential business or organizations to continue their services. In this regard, Myanmar and northeast Syria are concrete examples. On the other hand, there have also been more problematic responses as in the case of Colombia, where some armed groups adopted Covid-19 measures in the areas in which they were operating and decided to enforce their rules, including shoot-to-kill policies against those people who did not respect curfews.

Operationally, the ICRC passed a range of messages to armed groups with the primary objective of protecting persons affected by armed conflict and curbing the pandemic. For our legal colleagues, this dialogue also posed delicate legal questions, especially relating to the message that we could effectively pass to armed groups. There is no doubt that the ICRC uses every opportunity to speak confidentially to those groups and passes clear messages on their legal obligations under IHL. In several contexts, this message was rather simple as it referred to the fact that killing or ill-treating civilians was never justified, not even to enforce Covid-19 measures. The ICRC did this in the Philippines. In other contexts, and especially where armed groups *de facto* govern a territory, an effective dialogue will also involve questions such as when it is justified to limit the freedom of the movement of people. Perhaps, such issue pertains more to Human Rights Law rather than to IHL, and also raises the question about how much armed groups are bound by Human Rights Law. The ICRC did this in Yemen, which is a concrete example of such case.

Going forward, a key issue for us is the vaccination of persons living under the control of armed groups, also considering that, in many conflict situations around the world, people are very hesitant and sceptical about getting vaccinated. We estimate that about 50 million people live under the full control of armed groups and about 100 million people live in areas where control is contested.

Given that the ICRC is present and operational in most of these areas, we are offering our services to Parties to armed conflicts to facilitate safe and effective vaccination campaigns. As there is no single solution in these diverse contexts, facilitating vaccinations might mean reminding authorities
of their responsibilities to provide for health care needs of persons affected by armed conflict, to act as a neutral intermediary facilitating dialogue between Parties to armed conflicts, ensuring safe access to those providing vaccines, or working hand-in-hand with the authorities, National Red Cross and Red Crescent Societies to facilitate and guide their vaccination campaigns.

_Edoardo GREPPI_

What mitigating measures were put in place to protect the force and prevent the spread of the pandemic within the force or between force personnel and civilians?

_Dennis GYLLENSPORRE_

First of all, there were regulations put forward by the Malian Government and the force, of course, had to comply with them. We also concluded that we needed to take additional measures and, in consultation with the UN Headquarters in New York, specific regulations were put forward to protect.

All the soldiers who were coming at the later stage, had to undergo 14 days of quarantine, and additional 14 days of quarantine upon arrival. This procedure had, and still has, logistical implications for us as we need to have more camp space, establish facilities for isolation and suspected cases, and Covid-19 tests have been taken as a mandatory requirement to come in.

During the first months of this situation we also stopped, basically, all incoming units or incoming peacekeepers to the Mission. I think this was the most significant decision we made because it prevented any spread coming in from other countries but it also had some implications on the morale as well as on the people who had to stay on for an undefined period of time beyond their contract. That was a sound and a difficult decision to take as we did not have any leave or any chance to go out of the country. However, I am still convinced, that such tough measures helped to mitigate the effects a good deal.

_Edoardo GREPPI_

Which safeguards does IHL envisage to protect persons deprived of their liberty from a pandemic? How did the ICRC assist detention authorities in putting in place measures to prevent the spread of the pandemic in places of detention?

_Cordula DROEGE_

Thank you for this question. The protection of detainees is at the core of IHL rules. There are many rules in IHL that also pertain to health and hygiene of detainees, which makes sense in light of a reality in which places of
detention are often overcrowded, have poor hygiene and lack ventilation. These aspects, combined with the fact that detainees are at particular risk and at the mercy of detaining authorities, justify the need for these explicit rules.

For instance, IHL rules governing conflict-related detention both in international armed conflicts and non-international armed conflicts require that detainees are afforded the basic measures of health and hygiene and the medical attention required by their condition, which is defined merely on medical considerations as other considerations are not allowed for medical care. With regard to prisoners of war in an international armed conflict, Article 29 of Geneva Convention III requires the detaining power to take all necessary sanitary measures to ensure the healthfulness and cleanliness of camps and prevent epidemics. I think this is quite an interesting rule as IHL, in a way, has always been aware of the situation of epidemics and pandemics.

The fulfilment of these obligations may render the implementation of pharmaceutical or non-pharmaceutical public health measures necessary, including medical examinations to detect infections upon entry, disinfection of premises, supply of personal protective equipment, airing of premises, isolation of suspected cases, installing hand-washing stations, providing soap and other washing equipment, creating isolation wards, and administering vaccines. Very often, these measures are difficult to meet by the detaining authorities. During the Covid-19 pandemic, the ICRC could give support by working together with the relevant authorities to strengthen standard practices such as the medical screening of new arrivals in places of detention and the setting up of hand washing stations for detainees, visitors, staff, and delivery personnel. The ICRC also supported disinfection measures such as fumigation campaigns, and distributed soap and other hygiene and cleaning material to detainees. The ICRC team likewise worked on improving sanitation and other infrastructure in prisons, trying to reinforce the basic health and hygiene measures which are often inaccessible for many people in armed conflicts in general, and, perhaps, even more so in places of detention.
I. The Provision of Medical Care in Times of Armed Conflict
Legal and Operational Challenges for the Provision of Health Care during Armed Conflict and Pandemics

Jean-Emmanuel PERRIN
Captain, French Navy, Deputy Director, Military Department, IIHL, former Senior Legal Adviser to Operation Barkhane

The question of the provision of care during armed conflicts, whether these are qualified as international or non-international armed conflicts, is fully enshrined and developed in the law of armed conflict and creates a number of obligations to which the forces engaged must naturally submit. It is thus provided that “the rights of the wounded and sick must be respected in all circumstances; any attack on the life and person of the wounded and sick is strictly prohibited. Killing them intentionally, causing them great suffering or serious injury and endangering their health are serious breaches of the Geneva Conventions, and therefore “war crimes”.

If the question of access to healthcare for civilian populations is described in a fairly extensive manner by conventional and customary international humanitarian law, the recent epidemic caused by SARS-COV 2 naturally leads us to ask ourselves the question of the applicability of standards defined for the wounded and sick in armed conflict, whether international or non-international.

The difficulties that may arise in the particular case of a pandemic are in reality as much due to the particular nature of the sanitary measures taken against the spread of a virus, which supposes the implementation of strategies for the prevention of health risks and massive vaccination, as it due to the nature of the conflict as well as the willingness of the parties involved to comply with international obligations and the means available to each of these parties to fight against the spread of such a pandemic.

My remarks will focus in particular on the recent situation in which we were engaged against the SARS-COV 2 virus and I will endeavour to compare the prescriptions of international law with the particular case of a non-international armed conflict in which Western states intervene, in support of a host state. This scenario corresponds to the ones encountered by Western troops engaged, under the NATO banner, in Afghanistan, but it is also the one that France is currently experiencing in the Sahelo-Saharan strip. To do so, I relied on the recommendations formulated by the ICRC with a view to respecting and protecting health care in armed conflicts and in situations not covered by international humanitarian law. I will then address
the question of the applicability of international human rights law standards relating to the protection of health and I will quickly end with the specific case of the obligations made to occupying forces.

International humanitarian law requires Parties to an armed conflict to take all possible measures without delay to search for and collect the wounded and sick. While the case of collecting the wounded, whether they belong to Allied troops or opposition forces, does not in reality pose any difficulty, the particular case of the sick in fact raises many questions. Indeed, is a person considered sick from the time they test positive for Covid-19 or from the moment they develop symptoms of the disease, such as respiratory failure? Should the collection of patients, when they appear in large numbers, lead to the establishment of specific reception areas or be limited only to the populations interfering with the conduct of operations? Finally, should the forces physically present in the territory conduct a policy of systematic screening against all the people over whom they exercise control? What happens when these screening capacities are themselves limited, or even insufficient for the personnel of the forces engaged?

International humanitarian law also provides that when circumstances permit, the parties involved must make arrangements for the evacuation or exchange of sick persons. This possibility, which is easily conceived in the context of an international armed conflict, seems more difficult to implement in that of a non-international armed conflict. Indeed, people captured by the forces in presence cannot claim the status of prisoners of war within the meaning of IHL and they are intended to be handed over as quickly as possible to the judicial authorities of the host State. When such a transfer is considered, however, it should be recommended that the captured individual be transferred with an indication of his medical status with regard to the epidemic, in particular with the aim of avoiding the spread of the virus in the population of prisoners.

IHL also provides that all parties to a conflict must protect the wounded and sick against looting and ill-treatment, and ensure that they receive appropriate medical care, to the extent possible and in the shortest possible time. There is no doubt that the armed forces of Western countries engaged in the most recent non-international armed conflicts have been, and continue to be able to guarantee the absence of mistreatment of sick persons, including for periods during which they would come to be under the control of the armed forces in question. The question of the capacity of these forces to provide appropriate medical care in reality only makes sense for the people over whom they exercise control, as the mass effect generated by an epidemic would make it impossible to scale up the care to be provided for all those concerned. In addition, the obligation weighing on the host State to
organize health policy capable of countering the effects of the pandemic must not be thwarted by measures taken by the armed forces present on its territory and which have not vocation to replace the efforts undertaken by this State in this area.

While it is a given that the armed forces engaged in a NIAC alongside a host State endeavour to never establish a distinction in the treatment of the wounded and the sick, who must all be treated without discrimination, and to never make any distinction between the treatment of the wounded and the sick based on criteria other than medical, reality requires us to consider the fact that the vaccination strategies are put in place in order to guarantee in the first place the protection of the members of the armed forces concerned. There could be a strong temptation to consider that in certain circumstances refusal to provide care could be equated with cruel, inhuman and degrading treatment; however, the prioritization given to the vaccination of the armed forces cannot be seen as extending to the entire population present in the Joint Operations area; this point of view is justified in particular because of the rationing of the vaccine doses available and the need of each nation to guarantee the health and physical integrity of the men and women it deploys in operations abroad.

On the International Human Rights side, the ECHR has already had the opportunity to express itself on numerous occasions on the responsibility borne by States Parties to an international armed conflict exercising control, and by extension their jurisdiction over persons whom their forces may apprehend. Although the recommendations made by the Human Rights Committee are addressed in particular to situations which do not amount to armed conflict, there is no doubt that the provisions relating to international human rights law continue to apply, concomitantly to IHL and that the considerations relating thereto would not fail to impact the States in question, which would certainly have to integrate these obligations under IHL in the planning of their operations.

Thus, the United Nations Human Rights Committee has stated on numerous occasions that States are required, under the right to security, to take the necessary measures to protect persons within their jurisdiction, including against individuals. The right to health also requires States to take all necessary measures to “protect persons within [their] jurisdiction against infringements of the right to health attributable to third parties” (General Comment No. 14).

Under the right to health, States thus have the non-derogable obligation to “guarantee the right to have access to health equipment, products and services” (General Comment No. 14). Where persons, such as the wounded and sick, cannot realize this right on their own, States must therefore take the
necessary measures to ensure such access, including, where appropriate, seeking and collecting the injured and sick.

According to General Comment No. 6 of the Human Rights Committee, the right to life set out in the International Covenant on Civil and Political Rights (ICCPR) also requires States to adopt positive measures – in particular to ensure the provision of health care, in particular in situations where human lives are in danger. It is easy to imagine that in the particular case of a pandemic, and given the number of people affected by it, such an obligation would require States parties to a conflict to include in the conduct of hostilities in which they are engaged all the measures necessary to guarantee a fight against this pandemic against the persons over whom they exercise jurisdiction.

Articles 2.2 and 3 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) provide that the right to health must be exercised without any discrimination. Access to health care for the wounded and sick must be equitable. This obligation is immediate and non-derogable. According to article 4 of the ICESCR, states are empowered to limit the exercise of the right to health. Such restrictions must, however, be in accordance with the law, including human rights standards, consistent with the nature of the rights protected by the Covenant and imposed for legitimate purposes, exclusively for the promotion of the general well-being of the country in a democratic society.

The question of the conditions for exercising such a limitation is not, however, addressed in International Humanitarian Law nor in International Human Rights Law and we must ask ourselves how to define the fair balance between such a limitation of access to care, made necessary both by the obligation to preserve the smooth running of operations and the health support associated with them, but also by the necessary preservation of the health of members of the armed forces engaged in the field, being themselves in contact with individuals potentially carrying the virus.

As far as occupation is concerned, article 56 of the Fourth Geneva Convention provides that, in an occupied territory, the occupying power must, to the maximum extent of its means, ensure and maintain (with the assistance of national and local authorities) the establishments and medical and hospital services, as well as public health and hygiene, in particular by adopting and applying the prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics. However, this obligation may seem difficult to implement, especially when these occupied territories are subject to embargo or even blockade measures which, if they do not directly target health products, have a real impact on the functioning of health infrastructure.
Although IHL and IHRL allow states to make the execution of their obligations conditional on available resources, a lack of resources cannot justify inaction. The ICRC therefore recommends that “even when their means are extremely limited, states should adopt inexpensive programs targeting the most deprived and marginalized groups of the population”. How, however, can we imagine what the level of societal acceptance could be of a measure aimed, for example, at vaccinating the population of an occupied territory even though the population of the occupying state could not be itself vaccinated given the scarcity of available vaccines? Although this is not a question of law strictly speaking, there is no doubt that such a factor would be such as to jeopardize compliance by that State with such a provision, in the name of a certain "national health preference".

In conclusion, both international humanitarian law and international human rights law show the difficulty that arises in apprehending a phenomenon as particular as that of a pandemic. The reasons that could explain why these two paradigms are found to be inadequate with the consequences imposed by the measures to protect and fight against a virus lie essentially in the mass effect to which the armed forces deployed by the different parties to a conflict find themselves confronted to. When civilians potentially affected by a virus number no longer in thousands but in tens or even hundreds of millions, the conditions for the implementation of the law reach their natural limits, in the same way as the systems which implement these measures themselves are reaching their own limit. It is therefore certainly in the light of this first global pandemic of the twenty-first century that it will be necessary to question the way in which IHL and IHRL are intended to apply, or, more likely, not to apply, or apply only imperfectly given the inevitable derogations from the application of the rules which will result from it, under the constraint of the difficulties of our political, legal, social and economic systems to apprehend such a catastrophe.
Operationalising the Protection of Health Care: ICRC Guidelines for Military on Protection of Healthcare

Mohammad SUMON REZA
Brigadier General, Bangladesh Army

Distinguished Professionals from all around the world and other dignitaries present here, good day. I am thankful to the Institute for giving me the scope to speak at this forum. At the very outset, let me extend my heartiest felicitations to the ICRC for its outstanding effort in drafting the Booklet “Protecting Health Care: Guidance for the Armed Forces”.

As we all know, the ICRC is the largest humanitarian network in the world with a presence and activities in almost every country. The ICRC helps people around the world affected by armed conflict and other violence, doing everything possible to protect their lives and dignity and to relieve their suffering, often with its Red Cross and Red Crescent partners. The organization’s long experience and expertise enables it to respond quickly, effectively ensuring, most importantly, neutrality while maintaining humanitarian law.

Coming to the Handbook prepared by the ICRC for the guidance of Armed Forces, the first thing I would like to mention is that the ICRC health care provision is working smoothly with some hiccups or difficulties in certain areas. Yet, the ICRC thinks that the protection of the health care personnel, equipment, vehicles and also the effective use of the health care services both by civil and military authority, need more attention.

Now, if we critically analyze the background of the ICRC’s initiative of drafting this document to operationalise the health care service more effectively, we will find that the core requirement is to find out how the Armed Forces can better protect medical workers and equipment and safeguard access to care during any armed conflict or other violence.

First of all, I will talk about some aspects of concerns, problems, difficulties or hiccups with ICRC and Military Forces in terms of protection and access of health care personnel and services with special emphasis on the Covid-19 pandemic scenario. Then, I will highlight how to operationalise the health care service in conflict zones, including UN Mission areas.

* The following text is based on the transcript of the recorded session. It has not been revised by Brig. Gen. Sumon Reza and does not commit him with regard to the views expressed.
Here, I would like to mention that the ICRC still has some concerns about the protection of its health care personnel and equipment. There are concrete reasons for such concerns as, in recent days, attacks were carried out against health workers and facilities which actually disrupted access to health care services and brought health care programmes to a halt. The recent attacks included the destruction or the damage of a medical facility or vehicle, forced interference in a health care facility (including armed entry), threats against health care workers, the denial of access to the wounded and sick, and the obstruction of or interference with a medical vehicle.

Going through the Booklet of the ICRC, I have found that the document has successfully identified a series of practical measures that the State’s Armed Forces can take to keep medical personnel and equipment safe from harm while carrying out their assigned military operations. However, being part of the military personnel, having working experiences with the ICRC in some affected areas and two UN Missions, I would like to highlight a few points of contention or disagreement between the ICRC and conventional Forces:

- access by health care workers to various casualty locations depends on the tactical and security scenario where the local tactical commanders may be compelled to stop access without divulging a tactical plan. This may result in access denial to the Health Care Workers (HCW) during traditional military operations. Here, I would like to explain that sometimes, as a military Commander, I would never compromise with my tactical plan and the security scenario. In such situations, all the parties, including the ICRC, should consider whether it is the proper time to enter the casualty locations;

- evacuation of civilian casualties by military Casualty Evacuation (CASEVAC) or Medical Evacuation (MEDEVAC) chains may overwhelm the military medical facilities. Much of it will depend on the tactical scenario of the battlefield and the capability of military medical units operating therein. Again, I would say that sometimes, there are a lot of casualties and, although they are capable, the medical personnel does not take care of them for two reasons. The first one concerns tactical and security considerations while, the second one, concerns the capability of the medical team. Normally, the military first take care of their own personnel and then of civilian casualties, if the tactical and security situation allows them to do so;

- UN Missions or Counter Insurgency Operations, that are different from conventional war, have different ROE and gradation of escalation which does not commensurate with traditional war or war-like scenarios. The Handbook prepared by the ICRC focuses on the
protection of health care workers and health care facilities in war zones. This may not always translate equally for UN Missions where the aim of the mission is peacekeeping and the threshold of violence is less compared to limited war scenarios. However, much of the issues highlighted by the ICRC Booklet are covered in various Geneva Conventions and Additional Protocols;

- extending medical or health care facilities to civilians in UN Missions depends on the mandate and sensitivity of the host government. Again, this aspect depends on the national policy and on the availability of facilities by the military. The ICRC should consider such an aspect and recognize that it is very much linked to the country and place where the military forces operate;

- inadequate capacity of the national health systems in different countries in managing a pandemic like Covid-19 affects delivery of the overall health service. The challenges are in the areas of human resources, medical supply chain management and availability of adequate guidelines and protocols for Covid-19. For low- and middle-income countries, resource mobilization for this pandemic has put significant stress on the economies and, in many cases, the health facilities may not have been sufficiently prepared for the pandemic. As this is a different situation, we should approach at it in a different manner;

- health facilities, from primary health care centres to tertiary level hospitals, need to follow the Covid-19 prevention protocols at every step of service delivery. In that respect, the ICRC should take into consideration that the social and behavioral change of people to improve relevant practices is important but also extremely difficult and challenging in times of pandemics.

Having said all this, I now want to proceed by highlighting some measures to operationalise the protection of health care.

For the benefit of both the military and civilian component, an intimate coordination is very much essential especially during the time of conflict or other violence. In such regard, a comprehensive framework for carrying out coordination at different levels of conflict may be more suitably worked out but the country of operation and the tactical situation should also be considered.

ROE generally define actions leading up to and the proportionality of the use of force, so the ICRC Handbook recommends treatment procedures of civilians in a war zone and other similar issues which are not directly related
to the use of force. All these need to be included in the ROE of UN Missions otherwise the ICRC may not be allowed to access where support is needed.

In order to operationalise health care protection in this pandemic situation, all actors in the health sector, including medical staff, health care managers, humanitarian and development partners and the military need to work together to tackle current challenges even if it means going beyond the conventional approach. In such a case, it is important to consider the local context of any health system to identify the areas of support and coordination, and the military might have to readjust their CASEVAC system and plan in consideration of the pandemic.

Appropriate allocation or realignment of resources at this time may be useful to tackle the pandemic in a collaborative and more effective way. The armed forces, civil authorities and other partners need to work together to develop and follow a common strategy and action plan to ensure the protection of health care during this challenging time.

The last thing that I would like to say is that there has to be coordination between the military forces and the ICRC. I do not find any difficulties in that. We, as military, always welcome the ICRC, and we will always do so.

I would like to thank you, once again, for your patience. May the Almighty save us all in this pandemic and I wish you all good health.
Good afternoon,
as Strategic Adviser at Médecins Sans Frontières (MSF), today, I will talk about the efforts of MSF to better understand and tackle Misinformation and Disinformation, which have intensified since the start of Covid-19 Pandemic.

MSF is a medical humanitarian organisation, and I think some of you may have come across us in the field. We work in many conflict zones, guided by the principles of neutrality, independence, and impartiality. Another important aspect to mention about MSF is that this organization is fully funded by private donations and does not receive funding from governments.
We are living in a changing information environment. Whilst rumours and propaganda have been around for a long time, and social media has vastly increased the speed at which they travel. As you can see from this photo, which was taken in South Sudan, even in the most remote places in the world where there are issues relating to electricity, internet access is growing fast, and having a profound change on our society.

Let me first start by explaining what we mean by Misinformation and Disinformation. Misinformation is characterized by information that is shared without intent to harm while, on the other hand, disinformation is false information that is shared with intent to harm. We also have another category called Malinformation that refers to correct information presented in a misleading or false way, out of context or a mix of real and false
information. The organization *First Draft* has defined all this an “information disorder”.

Misinformation and rumours related to Covid-19 are present in every country. Poor quality of health infrastructure and access to healthcare make health-related misinformation stick. In fact, when people’s experience of healthcare has not been positive historically, they are more likely to believe rumours that have the effect of dissuading them from seeking healthcare. Such an atmosphere of mistrust is a worrying aspect for healthcare providers.

Disinformation operations targeting opponents of governments, both foreign and domestic, have increased massively in the past years. According to the Oxford Internet Institute’s Cybertroops report 2020, the governments of 81 countries are using social media to spread computational propaganda and Disinformation. They increasingly use commercial companies to launch these campaigns.
Social media platforms, such as Facebook, are removing vast quantities of “Coordinated Inauthentic Behaviour” but ultimately have not been able to eradicate the practice. Even though false accounts and bots are being tackled by the social media companies, the matter becomes difficult when a real person, and actually a real person of influence and authority, spreads “authentic” Disinformation. This last case is a challenge for us as a society.
Why is this relevant for humanitarian agencies? In Myanmar, for instance, the recent internal tensions and conflicts have been reflected in the online world. In such a country, there is an ongoing “virtual battlefield” where the protesters use social media to motivate and mobilise supporters. These, in turn, have been met by internet shutdowns to slow the spread of information and impede the organisation of the civil disobedience movement. Myanmar is one of the top five countries identified by Facebook where “Coordinated Inauthentic Behaviour” circulates.

What happens offline, is reflected, and distorted online. Being able to provide safe and accessible services for patients in a conflict situation requires humanitarian agencies to have the trust and acceptance of populations. If that trust is eroded through false information, it can affect the security of our staff and patients, as well as their health-seeking behaviour.

How is this affecting an organisation like MSF? Let’s see a few examples.
In Niger, Covid-19 vaccine misinformation has been circulating since last year, creating mistrust. What we have seen is that it has affected our patients, who are now hesitant to come and get vaccines, even the ones that had always been part of the regular preventative health routine (i.e., routine vaccinations).

In Yemen, we have had a persistent rumour around “lethal injections” for which people are afraid to come to hospitals and wait until they are very sick. We have seen such situations quite a lot, especially in cases of patients with Covid-19.
In Brazil, the overwhelming amount of disinformation has fuelled sickness and death. Public health measures became politicised in the country. As a result, science-based policies are associated with political opinions, rather than the need to protect individuals and their communities from the Covid-19 pandemic. This affected the wearing of masks, physical distancing, the restriction of movement and other non-essential activities.

In all of the conflict zones where MSF operates, there is a toxic mix of online Disinformation and influence operations. We have also experienced Disinformation targeting us since we have had fake tweeters try and discredit our reports, and Facebook pages set up to slander our staff. There have been tweets falsely accusing us of using experimental vaccines, and conspiracy theories have been used by politicians to try and discredit our work. We have seen bots promote or attack our online channels, depending on whether our reports and updates have favoured the point of view of their masters. As what happens online can easily transfer into real life, we are starting to consider the mentioned online attacks against humanitarians in terms of security risks.
What are we doing about it?

Firstly, we are trying to support our teams to improve our response to rumours and health Misinformation. We are piloting a project to better identify rumours that might affect health-seeking behaviours and to coordinate a response. While Misinformation is a global phenomenon, it has a local flavour. The context of a rumour or a piece of false information is as
important than its content. Along with debunking the rumour, it is important to understand why it circulates, in the first place, and related local dynamics.

Misinformation and Disinformation are part of a wider range of digital risks we face. To address such challenge, we are in the process of developing better response mechanisms that include a wide range of MSF competencies as these attacks go beyond just “digital” issues, training our teams and building digital resilience, reinforcing reporting mechanisms with the Big
Tech companies to be able to flag dangerous content quickly, and developing incident management and recording systems to better learn from these cases.

We are an increasingly interconnected world, and this is going to change our societies. MSF believes it is vital to better understand how the online space is developing in order to continue to provide humanitarian assistance to people who are affected by crisis.
II. The Role and Challenges of Humanitarian Actors in Providing Aid and Assistance to Populations Affected by Armed Conflict and Pandemics
The Delivery of Humanitarian Relief for Displaced Populations in times of Armed Conflict and Pandemics

Nancy POLUTAN-TEULIERES
Head of Policy and Standard Setting, Global Protection Cluster

Today, I will talk about how the Global Protection Cluster has continued to deliver humanitarian assistance and protection to affected communities during times of armed conflicts and pandemics. The number of internally displaced persons (IDPs) has reached an historic high of 48 million due to conflict and violence at the end of 2020, as reported by the Global Report on Internal Displacement 2021 of the Internal Displacement Monitoring Centre.

As Ambassador Lehto mentioned, I am working with the Global Protection Cluster (GPC), a network of non-governmental organizations (NGOs), international organizations and United Nations agencies engaged in protection work in humanitarian crises due to armed conflicts, climate change and disasters. We work in 32 protection cluster and cluster-like mechanisms globally with our Child Protection, Mine Action, Housing, Land and Property, and Gender-Based Violence Areas of Responsibility (AoR) Partners. UNHCR leads the GPC in 29 of the mentioned 32 operations. We also have 25 Sectors, 7 Working Groups led by Housing, Land and Property, and about 1400 Members which makes up a very diverse group of Partners.
Let me discuss more about what we, as GPC, do in terms of protection and humanitarian assistance. The Inter-Agency Standing Committee (IASC) defines protection as “all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law, including International Human Rights Law, International Humanitarian Law and International Refugee Law”. I know that my distinguished colleagues will later address such aspect in more detail, however, I wanted to raise it in reference to the work that is done by the GPC.
We are working not only under the leadership of UNHCR but under the IASC Protection Policy. We understand the risks and violations faced by the affected populations in times of humanitarian crisis and formulate a response to eliminate or address, as a protection cluster, these protection concerns and needs. Our Partners and other humanitarian agencies on the ground are contributing to the protection of communities. All humanitarian actors irrespective of their sector-specific expertise, can contribute to protect.

**Centrality of Protection**

- IASC Protection Policy 2016
- Understanding the risks and violations faced by affected populations in crisis
- Formulating a response to eliminate or address these is part of every response
- All humanitarian actors irrespective of their sector-specific expertise can contribute to protection of affected persons

The theme of my discussion today is how we, as GPC, are dealing with our operational challenges as a result of conflict and Covid-19. What we have seen is that many operations from Syria to countries such as Niger, Nigeria and Ethiopia, have had to face an intensifying of conflicts and violence with attacks on both civilians and humanitarian workers. As a result, some of the common challenges faced by our protection clusters relate to security, logistical issues and constraints from both local authorities and non-state actors. Escalating conflict as well as political instability has, in many ways, undermined our efforts to curb the spread of Covid-19 in such countries. Some challenges are faced by persons of concern due to the socio-economic impact of Covid-19 or in terms of the support that we can provide to marginalized and discriminated groups due to the obstacles related to humanitarian access. Moreover, during the last period of time, there have
been challenges arising from the de-prioritization of protection activities as well as reduced access for protection monitoring.

In order to address some of the mentioned challenges, we have tried to adapt our systems to monitor protection risks and incidents, to provide a response to immediate health needs resulting from the Covid-19 pandemic, and to ensure the continuity of vital services such as protection services. Moreover, due to Covid-19, our protection cluster and Partners had to adapt the existing systems to remote ones through community networks, leaders and grass root organizations as well as develop online modalities to continue to ensure the provision of both legal and protection consultations.

Protection cluster and AoR responses

- Adapting systems to monitor protection risks and incidents;
- Support response to immediate health needs resulting from COVID-19 pandemic, also ensuring continuity of vital services—protection;
- Due to COVID-19, protection cluster and partners to adapt existing systems to remote ones through community networks, leaders and grass root organizations.
- Partners developed online modalities to continue the provision of legal and protection consultations;
The Covid-19 crisis has helped to reimagine the way to monitor and respond to the needs of affected populations. Protection Partners have been working side-by-side with the community to address protection and imminent threats despite, in some locations, being unable to physically reach them. In such cases, they have started virtual trainings for the community members.

In Zimbabwe and Mozambique, protection monitoring has been achieved through distributing sim-cards and phone credit to community mobilizers to facilitate protection and remote activities as well as to ensure access and refer to vital protection services.

In South Sudan the Gender-Based Violence AoR has continued to scale up the capacity of hotlines and hopelines as an entry point for referrals to expand the availability of shelters for survivors or for those at risk of violence.

The Protection Actors in Syria have conducted, as I mentioned earlier, virtual trainings on gender-based violence and child protection referral pathways for both community volunteers and hotlines staff. More specifically, in northwest Syria, the Protection Cluster has also provided emergency response for civilians displaced from Idlib and Aleppo due to ongoing hostilities. This involved Child Protection Partners and Mine Actions teams.

In El Salvador a hotline has been established with the issuance of additional cards specifically for protection services required both by IDPs and returnees to El Salvador. In some of these countries, for instance, in Chad, Libya and Niger, there remains the challenge of connectivity that hampers the ability for affected populations to be informed, to react to the management of responses due to Covid-19, or to face other challenges resulting from continuing conflicts in operations.

We also had some challenges in Myanmar. As you know, a significant rise in public health-related constraints was observed in the country due to the rapid spread of Covid-19 which has impeded the delivery of assistance across all sectors and created additional challenges for humanitarian partners accessing communities to provide them with basic services. Preventative measures, including restrictions of movement, were introduced by de facto authorities which had an immediate impact on the access of people to basic services and livelihood activities, consequently exposing them to extortion as well as creating operational challenges for humanitarian partners in the delivery of services.

Perceptions of safety and security in displacement sites remained poor, with 60% of IDPs reporting feeling safe only some of the time and 8% reporting not feeling safe at all in June, as their freedom of movement as well
as their access to basic services was made difficult. Freedom of movement was significantly affected due to the heightened presence of security forces and the increased number of checkpoints, coupled with identity checks along the route. Additionally, self-restriction on movement due to safety and security and discouragement by community or camp leaders to move outside the camps or displacement sites to minimize risks, also created challenges for accessing services.

As mentioned earlier, we have tried to reimagine the ways our Protection Partners can operate, monitor and respond to the needs of affected populations. We have worked side-by-side with the communities, we have done virtual trainings, continued our protection monitoring in operations and have also enhanced our protection monitoring in Iraq, Mali, Burkina Faso, Central African Republic, Chad, Libya, Niger, Somalia and Mozambique.

In conclusion, we have been working to ensure the centrality of protection and the protection of mainstreaming principles, which include accountability to the affected population and ensuring the voices of our affected populations are heard. In the last period of time, the legal representation of our persons of concern has continued despite the challenges of Covid-19 and conflicts. We have also been working on collaborative responses with Protection Partners and AoRs to ensure training, guidance and referral services for displaced persons during situations of conflict, access issues and Covid-19; we have enhanced our protection monitoring of displaced communities in the mentioned countries; and we have focused on the key aspect of ensuring advocacy with humanitarian leadership. We have faced a lot of challenges due to Covid-19 and conflicts, and we have tried to reach out and provide
advocacy messages to ensure the continuity of funding for our populations in crisis. We have engaged in communication with communities as well as working with community leaders and grass roots organizations. Together with the Protection Cluster, we are continuing our work, seeking other innovative ways to ensure that our persons of concern are provided with the protection services they require.

Conclusion

* Centrality of Protection and protection mainstreaming principles;
* Collaborative response with protection partners and AoRs to ensure training, guidance and referral services for displaced persons during situation of conflict, access issues and covid-19;
* Protection monitoring of the displaced communities;
* Protection advocacy with humanitarian leadership;
* Ensuring critical protection funding due to the covid-19 and conflict;
* Communication with communities and working with community leaders and grass roots organizations;
Humanitarian Relief Operations for Populations affected by Armed Conflict and Pandemics: The Commonalities and Differences between International Humanitarian Law and International Disaster Law

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Introduction

In case of armed conflicts and disasters, including epidemics, a key priority is to provide humanitarian assistance to the population in need eventually through the support of external actors. Regardless of their common interest, however, these situations are regulated by different legal regimes, namely international humanitarian law (IHL) in case of armed conflict scenarios, and, for disaster settings, instruments set up to aid victims of disasters and foster prevention for such events, currently labelled under the term international disaster law (IDL). The purpose of this contribution is to illustrate some common regulatory challenges pertaining to humanitarian relief operations in such scenarios and provide a comparison between the two regimes. Even if this assessment will identify several similarities, it could also highlight some distinctive inputs present in the IDL regime, particularly considering recent legal trends and initiatives aimed to specifically address health emergencies which might eventually provide

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Legal Backgrounds for Humanitarian Relief Operations

As mentioned, the legal framework regarding humanitarian relief operations deployed in armed conflicts or disasters is framed around different legal regimes. Concerning treaty provisions pertaining to humanitarian assistance in IHL, it is self-evident how such provisions have a more detailed character in relation to international armed conflicts (IACs), as exemplified by arts. 59 and 61 of the 1949 IV Geneva Convention (GC) or arts. 70-71 of the 1977 I Additional Protocol (AP), rather than with regard to non-international armed conflicts (NIACs), specifically addressed by art. 18 of the II AP. These treaty provisions are furthermore complemented by Rule 55 of the Customary IHL Study elaborated by the ICRC4 which maintains how in IACs and NIACs, ‘(t)he parties to the conflict must allow and facilitate rapid and unimpeded passage of humanitarian relief for civilians in need, which is impartial in character and conducted without any adverse distinction, subject to their right of control’.

In general terms, apart from more specific provisions drafted for occupied territories scenarios, IHL mainly requests parties to the conflict to make their best efforts, according to a due diligence approach5, to facilitate principled humanitarian assistance, lacking pre-arranged detailed regulations on how to concretely implement relief activities. Indeed, several issues raised in the management of humanitarian relief operations are deferred to operational solutions arranged through technical arrangements. As a result, the presence of grey legal areas on the interpretation of some provisions and the need to provide more content and guidance on the potential application of some IHL obligations, as well as the interest to reflect current practice, has led to recent private codification efforts aimed at better identifying legal provisions pertaining to humanitarian assistance in armed conflicts. A specific mention should be made to the Oxford Guidance on the Law Regulating


Humanitarian Relief Operations in Situations of Armed Conflict, commissioned by UNOCHA and drafted in 2016. This text represents a significant element of reference for analysis pertaining to this area: apart from reaffirming some basic principles, its more detailed content represents a helpful contribution to better understand and operationalize relevant legal principles pertaining to humanitarian assistance.

Humanitarian assistance is also a core element of IDL instruments addressing disasters. However, in this scenario we cannot identify a universal flagship treaty dealing with the regulation of international assistance in the event of disasters, even if the United Nations (UN) General Assembly is currently debating the proposal made by the International Law Commission to adopt a treaty in this area based on its 2016 Draft Articles (DAs) on the Protection of Persons in the Event of Disasters. The legal landscape pertaining to prevention and response of disasters is thus composed of a ‘pot pourri’ of international and domestic instruments characterized by a binding or soft-law approach with varying impacts on scenarios under exam. Several universal treaties have addressed specific types of disasters, in particular technological ones, or specific forms of assistance, although these might be limited by their low ratification numbers and specialized character. Regional treaties and secondary law involving regional international
organisations, especially in Europe, Asia, the Caribbean and the Americas, are conversely assuming an increasingly important role, giving rise to a phenomenon of regionalization of international disaster law. However, the effective impact or self-sufficient character of such regional initiatives can be doubted\(^\text{12}\), especially in the face of large-scale disasters, and similarly bilateral treaties lack coherence, being sometimes limited to an exchange of good practices and information between States.

In light of States’ reluctance to address the legal regulation of disaster preparation and response through binding provisions, this area has also been characterized by an impressive number of soft-law instruments\(^\text{13}\). Such documents range from pivotal UN strategies for disaster risk reduction endorsed by UN General Assembly resolutions\(^\text{14}\) to instruments elaborated by non-State actors such as humanitarian organizations and NGOs, reflecting trends towards informal international law-making approaches\(^\text{15}\). However, the concrete impact of such instruments is hardly predictable, even if some of them have acquired a specific standing, as exemplified by the Guidelines for the Domestic Facilitation and Regulation of International Disaster Relief and Initial Recovery Assistance (IDRL Guidelines)\(^\text{16}\) adopted by the 27th International Conference of the Red Cross and Red Crescent or the Sphere Standards\(^\text{17}\). Furthermore, domestic legislation aimed at facilitating international assistance, eventually informed from international standards as the IDRL Guidelines, might play a significant role in light of such fragmented international rules.

This area of law is thus characterized by multiple instruments and indeed a database elaborated by the IFRC Disaster Law Programme and Roma Tre University has recently identified more than 1,500 international and


\(^{14}\) See the *Sendai Framework for Disaster Risk Reduction*, UN Doc. A/RES/ 69/283, 23 June 2015.


\(^{17}\) On this initiative see https://spherestandards.org/.

domestic instruments specifically pertaining to disaster scenarios, through a
survey still far from being exhaustive. This element also confirms one of
the main shortcomings of the IDL legal framework, namely its patchwork
character. However, in comparison with the universal regime provided by
IHL in relation to humanitarian relief operations, mainly aimed at identifying
some general principles in this area, IDL has addressed some aspects
pertaining to relief operations with a more granular content, as coupled by
the possibility to easily adapt its content to new challenges through the
development of some tailored solutions in relation to evolving scenarios.

Regarding epidemics, it must however be specified how we cannot record
ad hoc treaties aimed at facilitating response to health emergencies in the
framework of IDL. The International Health Regulations do not address this
element at all and only some recent initiatives developed by WHO and other
international organisations have recently addressed some aspects relevant for
humanitarian relief operations in such scenario. Nonetheless, the IDL
framework and its constitutive instruments can significantly address some
common regulatory challenges posed by humanitarian relief operations to be
carried out in case of epidemics and can thus represent an element of
reference for our analysis.

The subsequent sections will make a comparison between IHL and IDL
in relation to some challenges commonly raised by humanitarian relief
operations to be carried out in front of an epidemic. In particular, the analysis
will address: a) Consent to relief operations; b) Facilitations to relief
personnel, goods and equipment; c) The capacity to provide specialised
health care in epidemics and quality of health assistance. Furthermore,
considering how principles and solutions pertaining to IDL instruments have
attracted less attention in analysis addressing humanitarian relief assistance,
a preference will be made to this scenario.

Consent to Relief Operations in front of Epidemics

The first legal challenge for any international relief operation is
represented by consent of the concerned State. In this regard IHL and IDL
do not significantly differ regarding legal solutions on such issues even if
recent debates have permitted to shed light on this requirement.

In IHL it is commonly maintained how relief operations cannot be carried
out without the consent of States parties to IACs or NIACs. This general
assumption is reiterated in the commentary to rule 55 of the ICRC Customary

18 See the Disaster Law Database at https://disasterlaw.ifrc.org/disaster-law-database.
IHL and is reaffirmed in the Oxford Guidance\(^\text{19}\), even if an exception could be provided by art. 59 of the 1949 IV GC according to which ‘the Occupying Power shall agree to relief schemes on behalf of the population of occupied territories inadequately supplied’, thus limiting its authority only to the definition of technical arrangements. Similarly, the UN Security Council could also impose the deployment of humanitarian relief operations regardless of the consent of the concerned State, as occurred through a series of resolutions addressing Syria\(^\text{20}\).

The same legal principle is present in IDL, as maintained by art. 13.1 ILC DAs, according to a solution already tested in relation to humanitarian relief operations related to epidemics. Reference could be made, for instance, to the 2014 joint letter of the Presidents of Guinea, Liberia and Sierra Leone to the UN Secretary-General requesting a coordinated international response to end the Ebola outbreak\(^\text{21}\), paving the way for establishing the UN Mission for Ebola Emergency Response\(^\text{22}\). The consent requirement is obviously consistent with the protection of the principle of sovereignty for the concerned State, but could also satisfies other rationales, as the possibility for this latter to properly regulate the influx of humanitarian actors, avoiding the provision of unnecessary assistance or the involvement of non-professional relief personnel\(^\text{23}\).

However, both IHL\(^\text{24}\) and IDL maintain how consent must not be denied in an arbitrary manner as to avoid jeopardizing the protection of affected

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\(^{19}\) According to the Oxford Guidance, cit., p. 16, ‘(t)he consent of the concerned states is required before offers to conduct humanitarian relief operations may be implemented’.

\(^{20}\) See, in particular, resolution 2165 (2014) where the UN Security Council adopted a binding decision authorizing UN humanitarian agency and their implementing partners to use specified border crossing posts to provide humanitarian assistance.

\(^{21}\) See Letter dated 15 September 2014 from the Secretary-General addressed to the President of the Security Council, UN Doc. S/2014/669, 15/9/2014.

\(^{22}\) See UNSC Resolution 2177(2014) and UNGA Resolution 69/1 (2014).


\(^{24}\) During the negotiations of the 1977 Additional Protocols, the requirement that consent must not be arbitrarily denied was discussed in-depth by the delegations. Indeed, even if both Article 70 of Additional Protocol I and Article 18 of Additional Protocol II affirm that relief activities are subject to the agreement of the parties/high contracting party concerned in such relief actions, the Commentary is clear in restating, on the basis of the official records of the diplomatic conference, that this clause ‘did not imply that the Parties concerned had absolute and unlimited freedom to refuse their agreement to relief actions. A Party refusing its agreement must do so for valid reasons, not for arbitrary or capricious ones’. On this issue see Yves Sandoz, “Article 70”, in Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds.), *Commentary on the Additional Protocols*, Geneva, 1987, p. 816, para. 2085. For a similar approach, see Sandesh Sivakumaran, “Article 3”, in ICRC, *Commentary on the First Geneva Convention: Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, Geneva, 2016, paras. 832-839.
individuals. This principle has been confirmed both in IHL, as restated in the Oxford Guidance\(^{25}\), and in IDL, as exemplified by art. 13.2 ILC DAs\(^{26}\). Both documents have also tried to highlight potential conditions for making assessments on the lawfulness of denial of consent. For instance, it has been maintained how this principle is not breached whether the concerned State refuses unprincipled assistance or has the chance to get required assistance by other actors. Conversely, both documents have highlighted how a denial of assistance could be arbitrary whether it violate State’s obligations under international law, as exemplified by fundamental human rights potentially affected by unbalanced evaluations made by the concerned State.

Therefore, in the framework of epidemics, the possibility to refuse access to external humanitarian actors, based on potential further health risks posed by their access to the affected State, should be parameterized against these principles, particularly in front of extreme cases related to epidemics where the right to life of local population could be seriously jeopardized in front of serious shortcomings by the concerned State. As recently reaffirmed by the ICRC, ‘under IHL, the necessity to counter the spread of Covid-19 alone is not a valid ground to deny consent to humanitarian activities undertaken by impartial humanitarian organizations…Such a refusal may also amount to an unlawful denial of consent when it results in a separate violation of the party’s own IHL obligations. This will be the case, for instance, …when such refusal would prevent it from fulfilling its primary obligation, referred to above, by depriving the population of supplies essential for its survival, including in the field of health’\(^{27}\). Similar reasonings could be applied once addressing this issue through IDL lens.

**Facilitations for Humanitarian Relief Operations**

A second common regulatory problem for IHL and IDL is represented by the need to provide facilitations for relief actors. Indeed, even if a general consent could be identified for the performance of relief activities in the concerned States, the capacity for international assisting actors to efficiently operate might also be jeopardized by challenges related to more practical


aspects, as the entry of international personnel, equipment and goods, management of custom and tax issues or, even, professional qualification and quality of assistance.

In IHL strict rules could only be identified regarding occupied territories, as for art. 61 IV GC\(^\text{28}\) which maintains the obligation for all States parties to permit the transport, free of charge, of relief consignments for occupied territories. In other scenarios, mild obligations of facilitations, based on a due diligence approach, could be identified, as exemplified by Rule 55 of the ICRC Customary IHL Study according to which ‘(t)he parties to the conflict must allow and facilitate rapid and unimpeded passage of humanitarian relief for civilians in need’, lacking detailed regulations on concrete measures to be adopted. Recommended measures could nonetheless be identified in the Commentaries to the APs, particularly for art. 70 AP I, which maintains how parties are required ‘to avoid any harassment, to reduce formalities as far as possible and dispense with any that are superfluous. Customs officials and the police in particular should receive instructions to this effect’\(^\text{29}\). Similarly, regarding art. 71 AP I, a reference is made for ‘the receiving Party to do its utmost to facilitate the task of relief personnel, particularly by simplifying administrative formalities as much as possible, by allowing the personnel to find accommodation if there is any problem with this’\(^\text{30}\). The Oxford Guidance has also suggested similar measures\(^\text{31}\).

However, in armed conflict scenarios, more room is left for control measures potentially applicable by parties to the conflict, particularly through technical arrangements, including search of convoys or the possibility for the receiving Party to refuse the participation of a particular relief personnel, including the right to terminate the mission of any member, as maintained by art. 71.4 AP I. In front of epidemics, additional conditions related to health concerns could represent an obstacle for the activities of humanitarian actors. Indeed, ‘during a virulent pandemic, these “technical arrangements” might validly include measures to contain the spread of disease such as temporary quarantine’\(^\text{32}\). In the particular context of epidemics, therefore, the application of such control measures might thus

\(^{28}\) Art. 61 IV GC: ‘All Contracting Parties shall endeavour to permit the transit and transport, free of charge, of such relief consignments on their way to occupied territories’.

\(^{29}\) Yves Sandoz, “Article 70”, in Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds.), Commentary, cit., para. 2829.


imply further hurdles for humanitarian relief personnel with the need to find a proper balance between the requirement to provide basic protection for the affected population and potential concerns related to health aspects, to be solved based on a humanitarian dialogue informed by good faith involving parties to the conflict.

The provision of facilitations for humanitarian relief assistance is also a core concern for IDL. However, in IDL, lacking a flagship universal treaty, facilitations might be provided by multiple sources and would eventually be the result of a complex mixture of different legal approaches. Bottom-up solutions could be arranged through uniform rules regulating such aspects provided by international treaties (as for regional assistance treaties or bilateral agreements) and binding international acts (as for the EU context). However, international rules might be lacking for the disasters at stake, as the affected State could not have ratified potentially relevant instruments, international instruments might eventually only address some legal issues or, more drastically, binding acts do not exist for the scenario under analysis.

Nonetheless, top-down solutions could also supplement international rules. Indeed, the domestic legal and institutional framework of affected States might autonomously provide for facilitations for external humanitarian relief assistance. A bottom-up approach has indeed been endorsed by art. 15 of the ILC DAs, according to which ‘(t)he affected State shall take the necessary measures, within its national law, to facilitate the prompt and effective provision of external assistance’, making reference to issues such as ‘privileges and immunities, visa and entry requirements, work permits, and freedom of movement’. States could take advantage of detailed recommendations and ready-to-use solutions identifying best practice in this area, as particularly provided by the abovementioned 2007 IDRL Guidelines. Similarly, the recently adopted 2021 Resolution of the Institut de droit international on Epidemics, Pandemics and International Law has recommended States to rely on a top-down approach, maintaining in its art. 12.2 how ‘(t)he affected State shall take the necessary measures, within its national law, to facilitate the prompt and effective provision of external assistance’, through a solution ‘taken from Article 15 of the ILC Articles’.

However, the bottom-up approach is largely dependent on the capacity of States to pre-arrange a comprehensive assessment of their legal framework to identify appropriate solutions for incoming assistance. Unfortunately, this complex law-making process is normally not a priority in domestic agendas, thus requiring on several occasions to rely on emergency legislation in the

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aftermath of a disaster through solutions not facilitating coherent and reliable approaches. In this regard the claim made in the report accompanying the IDI resolution, according to which ‘if a group of medical doctors is invited to assist, the affected State must arrange their visa and entry procedures (privileges and immunities in some cases) and its national law relating to the license for medical practice and work permits may need to be amended or suspended for facilitating recognition of foreign credentials’\textsuperscript{34}, could not be taken for granted.

Regardless of the possibility to rely on top-down or bottom-up solutions, or a combination of both approaches, humanitarian relief operations raise a series of recurring legal and regulatory challenges going to be assessed in subsequent sections.

\textbf{Access for Relief Personnel, Goods and Equipment}

A preliminary issue is the possibility for international relief personnel, including staff addressing health emergencies, to get access in affected countries. Normally this possibility could be hampered by regulatory challenges as visa procedures, costs related to get such permissions and time spent in getting approvals or renewals of authorizations.

This problem has been properly identified in the Commentary to art. 71 AP I where a request is made to ‘simplify and expediting entry-visa procedures for personnel participating in humanitarian relief operations, or temporarily waiving the requirement for visas altogether’, as reiterated by the Oxford Guidance\textsuperscript{35}. The ICRC too, in the framework of Covid-19, has reaffirmed how parties to the conflict are required at ‘(s)implifying administrative formalities as much as possible to facilitate visas or other immigration issues (waiving entry-visa requirements for personnel participating in humanitarian operations or establishing a simplified and expedited “transit” visa)’\textsuperscript{36}.

Similar issues are addressed in IDL instruments which commonly recognize specific exemptions for international relief personnel in order to facilitate their entrance and movement in the affected country\textsuperscript{37}. A similar result could be provided through domestic legislation facilitating so-called disaster visa procedures and indeed, in front of Covid-19, tailored reforms

\textsuperscript{34} Institut de droit international, \emph{Report}, cit., p. 116, para. 135.
\textsuperscript{35} Oxford Guidance, cit., p. 27.
\textsuperscript{36} ICRC, \emph{IHL Rules}, cit., p. 3.
\textsuperscript{37} On such issues see Stefano Silingardi, “The Status of Emergency Workers”, in De Guttry, Gestri, and Venturini (eds.), \emph{International}, cit., p. 551 ff.
were introduced to facilitate the access and permanence of specialized foreign health staff in affected countries\(^{38}\).

Epidemics might arise a separate issue than other disasters, namely restrictions on entrance and movement of relief actors motivated by border closure linked to health precautions. Even if border closures could be justified under the International Health Regulations, the same World Health Assembly has called States ‘to ensure that restrictions on the movement of people and of medical equipment and medicines in the context of Covid-19 are temporary and specific and that they include exceptions for the movement of humanitarian and health workers, including community health workers, enabling them to fulfil their duties, and for the transfer of equipment and medicines required by humanitarian organizations for their operations\(^{39}\). This general plea could be extended to cross-border humanitarian relief operations and therefore the ICRC has maintained how a potential facilitation to be provided by the parties to the conflict is the possibility of \((c)\)onsidering the work of impartial humanitarian organizations as an essential service, and humanitarian personnel accredited by authorities as essential workers benefiting from waivers of movement restrictions\(^{40}\). On a similar manner, the IFRC Disaster Law Programme has recommended that \((l)\)aws that establish border closures or restrictions during a PHE (public health emergency) should expressly exempt the personnel of eligible assisting humanitarian organisations (subject to appropriate health safeguards)\(^{41}\). However, the same IFRC, based on a review of actions carried out by States affected by Covid-19 with regarding to incoming international assistance, has been able to recognize only few cases where specific procedures for facilitating the entrance of international humanitarian relief actors were adopted in front of domestic restrictions related to restrictions of entrance and movement. On some occasions it has been necessary to rely on discretionary decisions made by public authorities based on exceptions for humanitarian grounds or persons with a function\(^{42}\).

\(^{38}\) For some facilitations see for instance the 1-year visa extension for free managed by the UK, www.gov.uk/coronavirus-health-worker-visa-extension.


\(^{40}\) ICRC, IHL Rules, cit., p. 3.


Apart from relief personnel, the management of relief equipment and goods represents one of the commonest legal and operational issues in humanitarian operations, as also experienced with regard to past health emergencies by lengthy and unclear customs procedures during the 2014 Ebola international response.

Such issues are not ignored in armed conflicts, as exemplified by references to the need to permit the transit of relief consignments to occupied territories ‘free of charge’ (art. 61 IV GC) even if in this area we can only recognize general references encapsulated in due diligence obligations, as for the need to ‘allow and facilitate rapid and unimpeded passage of humanitarian relief for civilians in need’ (Rule 55 Customary IHL). This latter reference might also imply, as exemplified by the Commentary to art. 70 AP I, the need to reduce ‘formalities as far as possible and dispense with any that are superfluous. Customs officials … should receive instructions to this effect’. These principles have been reiterated by the ICRC in relation to the Covid-19 pandemic, with the request to the parties of conflicts for ‘(e)xpediting customs procedures and granting priority to consignments of humanitarian supplies and equipment; - Allowing the passage of consignments free of charge by not levying entry and exit taxes and other fees; and - Exempting humanitarian flights from any existing ban on international flights and allowing priority landing of airplanes carrying humanitarian assistance supplies’.

With regard to disaster settings, we can recognize a series of instruments and rules specifically addressing facilitations for relief equipment and goods. First, there might be the possibility to invoke facilitation clauses included in regional or bilateral IDL instruments which commonly require States parties to accord exemptions from taxation, duties and other charges of a similar nature on the importation and use of relief equipment and goods, as exemplified by art. 14 of the 2005 ASEAN Agreement on Disaster Management and Emergency Response. However, more significantly, a series of universal treaties and regulations specifically addressing such issues have been adopted under the aegis of the World Customs Organizations

43 According to the ILC DAs, particularly its art. 3 (g), relief equipment includes technical items required by humanitarian relief personnel, while relief goods refers to items necessary for the survival and fulfilment of the essential needs of victims, such as foodstuffs or medical supplies.


46 ICRC, IHL Rules, cit., p. 3.
(WCO). However, they are largely unable to fix all issues due both to their content and ratification status.

A first example is provided by the Kyoto Custom Convention on the Simplification and Harmonization of Customs Procedures, originally adopted in 1973 and amended in 1999. This treaty is supplemented by a series of optional Annexes, two of them relevant for disasters. However, these Annexes can hardly be qualified as conclusive, having been ratified by a very limited portion of the around 120 States parties to the Kyoto Convention. Furthermore, the exhortative character of relevant provisions could be identified as an additional limit. Particularly, Annex B.3 of the Kyoto Convention identifies as a recommended practice the exemption from duties and taxes for ‘goods such as foodstuffs, medicaments, clothing and blankets sent as gifts to an approved charitable or philanthropic organization for distribution free of charge to needy persons’. Conversely, Annex J.5 sets a more complex system of binding standards and recommended practice for relief consignment. For instance, it mandates their clearance as a matter of priority or outside office hours and the acceptance of partial documentation to be completed within a specific period, while facilitations such as the waiver of import/export duties and taxes are just qualified as recommended practice.

WCO also adopted the 1990 Convention on Temporary Admission (so-called Istanbul Convention), whose Annex B.9 requests the waiver of import duties and taxes and simplification of documentation for the temporary import of relief items, including medical equipment, provided they will be re-exported by one year, are loaned free of charge and dispatched to persons approved by the competent authorities in affected State. The Convention involves more than 70 States, but its focus on temporary admission of relief items significantly limits its impact to specific typologies of relief items, being only relevant for equipment rather than goods. Regardless of the potential limits of treaties developed under its auspices, the WCO has continued to raise awareness on challenges posed by disasters, as flagged in the 2011 WCO Council ‘Resolution on the role of Customs in natural disaster relief’\(^{47}\), calling upon States to implement abovementioned measures.

WCO has also played a role regarding epidemics. For instance, taking into account vulnerabilities affecting areas prone to health emergencies, in 2016 WCO launched tailored capacity-building initiatives for epidemics,

namely the ‘Customs for Relief of Epidemic Diseases (C-RED) Project’\(^48\). Through this initiative WCO has provided support to the Customs Administrations of some African States to better manage customs issues related to potential incoming international assistance for epidemics and other disasters, including the drafting of standard operating procedures to improve their domestic regulations in front of shortcomings experienced in past epidemics.

During Covid-19, WCO has furthermore developed multiple activities, particularly in cooperation with WHO. A prominent example has been provided by the joint elaboration of the HS (Harmonized Commodity Description and Coding System) classification reference for Covid-19 medical supplies\(^49\). This list of standardized codes permits the easy identification of critical goods and equipment relevant for the management of the pandemic and has been the basis for decisions adopted by States aimed at facilitating the cross-border movement of relevant goods and equipment, applying contingent tariff and non-tariff relief policies. Similarly, the WHO/WCO List of Priority Medicines has been used to facilitate the classification and identification at the international level of medicines employed in treatments against Covid-19\(^50\). Furthermore, in view of the forthcoming vaccination campaigns, in December 2020 the WCO Customs Co-operation Council adopted a resolution demanding for facilitations in the cross-border movement of vaccines\(^51\). This resolution urged Member States to clear such goods as a matter of priority in appropriate facilities to prevent possible detrimental product temperature variations, perform examinations on shipments of medicines and vaccines only in exceptional circumstances or provide for special custom procedures for supply chain actors. However, the resolution can only have a recommendatory character for Member States.

Furthermore, Covid-19 has also prompted activities by regional organisations, regarding customs regimes dealing with relief equipment. For instance, the EU has a complex regime concerning facilitations in front of

\footnote{48 For this initiative see \url{www.wcoomd.org/en/topics/facilitation/activities-and-programmes/natural-disaster/wco-c-red-project.aspx}.}


\footnote{50 See \url{www.wcoomd.org/-/media/wco/public/global/pdf/topics/nomenclature/covid_19/prioritization-medicines-list-during-covid_19-_v9_wco_en.pdf?la=en}.}

disasters particularly regarding temporary admission, relief of import and customs duties as well as value added tax. These provisions have been tested by the Covid-19 outbreak as the EU Commission, originally through Decisions 2020/491 and reiterated in subsequent Decisions, extended both facilitations in relation to goods aimed at addressing this pandemic whether intended for the benefit of State bodies or by organisations listed and approved by the EU Member States for being distributed or made available free of charge to persons affected by or at risk from Covid-19 or involved in combating the outbreak. The indicative list of products eligible to such facilitations was based on the abovementioned WCO/WHO list for Covid-19 medical supplies. Similarly, in light of challenges raised by Covid-19, in July 2020 the East African Community Council modified its 2004 Customs Management Act, providing exemption regime from customs duties for relief goods and equipment imported by a government or an NGO in case of disasters, to include the scenario of “any supplies for diagnosis, prevention, treatment, and management of epidemics, pandemics and health hazards”.

Apart from international instruments, domestic regulations can pre-arrange comprehensive solutions in this area, as exemplified by art. 41 of the 2013 Vietnamese Law on Natural Disaster Prevention and Control, according to which “foreign organizations and individuals and international organizations” participating in relief operation will be exempted from import and export duties for their goods and equipment and enjoy priority in related procedures, provided they register with competent Vietnamese agencies.

Such provisions can also be applied to response to health emergencies. However, Covid-19 has emphasised how the very large majority of States were unequipped with pre-identified solutions in domestic legislation, implying a massive recourse to emergency legislation as exemplified by the impressive list of measures for facilitating the cross-border movement of relief and essential equipment related to Covid-19 communicated to WCO by its Member States which has thus acted as a fruitful hub for exchange of


information in this area\textsuperscript{56}. In particular, States have promptly introduced exemptions or reductions for duties and taxes related to humanitarian organisations or medical materials and equipment imported by health structures, including setting-up special and priority customs clearance procedures particularly for those items mentioned in the abovementioned HS reference list jointly elaborated by WCO and WHO, lacking however uniform approaches.

It could thus be concluded how, in comparison with general principles provided by IHL instruments, IDL has certainly addressed such issues with a more detailed content, even if some limits could be identified as exemplified by the lack of universal participation for some WCO treaties potentially relevant and some shortcomings on their effective content. Still this area has also been characterized by an energetic and flexible role played by concerned stakeholders during the pandemic crisis, according to solutions which might pave the way for further reforms in the next future.

**Quality of Assistance and Specific Initiatives aimed at addressing Health Emergencies**

Regarding the characteristics of relief operations, a further element of interest, apart from the need to apply relevant humanitarian principles provided by IHL and IDL\textsuperscript{57}, could be identified in the quality of assistance and initiatives aimed at fostering the capacity of relief entities to address health emergencies.

As for the quality of international assistance, lacking binding documents developed by States or international organisations, a commonality of IHL and IDL is to rely on documents developed by non-state humanitarian actors for identifying normative and technical standards in their operations. A prominent example is provided by the Sphere standards developed in the last decades by a network of humanitarian actors committed to act according to


\textsuperscript{57} As for IDL see, in particular, art. 6 of the ILC DAs according to which ‘Humanitarian principles Response to disasters shall take place in accordance with the principles of humanity, neutrality and impartiality, and on the basis of non-discrimination, while taking into account the needs of the particularly vulnerable’.
such principles. The issue of quality of assistance has been highlighted by the ICRC in the framework of Covid-19, maintaining how technical arrangements involving parties to the conflict and impartial humanitarian actors might also include the request ‘that humanitarian supplies and equipment meet minimum health standards. For example, medications may have to be approved for use in both the originating and receiving state or be prequalified by the World Health Organization’. In the context of health emergencies, a proper operational response might also imply to adapt humanitarian operations to additional challenges, as for the possibility to designate hospitals as being exclusively dedicated to Covid-19 affected people or favoring the distribution of relief goods in phases and in smaller groups of beneficiaries to avoid congregation of too many people at once. At the same time the ICRC has reiterated how technical arrangements aimed to foster quality of assistance and a proper management of humanitarian operations ‘may not, however, be such that, for all practical intents and purposes, they amount to a refusal of consent, unduly delay humanitarian operations, or make their implementation impossible’.

In this area, some specific activities tailored for the health sector could be mentioned, as for the WHO Emergency Medical Teams (EMT) initiative aimed at favoring a certification and global registration system in front of qualitative shortcomings in the health assistance provided in past disasters and epidemics. This latter initiative is managed by WHO in cooperation with national public and private emergency medical teams, through a peer-review process based on the fulfillment of specific pre-defined quality standards thus confirming the trends toward public-private partnerships involving institutional and informal global network of experts. Even if accreditation from the WHO does not provide such teams with specific facilitations by concerned States, this initiative can significantly increase the quality of assistance and might act as a global quality benchmark. For instance, as explored below, the EU Commission Implementing Decision

59 ICRC, IHL Rules, cit., p. 4.
60 ICRC, IHL Rules, cit., p. 4.
2018/142\textsuperscript{62}, which created the European Medical Corps, maintains how its certification and registration process requires to take into account internationally recognized standards, including the ones provided by WHO through its EMT initiative. During Covid-19 a series of EMTs were deployed in some States to provide support and mentoring activities, thus confirming the increasing opportunities for developing tailored and specialized response capacities to face epidemics\textsuperscript{63}.

Indeed, a further trend which could be recognized, particularly in the context of IDL, is the growing interest of humanitarian actors in fostering their specific capacities to address health emergencies. In this area a first reference could be made to the recent shift of WHO toward an operational capacity. In particular, the WHO Health Emergencies Programme launched in 2016 aims to provide ‘new operational capacities and capabilities for its work in outbreaks and humanitarian emergencies’ to WHO\textsuperscript{64}, attributing WHO with operational tasks also through recourse to a roster of experts to be deployed in health emergencies missions.

Furthermore, additional initiatives have recently been developed within disaster management frameworks aimed at fostering the capacity of States to specifically respond to health emergencies and manage cross-border operations in this area. A prominent example is provided by the EU Civil Protection Mechanism\textsuperscript{65}, particularly through its European Civil Protection Pool, namely a set of voluntary pool of pre-committed response capacities of EU Member States potentially available for emergency responses coordinated by the Mechanism. Such capacities must be registered and certificated by the EU Commission based on established international standards, while Member States have the advantage of sharing significant


\textsuperscript{65} On this mechanism see: Marco Gestri, “La risposta alle catastrofi nell’Unione europea”, in Marco Gestri (ed.), Disastri, protezione civile e diritto: nuove prospettive nell’Unione europea e in ambito penale, Giuffrè, 2016, p. 3 ff.
costs related to such resources with the EU, keeping the ultimate decision on their effective deployment.

Based on difficulties experienced to mobilize health experts and specific resources during the 2013-2016 Ebola outbreak, in February 2016 the European Medical Corps initiative was launched. As formalised in Commission Implementing Decision (EU) 2018/42, according to which the “‘European Medical Corps’ means the part of the EERC available for response operations under the Union Mechanism in case of acute health emergencies”, multiple resources related to health emergencies could be registered, as for emergency medical teams, medical aerial evacuation modules and mobile biosafety laboratories. Furthermore, their accreditation process has significantly been linked with abovementioned quality requirements fixed by WHO for the EMT initiative. Indeed, according to Annex III of the Commission Implementing Decision (EU) 2018/42, ‘Emergency medical teams (types 1, 2, 3 and specialised care) are considered certified if they have undergone the verification process of the World Health Organisation’, thus making a strict link between the EU system and the WHO Emergency Medical Team initiative. Until 2020, eleven EU States contributed to the European Medical Corps through the accreditation of 14 modules, response capacities and experts devoted to health issues. Since 2016, once a team was sent to Angola to address a yellow fever outbreak, such resources have mainly been deployed in a series of health emergencies outside the EU, particularly in Africa, Asia and Oceania, before being involved in the same EU during the Covid-19 pandemic.

As part of the 2019 reforms to the EU Civil Protection Mechanism, a new tool for pre-committing resources was added, namely rescEU, consisting in a series of capacities acquired, rented or leased by Member States with an even stronger financial support of the European Commission and deployed by this latter as a last resort opportunity in overwhelming situations where national capacities and those pre-committed through the European Civil Protection Pool are unable to ensure an effective response. Among potential areas of interest for rescEU, ‘emergency medical response’ was included, as

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67 Ibidem, art. 1(1).

68 For such data see https://ec.europa.eu/echo/what-we-do/civil-protection/european-medical-corps_en.

69 For a review see J.M. Haussig et al., The European Medical Corps: First Public Health Team Mission and Future Perspectives, Euro Surveillance 2017, available at www.ncbi.nlm.nih.gov/pmc/articles/PMC5607656/.
provided by Commission Implementing Decision (EU) 2019/1930 referring to medical aerial evacuation capacity for highly infectious disease patients and disaster victims and type 3 medical teams, namely those able to provide very comprehensive support, including intensive care capacity. Covid-19 has implied a further strength for the health component, through the Commission Implementing Decision 2020/414 adopted in March 2020, enlarging rescEU to include other categories of emergency medical teams capacities (1 and 2) and the stockpiling of medical countermeasures, as ventilators, and personal protective equipment. Stockpiles are currently hosted in nine EU states to maintain a geographical balance as required by the same Decision and were largely distributed during the pandemic. Even if their total number (eg. 3.5 million individual protective equipment distributed) was far from being decisive, the extension of rescEU capacities to the health sector permitted to confirm a solidarity approach for critical resources and provide more flexibility for the EU Commission in this area, particularly in front of denials experienced to request of provision of protective equipment made by Italy in February 2020 through the EU Civil Protection Mechanism.

This increasing attention toward factoring health concerns in the EU Civil Protection system has been confirmed in the Regulation (EU) 2021/836 adopted in May 2021 and further amending the Mechanism and its original Decision 1313/2013. This link is strongly confirmed by the same amendment to the definition of disasters originally included in art. 1.2 of Decision 1313/2013. Based on the new text introduced through Regulation (EU) 2021/836 this definition now also includes ‘acute health emergencies, occurring inside or outside the Union’. Indeed, as highlighted by the Preamble, due to ‘…global health challenges, the Union Mechanism should contribute to improving prevention, preparedness and response capacity also in respect of medical emergencies’. In the reformed rescEU system, where a stronger role has been attributed to the EU Commission in managing

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72 For this data see https://ec.europa.eu/echo/what/civil-protection/resceu_en.
73 Charlotte Beaucillon, International and European Emergency Assistance to EU Member States in the Covid-19 Crisis: Why European Solidarity Is Not Dead and What We Need to Make It both Happen and Last, European Papers, 2020, p. 387 ff.
75 Ibidem, preambular para. 7.
critical means and services, ‘emergency medical response’ have been confirmed as a focus of interest. Furthermore, Regulation (EU) 2021/836 does not affect the possibility for the Mechanism to favor a better preparedness through the abovementioned European Medical Corps operating under the European Civil Protection Pool. The EU Civil Protection Mechanism is thus a prominent example of the possibility to institutionalize and operatively integrate health concerns in supranational disaster management systems.

Concluding Remarks: The Links between IHL and IDL in Managing Epidemics

The above survey of relevant rules and initiatives provided by IHL and IDL in relation to the management of humanitarian relief operations in an epidemic context has thus emphasized the existence of a patchwork of instruments which might potentially play a role in favoring such activities.

In this regard a final question is the relationship between IHL and IDL rules in such scenarios. Once epidemics affect areas already involved in an armed conflict it could be maintained how the primary set of provisions is provided by IHL instruments, as maintained by the ILC DAs and its saving clause expressed through its art. 18.2 according to which ‘The present draft articles do not apply to the extent that the response to a disaster is governed by the rules of international humanitarian law’. This provision was included to attribute primacy to IHL rules for the regulation of humanitarian assistance in States affected by both an armed conflict and disasters according to a solution which permits to mark potential benefits in invoking IHL rules, rather than principles pertaining to IDL, for managing humanitarian assistance in such circumstances. An example could be provided by the application of the consent rule in humanitarian operations to be carried out in occupied territories which is regulated by a strict obligation for the occupying power, as provided by art. GC IV.

However, art. 18 leaves unchanged the possibility for the DAs to apply as a residual and complementary legal framework for issues not governed by IHL in case they might arrange more detailed solutions than the general

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obligations of facilitations maintained by IHL. This solution could be generally maintained for other IDL instruments, provided they might be fit to be applied in an armed conflict context where, for instance, military concerns and technical arrangements might play a role in requiring further limitations. Similarly, based on the same caveat, domestic legal frameworks pre-arranged for facilitating assistance in front of disasters might facilitate response in front of epidemics affecting a State involved in an armed conflict. Furthermore, some recent initiatives aimed to specifically address health emergencies, as for the identification of quality standards in health capacities or the establishment of specialised medical units by civil protection authorities, might eventually provide further inputs on the way in which IHL and humanitarian actors could address epidemics in armed conflict scenarios.

It would thus be required, in each context, to explore potential synergies in the application of IHL and IDL instruments, particularly being this latter area of law able to promptly evolve and elaborate tailored and innovative solutions for the management of relief operations in epidemics which might be of potential interest for armed conflicts too.
Balancing Public Health and Public Security: Operational, Legal, and Policy challenges posed by Counter-Terrorism Measures

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I would like to thank the International Institute of Humanitarian Law and the ICRC for convening today’s event. I am honored to take part in the 44th edition of the Sanremo Round Table.

At HLS PILAC, we have been researching the impact of counterterrorism measures on principled humanitarian action for many years. Today, I will focus my remarks on five areas of impact that may be especially relevant to States seeking to calibrate a normatively sound balance between public health and public security by identifying and addressing operational, legal, and policy challenges posed by counterterrorism measures to humanitarian actors. I will close with two recommendations for further consideration.

My core argument is that a growing global counterterrorism architecture is increasingly predominating in practice over principled humanitarian action. If the current trajectory continues, two possibilities seem likely to come to pass over the next decade. One is that counterterrorism measures may further constrain the practical scope of impartial humanitarian activities. A second is that an ever-expanding counterterrorism system will ultimately redefine what constitutes legitimate humanitarian activities. To effectively safeguard principled humanitarian action through the coming years, States must anticipate and address these potential developments now.

To delve into these issues, I will identify five areas where our research and that of others demonstrates a detrimental impact on the provision of principled humanitarian assistance in situations of armed conflict due to the impact of counterterrorism measures. All of these impacts predate the pandemic but have likely been exacerbated by the public health crisis.

First, in situations of armed conflict, IHL not only safeguards but requires the provision impartial medical care to all wounded and sick hors de combat. That encompasses civilians as well as wounded and sick fighters who have been placed hors de combat, including — indeed especially — impartial medical care for perceived adversaries. Under IHL, these protections attach irrespective of a terrorism designation under national law. Researchers have documented, however, that several counterterrorism frameworks have been instituted in ways that criminalize precisely what IHL mandates in this area.
Second, counterterrorism measures can undermine or erode humanitarian action. This erosion can cause what we refer to as a “chilling effect,” where humanitarian actors may limit or halt certain programming because the (perceived or actual) risks of violating counterterrorism measures are considered too great.

Third, there is the risk of criminalization of the provision of support to designated terrorists. This can affect operational actors, and as previously noted, it can also affect medical care providers.

Fourth, our research has shown that humanitarian actors face challenges related to the financial stability and security. Banks and other financial institutions may decide (without governments requiring them to) to limit or completely halt the provision of services to humanitarian actors on the basis that the work of humanitarian actors expose the bank or financial institution to an unacceptable amount of risk. This process is often referred to as de-risking or de-banking.

Fifth, our research has found that restrictive clauses in agreements between donors and humanitarian actors, including clauses that may require extensive vetting of beneficiaries or of local partners, may further contribute to a “chilling effect” or expose humanitarian actors to legal or financial risks. Our research has also examined contract clauses that require humanitarian actors to seek prior approval before providing life-saving assistance to civilian populations, which may undermine principled humanitarian action.

Spanning out, a key contextual point is that, each year, more and more responsibilities for safeguarding principled humanitarian action are being reposed not in States or humanitarian agencies but in anti-terrorism bodies, especially at the Security Council and its sub-entities tasked with countering terrorism. Further, the vast majority of new binding multilateral counterterrorism obligations, recommendations, and the like are being developed behind closed doors. From my perspective, States ought to own these issues. And, in doing so, States should subject these developments to much greater public scrutiny. Further displacing these authorities to international bodies of limited membership and their bureaucratic security entities risks undermining States’ sovereignty and diminishing States’ responsibility for developing and interpreting international law, including IHL pertaining to humanitarian action.

In this environment, two sets of measures would, I believe, help address the core challenges to safeguarding humanitarian action in counterterrorism contexts.

First, States and other international actors ought to develop and implement more concrete measures to uphold respect for existing IHL protections for principled humanitarian action. That includes securing
respect for foundational IHL rules even — and indeed especially — where
the protections pertain to people characterized as terrorists. This would
mean, in short, taking the steps necessary — across all relevant State
agencies and organs — to respect the humanitarian imperative; to facilitate
humanitarian services; and to ensure that ethically sound medical care is
never punished. It would also require States to call on other States to respect
IHL. As part of those efforts, States may need to assert that certain definitions
of ‘terrorist’ conduct are illegitimate because they sweep in justifiable —
even morally required — activities, including the provision of impartial
humanitarian services under IHL.

States’ responsibility for respecting and ensuring respect for IHL
demands nothing less than taking these internal and external measures as
well as exercising scrutiny over counterterrorism bodies tasked with related
mandates.

To state one of the underlying issues plainly: some States evidently
continue to conceive of some humanitarian and medical services —
including several activities protected under IHL — as constituting
illegitimate support to terrorists. This approach, which apparently some UN
counterterrorism bodies have also adopted, represents, from my perspective,
both a conflict with existing legal obligations and a non-acceptance of the
values underlying principled humanitarian action.

In this context, states may wish to ask themselves who is, and who ought
to be, in a position to authentically and authoritatively interpret and apply
IHL in this area. This ought to include forming and expressing views on the
relationships between IHL and other possibly relevant regulatory
frameworks, including counterterrorism mandates flowing from decisions of
the U.N. Security Council.

So far as our research team has uncovered, there has been little to no
public discourse, at least among States, as to whether a counterterrorism
entity (such as CTED) has already been, or ought to be, tasked with engaging
substantive — including threshold — questions of IHL and perhaps even
assessing States’ IHL compliance in this area. Nor, so far as we are aware,
and despite applicable U.N. Security Council resolutions, have any States
publicly elaborated their views regarding modalities to interpret and apply
IHL as it may relate to relevant Security Council counterterrorism mandates.

Safeguarding humanitarian action arguably requires taking these issues
head-on.

As a second step, States ought to question and contest constraints on
impartial humanitarian activities arising from counterterrorism rationales.
Respect for impartial humanitarian activities is increasingly being framed in terms of whether those services comport with the counterterrorism architecture. In the process, some pillars of impartial humanitarian activities are at risk of political, legal, and cultural erosion.

Currently, the humanitarian community seeks to devise technocratic workarounds to safeguard as many of their services as possible in counterterrorism contexts. Seeking to support those initiatives, some States may advocate for carve-outs for humanitarian activities from counterterrorism measures as a technical solution. From my perspective, such efforts — which may be warranted and salutary in certain important respects — need to be understood within a much broader framework. That is because, without that context, these technical-level efforts — even if partly successful — paper over bigger fault lines.

It is time instead to articulate and enact a more comprehensive, more values-driven notion of peace and security — one that elevates respect for principled humanitarian action. States and other international actors therefore ought to re-center and ground respect for impartial humanitarian activities as an urgently necessary objective in itself, not one refracted through a counterterrorism lens. Recent weeks have once again demonstrated that States are keen to devise strategies, enact policies, and allocate funding to counter terrorism. Yet new laws, policies, and institutions aimed, first and foremost, at securing respect for the humanitarian imperative are relatively rare indeed. Amid unprecedented global humanitarian needs, it is time to boldly and unflinchingly protect the humanitarian initiative.

Both of these steps will require consistent and concerted efforts, especially by States. To be certain, U.N. system actors will no doubt have a role to play. But, from my perspective, the necessary change cannot come solely or even mainly from U.N. entities, humanitarian organizations, or counterterrorism bodies. These matters require State action.

Thank you for your time and attention. I look forward to the discussion.
III. The Protection of Persons Living in Areas beyond State Control and the Role of Non-State Armed Groups in Addressing the Pandemic
The Humanitarian Impact of Covid-19
Measures adopted and enforced
by Non-State Armed Groups

Sandra KRÄHENMANN
Thematic Legal Adviser, Geneva Call

It is most welcome that the San Remo Institute chose to have a specific panel on the humanitarian impact of measures adopted by non-state armed groups in response to Covid-19 because most international attention and support for the public health emergencies resulting from the Covid-19 pandemic has focused on state-led responses, including in conflict-affected areas. However, millions of people live in areas under the control or influence of non-state armed groups. Therefore, addressing the needs of people in such areas is not only necessary from a public health perspective, but more importantly a humanitarian imperative. For this reason, Geneva Call has been highlighting since the beginning of the pandemic that we must ensure that the response to Covid-19 and the humanitarian response thereto does not leave behind the millions of people living in areas under the control or influence of non-state armed groups. Moreover, with humanitarian engagement of armed non-state groups, such groups can also contribute to bringing the pandemic under control, at both the national and international level. Understanding the diverse ways in which non-state armed groups have responded to Covid-19 is a first step to analyze the impact of their measures, their response capacity as well as the various way in which international actors can engage them to provide relief to the population in need.

Governance in times of crisis

As the word grappled with the pandemic and governments resorted to a broad range of extraordinary measures to contain the spread of Covid-19, non-state armed groups followed suit. A unique feature of the response to Covid-19 deserves to be highlighted. As is well known, non-state armed groups are not only involved in hostilities, but to varying degrees also adopt

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measures that regulate the day-to-day life of the population under their control. There is a growing body of research and analysis of this so-called rebel governance. However, Covid-19 measures are exceptional measures in response to a public health crisis. For the first time we see a broad variety of non-state armed groups responding to a public health crisis all over the world in very different contexts. As such, the analysis of their responses also offers some unique insights into how armed non-state actors govern in times of emergencies.

A broad variety of measures

Since the beginning of the pandemic, Geneva Call has been tracking their responses with our Covid-19 Response Monitor². Four types of measures were the most common.

First, most non-state armed groups took general preventive measures, namely information campaigns on barrier gestures or encouraging people to stay home. For example, in June 2020, the leadership of APCLS in the DRC issued a communication to its units, highlighting that Covid-19 was not an imaginary disease and recommending the adoption of barrier gestures³. NAS⁴ in South Sudan or the NPA⁵ in the Philippines made similar statements, the latter producing leaflets with the barrier gestures. Other non-state armed groups used the pandemic for propaganda purposes, for example Boko Haram in Nigeria. In an interesting study, Zakayo and O’Neil analyzed how the messaging of armed groups influenced the perception of the pandemic and individual health choices in Nigeria, further illustrating the necessity to take this factor into account⁶.

Such general preventive measures focused on information were relatively common, amongst others because they do not require significant resources. However, other non-state armed groups took more concrete preventive

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measures, for example the KNU/KLA in Myanmar had introduced
temperature screening posts.\footnote{For further examples of armed
non-state actors establishing temperature screening post
and the international legal framework applicable to screening posts, see X.
Galvez, COVID-19 Screening Posts and their Protection under International
}

Second, many non-state armed groups imposed restrictions, mimicking
those imposed by States, for example forms of lockdown,\footnote{See for example DPR, Statement on Additional Restrictive Measures Related to the COVID-19 Threat, 31 March 2020, available at: https://genevacall.syselshare.ch/dl/1GYvbdfl71pdSXbm.}
restrictions for movements across contact lines, including quarantines,\footnote{See for example LPR, Order No 273, 11 March 2020, available at: https://genevacall.syselshare.ch/dl/pMSQpJQXjjKRsxVT7.}
general movement restrictions in territories under their control,\footnote{See for example RCSS, Statement on Restrictions of Travel in Rural Areas, 5 October 2020, available at: https://genevacall.syselshare.ch/dl/pMSQpJQXjjKRsxVT7.}
}

Third, many non-state armed groups called for humanitarian and medical
assistance to address the pandemic, highlighting the lack of essential medical
}
At the same time, many of them also pledged to respect and guarantee the safety of humanitarian
}
}
in the Central African Republic.

Fourth, heeding the appeal of the UN Secretary General, many non-state
armed groups initially declared temporary unilateral ceasefires on humanitarian
}
}
in Thailand, or the NPA\footnote{NPA, Ceasefire Order, 26 March to 15 April 2020, available at: https://cpp.ph/statements/ceasefire-order-00-00h-of-26-march-2020-to-23-59h-of-15-april-2020/.}
in the Philippines, but in most instances the ceasefires did not last.
In conclusion, the types of measures taken by non-state armed groups is remarkably similar to measures taken by States.

The humanitarian impact of these measures

These measures can be analyzed from an international law perspective, but the humanitarian impact of these measures goes beyond the question of their lawfulness from an international law perspective. It is quite challenging to assess the humanitarian impact of measures taken by non-state armed groups, for a variety of reasons. On the one hand, these are not the only measures taken that affect the population in areas under the control or influence of armed groups. In many contexts with a weak state governance, a multitude of actors will take and implement measures, not just various non-state armed groups, but also local authorities. In addition, measures taken by the territorial State will interact with the measures imposed by non-state armed groups, most notably restrictions on movements, including to cross from government-controlled areas into non-government-controlled areas. On the other hand, the international response to Covid-19 also has an impact: in particular at the beginning of the pandemic, most states responded with border closures and travel restrictions, which in turn hindered the ability of all states and humanitarian actors to respond to the crisis. Similarly, some of the most urgent needs generated by Covid-19 in conflict-affected areas initially could not be met because supplies were limited and absorbed by wealthy countries, a dynamic repeated with vaccines.

Finally, when assessing the humanitarian impact of measures taken by non-state armed groups, we need to bear in mind that these measures are taken against the background of an armed conflict, or in other words, there are pre-existing protection and assistance concerns. In particular, essential infrastructure and services to address the pandemic were already serious weakened, including the healthcare and sanitation infrastructure. In this respect, the response to Covid-19, in particular in the form of travel restrictions, exacerbated the already existing challenges to meet basic needs, including healthcare needs, in conflict-affected areas. As a result, the humanitarian impact of Covid-19 undoubtedly was and continuous to be most strongly felt in conflict-affected areas, and in particular by populations living under the control or influence of armed non-state groups.
The Adoption and Enforcement of Covid-19 Measures by NSAGs: what Legal Framework applies?

Tilman RODENHÄUSER
Legal Adviser, ICRC

In 2020, armed groups in Colombia began imposing Covid-19 containment measures ranging from bans on traveling in boats and vehicles to shop closures, night-time curfews and lockdowns of entire communities1. This is only one example of measures adopted by armed groups to try to halt the spread of the Covid-19 pandemic2. In many cases, these measures mirrored those taken by States; in some cases, however, measures were enforced by brutal force and caused great suffering3.

Covid-19 measures by armed groups have brought to the fore a much wider phenomenon, namely governance activities undertaken by various armed groups. For lawyers, this reality raises intriguing questions, some of which this contribution aims to explore specifically with regards to Covid-19 measures4. Thus, this piece first analyzes the extent to which international humanitarian law (IHL) imposes limits on Covid-19 measures taken by armed groups; and, second, whether and to what extent international human rights law (IHRL) could play a role.

Covid-19 measures adopted by armed groups – diverse realities

The ICRC estimates that that in 2021 around 50 million people lived under the exclusive control of armed groups, and 100 million in territories

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* Dr Tilman Rodenhäuser is legal adviser at the International Committee of the Red Cross (ICRC). The views expressed in this article are those of the author and do not necessarily reflect those of the ICRC.


3 ICRC, above note 1, p. 47.

4 For a more in-depth analysis of the wider issue, see Tilman Rodenhäuser, The legal protection of persons living under the control of non-State armed groups, International Review of the Red Cross, 2022.
over which control is disputed. Behind these numbers, there are complex realities, three of which shall be briefly highlighted here.

First, for civilian populations, living under the de facto control of an armed group can exacerbate pre-existing needs and vulnerabilities, create new ones, or – in other instances – provide a degree of stability in conflict-ravaged environments. Regardless of whether civilians live under the control of a State or an armed group, several of their basic needs – such as security, work, education and livelihoods – were likely affected by the pandemic.

Second, there are significant differences between armed groups, ranging from gangs in favelas to groups with stable control over territory and the capacity to act like a State authority. This diversity of groups is evident when looking at two examples of measures taken by armed groups during the pandemic.

- In the first case, the armed group was party to a non-international armed conflict without exercising stable control over the territory. When the pandemic hit the area in which it was operating, the armed group adopted strict Covid-19 measures and enforced them by shooting those who did not comply with them.
- In the second case, the armed group had been exercising control over important parts of the territory for several years and had established a de facto administration that resembled that of a State. During the pandemic, this armed group established quarantine centers for individuals entering its territory.

Third, from a legal point of view, not every armed group can be classified as a party to a non-international armed conflict and therefore be bound by IHL. Out of the approximately 600 armed groups of humanitarian concern identified by the ICRC, only 100 were classified as party to a non-international armed conflict. The following legal analysis is limited to the

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6 The armed group must reach a certain level of organization. For a comprehensive analysis of what the “organization” criterion for a non-state armed group under IHL means, see Tilman Rodenhäuser, Organizing Rebellion: Non-State Armed Groups under International Humanitarian Law, Human Rights Law, and International Criminal Law, Oxford University Press, Oxford, 2018, pp. 19-120.

obligations of non-State armed groups (NSAGs) that can be classified as parties to armed conflicts.

International humanitarian law – a bottom line of protection when armed conflict and pandemics intersect

For NSAGs that are classified as parties to armed conflicts, IHL provides a generally accepted set of legal obligations. By imposing limits on permissible behavior by NSAGs, it primarily aims to protect the lives and dignity of civilians and addresses their acute humanitarian needs.

Looking at the types of Covid-19 measures commonly imposed by State and non-State authorities, however, it appears that IHL does not have much to say on what kind of measures NSAGs may or may not take to curb the spread of a pandemic (such as limitation to the freedom of movement or the right to work).

At the same time, IHL might have something to say about how NSAGs enforce these Covid-19 measures. Notably, IHL provides a set of fundamental guarantees that protect civilians affected by non-international armed conflicts. For instance, under IHL, the murder or ill-treatment of civilians is prohibited at any time and in any place whatsoever. Going back to the first example given above, would the injuring and killing of civilians by a NSAG for not complying with the group’s Covid-19 measures constitute an IHL violation? For the authors of this post, the answer is positive.

In non-international armed conflicts, IHL applies to conduct that has a ‘nexus’ to the conflict and protects persons who are ‘affected by the conflict’. It is difficult to imagine that people living under the control of a NSAG, and being subjected to violence by that NSAG, should not be

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8 According to common Article 3, each party to the conflict shall in all circumstances treat “persons taking no active part in the hostilities” humanely and shall abstain from a number of acts with respect to these persons, including “violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture”. See also Additional Protocol II (AP II), Article 4, and Jean-Marie Henckaerts and Louise Doswald-Beck (eds.), Customary International Humanitarian Law, Vol. 1: Rules, Cambridge University Press, Cambridge, 2005 (ICRC Customary Law Study), Rules 89 and 90, available at: https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1.

considered as affected by the armed conflict. For example, if a non-State party takes control over parts of a State’s territory in the course of a NIAC, people living in that territory will often be affected by hostilities between the parties. At least during the period in which fighting over control of a village or town is ongoing, and territorial control is disputed between State and non-State forces, inhabitants will undoubtedly be affected. More generally, once the NSAG establishes itself as the new military (and political) authority, persons living in territory under the NSAG’s control will find themselves subjected to a new governing authority and will thereby be affected by the acts of one party to the conflict. If a NSAG inflicts violence on the civilian population in the context of a NIAC, it will likely amount to a violation of IHL – regardless of whether the violence was exercised for reasons directly linked to combat operations or for governance reasons, which encompass not only religious, ideological or political motivations but also the objective of preventing the spread of a pandemic. As the ICRC argued during the negotiations of Additional Protocol II, IHL has precisely been established as a set of essential rules that apply and protect the civilian population ‘against the arbitrary authority of the Parties to the conflict when constitutional guarantees ha[ve] been generally suspended or … no longer appl[y] effectively’10.

The conclusion that IHL applies to how a NSAG treats persons living under its control is further supported by the interpretation of the nexus requirement in international criminal law. In the case law of both the ICTY11 and more recently the ICC12, the link between an act and a conflict is established if ‘the existence of an armed conflict [has played], at a minimum, […] a substantial/major part in the perpetrator’s ability to commit [the act], his decision to commit it, the manner in which it was committed or the purpose for which it was committed’13. There are compelling reasons to argue that several of these factors are met in the situation where a group conducts violence against a civilian population in order to enforce

11 ICTY, Prosecutor v. Dragoljub Kunarac et al., Case No. IT-96-23 & 23/1, Judgment (Appeals Chamber), 12 June 2002, para. 58.
13 Note that these elements have been criticized for being overly broad and may permit different conclusions in similar situations. See Harmen van der Wilt, War Crimes and the Requirement of a Nexus with an Armed Conflict, Journal of International Criminal Justice, Vol. 10, No. 5, 2012.
governance measures. First, in most cases, the group would not have had the ability to impose such measures and enforce them without the existence of an armed conflict. Second, the manner in which these acts are conducted by the armed group is shaped by the group’s position as a party to the conflict and as the new authority operating in a region. Third, in many cases such measures are also an expression of power by the group, linked to the purpose for which the group operates14.

To what extent can human rights law complement IHL obligations?

Many Covid-19 measures, such as restrictions of the right to freedom of movement or to work have led to significant humanitarian needs. Such measures are not addressed by IHL but by human rights law. But does human rights law bind armed groups as a matter of international law?

When we look at most human rights treaties, obligations are defined for States, not for armed groups, reflecting the general understanding of States having the onus to respect human rights and to protect them against interference by non-State actors. Over the past two decades, however, the question of whether NSAGs may also have human rights obligations has been vividly discussed among academic experts15, probably inspired by – and also inspiring – a certain practice by UN human rights mandate holders that have called on armed groups to respect human rights16. There have also

14 While the reason for which an NSAG is engaging in armed violence is not relevant in determining whether an armed conflict exists, it is a relevant consideration for determining a link between an act and the conflict.


been multiple instances of States in UN bodies calling upon armed groups to stop human rights abuses.

In light of this practice, it appears that there is a certain expectation, or demand, by States and human rights experts for armed groups not to violate human rights. However, a legal analysis of this practice shows that it remains unclear what legal sources are relied on in order to ground such human rights obligations in international law. In addition, some of the more comprehensive studies found that current State practice does not seem sufficient to find that human rights obligations exist for armed groups under customary international law. As a result, it is difficult to conclude that these expectations are currently based on armed groups having human rights obligations as a matter of law.

This legal conclusion should, however, not necessarily be an obstacle to using human rights “standards” or “expectations” in humanitarian dialogue with armed groups. For instance, for several years, the ICRC has pursued an approach that when it operates in a context in which an NSAG ‘exercises stable control over territory and is able to act like a State authority’ and the organization cannot rely on IHL alone to address the protection needs of the civilian population, the ICRC takes a ‘pragmatic approach’ and refers to the de facto ‘human rights responsibilities’ of such groups.

Conclusion

Due to the diversity of armed groups and contexts in which they operate, adopting a case-by-case approach to determine the applicable law and necessary protection messages is essential. IHL provides a fundamental set of obligations which impose clear restrictions on how NSAGs may treat civilian populations under their control, including with regards to Covid-19 measures.

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18 See for instance J. Burniske, N.K. Modirzadeh and D.A. Lewis, above note 17, p. 27.

19 ICRC, above note 5, p. 54. In such cases, the ICRC explains that it “operates on the premise that ‘human rights responsibilities may be recognized de facto’ if a non-State armed group exercises stable control over territory and is able to act like a State authority”.
When it comes to using human rights messages in humanitarian dialogue with armed groups, important questions must be considered to ensure that such dialogue advances the protection of people and does not undermine it. For instance, focusing on permissible restrictions of human rights when discussing with NSAGs lacking stable control over territory might not be the best strategy in order to achieve a protective outcome. Indeed, when it comes to such groups, which are similar to the first example given above, the basic message of ‘do not kill’ or ‘do not ill-treat’ is the most essential one and can, in situations of armed conflict, be based – as a matter of law – on IHL only. Conversely, in other circumstances, such as when interacting with the few NSAGs having established State-like governance structures, going beyond IHL and referring to human rights can be sensible in order to strengthen the protection of affected persons. This would be the case, for instance, with regards to the quarantine measures mentioned above.
Ensuring Vaccinations in Territories under the control of Non-State Armed Groups

Nathalie WEIZMANN
Senior Legal Officer, UN Office for the Coordination of Humanitarian Affairs (UNOCHA)

It is a true privilege to be joining the Roundtable and this panel. I will pick up where Tilman (Rodenhäuser) left off and look at what international human rights law and international humanitarian law have to say about vaccination against Covid-19.

Resting on the points that Tilman made on the applicability of human rights law to armed groups, I would also cite the position of the Interagency Standing Committee Policy (IASC) that recognizes that “de facto authorities or non-state armed groups that exercise government-like functions and control over territory are increasingly expected to respect international human rights norms and standards when their conduct affects the human rights of individuals under their control.” To recall, under the International Covenant on Economic, Social and Cultural Rights, there is a recognition in article 12 of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. This entails the prevention, treatment, and control of epidemic diseases. In its General Comment 14, the UN Committee on Economic, Social and Cultural Rights has found that this also entails an obligation to “provide immunization against the major infectious diseases occurring in the community.”

Resting once again on Tilman’s point that persons under the control of an armed group party to a conflict are necessarily affected by the conflict, there are at least three legal pathways to justify an obligation to vaccinate or allow vaccinations, all based on the fundamental guarantees under common article 3 to the Geneva Conventions applicable in non-international armed conflict.

The first is the obligation of humane treatment of persons taking no active part in hostilities, which of course includes the humane treatment of civilians living in areas under the control of an armed group party to a conflict. The ICRC’s 2016 Commentary on this provision refers to safeguards for health and hygiene and the provision of suitable medical care. A second aspect of the same set of fundamental guarantees in common article 3 is of course that the wounded and sick shall be collected and cared for. The same ICRC Commentary on this part of the provision refers to the fact that caring for the sick “may also entail taking preventive measures to ensure the basic health of the population, including vaccinating people against infectious diseases.”
As a third pathway, common article 3 foresees that an impartial humanitarian body may offer its services to the parties, including a non-state armed group party to the conflict. These services can include humanitarian relief, which, in turn, can include the provision of health care. Once the State’s consent is obtained, all parties, including armed groups, must allow and facilitate the rapid and unimpeded passage of impartial humanitarian relief for civilians in need. (Humanitarian relief was elaborated on during an earlier presentation at this year’s Roundtable).

It is still early days for Covid-19 vaccination, in particular in situations of armed conflict. Nevertheless, Covid-19 vaccination has been taking place in areas under the control of armed groups that are party to armed conflict, often with significant challenges. For instance, in Idlib, northwest Syria, AstraZeneca vaccine doses have been distributed as part of the COVAX arrangement, with priority to medical personnel, people over 60, and those with chronic diseases. Also through COVAX, vaccine doses have been provided in the semi-autonomous area of northeast Syria. In at least three areas of Myanmar under the control of distinct non-state armed groups, the Sinovac vaccine has been supplied with assistance from the Red Cross Society of China. In eastern Ukraine and in parts of Georgia not governed by the government, the Sputnik V vaccine has been provided. And in Yemen, the Houthis have so far agreed to 1,000 doses of the Covid-19 vaccine.

Many of the challenges to vaccination in areas under the control of non-state armed groups are similar to those we see elsewhere in situations of armed conflict (or even outside of armed conflict). First, it is important to emphasize a common backdrop in these areas: ongoing violence and significantly weakened health systems. Health facilities in situations of conflict are often damaged or destroyed; supplies are looted; medical personnel are killed, injured, and often flee. Reaching areas under the control of non-State armed groups, or, more generally, areas of armed conflict, can be a challenge because of ongoing fighting, difficult terrain, and frequent bureaucratic impediments. The challenge of providing medical care in armed conflict was the topic of the UN Secretary-General’s report on the protection of civilians issued in May this year (2021).

As we look at the challenges to vaccination for Covid-19, it is important to picture this backdrop. In Yemen, for example, we have reports that half of the country’s health facilities are dysfunctional and 18% of its 333 districts have no doctors at all, while water and sanitation systems have collapsed. A large number of medical facilities have been put out of service in Idlib, northwest Syria. Last year, 24% of the civilians surveyed in northwest Syria reported being unable to receive medical treatment because of an attack on a health-care facility, and 49% said they were afraid to access medical care out
of fear of an attack. At the end of 2020 in the Tigray region of Ethiopia, of more than 260 health centres in the area, only 31 were fully functional and 7 partially functional. These figures help illustrate the extent to which health facilities and systems are severely hampered in situations of armed conflict, including, of course, in areas under the control of armed groups. In addition, we often hear reports of the criminalization of impartial medical care provided to populations under the control of groups that are designated as terrorist.

To this, add the fact that in conflict settings public trust is often low to begin with. Weak governance can heighten exposure to misinformation and disinformation, which have been detected in a number of situations of conflict where armed groups operate or are in control. In Syria, for example, hesitancy has been detected, including among health staff, due to rumors in social media and misinformation. In Somalia, Al Shabaab warned the population against administering the AstraZeneca vaccine, echoing the ban in some European countries and labeling it as deadly and unsafe. So far there have not to our knowledge been any vaccinations against Covid-19 in areas under the control of Al Shabaab. In Yemen, the Houthis have been reportedly denying the gravity of the pandemic, imposing an information blackout on cases and deaths from Covid-19, and blocking international efforts to supply the vaccine.

Yet another challenge to vaccination is, of course, the general scarcity of the vaccine across many parts of the world. Just one context that illustrates the compounding effects of the challenges listed so far is the Democratic Republic of the Congo with a population of over 100 million. In March they received 1.7 million doses of the vaccine but had to return 1.3 millions of these because they were not able to administer them before they were going to expire. This was in part because it was the AstraZeneca vaccine at a time when it was under investigation in Europe, but also because of general hesitancy and gaps in the ability of the healthcare system to roll it out adequately and quickly enough.

Continued engagement with all parties to conflict, including armed groups, is vital to tackle misinformation and disinformation, to ensure access to populations, and to ensure respect for international humanitarian law and human rights. To this end, the UN Security Council adopted a resolution earlier this year – resolution 2565 – that explicitly recognized that those affected by conflict and insecurity are particularly at risk of being left behind. The resolution called for Covid-19 national vaccination plans to encompass, among others, those living in areas under the control of non-State armed groups. It also recalled the need to address misinformation and disinformation, called for full safe and unhindered access for humanitarian
and medical personnel and assets to facilitate Covid-19 vaccinations, called for respect for international humanitarian and human rights law, and invited Special Envoys and Representatives of the Secretary-General to use their good offices and mediation with all parties to armed conflict.
Concluding session
Closing Remarks

*Helen DURHAM*
Director of International Law and Policy, International Committee of the Red Cross (ICRC)

In the last few weeks with these sessions, we really have found that the topic of *Pandemics, Armed Conflict, and International Humanitarian Law* is an extremely important one. The fact that we have focused the discussions especially around the provision of medical services during armed conflicts and other situations, the challenges of humanitarian relief operations in times of pandemics, and the questions that arise in non-State armed groups or territories was very important.

As I always do at the end of these wonderful sessions, I want to stress that the Sanremo Round Table is very special and important to bring together practitioners from the humanitarian and military fields, and other experts to really look at these topics. I thank every single expert that has spoken in the last four sessions. Thank you also to the Institute for the cooperation with the ICRC, at the interpreters, and at the teams behind the scene.

Before I hand it over to Professor Greppi to formally close it, I wanted to give my sincere appreciation as this will be my last Sanremo Round Table I will be involved in. By this time next year, you will have a new Director of International Law and Policy for the ICRC. It has been a great privilege and a pleasure to play a role for over seven years. I have made many friends and I have had many discussions. My sincere thanks are both personally and professionally. Over to you Professor Greppi for the closing. Thank You.
Thank you Helen, we appreciate the role you have played over the years. This Round Table, as the one of last year, unfortunately had to be organised on webinars. We can only say that we have done our best to cope with this special situation. I wish to warmly thank the organising team of this Round Table based on four webinars, in particular Colonel Mark Dakers, Gian Luca Beruto and Edoardo Gimigliano on the side of the Institute, together with the Secretary-General Stefania Baldini and the team that helped them, Alessandro Buffa, Beatrice Barone and Greta Ciucci.

I would like to stress the fact that this Round Table, as it is now tradition since many years, is organised in close cooperation with the ICRC. I wish to particularly thank Helen because she has been crucial. We have had some doubts over the last months and Helen, together with Tilman Rodenhäuser, a very proactive member of the organizing team since the very first sessions, gave an important contribution to the organizing of this Round Table. We still firmly believe in the close cooperation between the IIHL and the ICRC. As an independent institute and as a very important actor in the international community, the IIHL and the ICRC have worked together on many occasions and for many years. I really wish that we will go on in such terms and organize the traditional Round Table in Sanremo in 2022 in which you are always welcome to participate. This has been done in the traditional spirit, well known around the word as the Spirit of Sanremo, which is still alive even in these so complicated times.

To conclude, thanks to all the panellists and to the chairs, Keith Eble, Marja Lehto, and Camille Faure. Thank you very much, because this is a real joint venture and all those who have contributed to it are really to be thanked for what they have done in this 44th Round Table in the 51st year of the IIHL.

From Helen and myself, the best wishes to you all. We are confident that the following months will be better than the ones we lived in the last year and a half. Welcome to Sanremo as soon as possible. Thank you.
### Acronyms

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<td>C-RED</td>
<td>Customs for Relief of Epidemic Diseases</td>
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<tr>
<td>CASEVAC</td>
<td>Casualty Evacuation</td>
</tr>
<tr>
<td>CIMIC</td>
<td>Civil-Military Coordination</td>
</tr>
<tr>
<td>CTED</td>
<td>Counter-Terrorism Executive Directorate</td>
</tr>
<tr>
<td>DAs</td>
<td>Draft Articles</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of the Congo</td>
</tr>
<tr>
<td>ECHR</td>
<td>European Court of Human Rights</td>
</tr>
<tr>
<td>EERC</td>
<td>European Emergency Response Capacity</td>
</tr>
<tr>
<td>ELN</td>
<td>National Liberation Army</td>
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<tr>
<td>EMT</td>
<td>Emergency Medical Teams</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>FCV</td>
<td>Fragility, Conflict, and Violence</td>
</tr>
<tr>
<td>FDPC</td>
<td>Front Démocratique du Peuple Centrafricain</td>
</tr>
<tr>
<td>GC</td>
<td>Geneva Convention</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
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<tr>
<td>GPC</td>
<td>Global Protection Cluster</td>
</tr>
<tr>
<td>HCW</td>
<td>Health Care Workers</td>
</tr>
<tr>
<td>HLS PILAC</td>
<td>Harvard Law School Program on International Law and Armed Conflict</td>
</tr>
<tr>
<td>HQ</td>
<td>Headquarter</td>
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<tr>
<td>IAC</td>
<td>International Armed Conflict</td>
</tr>
<tr>
<td>IASC</td>
<td>Inter-Agency Standing Committee</td>
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<tr>
<td>ICC</td>
<td>International Criminal Court</td>
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<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
</tr>
<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
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<td>ICRC</td>
<td>International Committee of the Red Cross</td>
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<tr>
<td>ICTY</td>
<td>International Criminal Tribunal for the Former Yugoslavia</td>
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<td>IDL</td>
<td>International Disaster Law</td>
</tr>
<tr>
<td>IDPs</td>
<td>Internally Displaced Persons</td>
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<tr>
<td>IFRC</td>
<td>The International Red Cross and Red Crescent Movement</td>
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<tr>
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<td>International Humanitarian Law</td>
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<tr>
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<td>IIHL</td>
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</tr>
<tr>
<td>KNU/KNLA</td>
<td>Karen National Union/Karen National Liberation Army</td>
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<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MEDEVAC</td>
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<tr>
<td>MINUSMA</td>
<td>United Nations Multidimensional Integrated Stabilization Mission in Mali</td>
</tr>
<tr>
<td>MSF</td>
<td>Médecins Sans frontières</td>
</tr>
<tr>
<td>NAS</td>
<td>National Salvation Front</td>
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<tr>
<td>NATO</td>
<td>North Atlantic Treaty Organization</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NIAC</td>
<td>Non-International Armed Conflict</td>
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<tr>
<td>NPA</td>
<td>New People’s Army</td>
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<td>NSAG</td>
<td>Non-State Armed Group</td>
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<td>PHE</td>
<td>Public Health Emergency</td>
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<tr>
<td>ROE</td>
<td>Rules of Engagement</td>
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<td>SC</td>
<td>Security Council</td>
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<td>Sustainable Development Goals</td>
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<td>SOCADEF</td>
<td>Southern Cameroons Defence Forces</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
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<td>WCO</td>
<td>World Customs Organization</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Acknowledgements

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This collection of contributions made by renowned international experts and practitioners addresses the new challenges in the field of IHL application that emerge from the outbreak of pandemics and large-scale diseases in armed conflict scenarios.

The 44th Round Table on current issues of humanitarian law focused on some of the most topical, legal and operational military issues generated by pandemics, particularly when they overlap with other humanitarian emergencies in areas of the world already affected by international and/or non-international armed conflicts. More precisely, the contributing experts stressed the dramatic impact on civilians of the misuse made by both governments and non-state armed groups of the restrictive measures related to the sanitary crisis, often implemented to exercise control over populations and territories at the expense of the most vulnerable categories of civilians in terms of human rights violations and limitations on their legal protection.

The Round Table provided a forum to discuss relevant topics related to conflict management during pandemics, the implications of the healthcare crisis in the application of IHL, the difficulties in guaranteeing the protection of civilians and health workers, delivering humanitarian aid and safeguarding humanitarian access.

The International Institute of Humanitarian Law is an independent, non-profit humanitarian organisation founded in 1970. Its headquarters are situated in Villa Ormond, Sanremo (Italy). Its main objective is the promotion and dissemination of international humanitarian law, human rights, refugee law and migration law. Thanks to its longstanding experience and its internationally acknowledged academic standards, the International Institute of Humanitarian Law is considered to be a centre of excellence and has developed close cooperation with the most important international organisations.