HUMANITARIAN LAW & POLICY

Reaffirming IHL's specific protection of hospitals

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North Kivu, Democratic Republic of the Congo. A surgical team in the only hospital in the region, where attacks against health-care structures and medical evacuation teams are unfortunately all too common. c/ Alvaro, Ybarra Zavala, 2012.

In today's armed conflicts, hospitals are increasingly being attacked or misused for military purposes, undermining one of international humanitarian law's most fundamental protections. These strikes have devastating consequences for the people who rely on hospitals for life-saving care, from patients and medical staff to entire communities. When hospitals are damaged or forced to shut down, critical services like paediatric care or intensive care treatment vanish, often with fatal results. Despite clear legal safeguards granting protection to hospitals, cases indicate that hospitals are at times misused for military purposes and attacks regularly ensue. In many cases, core IHL principles are either deliberately ignored or applied in a permissive manner, threatening the very idea that hospitals must be specifically protected as neutral sanctuaries by all sides to a conflict.

In this post, ICRC Legal Advisers Supriya Rao and Alex Breitegger explore how IHL's specific protection of hospitals is both robust and comprehensive, grounded in a presumption of neutrality that can only be lost in narrowly defined cases. Even when misuse occurs, parties are required to issue a warning and give time for it to stop, striking as a last resort only if the hospital meets the definition of a military objective — and even then, the rules of proportionality and precautions apply to limit the harm. Upholding this framework is essential to ensuring that the wounded and sick can access care, and that humanitarian principles endure, even amid the horror of war.

Imagine this: following a sharp escalation in hostilities during an armed conflict, a missile strikes the city's general hospital, centrally located in the capital. The hospital, a vital lifeline for the community, had been providing specialized medical services, including a children's ward well known for its life-saving paediatric services, a cardiology unit and an intensive care unit. Opposition forces claim responsibility for the attack, saying that the facility was being misused for military purposes and alleging it served as a military observation post. Hospital management and government forces strongly deny the accusation, questioning why, if such misuse had occurred, no warning was issued to cease such acts.

The attack resulted in devastating humanitarian consequences: twelve patients and fifteen health staff were killed, dozens were critically injured, and the hospital's paediatric and cardiology units were destroyed. While hospital authorities were able to evacuate 90 per cent of the 600 patients to other medical facilities, 20 critically ill patients died en route or shortly after, unable to receive the care they urgently needed.

Almost a year later, parts of the hospital are repaired and re-equipped, and the facility partially reopens. Following a pause in the fighting, hostilities resume in the area. Once again, opposition forces raid the hospital, this time justifying their actions by claiming it no longer qualifies for protection, arguing that its alleged hostile use has continued and that its medical status is no longer recognized.

Sadly, it does not take much imagination to see how such attacks unfold in real conflict situations — scenarios like this have unfortunately become a hallmark of contemporary warfare, with devastating consequences for patients and entire populations who are left without medical services that are unlikely to be restored in the near future.

Recurrent attacks, other military interferences with their medical functioning, and the misuse of hospitals for military purposes challenge the foundational principles at the very origin of IHL. Rules on the specific protection of hospitals were contained in the first Geneva Convention of 1864 and have since been refined and more comprehensively codified in the 1949 Geneva Conventions, their 1977 Additional Protocols and are also found in customary IHL.[1] The rationale is clear: hospitals must be protected as sanctuaries, delivering life-saving care to wounded and sick persons, regardless of the side

of the conflict with which they are associated. This protection can be lost only in the rarest and most exceptional circumstances – yet in many of today's recent and current conflicts, that presumption is challenged.

In light of the apparent growing disregard for the specific protection of hospitals in today's conflicts, the ICRC – through its *Global Initiative on IHL* – is undertaking an important examination of the main contours of this specific protection. The aim is to ensure that existing IHL rules granting specific protection to medical facilities are better known and understood, and to support states and other parties to armed conflicts in applying them in a way that upholds their humanitarian purpose and protective intent.

The following paragraphs frame the main legal and operational challenges to upholding hospitals' specific protection in contemporary conflicts. Through the Global Initiative's workstream on *Hospitals: Achieving Meaningful Protection in Armed Conflict*, the ICRC seeks to engage states and experts in addressing these pressing issues.

Specific protection of hospitals and other medical facilities

Under IHL, hospitals and other medical facilities – whether civilian or military – enjoy specific protection that goes beyond the general protection afforded to other civilian objects. This elevated protection ensures that they remain functional when they are needed most and are able to provide life-saving medical care to wounded and sick persons. Parties to armed conflict are obligated "to respect and protect hospitals and other medical facilities in all circumstances." To *respect* requires belligerents not only to avoid attacking medical facilities, but also to refrain from other military interferences with their medical functions and misusing them for military purposes. To *protect* requires belligerents to take positive measures, including all feasible measures to facilitate the functioning of medical establishments and protect them from harm, such as looting by third parties.

Although IHL affords hospitals one of the highest levels of protection from attack and military use, it does not categorically prohibit their use for military purposes or their targeting for attack. However, any military use of a medical facility requires an extraordinarily high threshold, justifiable only in cases of urgent military necessity and only if sufficient arrangements are made to ensure the continued care for the wounded and sick.[2] Certain uses of medical facilities, even then, are still strictly prohibited in all circumstances, such as misusing a hospital to shield a military objective.[3] Depending on the circumstances, uses of medical facilities for military purposes may amount to other specific IHL violations, such as violations of the obligation to respect and protect medical facilities; of passive precautions, of the prohibition of improper use of emblems where medical facilities display a red cross, red crescent or red crystal; and of the prohibition of perfidy.

Loss of specific protection and its consequences

To ensure the strongest possible protection for medical facilities, IHL sets out particularly stringent cumulative conditions for the loss of specific protection. First, the medical facility must be used to commit acts harmful to the enemy that fall outside its humanitarian duties. Second, a warning must be provided, setting – whenever appropriate – a reasonable time limit to cease such acts. Third, the loss of specific protection may be effective only if such a warning remains unheeded.

This raises the crucial question: what qualifies as an "act harmful to the enemy"? IHL treaties do not define the term, nor do they provide a list, but state practice offers guidance. Acts considered to be harmful to the enemy include: firing at the enemy for reasons other than individual self-defence; installing a firing position in a medical post; the use of a hospital as a shelter for healthy combatants, an arms or ammunition dump, or a military observation post; or the placing of a medical unit in proximity to a military objective with the intention of shielding it from the enemy's military operations. The ICRC has interpreted acts harmful to the enemy as "acts the purpose or effect of which is to harm the adverse Party, by facilitating or impeding military operations", thereby encompassing the use of a medical facility to interfere directly and indirectly with military operations.[4]

This seemingly broad understanding of the concept must, however, be read together with the explicit regulation in IHL treaty law of acts that *do not* constitute acts harmful to the enemy, for instance: medical personnel equipped with light weapons for their defence or for that of the wounded and sick in their charge; a medical facility guarded by a picket or sentries or by an escort; small arms and ammunition taken from the wounded and sick and not yet handed back to the proper service and found in these units; or wounded and sick combatants in civilian medical facilities for medical reasons.

While this list helps to narrow down the acts that could be considered as harmful to the enemy, the lack of a definition or exhaustive list in IHL treaty law leaves room for ambiguity. This creates a dangerous environment in which on the one hand, medical facilities can be easily misused for military purposes, and on the other, allegations by attackers that such acts have been committed can be easily made and are hard to refute. The problem is compounded by the fact that there is currently a lack of transparency by armed forces on a range of crucial information: whether standard operating procedures and operational plans are framed to avoid military activities in medical facilities as far as possible; whether they establish the exceptional situations that may justify such use and, even in such cases, the limitations that continue to apply; and whether they guide assessments that medical facilities are used for acts harmful to the enemy, and what procedures are in place to decide on the consequences of such a determination, including communicating with the adversary and those in charge of health facilities to address these cases. Concretely, having such military documentation and procedures would help belligerents comply with their obligation to respect medical facilities.

It is important to underscore that under IHL's protective framework, misusing a hospital to commit acts harmful to the enemy does not automatically render it a legitimate military objective. Before any attack, the party considering such action needs to determine – in line with the principle of distinction under IHL – whether the hospital, due to its misuse, meets the two-pronged definition of a military objective under Article 52(2) of Additional Protocol I.

Warning as a safeguard before any military response to a loss of specific protection

Before, however, any military response by a party to a conflict following a determination of an act harmful to the enemy, that party must issue a warning setting, whenever appropriate, a reasonable time limit to cease such acts and which must go unheeded.[5] Unlike warnings required as part of feasible precautions for other civilian objects, where a warning can be dispensed with where the military circumstances do not permit, this essential safeguard cannot be waived for medical facilities on the grounds of military necessity. The warning here has a different purpose: to provide an additional safeguard to avoid the severe consequences for patients and medical personnel and to the medical facility itself from any military response to a loss of specific protection. It prioritizes communication with those committing acts harmful to the enemy so that such acts can be stopped and protected persons can be evacuated, over preserving tactical surprise, which is lost when forewarning the adversary of the attack. Where acts harmful to the enemy cease, no military response whatsoever can be undertaken against a medical facility.

Such a warning should also allow for making arrangements to secure safe evacuation, where possible, of patients in view of any impending military response. Finally, it should allow for verification of allegations of acts harmful to the enemy and to correct any errors in that assessment. In practice, questions arise such as: Who are addressees of the warning? How should communication be established with the addressee? Which channels of communication are most effective to achieve this? What factors would determine the appropriate time limit for compliance with such a warning, and how should compliance with the warning be assessed?

Minimizing the impact of any military response to a loss of specific protection

Even when a hospital loses its specific protection and becomes liable to attack, belligerents still remain bound by the obligation to collect and care for the wounded and sick, which would be impossible to fulfil without functioning health facilities. It could be argued that the overarching obligation to care for the wounded and sick imposes an additional legal restraint alongside the rules of proportionality and precautions, shifting the balance in favour of preserving medical functions as far as possible even when hospitals may become liable to attack.

This raises questions, such as how in the planning of military operations both the immediate harm and the long-term impact of attacks on hospitals for affected local populations are taken into account in proportionality assessments, when few facilities within the health system offer specialized life-saving medical services such as maternity, paediatric, or intensive care. Or, in terms of precautions, how to avoid and, in any event, minimize the incidental harm caused to health facilities that impacts the delivery of health care, such as breakdown of electricity, water supply and access routes for patients and healthcare providers, and for delivering medical supplies. In this regard, are there certain means and methods of warfare that should be avoided to comply with the obligation to take all feasible precautions in attack? What good practices exist for managing the evacuation of patients – including post-operative and intensive care patients, as well as those facing specific risks or having specific needs – and medical personnel, to ensure they can continue to receive medical services?

Finally, where a medical facility has been used to commit acts harmful to the enemy but where subsequently, medical services can be restored, the question arises whether that medical facility could then benefit from renewed specific protection.

Regaining specific protection is desirable from a humanitarian point of view so that the wounded and sick can benefit from the unhindered provision of medical care.*[6]* Moreover, an argument in favour of a temporary rather than a permanent loss of specific protection is that the status of an object during hostilities may change from a civilian object to a military objective, depending on the circumstances prevailing at a given time. Therefore, a hospital may become a military objective for such time as the criteria of a 'military objective' are fulfilled. Subsequently, when these conditions no longer exist, it ceases being a 'military objective' and once again enjoys specific protection from attack.

But does a hospital that is repeatedly used to commit acts harmful to the enemy automatically regain specific protection each time such acts cease? Some argue that at some point, repeated use of a hospital in this way justifies a permanent change of its status to a military objective. Yet, even in such cases, the possibility of regaining specific protection should not be categorically ruled out. On a practical level, however, repeated misuse may erode the trust of the enemy and therefore the specific protection it is obliged to afford. This raises a critical question as to what factual indications the adversary would need to be assured that the hospital will once again be exclusively devoted to medical purposes. Restoring protection may require more than the mere resumption of medical services – it demands rebuilding confidence in the hospital's exclusively humanitarian function, a principle at the heart of IHL.

References

[1] Geneva Convention I for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field,12 August 1949 ("GC 1"), Arts. 19, 21 and 22; Geneva Convention IV relative to the Protection of Civilian Persons in Time of War, 12 August 1949 ("GC IV"), Arts. 18 and 19; Protocol Additional to the Geneva Conventions of 12 August 1949 and relating to the Protection of Victims of International Armed Conflicts (Protocol I), 8 June 1977 ("AP I") Arts. 12 and 13; Protocol Additional to the Geneva Conventions of 12 August 1949 and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), 8 June 1977 ("AP II"), Art. 11; ICRC, Customary IHL Study: *https://ihl-*

databases.icrc.org/en/customary-ihl/rules ("ICRC, Customary IHL Study"), Rule 28 applicable in international and non-international armed conflicts.

[2] Art. 33(2) GCI.

[3] AP I, Art. 12(4); ICRC Commentaries to AP I Art. 12, para. 540; See explanations provided in ICRC Customary IHL Study, Rule 28.

[4] ICRC Updated Commentary (2016) to GC I Art. 21, para. 1840; ICRC Commentary (1987) to Art. 13, AP I, para, 550.

[5] GC I, Art. 21; GC IV, Art. 19; AP I, Art. 13(1); AP II, Art. 11(2); See explanations provided in ICRC Customary IHL Study, Rule 28.

[6] ICRC updated Commentaries (2016) to GC I Art. 21, para. 1856.

See also:

- Khang Phan and Thao Nguyen, *Hospitals under fire: legal and practical challenges to strengthened protection*, March 6, 2025.
- Marnie Lloydd, Caroline Baudot, Peter Herby, and Tobias Ehret, *Protecting essential service personnel is a vital part of humanitarian action*, October 10, 2024.
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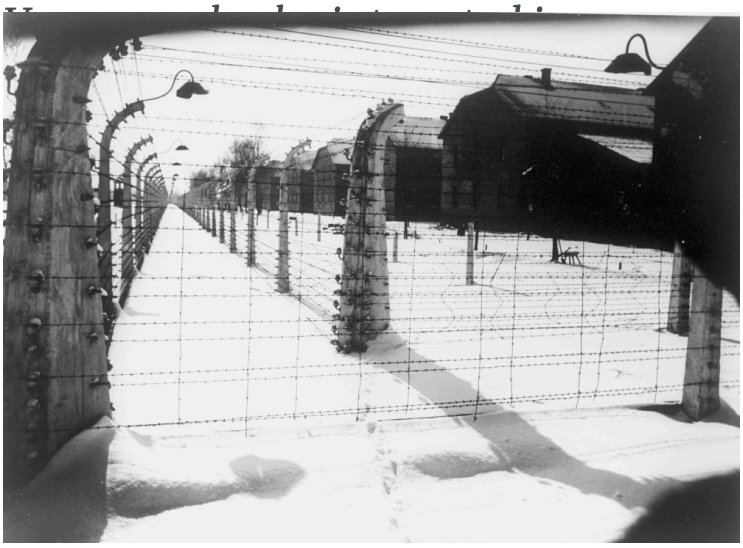

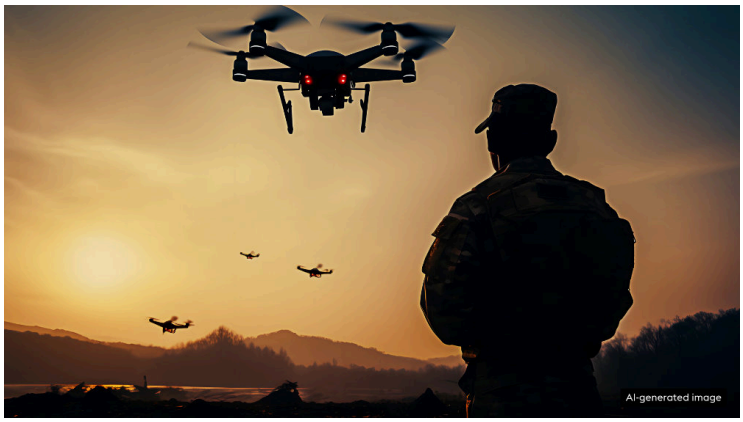

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