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A collective step forward: the outcome document on achieving meaningful protection for hospitals in armed conflict

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Hospitals and other medical facilities enjoy specific protection under international humanitarian law (IHL), yet the reality in contemporary armed conflicts is starkly different. Attacks against health-care facilities, their misuse and impediments to their

functioning continue to put patients and medical personnel at risk and undermine access to essential medical care. Against this backdrop, more than 100 states from all regions came together through the Global IHL Initiative to examine what meaningful protection for medical facilities requires in practice.

In this post, ICRC Legal Advisers Supriya Rao and Alexander Breitegger examine the recently released outcome document on Achieving Meaningful Protection for Medical Facilities in Conflict, resulting from several rounds of consultations with states led by Nigeria, Pakistan, Spain, Uruguay and the ICRC. This piece highlights key parts from the outcome document, including what the specific protection afforded to medical facilities entails, the strict conditions under which that protection may be lost, and the rules that continue to constrain attacks even when it is lost. Drawing on two years of state consultations and expert discussions, it also considers areas of disagreement among states and explains how the positions reflected in the outcome document can help states translate their existing legal obligations into meaningful protection on the ground.

ICRC Humanitarian Law & Policy Blog · A collective step forward: the outcome document on achieving meaningful protection for hospitals in armed conflictHospitals and other medical facilities enjoy one of the highest levels of protection under ir

Hospitals and other medical facilities enjoy one of the highest levels of protection under international humanitarian law (IHL), reflecting their life-saving function and going beyond the protection enjoyed by other civilian objects. Yet there is a widening gap between the protection the law provides and the grim reality on the ground, as attacks against health-care facilities, their misuse and impediments to their functioning continue to take a devastating toll. It was in response to this gap that the protection of medical facilities was chosen as one of the workstreams of the *Global IHL Initiative*.

Led by four co-chairing states – Nigeria, Pakistan, Spain and Uruguay – together with the ICRC, the workstream sought to reaffirm and deepen understanding of the existing IHL rules protecting medical facilities in contemporary armed conflict. It also aimed to identify practical measures, drawing on existing law and good practices from states, to strengthen implementation of those rules. The resulting outcome document, *Achieving Meaningful Protection for Medical Facilities in Conflict*, does not seek to create new law and is not open for endorsement. It reflects five consultations with more than 100 participating states from all regions of the world over 18 months, complemented by two expert workshops bringing together a wealth of experience and expertise.

At a time when hospitals are increasingly targeted or otherwise affected by hostilities, the outcome document provides an important reaffirmation of the specific protection IHL affords medical facilities. It examines what that protection requires in practice and offers states a concrete tool for translating their legal obligations into meaningful protection on the ground. In doing so, it demonstrates that respecting and protecting medical facilities during armed conflict is both possible and essential to fulfilling the fundamental obligation to care for the wounded and sick. It may also contribute to countering narratives and interpretations that portray the IHL rules protecting hospitals as significantly more flexible than they actually are.

The outcome document addresses a number of difficult questions about how these rules apply in practice, like: What does the obligation to respect and protect such facilities require of parties to armed conflict? When can specific protection be lost, and what legal protections remain even then? And how should parties account for the potentially far-reaching consequences of attacks affecting hospitals?

The defining elements of medical facilities

The document recalls the two elements that civilian and military medical facilities must meet under IHL to benefit from specific protection: first, they must be organized for medical purposes; and second, they must be assigned exclusively to medical purposes by a party to the conflict.*[1]*

It is not sufficient that medical facilities are staffed, managed and equipped in terms of being organized to meet medical needs. A competent authority of a party to a conflict must also determine that the facility is intended exclusively for medical purposes as to be assigned exclusively to such purposes.

This ensures the authorities exercise some form of control over either a civilian or military medical facility. For civilian medical facilities other than those belonging to a party to a conflict, IHL also uses the notion of "recognition and authorization".*[2]* These terms do not establish requirements additional to exclusive assignment, but are specific expressions of it.

IHL leaves it to the domestic level to determine the form and process of an assignment, which besides taking the form of a law or decree issued prior to the start of an armed conflict, could also consist of a simple declaration made in the midst of hostilities. This means that an object previously serving a non-medical purpose, such as a school, civilian apartment – or even a tent previously used to store ammunition – can subsequently be assigned exclusively to medical purposes, for example for use as a field hospital or first aid post. Conversely, the intended medical function of a medical facility does not change merely because no wounded and sick people are present at a particular moment, or because displaced people take shelter there out of humanitarian necessity during an armed conflict.*[3]*

Understanding specific protection

The outcome document then turns to what specific protection entails and the practical measures belligerents can take to meet their obligations. In addition to complying with the relevant rules protecting the wounded and sick, medical personnel, and civilian objects, parties to armed conflict must respect and protect hospitals and other medical facilities in all circumstances.*[4]*

The obligation to *respect* requires belligerents not only to refrain from attacking medical facilities, but also otherwise interfering with their medical functions or misusing them for military purposes. The obligation to *protect* requires positive measures, including all feasible measures to facilitate the functioning of medical establishments and protect them from harm, such as looting by third parties.

To give practical effect to these obligations, the outcome document emphasizes the role of targeting processes, explicit orders and training for armed forces in reinforcing the prohibitions against attacking and misusing medical facilities. It also calls on parties to the conflict to identify and regularly update information on the location and capacity of medical facilities, as well as the essential services on which they depend, with a view to ensuring patients' continued access to medical care.

More concretely, as the outcome document explains, the obligation to protect requires parties to the conflict to take all feasible measures to ensure that medical facilities receive adequate medical supplies and equipment, retain access to essential services that are critical to their functioning, such as electricity, fuel and water, and remain accessible to medical personnel and patients. Like the obligation to respect, the obligation to protect rests with both parties to the conflict, not only the party exercising control over the facility. Views to the contrary are difficult to reconcile with the plain language of the relevant treaty provisions, which are addressed to the "parties to the conflict".*[5]*

Even where one party controls the medical facility itself, the opposing party may control supply routes for medicines and equipment, electricity, fuel or water networks, or routes used by patients and medical personnel to reach the facility. Both parties may therefore have a role to play in supporting its continued functioning. This can include securing reliable information on existing supply routes, identifying alternatives where necessary to ensure safe access for medical personnel and patients, and mapping the water, electricity and fuel systems on which medical facilities depend. As a practical means of facilitating these measures, the outcome document proposes establishing coordination platforms between armed forces, health-care providers and relevant authorities.

The outcome document recalls that medical facilities do not lose their specific protection unless they are used by a party to the conflict to commit acts harmful to the enemy outside their humanitarian function (hereinafter "acts harmful to the enemy"). This concept must be interpreted narrowly and in good faith, so that loss of protection remains an extreme exception.

This narrow interpretation is important both to discourage parties from misusing medical facilities to commit acts harmful to the enemy and to guard against overly expansive assessments of what constitutes such an act. The outcome document therefore sets out both the acts treaty law expressly excludes from this category and those identified through state practice.

Importantly, providing treatment or preventive care to combatants in a medical unit, without any adverse distinction, never constitutes an act harmful to the enemy. On the contrary, providing such care is a fundamental humanitarian activity and has been an obligation under IHL since the adoption of the first Geneva Convention in 1864.

During the consultations, states proposed several practical measures in this regard, which are reflected in the outcome document. For instance, the document recommends that military doctrine set out the exceptional circumstances in which a medical facility may lose its specific protection, and that any decision to that effect be taken at the highest level of military command. It also stresses the importance of verifying any allegation that a medical facility is being used to commit acts harmful to the enemy, based on specific information gathered from all credible sources.

Even when an act harmful to the enemy is alleged, the law sets strict conditions that must be met before a medical facility loses its specific protection. Parties are required to issue a warning containing sufficient details and, where appropriate, setting a reasonable time limit for the opposing party to cease an act harmful to the enemy. This type of warning also provides an opportunity to clarify, including through the medical personnel in charge of the facility, that the allegation is unfounded. Where the situation cannot otherwise be resolved, a warning can also provide time for patients to be evacuated, where this is feasible and safe. Only if the warning goes unheeded can specific protection be lost. The warning requirement therefore provides an additional safeguard against attacks and interference with medical functions, reinforcing the comprehensive prohibition of attacks against hospitals under IHL.

The outcome document reaffirms the strict obligation to issue a warning containing sufficient details about the alleged act harmful to the enemy. Generalized allegations that acts harmful to the enemy are being committed do not satisfy the warning requirement, a point that emerged strongly from the state consultations. Most states that expressed a view on this issue supported the understanding that a warning must provide enough detail about the alleged act for those responsible to understand what must be done to stop it. During the expert workshops, concerns were raised that providing such detail could compromise military intelligence sources. These concerns, however, were outweighed by the broader interest in ensuring that an "effective warning" is given, putting the responsible party on notice of the specific act alleged.

As for how warnings should be delivered, several states advocated using direct means of communication, such as phone calls, emails and text messages, followed, where appropriate, by more indirect means, such as public announcements and leaflets. Participating experts cautioned against relying primarily on indirect means, given the confusion and disruption this could cause within the hospital.

The state consultations also addressed who should receive the warning. There was broad agreement that, to be effective, a warning should be directed first and foremost to the party using the facility to commit acts harmful to the enemy, as well as to the relevant health authorities and the medical personnel in charge of the

medical facility. Following this, the opposing party and the relevant authorities should confirm receipt of the warning and that the party issuing the warning verify that it has been heeded.

The outcome document recalls that the loss of specific protection can only be temporary, not permanent. Even a medical facility that has been repeatedly misused regains its specific protection as soon as the act harmful to the enemy ceases, a point highlighted by several states and experts.

In practice, however, repeated misuse may erode the opposing party's trust, making it more difficult to restore confidence in the facility's exclusively medical function. The outcome document stresses the particular importance of the party responsible for the misuse making all reasonable efforts to demonstrate that the facility is no longer being used for military purposes and will henceforth be exclusively used for medical purposes.

Loss of specific protection is not a grant of permission to attack

The outcome document then turns to an important question: what rules apply in the exceptional case that a hospital loses its specific protection? Loss of specific protection does not in itself make a medical facility liable to attack. An attack may only be carried out if the part of the hospital being used to commit acts harmful to the enemy qualifies as a military objective and the rules of proportionality and precautions are respected.

Compliance with the rule of distinction requires that only the part of the hospital being used to commit acts harmful to the enemy be assessed against the two-pronged definition of a military objective set out in Article 52(2) of Additional Protocol I.[6] Where a medical facility consists of several distinct parts, only the smallest distinct part being used to commit hostile acts may qualify as a military objective and become liable to attack, rather than the facility as a whole. This follows from the text of Article 52(2) of Additional Protocol I, which requires that attacks "be limited strictly to military objectives." The remainder of the hospital retains its protection as a civilian object and cannot lawfully be targeted.

The outcome document further emphasizes that a medical facility may qualify as a military objective only if, by virtue of its *use* to commit hostile acts, it makes an effective contribution to the enemy's military action. A hospital's location, nature or purpose, although each is a criterion contained in the first prong of the definition of a military objective, can never be considered to make an effective contribution to military action.

One contrary view was presented during the consultations. In the ICRC's view, however, such an approach would risk undermining the narrow scope of the rule governing loss of specific protection, for several reasons.

First, treaty law identifies the *use* of a medical facility to commit acts harmful to the enemy as the sole criterion for the loss of specific protection. Justifying the loss of protection on other grounds than the "use" would therefore compromise this as a sole criterion.

Secondly, with regard specifically to "location", the requirement that an act harmful to the enemy be committed "outside the humanitarian function" of the medical facility rules out location as a basis for loss of protection. This covers situations in which, for example, a medical facility carrying out its humanitarian function inadvertently happens to be located in a strategically important position where it may block a military advance.[7]

Thirdly, the argument that "purpose", meaning its intended future use, could result in a loss of specific protection cannot be reconciled with treaty law, which looks only to the facility's present use to commit acts harmful to the enemy.

Even where part of a hospital meets the strict conditions for qualification as a military objective, any attack must still comply with the other rules governing the conduct of hostilities. The outcome document examines the principle of proportionality in two situations: where part of a medical facility has lost its specific protection, qualifies as a military objective and becomes liable to attack; and where a medical facility risks being incidentally harmed by an attack directed against another military objective. In both cases, the proportionality assessment must take into account all foreseeable direct and indirect incidental harm expected from the attack.[8]

The outcome document includes the death or injury of wounded and sick combatants within the "direct harm" to be considered in the proportionality assessment. A few states favoured a stricter legal reading, arguing that because the prohibition of disproportionate attacks expressly refers to "loss of *civilian* life and injury to *civilians*", it does not extend to combatants or fighters, even when they are receiving medical care. The consultations, however, showed stronger state support for the position that excluding wounded and sick combatants from the proportionality assessment would be incompatible with the obligation to respect and protect them in all circumstances.[9]

As for "indirect harm", the outcome document finds that, where reasonably foreseeable, this includes the longer-term harm to patients resulting from a hospital's inability to operate, as well as the additional strain placed on the health-care system as a whole. Practical measures for assessing such harm include consulting public-health or medical experts about the expected incidental effects on the medical facility and the broader health system. The assessment should also take into account the overall state of the health system, including the extent to which it has already been degraded or placed under strain by the hostilities.

These discussions underscored the potentially severe consequences of attacking a medical facility. Given the substantial harm that can be expected from such an attack, the outcome document reflects the view that it is difficult to envisage circumstances in which an attack on a medical facility would be lawful under the principle of proportionality.

The outcome document also reaffirms that the principle of precautions must be respected both where a part of a hospital becomes liable to attack and where a hospital risks being incidentally harmed by an attack against a military objective, including where attacks target infrastructure essential to the hospital's functioning, such as electricity, water and fuel lines.[10]

A range of practical measures were proposed to give effect to the principle of precautions, including protecting medical equipment from damage and destruction; paying particular attention to potentially dangerous equipment and biological hazards that could magnify the effects of the attack; and taking account of the interconnected systems on which modern medical facilities depend. Other precautionary measures include preparing contingency plans for disruptions to health services, with clear guidance for safe evacuations. Given the challenges involved in organizing safe evacuations, it was emphasized that they should be undertaken only when necessary to preserve the life and health of patients.

Taken together, these elements reinforce a central point of the outcome document: even in the exceptional case where a medical facility loses its specific protection and becomes liable to attack, the strict application of the rules governing the conduct of hostilities imposes further constraints and significantly limits the circumstances in which such an attack could be lawful.

Finally, the outcome turns to implementation and accountability, recognizing that the protection IHL provides is only meaningful if it is translated into practice and supported by effective accountability mechanisms.

One recurring question during the consultations was whether a neutral intermediary could help address contested claims that a medical facility has been misused or allegations that IHL rules protecting medical services have been violated. In this context, a few states pointed to the mandate of the International Humanitarian Fact Finding Commission (IHFFC), which encompasses both fact-finding and using its good offices to help restore an attitude of respect for IHL. The outcome document mentions the IHFFC among existing neutral and independent mechanisms, as it could help establish the facts in cases of alleged IHL violations affecting medical facilities and present its findings to the parties to the conflict. [11] In particular, it could help establish the facts surrounding allegations of acts harmful to the enemy, including whether a warning was issued and whether it was heeded.

From consultations to meaningful protection

Perhaps the key takeaway from the two-year process that produced the outcome document is a simple but important one: meaningful protection for medical facilities in armed conflict is possible. The consultations have helped clarify what existing IHL requires, including on some of the most difficult questions surrounding the protection of medical facilities. They have also identified practical measures that can help ensure that medical facilities give effect to those obligations and ensure that medical facilities remain sanctuaries protected from the fighting.

The value of this work will ultimately be measured by its implementation. The outcome document provides states and parties to armed conflict with a concrete tool that can help preserve the functioning of medical facilities and strengthen protection for the wounded and sick, medical personnel and others who depend on them. The task now is to put that document into practice.

References

[1] Additional Protocol I ("AP I"), Art. 8(e) and (k) and Art. 12(2), ICRC Customary IHL Study Rule 28.

[2] API, Art. 12(2). Art. 18 of Geneva Convention IV ("GC IV") also envisages "State certificates" for confirming that civilian hospitals are not intended for any acts harmful to the enemy.

[3] Updated ICRC Commentary (2025) to GC IV, Art. 18 paras. 1809-1812.

[4] Geneva Convention I ("GC I"), Art. 19; GC IV, Art. 18; AP I, Art. 12(1); Additional Protocol II ("AP II"), Art. 11(1); ICRC Customary IHL Study Rule 28.

[5] See updated ICRC Commentaries (2016) to GCI, Art. 19 paras. 1798, 1806; Updated ICRC Commentaries (2025) to GCIV, Art. 18 paras. 1793, 1801.

[6] AP I, Art. 52(2); ICRC Customary IHL Study Rules 7-12.

[7] Updated ICRC Commentary (2016) to GC I, Art. 21 para. 1844.

[8] AP I, Art. 51(5)(b) and ICRC Customary IHL Study, Rule 14.

[9] GC I, Art. 24.

[10] AP I, Art. 57(1) and (2); ICRC Customary IHL Study Rules 15-18.

[11] AP I, Art. 90.

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