Leo van Bergen & Françoise Barten (eds.)

Medical Neutrality Revisited
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The relevance of discussing medical neutrality

Violations of medical neutrality are a significant and growing problem. As was stated by Geiger (1996)\(^1\), in the broadest sense violations of medical neutrality have to be considered an assault on public health. The concept of medical neutrality is complex, ill-defined, however frequently-used. It evolved from its initial sense to the meaning set out in the four Geneva Conventions of 1949 and their two Additional Protocols of 1977. Today, it refers to the rights and duties of health workers in situations where human right are endangered or violations of human rights are taken place. This, however, would imply in many circumstances an attitude of active neutrality or solidarity with exposed groups. As the term allows for different interpretations, it continues to be a topic of debate. It should also be recalled that the concept as such does not appear in the humanitarian law in force, and therefore has no legal status. However, various instruments of international humanitarian law protect medical neutrality, defined as the duty of medical personnel to perform their task without discrimination. International humanitarian law on the other hand, does not apply in peacetime or in situations which are sometimes known as situations of internal conflict or as states of emergency without declared conflict.

The Geneva Conventions (1949) and the Additional Protocols (1977) developed guidelines for codes of conduct for - primarily - international armed conflicts i.e. between two or more signing parties (countries). Violations of medical neutrality in so-called low-intensity conflicts between political groups within nations became the norm, rather than the exception in almost every major conflict particularly in the past decade.

However, only a limited number of guidelines apply to non-international armed conflicts within the territory of a signing party, which have become the most prevalent conflicts during the nineties. Also as the Geneva Conventions and Additional Protocols were established well before Alma Ata, and the Primary Health Care strategy, it is not clear what exactly is meant by ‘the medical mission and medical duties’. Is exclusive reference made to the provision of individual curative care (medical care in limited perspective) or does this also encompass the preventive, organisational and promotive aspects of health care?

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\(^1\) Geiger H (1996). Public health expertise in defence of medical neutrality. Medisch Contact, 45;51 (1460-1461)
First Nijmegen Symposium on Medical Neutrality, 28 March 1992

On 28 March 1992 the first Nijmegen Symposium on the Violation of Medical Neutrality was held at the University of Nijmegen (the Netherlands). The purpose of that seminar which was attended by representatives of Dutch development and government organisations, humanitarian aid agencies, the medical profession and solidarity campaigns, was to provide guidelines to different agencies in safeguarding/protecting medical neutrality and to ensure effective opposition against violation of human rights. After introductory readings, round table discussions were organized on the role of the medical profession, development organisations and government policy. This symposium led to the so-called 'Nijmegen Recommendations'.

Second Nijmegen Symposium on Medical Neutrality, 10 May 1995

On 10 May 1996 a second conference on the theme took place at the same university. This symposium was a joint initiative of the Medical committee for El Salvador (the Yamiel Foundation) and the Nijmegen University. The apparent increase of loco-regional armed conflicts and parallel human rights violations had illustrated the existing weak protection of so-called medical neutrality, while the persecution of health professionals for providing medical care and upholding principles of medical ethics, continued to underline the need to establish the rights and obligations of health professionals/health workers in the protection and promotion of human rights. These and the increased frequency and scope of violations of medical neutrality, were the main reasons to reopen the debate in May 1996.

Initiatives to denounce violations of medical neutrality taken by several organisations such as the International Commission of Medical Neutrality, the American Physicians for Human rights, Amnesty International, Human Rights Watch and the Dutch Johannes Wierstichting without any doubt are considered of great significance. However, as these actions are often performed on an 'ad hoc' basis or have a rather incidental basis, the need for a more systematic approach in monitoring violations of medical neutrality, as advocated in the Nijmegen Recommendations, continued to exist.

Even during the preparations of the symposium in February 1995, the Jesuit Refugee Service (JRS) urged the international community and development agencies in general to pay attention to human rights violations and in particular to violations of medical neutrality in the southern zone of Mexico, Chiapas. The military siege and arrival of the Mexican army in the so-called controlled zones by the Zapatista National Liberation Army, had made the provision of humanitarian aid to the
displaced population almost impossible. Recommendations very similar to the Nijmegen Recommendations I were emitted, in which respect for human rights of the entire civilian population were demanded, the re-establishment of free zones, and the possibility for the International Red Cross to enter the zones and provide humanitarian aid to the entire civilian population. It was also argued that the Zapatista National Liberation Army (EZLN) met all the criteria for recognition as a belligerent force according to international law, the Geneva Convention and Additional Protocols were to be observed.

Although violations of medical neutrality tend to appear most clearly during armed conflicts, the organisers of the Second Nijmegen Symposium, considered a definition of medical neutrality which would only refer to the involvement of medical professionals armed conflicts or other types of international interventions such as UN peace-keeping operations as too limited. Therefore, the actual context which is conducive to violation of human rights and the Universal Declaration of Human Rights was taken as a starting point.

In the first chapter the development sociologist Lou Keune, elaborates on the close relationship which exists between the promotion and protection of human rights (including opposition to violations of medical neutrality) and the international development policy as it evolved under the direction of the OECD countries and international institutions such as the World Bank and the International Monetary Fund. A differentiation is made between a narrow approach which limits the application of the concept of medical neutrality to situations of organized armed conflicts between or within countries and a broader definition which includes all situations of human rights (civil and social) on health conditions and health care. International development policy defined to be the whole of policies which influences the conditions of development in ‘developing countries’, is according to Keune co-responsible for the many situations of violation of medical neutrality in the world. With his interesting and original view on the matter Keune makes perfectly clear that what an English lawyer said on the medical neutrality conference of the Johannes Wier Stichting in November 1996, is beside the mark. She argued that she could not define medical neutrality, but she recognized a violation of it when she saw it. Violations however can be invisible and are not always an act of individuals, but can be a result of world order.

After that, Leo van Bergen et al, explore the relevance of the theme medical neutrality. The visible as well as the invisible violations are taken into consideration, the different ways neutrality is defined, as well as the problems coming out of it when put into practice, for instances in cases of the exploitation of humanitarian aid for political purposes.
The existence of two different systems of law, the International Humanitarian Law (IHL) during war time and the Human Rights Law (HR) for peace time, is according to Jose Quiroga of the International Committee on Medical Neutrality simplistic and more inadequate every day, given the type of non-international war prevalent in modern types. The Geneva Conventions are explicitly meant for inter-state conflict and Quiroga therefore argues for an expanded definition of medical neutrality which should cover intra-state struggles and ‘non-declared wars’. The refusal of some states to apply the conventions in situations that are clearly under jurisdiction of the covenant is identified as one of the principal problems in the implementation of IHL.

Willem van Genugten, professor in international law, further elaborates on the implications of the changing characteristics of war in the last decades and focuses on some headlines which should be kept in mind when speaking on the issue from the perspective of international law. Next to the field of international humanitarian law—the Geneva Conventions and the Second Protocol, several other provisions are to be found in international human rights law which also relate to the right to health and adequate health care and are to be applied in times of ‘internal conflict’. Referring to provisions such as the United Nations Convention on Economic, Social and Cultural Rights, the Charter of the United Nations, the Universal Declaration of Human Rights, the Convention on Civil and Political Rights, the Convention on the Elimination of All Forms of Racial Discrimination, the Rights of the Child etc, Van Genugten concludes that the principal problem is not of a legal, standard-setting character, but relates to the political will of states to implement the conventions. Emphasis should therefore be placed on the reinforcement of the existing control mechanisms.

In his proposal Van Genugten skips non-legally binding declarations such as the 1978 WHO/Unicef Declaration of Alma Ata. However, analyzing the issue from a perspective of public health, the Alma Ata Declaration is crucial in defining what is meant by ‘duties and responsibilities of medical personnel’ and /or ‘health care’ as this certainly has been evolved beyond individual curative care since the Primary Health Care strategy was launched in 1978 as a means to achieve ‘Health for All’.

The difficulties between human rights and humanitarian organisations is brought to the fore as well as the friction between civilian and military aid in the following contributions. Military doctor A.J. Van Leusden gives his views on military health care, military humanitarian assistance and relief work. E. Schenkenberg van Mierop and Jose Albizu do the same, but now from the view of civilian aid, in casu Médecins sans Frontières (Netherlands) and Medicos del Mundos (Spain). Interesting is the difference in perspective between those representatives of humanitarian
organisations. While Schenkenberg van Mierop considers 'medical neutrality primarily as a means and not an end in itself and 'a useful principle as long as it serves the purpose of facilitating access', Albizu uses a concrete case-study - the massacre of Xaman, Guatemala - to conclude that 'medical neutrality can be nothing else than the demand that human rights incl. the right to health are respected and protected'.

Finally, E Tarimo of the World Health Organisation (Geneva) after discussing the similarity in overall objectives, relates the discussion on medical neutrality to the 'Health for All' strategy and movement. The implications for medical neutrality when leaving the traditional 'medical model' and accepting a 'Health for All strategy' as starting-point such as proposed in Alma Ata, are discussed. The need for a legal framework - a code of ethics- to enhance health for all is put forward while the roles different social partners should play is analyzed.

This booklet contains the most important recommendations of the Nijmegen II conference, and must be considered as an addition to the Nijmegen I Recommendations. The organizers hope that it will help foster initiatives and programs for monitoring both the observations and reporting of violations of medical neutrality, and the adequate steps to be taken by existing institutions (supervisory committees, governments, international institutions and others to act according to already established norms and responsibilities.

Last but not least, we would like to thank all organisations and individuals, such as Rudy Scholte and Mieke Daalderop, who through their support enabled the organisation of the second Nijmegen Symposium on Medical Neutrality.

Françoise Barten, Nijmegen Institute for International Health
Leo van Bergen, Peace Research Centre
Johan van Hout, Yamillet Foundation

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1 Nijmegen Institute of International Health; Peace Research Centre Nijmegen; Yamillet Foundation; Catholic University of Nijmegen, the Netherlands (KUN); Medical Faculty KUN; MSF the Netherlands; Dutch Red Cross; NCDO; SSMP; KNMG
International Development Policy and Medical Neutrality

The subject of my lecture is the relationship between international development policy and medical neutrality. My central thesis is the following: the international development policy as it has evolved under the direction of the OECD-countries and the international institutions The World Bank and The International Monetary Fund, has caused and still causes situations of violation of medical neutrality.

I do distinguish two definitions of medical neutrality. The narrow definition limits the application of the concept to situations of organized armed conflicts between or within countries. The broad definition includes all situations of human rights (civil and social) on health conditions and health care.

At the same time I depart of two definitions of the concept of development policy. A narrow definition limits itself to programmes and projects of development aid. The broad definition refers to the whole of policies that influences the conditions of development in developing countries. In this contribution I will make use of the broad definition with reference to the development policy as it has evolved since World War II.

I will develop my argument according to the following steps (see annexo):

a. Unequal conditions of development
b. International development policy
c. Unequal development
d. Violation of medical neutrality (broad definition)
e. War
f. Violation of medical neutrality (narrow definition).

International development policy and unequal development

The starting point of the development policy can be found at the end of World War II. Based on, among others, the Universal Declaration of Human Rights, the US president Truman came to the conclusion that the enormous differences between the conditions of development, both internal as international, of the South versus those of the North (see a.) were unacceptable. Starting with his famous Point IV (1947) he formulated the responsibility of the United States and the other rich countries, and of the international institutions like the United Nations, the World Bank (WB) and the International Monetary Fund (IMF) to assist the improvement of the development conditions of the South.
From then on a great number of initiatives were undertaken (see b.). One group of programmes got the label of development aid. When we do apply the broad definition of development assistance as used by the Development Assistance Committee of the OECD, we can see that the total flux of international finance from the north to the south, including the Official Development Aid (ODA), private investments, and public and private loans, had grown up to the level of (gross figure) \( \pm \) US $ 160 billion per annum.

A second group of initiatives refers to the international trade relations. In 1964 the first UN Conference on Trade and Development (UNCTAD) took place. An amazing number of proposals and principles were formulated to arrive into a situation of 'honest trade'. Unfortunately very little has been realized. In fact the most important outcome has been reached outside the UNCTAD. The so called 'liberalization' of world trade has been enforced on the world by the governments of the OECD countries, within the deliberations of the General Agreement on Tariffs and Trade (GATT) and the World Trade Organization (WTO). Liberalization is an important element of the programmes of structural adjustment enforced on many developing countries by the World Bank and the IMF.

In the field of the world monetary system a process of fast and far reaching monetization of the economies of the South has taken place. In concordance with the growing outward orientedness of their economies, the monetization led to monetary crises in many developing countries, and to a dependency of international finance institutions as the IMF. It led also to the so-called dollarization of Latin America and the francization of several African countries.

At the same time a process of 'modernization' of societies (including agriculture, industry and services) was stimulated. This process enforced on the one hand the dominance of new centres of power including the transnational companies, and the marginalization of hundreds of millions of people who had to look for new opportunities in 'natural' areas, in the cities and in the North. At the same time the western model of modernization led to an enormous growth of the levels of produc-
tion and consumption within the North. This resulted in an abuse of environmental resources.

Generally speaking this development policy led to a worsening of the international conditions of development of the South. Some examples:
a. During the eighties the flow of financial resources from the North to the South has been compensated by a growing flow of financial resources from the South to the North (the so-called 'reversed development aid'). This is illustrated by the next graph.
b. The terms of trade of the southern countries (excluding oil producing countries) has deteriorated as illustrated by the second graph.
c. In the case of Central America the combination of the effects of both the financial flows and the terms of trade resulted in a vast lost of resources (see the third graph).

d. According to UNDP the international relations as enforced by the OECD governments led to an overwhelming loss of opportunities as is shown by the fourth graph.

I do not want to take the stand that only negative results of the development efforts can be mentioned (b-*a). E.g. in the medical field there has been an enormous betterment of the conditions, as expressed in for instance the lowering down of the infant mortality rates. We also know of certain regions or countries which have undergone a process of the development of wellbeing of the majority of the people.

Nevertheless and generally speaking one can conclude that the international development policy has contributed to the unequal development (c.) both at the world level as within countries.
a. With respect to poverty UNDP has indicated that the inequality of income is growing. In 1960 the 20% poorest countries possessed 2.3% of world income. This
share has gone down to 1.4% in 1989. The share of the 20% richest countries has grown from 70.2% in 1960 to 82.7% in 1989. The ratio between the income of the 20% richest countries to the 20% poorest changed from 1:30 to 1:60. Comparing the 20% richest people at the world level with the 20% poorest the ratio is 1:150. The total number of people living below the UNDP standards of absolute poverty is still growing, at this moment around 1.4 billion of people.

b. At the same time environmental conditions are in a process of degradation. Several international reports are posing the problem (recently at the UN Habitat-conference) which includes many aspects of daily life (air, water, sewage, biodiversity, land, fishing waters, mining resources, temperature, and so on).

c. Equally the issue of human rights still is a world wide problem. It includes not only civil rights but also social rights like the right of medical care and of decent housing, and the right of children to be free of severe labour and of other forms of abuse.

*International development policy and medical neutrality*

The foregoing paragraph leads to the conclusion that the international development policy resulted in a growing inequality at the world level and within countries. Part of this inequality can be found in the medical sphere (d.). People do experience different health conditions. Among these the possibilities to undergo adequate care of their health and to get access to health facilities are unequal as well. This can be considered as a violation of medical neutrality in the broad sense of the word.

International development policy is equally co-responsible for violations of medical neutrality in cases of armed conflicts (f.). In my work as an investigator I have been observing armed conflicts in three countries: Colombia, Nicaragua and El Salvador (e.). In all these three countries it is very clear that these conflicts do have a concrete socio-economic background. These backgrounds are in a fundamental way determined by the changing international conditions including the international
development policy. In the modern literature on these policy\textsuperscript{1} one can find many data, examples and analyses to develop the thesis that armed conflicts do have international causes, directly or indirectly. Recently Hylke Tromp has posed the issue of the relationship between environmental degradation and armed conflicts. And in general armed conflicts as we know includes violation of medical neutrality (narrow definition).

Some conclusions

My general conclusion is that the international development policy is co-responsible for the many situations of violation of medical neutrality in the world. This has much to do with the character of this policy whereas it is determined basically by very specific interests of the elites in the OECD countries and of many elites in the South. The United Nations have taken several initiatives to pose the world wide problems of human rights, inequality and of environmental degradation. In recent years we have seen the New York Summit on and of children, the rio Summit on environment, the Copenhagen Social Summit, the Beijing Summit on and of women, and the Istanbul Summit on habitat. All these conferences have posed the need to come to a real breakthrough in the international relations. As long as these breakthroughs are not taking place, the international development policy will continue to be part of the problem of violation of medical neutrality.

But there are also positive aspects of this policy. One of them is that at the level of concrete human beings the policy has created new opportunities to establish networks, to pose the problem of the relationship between medical neutrality and international policies, and even to assist in a very concrete way to promote equality and human rights. From my experience with the civil war in El Salvador I know several examples of persons working within international institutions who have helped in saving human rights and lives.\textsuperscript{2} So let us also make a virtue out of a need.

Lou Keune
Development-sociologist, Catholic University Tilburg

\textsuperscript{1} Susan George: The Debt Boomerang

\textsuperscript{2} Lou Keune: Sobrevivimos la guerra
Annexo

a. Unequal Development Conditions

| Interior | Worldwide |

b. International Development Policy

| Aid       | Trade    | Monetary System | Marginalisation | Abuse of Environment |

c. Unequal Development

| Poverty | Environmental Degradation | Degradation of Human Rights |

d. Violations of Medical Neutrality
(broad definition)

| Unequal Rights to Health Care | Unequal access to Health Facilities |

e. War

f. Violations of Medical Neutrality
(Narrow definition)
Relevance of the theme medical neutrality

A short while ago a book was published called Experiments on men. German Physicians in the Nazi-era. Not for the first time as you probably know, the book concerns itself with an extreme version of what is one of the two examples people think about when discussing violations of medical neutrality: doctors forgetting their medical oath. Doctors and nurses who simply refuse to lend a medical hand, or who take the wareffort of their army as guiding principle in stead of medical ethics. The second one concerns acts, mainly committed by military personnel, that make medical help to warvictims impossible, be it sick or wounded soldiers, or sick or wounded civilians. This may happen by taking hostage the sick and wounded and/or the medical personnel or by stopping the supply of medical material.

But even if we do not take these more or less obvious violations into consideration, the term medical neutrality can give the medical men or women a headache, at least those who do not take it for granted and stop to think about its meaning and consequences. Sadly enough it must be said that sometimes it seems as if those who take the term for granted are a vast majority. They use the terms 'a-political' and 'neutral' with ease, but with little explanation, although they are far from simple. The first difficulty in explaining what medical neutrality is, is that it has no legal status. It is mentioned nowhere in the Geneva Conventions, the main legal reference in regulating the lending of help to the sick and wounded. In all it often is viewed as an overall-term that encompasses the right to medical care, the necessity of professional integrity and the inviolability of medical personnel. But with this the difficulties are all but over.

Is neutrality the lending of help to those who need it, knowing that this need is never equal? Is it the lending of help to both sides in the conflict in spite of unequal needs? Is it the lending of help everywhere where access by the military-political authorities is allowed? Is it the refusal of help in places where access is allowed if access is not also allowed in other places? Does the normally accepted necessity of neutrality not hinder thinking about the not always completely individual, but in some, or better: in most cases also political and economical reasons of health-problems and unequal, unjust healthcare?

Maybe the answer to the last question isn’t of great importance if the starting-point of the discussion is the medical model. Doctors and nurses get the sick and wounded patients and try - at least in theory - to help them to the best of their ability, not considering the question why they are sick or wounded. But an answer to this question is of an enormous importance if we step out of the boundaries of the
medical model. What does medical neutrality mean for those who set up healthcare-plans, for those who not try to cure the sick and wounded, but who try to prevent the people from getting sick or wounded in the first place. With this we step on the area of the right to healthcare, or even on the area of the right to health. We know very well that many see this last point in the same way as the right for men to get pregnant: an impossibility. And so it is if seen from an individual point of view and if health is defined as the absence of physical distress. The simple truth is than, that not everybody is as healthy as another. The question however is if, as peace is more than just the absence of war, health is not more than just the absence of illness. The right to education, the right to live in a democratic society etc. etc. could be seen as parts of the right to health. But even if we embrace a purely medical definition, seen from the point of view of areas, peoples, reasons of sickness beyond the sheer individual ones, the right to health gets a meaning. People embracing the right to health or even people only embracing the somewhat more limited but less vague right to healthcare, cannot neglect the question why an individual person belonging to a certain group of peoples or living in a certain area, has a far greater chance of getting sick or wounded than a person belonging to another group or living in another area. Only by determining the causes of the unhealthy situation this situation can be cleared. These causes are political-economic, and therefore they cannot act any differently than taking sides in the political debate. Even if they still embrace the medical neutrality, it surely has not got the meaning of aloofness or non-engagement.

If medical neutrality is defined as lending help according to the need, it is completely incompatible with practice. Precisely those least in need of help are the same that have the most access to it. One individual gets more help than another, even when the need is just as big. This goes for groups in the so-called First World and it even more goes for groups in the Third. In short: healthcare isn’t neutral, not in the sense that everybody gets it and not in the sense that those who are more in need of it also receive more of it. Those who actually believe that medical aid in itself is neutral, also believe that the lending of aid is not a political thing and stands in fact outside the conflict in which the aid is given. This unfortunately is all but true. Aid always has had, has and will have, and especially in times of war or times of severe humanitarian distress, political dimensions and political consequences.

In my view striving towards a more equal distribution of medical care is a sign of medical neutrality. This has to be accompanied by structural activities, activities aimed at making emergency-help superfluous. In this sense the constant pressure that the budget of development-cooperation is under, at least here in the Netherlands, in a time emergency-help is embraced by public, media and therefor politicians, could
be called a violation of medical neutrality as well. Humanitarian emergency-aid is no - or at the most a very short-term - answer to health-problems with a political, military and/or economical background. The popularity of emergency-aid is therefor again a sign of medical partiality. By the way, a not very thoroughly considered popularity because negligence of structural and fundamental healthcare, neglect of attacking the real causes of ill health, for instance as a consequence of IMF-forced budget-cutting, can only lead to more and more so-called humanitarian emergency-aid.

Neutrality also can be seen as the conviction that the person in question himself is indeed acting in a neutral way, or it can be seen as the wish to be seen as acting in a neutral way by the participants in the conflict. This last option for instance is the Red Cross-definition of neutrality in practice. The major advantage of it is that neutrality time and time again has to be proven. Neutrality is not a fixed entity in the 'I am a doctor and therefor I am neutral'-sense. Disadvantage of course is that organizations can be seen as neutral without them actually being so. With this we are on the terrain of humanitarian aid in times of war and/or great humanitarian distress. Also then it turns out that the question of neutrality is a question unjustly raised to little, something Médecins sans Frontières (MsF) tried to do something about, about a year ago.

MsF and the Red Cross

According to MsF the lending of help is useless if justice failed to appear, in casu: the conviction of those that were guilty of making the wounds the doctors had to heal. Neutrality was a guiding principle, but should not get in the way of necessary aid. Neutrality was a means, not a goal. The Red Cross however stuck to neutrality. Without it access, and therefor the lending of help in the first place, was impossible. This however can have the consequence that cooperation is needed with those authorities that were responsible for the wounds that had to be healed. On the other side: the attitude of MsF has already a few times led to a call of doctors for armed intervention. This of course happened in the hope that greater calamity could be prevented, but still the image remains of people trained to ease suffering calling for a situation that surely will cause suffering. Furthermore the Red Cross of course is right when it states that there already are organizations that protest against violations of civil rights, like Amnesty International. But if this should lead up to the conclusion that doctors and nurses should heal in complete silence, remains an open question. Both organizations however agree on one point. Neutral aid has existed and still exists. But is that the case? Has medical-humanitarian aid in common, and
especially during wartime, ever been impartial, neutral, a-political? Moreover: should the question not be if it is possible that medical neutrality is impartial, neutral, a-political, or is this a sheer impossibility? Furthermore nowadays the role of the armed forces has to be taken into consideration, forces who are more and more seen by the public as a humanitarian organization. How neutral are they, now that since the beginning of the new world order soldiers no longer have to keep opposing soldiers at bay, but have to try to prevent conflicts from bursting out into war and giving hungry civilians food and medical care in so-called peace-keeping operations under UN-flag? (There of course is no need to discuss neutrality during enforcing-operations. There simply is no neutrality when engaging in war.)

The Red Cross and neutrality

Medical humanitarian neutrality is always coupled to the Red Cross. However many times, also in the critique of MsF, it is not clear which part of this great and complex organization is meant. The master-organization International Red Cross? The International Committee of the Red Cross (ICRC) in Geneva, existing of only Swiss-countrymen? The Ligue of National Red Cross Societies? A national Red Cross-organization?

At any case the national organizations are not neutral. They have, and certainly in the time when states fought against states, a time that according to MsF was the time of medical neutrality, always kept the national-military urgency more in mind than the international-humanitarian. (See for instance the Bosnian-Serb Red Cross, although not acknowledged, of which the wife of Radovan Karadziz is president.) In fact national organisations were not much more than cheap accessories of the national military health service (MHS). That service as you know is all but neutral. It fights with medical - and if necessary also with non-medical - arms for the victory of the national or allied army. Also when the national societies send an ambulance to battlefields on which their own army did not fight, only in name they were impartial, because they had to join an MHS of one of the countries who were fighting. There has been said that just because of the neutrality-problem of national societies, there are so many different Red Cross-organizations. If one organization fails, another can come in to fill the gap. With other words: the organizations in itself are not neutral, but the entire family of Red Cross-organizations is.

1 Lecture mr. R. Drouen, staff-member International Law Dutch Red Cross, Arnhem, the Netherlands, 15-6-1995
L. V. BERGEN, F. BARTEN, J. V.D. HOUT

As a proof of the perniciousness of neutrality, critics seldom fail to point at the holocaust. It must be said that the days of the holocaust cannot be considered as the Red Cross finest, but the question is if this was (completely) due to the neutrality-philosophy. The complex judicial status of the Jews in Germany and the occupied countries has to be taken into consideration. Also citizens were not yet mentioned in the Geneva Conventions. Furthermore hell had broken loose over the ICRC when it proclaimed an anti-poisongas-proclamation in the spring of 1918. All (!) parties in the conflict latter known as World War I, accused the committee of impartiality.1 Some commentators speak of anti-semitism within the committee, but others wave this away, and not only those who try to plead non-guilty.2 But mainly the political and economical interests of Switzerland, which were profited by German friendship, has to be taken into consideration. (Max Huber, chairman of the ICRC in those dark days, also owned some aluminum-factories, which were of great importance to the German armaments-program.) One can compare it with Switzerland itself. That country wasn’t not attacked because of its neutrality, but because of a number of more down-to-earth reasons, amongst them the presence of the ICRC. A non-occupied Switzerland came in handy for all warring countries.3

Of course all of this does not explain away the attitude of the ICRC - on the contrary we should say - but it does make clear that the neutrality of the ICRC was not the only, not even the most important reason for the ICRC to act the way it did. Therefore the holocaust is not a good argument against it. However it also makes clear - especially the examples of Swiss political and economic importance - that neutrality is far easier said than put into practice, also in the days that battles were fought between states and not in states.

The end of the Cold War, and with that the end of stalemate in the Security Council and the emergence of intrastate wars, made according to MsF an end to neutrality. Personally we believe the chance on more or less neutral medical help has only grown since then, because nowadays the protection of medical workers lies in the hands of UN-soldiers who are in principle no part of the conflict, whereas in the old days protection was given by soldiers of one of the warring parties. But even

1 Leo van Bergen, De zwaargewonden eerst? Het Nederlandsche Roode Kruis en het vraagstuk van oorlog en vrede, Rotterdam 1994, 210
2 Heiner Lichtenstein, Angepfligt und treu ergeben, Keulen 1988, 78, 82, 102, 149; Rapport de la commission d’enquête inquête sur le recours de la Croix-Rouge et autres institutions de l’ordre public, recouvert dans la campagne de guerre de la Croix-Rouge et d’autres institutions de l’ordre public pendant la durée de la dites guerres, Amsterdam 1918, n.p. 109; Jean Claude Favez, Une mission impossible?, Genève 1988, 369
3 Van Bergen, o.c., 387-398, esp. 395; Markus Heiniger, Dreizehn Gründe warum die Schweiz im Zweiten Weltkrieg nicht erobert wurde, Zürich 1989
now strict and by the fighters recognized neutrality seems rather a longing that one calls noble and another rejectable.

More views on neutrality

We already discussed some meanings of neutrality. Let me just add some more. Neutrality can be a principle and in trying to uphold that principle everything that could endanger the neutral status will be left off. But it also can be just an intention. Something that is worthwhile striving for, but may never get in the way off giving help when help is needed. Neutrality can be the outcome of the conviction that in a struggle both parties are to blame and both parties are guilty of atrocities taking place. Not being neutral would mean varnishing over civil rights abuses of one of the parties. But it can also be the result of a strategic weighing that help is only possible by not choosing sides, even if one is personally convinced that one of the sides is most to blame.1

Different meanings and different reasons have an effect on the way neutrality is put into practice, but sadly enough it seems that most organizations, or better: the field-workers of those organizations, have not given this a real thought. They speak of ‘neutrality’ and think further explanation superfluous.

As no other organization the Red Cross (national as well as international) is penetrated with the notion that every action, how small and perhaps unintended, can endanger the neutral status. The consequence of this however is that it chose not, or better: only very seldom, to publicize findings on political, economic and social causes or abuses, let alone put it into the pillory. This would be politics and according to the Red Cross, a mixture of politics and charity is perilous.2

But as said, in contradiction to the Red Cross, for a vast number of NGO-participants - probably even of the Red Cross itself - the neutrality of aid is self-evident, and not only for themselves, but also for those that help is given to. They don’t look at politics, race or believe, but only at hunger, sickness and wounds. This attitude is as well naive as dangerous. Because of the fact that the reasons behind hunger and illness can be very political indeed, it can give political and military leaders an opportunity to misuse the aid given for their own purposes.

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1 We now discuss the period after decolonisation. During the colonial period, the Red Cross, being an instrument of the so-called civilised countries, were a pillar of colonialism and by no means neutral.
Leo van Bergen, Voor onze jongens een sigaar. Een geschiedenis van het Nederlandsch Indisch Roode Kruis, Nijmegen 1993

2 A. van Emde, Het Rode Kruis in de branding, rede juni 1970
A number of things can endanger the neutrality of the doctors and OAS-workers. Firstly: necessary practical action. Aid-programs can and have offered protection to warring parties because military or political targets coincided with targets necessary for the program, such as airfields or roads. Also talking to, cooperation with or protection of OAS's can give political-military authorities an aura of good faith they absolutely do not deserve.

Aid-programs often have become a part of the conflict. Because of them help could be given to the armies of the party in power, for instance by just allowing access if a part of the foodsupplies is handed over, as happened in Bosnia several times. Also the party in power more than ones was in charge of division of supplies. One of the consequences of this activity - that is defended by saying that not allowing this to happen would mean that the victims would get nothing at all - can be a lengthening of the war. As is the case with the military health service, medical or other help of the aid-organizations keeps up the morale and the physical strength of the fighters. Without it armies would not be able to continue the struggle.

Also it can be necessary to compromise with the authorities of that area were help is needed. This necessarily is encompassed with a certain tolerance considering abuses as corruption and distortion. Compromise means discretion. An organization that for putting its program into practice depends on the good will of political and military authorities can and will not make a blunt statement on civil rights affairs very quickly. This again is varnished over by pointing at neutrality.  

Access

It appears that for some NGO's, NGO-members, neutrality has transformed itself from a means to make aid possible into a goal itself. Not the lending of help is the perspective but the wish to be neutral. Something of the kind has happened to the term 'access'. It means bringing food and medical aid to places on both sides of the front, independent of need, only because these places can be reached. Giving aid to places were the need of it is biggest, could endanger neutrality, and with it the activity itself. That in the so-called 'Mohonk-criteria' (criteria for humanitarian assistance, set up by the Task Force on Ethical and Legal Issues in Humanitarian Assistance) as well neutrality as aid in accordance to the need are embraced, is therefore much more easy said than done.  

B, even if party A has more need of it, than this will be seen by party B as a breach of neutrality and as a support to party A.

This is nothing new. Humanitarian organizations formulate fantastic criteria, sometimes with the length of only one word. On Red Cross-evenings for instance, time and again the seven ‘beautiful’ starting-points are mentioned, but without any explanation, without any reference to how difficult they are put into practice at a separate level, let alone in combination with each other. For instance, the ICRC had problems combining ‘neutrality’ with ‘universalism’ between 1933 and 1945, in a time the German daughter turned out to be in love with a guy called A. Hitler. The ICRC chose to uphold universalism and therefor chose for continuing cooperation with an organization led by famous Nazi-doctors like Ernst Grawitz, inventor of the gas-chamber. Not completely surprising therefor that Zyklon-B was transported in cans wearing the Red Cross-insignia.\(^1\)

It seems to me that nobody can be neutral facing genocide. Because humanitarian organizations can not be in favour of mass-murderers, they must be against them. Still this simple consequence is strictly avoided, because taking a stand could endanger the work that could be done.\(^2\) This was the official explanation for the ICRC-standpoint during the Second World War. The holocaust could not be stopped, so silence was the best attitude. If not it would endanger the work that could be undertaken, for instance in favour of the POW’s.\(^3\)

**Politics and charity**

What is a disaster? A disaster is an event which causes many people to die without it seeming to be somebody’s fault. In most cases we therefor speak of a natural disaster. But a storm force twelve in Bangla-Desh is sooner to be called a disaster than storm with the same strength in Western-Europe. The background of a disaster therefor often is not natural, but political and economical. A disaster with a political-economical background is in need of a political-economical solution. Charity cannot offer such a solution. It even can endanger such a solution. Yet charity is used in this way as well by instances of the giving countries as by instances of the receiving countries. Political leaders of receiving countries often state that international aid is a right and local aid a privilege, although it is exactly the other way around. Leaders

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1 Van Bergen, De zwaargewonden eerst? 385, 388-389, 422
2 Humanitarianism unbound, 29-30
3 Van Bergen, o.c., 383-399, esp. 396
of donating countries shift their responsibility for a necessary political solution by pointing at the aid they are already giving.  

The increase of the amount of Western supported aid-activities is the other side of the decreasing interest of the rich in the poor countries. This has for the governments of the rich countries the advantage that humanitarian aid is much more media-friendly than structural, more or less invisible and not very spectacular help. The decrease of structural help is explained away by pointing at charity.

Only a minority thinks about the consequences help has for political, social and economic status quo. Because of constant aid, it is nowadays no exception if in case of a new disaster local communities sit down and wait for help to arrive, in stead of trying to solve the problems themselves. If help stays out for whatever reason, the calamity will be greater than should have been. This is only one of many consequences of massive emergency-help, consequences who are not given the attention by NGO’s they certainly do earn. They are one of the factors, and certainly not the least, who should be considered when planning a new activity. As said: help is politics whether one likes it or not.  

A lot NGO’s do not speak out on human rights violations, implicitly denying the link between those violations and the humanitarian crises they are trying to solve. Help is only possible if politics are avoided. This however is not only a consequence of the political situation in the country where help is given. Condemning civil rights violations, however necessary for reaching a just society it is, can as well officially (for instance in the United Kingdom) as in the eyes of the public, cost the organization is charitable status. This status is literally of great value. Charity brings more money than politics, which brings us to a next term seldom heard in relation to aid, but none the less closely linked with it.

The selfish side of altruism

Help is not only altruistic, but selfish as well. Self-interest of as well governments as NGO’s play an important role. For instance donating countries can improve their foreign relations or connect help to economic orders. Receiving governments can use the aid given to increase their power over the people. Factories can test new or dump old products, and NGO’s can prove their right of existence.

1 Wemos, Noodhulp: noodzakelijk, noodlottig, Nijmegen 1989
2 Humanitarianism unbound, passim
4 Humanitarianism unbound, 10
5 Wemos, Noodhulp
Sometimes NGO-teams go to distant places without clear necessity. The public just wants or expects them to go, or they feel themselves they should go, perhaps only because a competing NGO had gone also. The question: is there anything we can do that can’t be done by local help-organizations or by non-local help-organizations who already have arrived, is not at order. No need to say that the help itself does not get any better by this.

It also has occurred that standard packages are send, without checking first if there is really need of the supplies these packages contain. The cry ‘we have to do something’ is rendered more important than the question ‘what can we do’, a question that surely should have ‘nothing’ as one of the possible answers.

Military humanitarianism?

A lot of the remarks made above also will do for soldiers taking part in so-called peace-keeping operations. Although they are a part of a party that in theory is no part of the conflict and has not chosen sides, that is not to say that their activities, even if they are meant to be neutral, will have a neutral effect or will be seen by the warring parties as neutral. The question we have to ask ourselves is: is a military force suited to give neutral humanitarian aid, a major and amongst the soldiers very popular part of peace-keeping and -building operations. Doubt raises its head.

Some time ago the Dutch general Homan wrote in a national newspaper that whatever the new tasks of the military men would be, a soldier should in the first place always be and always stay a warrior. Although we could not agree with him more, this of course has its consequences for military men acting as suppliers of food and/or medical care. If we look at the motivation of the military force for giving humanitarian aid, we could point at Indonesia during the so-called polititional actions (1947-1949) and at Vietnam twenty years later. Medical work was not done in the first place to ease the suffering, but to win the confidence of the people. Medical work was one of the pillars of the ‘hearts-and-minds’ military strategy. Aid not as a goal, but as a means. This is also the main reason behind the new tasks of the military force. As MsF-cooperator Schenkenberg van Mierop put it some months ago: ‘The decision to start or end a humanitarian activity by the military depends not on the question of need, but on political considerations. It is further-

more very much doubtful if this political short-term dimension coincides with the long-term humanitarian aid-dimension.¹

This was confirmed by a spokesman of the ministry of defence, who pointed out that humanitarian aid was merely an accessory matter for the military force, and that the ministry and the commander in charge, 'always have the freedom to give precisely that humanitarian aid which can be given considering the amount of supplies in accordance with the task he has to fulfil.'² This task mostly will be the keeping of the peace, for which the use of violence can be inevitable. In the giving of aid however the use of force has to be practically zero.

An example of political influence on the humanitarian task is given by the responsibility of the minister of defence for his soldiers. That responsibility mainly contains the safety of his personnel. Therefor that personnel shall be armed always, also when giving humanitarian aid. But, armament has its consequences on the aid given. It will no longer be seen as neutral, or not even as humanitarian. This again has its repercussions on NGO’s cooperating with the military. It is not to be expected that people who, by years of experience, have lost all faith in their ‘own’ army, will from scratch hail armies from other countries.³

Armament has a second effect. Although UN-armies in peace-keeping operations most of the time are not in the possession of heavy armaments, the people of a certain area will expect from them to use all the arms they have, when this area is threatened. Neutrality however forces them most of the time to leave the weapons at rest. Because of this they will not be seen as neutral, but as a pillar of support to the aggressor. The chance something like this will happen to NGO-cooperators is small. They do not carry weapons.

A second remark is that military forces are in general not trained to lend humanitarian aid. The lending of aid however, as well in the long- as in the short term, is a trade that has to be learned and cannot be learned in a couple of days. It is therefor no wonder that every once in a while reports come out throwing a bad light on the way UN-battalions behave.⁴ This can be explained by pointing at the difference in principles, norms and values between the military and a humanitarian organization. Cooperation between these two can therefor hardly not have difficulties as result.

¹ Seminar 'Krijgsman en ontwikkelingswerker: samenwerking of conflict?', Instituut Defensie Leergangen 'Ypenburg', 23-6-1995, 21
² o.c., 26
³ o.c., 30
⁴ As a solution there has been said that a police-force should do the job. They, so is said, do not think about victory, power, humiliation, the enemy.
This has brought MsF to the decision only to work together with the military if it is absolutely necessary.¹

Another problem is that soldiers very often only for a few months visit certain places. This has the very human effect that many of them feel inclined to distribute food, clothes and medicine at that place, without stopping to think about what this means for the neutrality of the rest of the humanitarian program. Several NGO's already have complained about this.² Also the army leaves when its main task is finished or has completely failed. The humanitarian aid-program however is at that time all but finished. It probably just started. Furthermore a failed peace-keeping operation can undo everything that has been done on the humanitarian field up until that moment and destroy all the confidence that was build up. Also the question can be raised in how far the aid-program of the military and of the NGO's are linked. In Bosnia several times a UN-convoy gave part of its food to roadblocks to buy passage. Red Cross-convoy turned around and waited until passage was free for free.³

The yielding of food or other humanitarian stuff by a part of the humanitarian workers has its effect on the way the humanitarian aid of all is seen. If one of the aid-agencies - be it UN, be it an NGO - undertakes actions that a part of the local inhabitants not see as neutral, the chance is fairly great that all the humanitarian aid will not be seen as neutral anymore. That this has consequences on the aid itself is evident.

Finishing this item we have to point out a factor that goes for all humanitarian aid-workers, but for soldiers in an even greater measure, because the sending out off soldiers is much costlier.⁴ These costs have to be brought up by the tax-payer. Even if help in itself is neutral, than still the question remains where help is given and were help is not given - an unavoidable choice and a choice evidently not neutral. The answer to it depends on a lot of factors and humanitarian need is only one of them. Cynics - or realists? - even say it isn't among the important ones. Geographical circumstances, economic importance, press-interest, political role in the world etc etc, stipulate that choice as much or even more.⁵

In short: an army still is a fighting-machine. Very much suited for what is now called peace-enforcing, but what used to be called war. Less suited however for the

¹ Seminar IDL., 24
² Conversation L. van Bergen with R. Drouen, 15-6-1995
³ o.c.
⁴ Seminar IDL., 35
⁵ Leo van Bergen (red.), *Pacifisme en interventie*, Delft 1994
humanitarian aid-activities for which it is frequently used nowadays and with which it tries to gain goodwill and right of existence.

**Human rights and humanitarianism**

The use of the term 'neutrality' to prevent having to take a standpoint against civil rights violations encompasses in the view of civil rights organizations such as African Rights an abuse of that term. To them the word 'neutrality' has become a loincloth behind which aid-organizations try to hide their lack of responsibility and their lack of aid in accordance to need.¹

Contrary to this view on neutrality - the refusal to take a political stand, with the legitimation of civil rights violations as a consequence - civil rights organizations use a juridical form of neutrality: inditing those who committed civil rights violations not considering the party this person belonged to. The neutrality of silence against the neutrality of speaking, but speaking always and everywhere.

This clearly indicates a major difference between humanitarian and civil rights organizations. The first one sees the lending of help as its principal guideline. The second one legal justice. The question is if on the long term one can do without the other. Will help continue to be accepted if it means that those guilty of the disaster or war that made help necessary, will not be convicted for this? From the other side, it is equally true that civil rights-neutrality can damage the lending of aid, certainly at short notice. The opinion that the two can go together quite easily can have as a consequence that none of them become practice.

**Recapitulation and closing remarks**

Medical neutrality could be considered a right and can therefore be violated. Although the term is not mentioned in the Geneva Conventions or any other universal declaration, and therefore has no legal status, one could denounce violations of the Geneva Conventions, the additional protocols, the Alma Ata declaration on Primary Healthcare, the universal declaration of human rights and the International Covenant on Economic, Social and Cultural Rights - when concerning 'medical situations' - as a violation of medical neutrality. In fact, that is what we're doing. This however, does not clarify the concept of medical neutrality, neither gives it a legal status. In order to be able to denounce certain violations of whatever

¹ Humanitarianism unbound?, 25
universal or internationally accepted covenants or declarations as real violations of medical neutrality, we should come up with a clear-cut definition. We have up to now discussed some problems concerning the concept of (what is and what isn’t) medical neutrality. We’ve also seen some practical examples of how and why it is difficult to decide whether to denounce certain violations or not. In order to establish guidelines for these situations, it could be helpful to divide the concept of medical neutrality (and with that the type of situation in which violations can occur).

First the type of violations of medical neutrality as violations of the Geneva Conventions and the Additional Protocols. The rights and duties of healthworkers, military personnel and civilians are well described in these conventions. Because of the fact that the conventions were drawn up in 1949 and the additional protocols in 1977, one can imagine that an up-date is necessary. First of all the types of conflicts have changed (from inter- to intrastate wars), secondly the ideas about health and healthcare have developed (certainly after the Alma Ata Declaration of 1978). If we could establish new guidelines to add to these conventions and protocols in order to ‘up-date’ them, part of what we think is medical neutrality would be formalized and therefore more clear. Violations of this part of medical neutrality could be seen as violations of the protection of healthworkers and civilians in times of conflict.

Secondly, the type of violations of medical neutrality as the violation of a basic human right to health or healthcare. These rights may not have as much a legal status as the Geneva Conventions, but no-one will deny the existence of those rights as described in the Universal Declarations of Human Rights and the International Covenant on Economic, Social and Cultural Rights. These rights can be violated as we know, and when applied to ‘medical situations’ we could speak of violations of medical neutrality. Here we don’t even need to ‘up-date’ the declaration or covenant: they’re quite clear as they are. What we do need to do however is to include these Declarations and Covenants into the discussion on violations of medical neutrality.

Thirdly, the type of violations of medical neutrality as the violations of what is agreed upon in the Alma Ata declaration of 1978. This would include violations against health development policies and healthworkers implementing the PHC strategy. Also this declaration is quite clear in itself, but has to be incorporated in the discussion on violations of medical neutrality.

Combining all three of the above mentioned types of (violations of) medical neutrality, we could come to a more clear-cut definition. This definition would embody those articles of all declarations, conventions, protocols and covenants internationally agreed upon which deal with health, health development, healthcare, healthworkers and armed conflicts, as well as an up-date on those parts which are
clearly outdated. The rights and duties regarding health in time of armed conflict could then be clearly outlined and violations of these rights and duties identified.

Medical neutrality, or medical impartiality or whatever better term one could invent, is nothing new. All the ingredients are there, but scattered around in various declarations and therefore lacking recognition. Ones given recognition or status, medical neutrality could become enforceable. This would imply, however, not only a set of rules, rights and duties defining medical neutrality, but also guidelines as to the implementation and control of it, as well as guidelines for denouncing and 'persecuting' violations of it.

In setting up new rules and guidelines for monitoring and detecting violations of medical neutrality, a few things have to be taken into consideration:

I: The term medical neutrality should either be replaced by another, better and broader term, or itself be interpreted in a broader way, so that healthworkers in a broad sense of the word come under the protection of the term and that also the hindering of their work will become a violation of medical neutrality.

II: The tendency that structural, long-term aid - aid put into practice to get health and healthcare of an area on a higher level on a structural basis - is constantly put under pressure, should be seen as a violation of medical neutrality. Certainly if this goes hand in hand with an increase of emergency-help popularity, emergency help that out of principal cannot be a political, economical, long term-solution for the problems that are tried to be solved.

III: According to MsF the time in which medical-humanitarian help could be offered in a neutral way is over. According to the several sections of the Red Cross-movement however neutrality still should be the guideline. Unless neutrality is defined as 'the parties saw us as neutral', the age of neutrality however never existed, and the question is if it ever will exist, even if neutrality stays the underlying principle.

IV: The lending of help, medical or otherwise, by NGO's or military forces, always and everywhere means making choices. Never, not in times of peace let alone in times of war, those choices will be free of political influence and consequence. Also they will always have consequences that hardly can be called neutral, even if the help was meant to be neutral, and even if everybody had tried its best to put it into practice in a neutral way.

V: As a consequence of own propaganda or press-coverage, aid-organizations have got an aura of goodness. As a consequence every criticism leads to spite. 'They mean well, so don't mock them'. However criticism is necessary and insurmountable if aid-organizations will keep on playing - or will be playing - the positive role in the world they play according to the existing image.
VI: Aid-organizations are not unlike other organizations. They have a goal and use certain means to get to that goal. Neither goal nor means are beyond criticism. Both have their positive, but also their negative sides. The way of the Red Cross has its disadvantages, but so has the way of MsF. Also juridical justice has its flaws, and speaking out surely will not always be superior to silence. Simply admitting all the dilemma’s discussed above, like the impossibility of help without political influence or consequences, would, if not on the short term, surely on the long term, be a major step in the right, the just direction, as well for the aid-organizations as for the victims.

Leo van Bergen, Peace Research Centre Nijmegen
Françoise Barten, Nijmegen Institute for International Health
Johan v.d. Hout, Yamillet Tilburg
Humanitarian Practice in Time of War

**International Humanitarian Law and Human Rights Law**

In general, the ideal situation should be to have a group of laws and covenants that protect human rights under all circumstances from international wars, non-international wars, to peace time. In actuality there are two systems of law: the International Humanitarian Law (IHL) in war time, and the Human Rights Law (HR) in peace time. This simplistic distinction does not apply to real life in the contemporary post World War II world.

International Humanitarian Law has a long historical background that began in Europe in the later seventeenth century and continued to the twentieth century. IHL originated in the war among nations and the necessity to avoid unnecessary suffering and to avoid disproportionate use of force. It has focused in the reciprocal protection of certain groups of people.

The concept of human rights began also in Europe at the end of the seventeenth century. The English Bill of Rights in 1689, the French Declaration of the Rights of Man in 1789, and the United States Constitution 1778 form the legal foundation. Modern human rights law has a more recent background, as it emerged in response to the atrocities of the Second World War. Their basic premise has been humanitarian principles.

We are witnessing a growing intersection between the laws of the war and human rights laws. The common Article 3 that applies to all conflicts not covered by the international covenant is a summary of the minimum non-derogable human rights in time of war:

**Article 3. (I)**

In the case of armed conflict not of an international character, . . . the party to the conflict shall be bounded to apply, as a minimum, . . . Persons taking not active part in the hostilities, including members of the armed forces who have laid down their arms and those placed hors of combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any similar criteria.

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To this end, the following acts are and shall be remain prohibited at any time in any place whatsoever with respect to the above-mentioned person:

a) violence to life in particular murder of all kinds, mutilation, cruel treatment, and torture.

b) taking hostage;

c) outrages upon personal dignity, in particular humiliating and degrading treatment.

d) ...executions without previous judgment.¹

The article 75 of Additional Protocols I and the articles 4 and 6 of the Protocol II also contain concepts of the HRL.

A similar growing intersection is observed in the implementation of these two systems of laws in contemporary situations.

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<thead>
<tr>
<th>During international war</th>
<th>International Humanitarian law</th>
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<tr>
<td>Severe internal war or struggles</td>
<td>Protocol II or Article 3 and Human Rights Law</td>
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<tr>
<td>Minor internal violence</td>
<td>Human Rights Law</td>
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<tr>
<td>Peacetime</td>
<td>Human Rights Law</td>
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The Physician has the obligation to give medical care in those different situations.

During international war, severe civil war, or severe internal struggles, IHL is applicable. IHL protects the victims of armed conflicts and the personnel responsible for taking care of them. Medical ethics in wartime is the same as in peacetime, but medical care under these conditions must be neutral and impartial in accordance with IHL.²

Of importance during peacetime or minor internal violence are: Article 25 of the Universal Declaration of Human Rights and the Article 12 of the International Covenant on Economic, Social and Cultural Rights. They establish the right to an adequate standard of living and medical care. Those 129 States that ratified the Covenant on Economic Social and Cultural Rights have the responsibility to provide this care in accordance with the resources of each State. The medical care is given under the national health care system of the country.³

JOSE QUIROGA

More countries have ratified either the Geneva Convention (most states are parties), the International Covenant on Civil and Political Rights (127 states are parties), or the International Covenant on Economic, Social and Cultural Rights (129 states are parties).

Concept of Medical Neutrality

The experience of horrors of the two major European battles Magenta and Solferino in 1859 forced Emperors Franz Joseph and Napoleon III to sign rapidly an armistice to finish the war. The suffering caused by these battles inspired Henry Dunant to create the International Red Cross Society, in order to diminish the suffering of wounded combatants in future wars. The International Red Cross was instrumental in calling the first Geneva International Conference of October of 1863. This conference approved the First Geneva Convention for the protection and care of the sick and wounded in war in 1864. The aims of the Convention were to alleviate the human suffering, and the protection of life and health in time of armed conflicts. The draft convention submitted to the conference by the Geneva Committee was adopted without mayor changes. The main objectives of the convention were:

- Relief of the wounded without any distinction as to nationality.
- Neutrality (inviolability) of medical personnel and medical establishment and units.
- The distinctive sign of the red cross on a white ground.

The concept of neutrality permeated all the convention and its definition was clearly stated.

...
In time of war the belligerent nations should proclaim the neutrality of ambulances and military hospitals, and that neutrality should likewise be recognized fully and absolutely, in respect of official medical personnel, voluntary medical personnel, inhabitants of the country who go to the relief of the wounded, and the wounded themselves.¹

The conference adopted the following definition in its Article 1, 2 and 5.

1. Ambulances and military hospitals shall be recognized as neutral, and as such, protected and respected by the belligerents as long they accommodate wounded and sick. Neutrality shall end if the said ambulance or hospitals should be held by a military force.
2. Hospital and ambulance personnel, including the quarter-master’s staff, the medical, administrative and transport services, and the chaplains, shall have the benefits of the same neutrality when on duty, and while there remain any wounded to be brought in or assisted. (...)
5. Inhabitants of the country who bring help to the wounded shall be respected and shall remain free. Generals of the belligerent powers shall make it their duty to notify the inhabitants of the appeal made to their humanity, and of the neutrality which humane conduct will confer.²

The word neutrality was used in four of only ten articles. It was omitted in the following Geneva conventions: 1906, 1929, and the four conventions and two additional protocols now in force dated August 12, 1949. In spite of the omission the concept of Medical Neutrality has remained.

In recent conventions the definition of protected persons has been more clearly specified. ‘Wounded’ and ‘sick’ mean military or civilian persons in need of medical care and who refrain from any act of hostility. All wounded sick and shipwrecked, to whichever party they belong, shall be respected and protected.

‘Medical personnel’ means all members of a medical unit as long as they are part of the medical services or assigned by one of the parties in conflict. The medical personnel must be neutral in fulfilling their obligations to the wounded and sick. Medical personnel, medical transportation, and medical units must be respected and protected in order to carry out the task to which they are assigned.

Restricted Definition of Medical Neutrality

Medical Neutrality is a concept meaning that during war the wounded and sick and shipwrecked persons, prisoners of war, and civilians exposed to the consequences of an armed conflict are protected by the provisions of IHL. The medical personnel, medical transportation and medical units assigned to one of the parties in conflict are also protected provided that they are clearly identified and remain neutral. (emphasis added)

Implementation of Geneva Conventions

The implementation of the four Geneva Conventions (GC) was entrusted to the Protecting Powers (PP) in the common articles 8/8/8/9. This is an old legal mechanism used by the states to protect their interests when another party becomes a temporary enemy. The countries in conflict name other countries to remain in communications with the enemy. As a mechanism to implement the Geneva Conventions this system is a failure.

The art. 9 of the convention states that ‘the International Committee of the Red Cross (ICRC) or any other impartial humanitarian organization may, subject to the consent of the parties to the conflict concerned, undertake for the protection of wounded and sick’. The protecting powers can also delegate in the ICRC ‘the humanitarian duties incumbent to the PP’.

To fulfil its obligation with the IHL, the ICRC has adopted four basic principles in their work: impartiality, neutrality, humanity, and independence. The first two are required by the GC.

- Neutrality means that the organizations do not take sides in the conflicts or controversies connected with them.
- Impartiality means that the care is done without discrimination of nationality, race, religious beliefs, social class, or political opinions, and the gravity of the case is the only factor determining the prioritization of medical care.
- Humanity means to succour, assist and protect victims in times of armed conflict.
- Independence means that the organization is free of the influence of any government.

The ICRC has made a remarkable contribution in defining the IHL and protecting the wounded, sick, prisoner of wars, and civilians in time of war. The services of...
the ICRC have been accepted and respected by most countries in war in modern times. The discretion and confidentiality demanded by ICRC’s work with governments in conflict have created problems in the new type of non-international wars, where the work of the ICRC is criticized by the forces opposing the government.

*Limits to the Applicability of the IHL*

Need of an Expanded Definition of Medical Neutrality.

Many international struggles can reach such magnitude that they become equivalent to an international war in the number of combatants, gun power, and numbers of war casualties. In spite of that the IHL is not applicable because the threshold of applicability was left purposely high.

Additional Protocol 2 (1977) applies only to armed conflicts which take place in the territory of an HCP between its armed forces and dissident armed forces or other organized army groups which, under responsible command, exercise such control over a part of its territory as to enable them to carry out sustained and concerted military operations and to implement this Protocol.¹

A dissident group needs a prolonged struggle to satisfy those territorial control requirements. Even if this threshold is achieved it needs to be ratified or acceded by a HCP. The affected government never recognizes this situation as has happened with the government of France in Algeria, with the FMLN in El Salvador.

Changes in the characteristics of war in the last four decades have been faster than the possibilities of change in the IHL that follow, a slow process always behind the real world. The ideal would be to have only one covenant which covers all types of armed conflicts, from international to non-international.

If we assume that IHL has been widely accepted,² as has been International Customary Law,³ and Medical Ethics,⁴ then we should agree that in any war the parties should follow at least the spirit of the IHL. For the purpose of monitoring violations, we should follow an expanded definition of Medical Neutrality applicable

¹ ICRC, Prot. 1977
² ICRC, Gen. Conv. 1949
³ Burgenthal, Harold, Public. Int. Law
⁴ Amnesty International, *Ethical Codes and Declarations Relevant to the Health Professions*, 1994 (3) (A.L. Publication)
in any internal conflict that should include: all medical personnel and volunteers providing medical care in the area of war, that respect medical ethics, and who are neutral, should theoretically receive the same protection. Human Rights Organizations (HRO) and Non Governmental Organisations (NGO) should document and report those violations to build a public consensus of the need to modify the IHL.

**Sovereignty and Humanitarian Assistance**

Since the Second World War an increased number of states have been confronting ethnic and religious strife, and socio-economic problems. At the same time we have observed an increase in the number of revolutionary struggles, civil wars, and insurrections. They have in common that they have been non-declared wars, and that most of them have been internal, rather than between states. These conflicts have originated the anti-colonial wars of 1950-1960, the national liberation struggles, and more recently the secession wars.¹

Since the collapse of the Soviet Union ethnic and regional tensions have erupted. Different secession movements have divided the Soviet Union in 15 different countries, and Czechoslovakia in two, the Czech Republic and Slovakia. Yugoslavia after the death of Tito suffered an identity crisis. A regressive, aggressive nationalism that promoted hatred and homogeneous national communities has produced the most violent war in Europe since 1945. The Balkan war was characterized by grave breaches of the IHL: concentration camps, mass executions, mass rapes, forced expulsions of civilian populations (e.g. ethnic cleansing), indiscriminate bombardment of civilian populations, and siege of civilian population with suspension of water, electricity, food.

IHL has many weaknesses that are more evident with the new type of warfare. The IHL was conceived initially as an interstate law, made by the states, to protect their interests and sovereignty. One of the principal problems in the implementation of the IHL has been the refusal of some states to apply the conventions in situations that are clearly under jurisdiction of the covenant.

In addition, one of the principal difficulties in the implementation of human rights law in war time has been the problem of derogation. The article 4 of the Covenant on Civil and Political Rights accepts the derogation of Human Rights in time of public emergencies which threaten the life of the nation as happens during war or internal conflicts.²

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² Meron, o.c.
Repressive governments in time of internal struggles declare constitutional states of emergency that permit them to apply the article 4. This conditions can be extended for years as happen in Chile and Argentina during their military dictatorships. The government establishes a system of repression and terror against opposition groups using threats, arbitrary detentions, torture, and political killing.

In recent years we have observed situations during serious internal struggles or wars where the government refused to apply the IHL, even the common Article 3. At the same time, it suspends the application of Human Rights Law using the derogation Article 4. In these circumstances the target population subject to repression is completely unprotected.

The increase in numbers of countries suffering from internal violence among ethnic, religious, political groups looking for power has produced a mass of refugees and internally displaced people. 'The largest refugee population in the last 30 years has come from Afghanistan, Vietnam, Cambodia, the North Horn of Africa, Angola, Mozambique that were exacerbated by superpower involvement'. The number of refugees has grown from 1.4 million in 1960 to 18.2 million in 1992. In addition the UNHCR estimated the number of internally displaced people to be more than 24 million. This massive flow of refugees presents a significant threat to international peace and security. The refugee population is in need of international protection.

UNHCR:

Refugee problems left unresolved are not only a affront to humane values; they are also feed back into the dangerous cycle of violent conflict and further displacement.

The United Nations have a tradition of respecting the sovereignty of the member states. Humanitarian assistance is provided with the consent of the affected country, or because of an appeal by that country. The right of sovereignty is not an acceptable argument to oppose urgent humanitarian relief in time of war. When those needs are acute, numerous NGO's have felt the need and moral obligation to act and to give the necessary relief without waiting for governments permission. These humanitarian activities in behalf of one side of the conflict could be seen as an hostile actions by the other side.

We are facing the possibility of forced humanitarian assistance in cases of gross violations of HRL or EL in protection of persecuted groups. This possibility has

2 o.c.
3 o.c.
been tested in two recent situations approved by the United Nations (UN). The UN Security Council set a precedent when passed the resolution 688 (1991) which authorized members states to deliver assistance to the Kurds by whatever means necessary. The Operation Provide Comfort has given humanitarian assistance to the Kurds without consideration of the wishes of the Iraqi government. Operation Restore Hope provided food and medical relieve to a starving population in Sudan as consequence of a civil war. In the former situation Sudan did not have a central government. These actions have created a precedent for future actions and received wide public support.

**Monitoring Violations of Medical Neutrality**

There is no organization that systematically collects information on violations of the IHL. Data are very incomplete and there is a lack of uniformity across the different organizations that have collected them. Data on violations of the Medical Neutrality are even more scarce.

There is no standard methodology in existence that includes specific categories of violations, that includes standard definitions of the categories, that includes the type of information to be collected in each category, and that includes a standard event and victim format to report the facts to a central office.

Reports on violations must include a detailed description of the event, geographical area, date and hour of the event, number of victims, victim characteristics, witnesses, supporting documents, role of the authorities, and source of information. When possible the report should include a detailed description of the characteristics of the victims.

A field office in the area of the war should collect this information and investigate each report. The information should be sent to a central office for collection, statistical analysis, and political analysis. A report should be sent to different locations and international organizations as well as any mass media interested.

Most violations of human rights and Human Rights Law clearly occur in a pattern as part of political or war strategies by the parties in the conflict. There are several ways to demonstrate that such abuses are in fact political rather than individual aberrations. One is the failure to eliminate the practice or investigate and prosecute the perpetrator. Another is the demonstration of patterns by numbers and

1 Andreopoulos, The age
2 Reiter et al., Guidelines
trends over time. It is for this reason that documenting cases is important to ascertain number of cases and events.\(^1\)

The International Committee on Medical Neutrality (ICMN) has been working to develop a methodology based on our experience in El Salvador. We have developed a group of categories and definitions. Because this experience was gained in a non-international war, we are now collecting information on the Balkan war. We hope to be able to complete this experience soon and elaborate on some methodology and produce a training manual to be used by any HRO interested.\(^2\)

*Violations of the IHL, Medical Neutrality, and Impunity*

In addition to the problem of applicability of the IHL in non-international conflicts and the lack of monitoring of the systematic violations of the parties in conflict, we also have the problem of impunity. Violations of the IHL and Medical Neutrality are under-reported. In the few cases that are known the government has rarely punished the violators. An exception was the prosecution of US army officer William Calley in 1971 for the killing of innocent civilians in the village of My Lai (Vietnam) in 1968.

Nuremberg and Tokyo prosecution were the case of victors administering justice to defeated German and Japanese war-criminals.

We have some hope that in the future New World Order the community of nations will be more willing to punish the grave breaches of the IHL. The Inter American Commission on Human Rights of the Organization of American States (OAS) has since 1960 inquired into many aspects of human rights violations during military dictatorship. The Security Council by resolution 780 (1992) appointed a Commission of Experts to Investigate grave breaches of the GCS in Yugoslavia. Despite the fact that some conflicts were internal the commission decided to apply the IHL. Later the Security Council by resolution 827 (1993) approved the nomination of an International Tribunal to prosecute persons responsible for serious violations of IHL.\(^3\) We will see what happens.

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1. Quiroga et al., Surveillance
2. Devin, o.c.; ICRC, Gen. Conv. 1949; ICRC, Prot. 1977; ICRC, Basic Rules; Kennedy et al., The Laws of War; Meron, o.c.; Quiroga, et al., Surveillance; Quiroga, et al., Methodology
3. Reisman et al., o.c.
Conclusions

The IHL is more inadequate every day for the type of non-international war prevalent in modern time and also ineffective because the parties in war do not have interest in its application in the conflict.

Medical Neutrality is a concept to be used only in cases of international or non-international wars where the IHL is applied. The Right to Health is the concept used during peacetime.

Violations of Medical Neutrality are a significant and growing problem. This has been especially evident in the Balkan war. There is no organization monitoring these violations systematically. Monitoring should be an important part of the work of human rights organizations. It is necessary to develop a methodology to monitor violations in the field. The ICMN has been working on the subject and will soon have a draft to be tested.

Jose Quiroga
International Committee on Medical Neutrality
Legal protection of medical aid during intra-state conflicts

The organizers of this meeting asked me to speak on 'Legal protection of medical aid during intra-state conflicts', the audience mainly consisting of non-lawyers. I therefore will skip some legal technicalities, and concentrate on a few headlines which should be kept in mind when speaking on this issue from the perspective of international law.

An Agenda for Peace

The issue consists of two components:
1) offering legal protection to medical personnel,
2) in conflicts which for a long time have said to belong to the internal affairs of states.

To start with the second element, let me quote Boutros-Boutros Ghali’s ‘An Agenda for Peace’, where it says that

so many of today’s conflicts are within rather than between States. The end of the cold war removed constraints that had inhibited conflict in the former Soviet Union and elsewhere. As a result there has been a rash of wars within newly independent States, often of a religious or ethnic character and often involving unusual violence and cruelty. The end of the cold war seems also to have contributed to an outbreak of such wars in Africa. In addition, some of the proxy wars fuelled by the cold war within States remain unresolved. Inter-State wars, by contrast, have become infrequent.

Although one can discuss the relation between the end of the Cold War and the existence of a growing number of intra-state conflicts, it is for sure that in the 90’s we have seen only a few international conflicts, while almost all of the conflicts are of an intra-state (or mixed) character. It doesn’t have to be discussed here in detail. What counts is the general picture.

Geneva Conventions 1949

How about the legal protection of medical personnel, being active during armed conflicts? Let me start by making some general remarks, not especially related to the protection in times of intra-state conflicts. The main legal source in this field, of course - the four Geneva Conventions of 1949. The Conventions are of paramount importance for the protection of medical assistance/workers during conflicts, although the concept of ‘medical neutrality’ is not defined (which, however, in practice to my mind is no problem).

Looking at the Conventions, however, we have to take care of the fact that they are explicitly meant for inter-State conflicts: see especially the common article 2, saying that the Conventions are applicable ‘to all cases of declared war or of any other armed conflict between two or more of the High Contracting Parties’. But how about the applicability of the Geneva Conventions in non-international - internal, intra-state - conflicts? We then first of all have to concentrate on the Common article 3 of the Geneva Conventions. It reads:

In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions:

1) Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria. To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to above mentioned persons:
(a) violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
(b) taking of hostages;
(c) outrages upon personal dignity, in particular humiliating and degrading treatment;
(d) the passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court, affording all the judicial guarantees which are recognized as indispensable by civilized peoples.

2) The wounded and sick shall be collected and cared for. An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict. The Parties to the conflict should further endeavour to bring into force, by means of special agreements, all or part of the other provisions of the present Convention.
The application of the preceding provisions shall not affect the legal status of the Parties to the conflict.

I would like to underline three elements:
- the article explicitly concentrates on conflicts 'not of an international character', and 'orders' states as well as non-state parties to the conflict to apply a series of provisions;
- the article speaks in terms of minimum standards, but what has been formulated as 'a minimum' is as such not inconsiderable;
- the article says that 'the wounded and sick shall be collected and cared for' and that 'an impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict' (emphasis added).

Article 3 of the Geneva Conventions can serve as a basis for legal protection of the medical personnel during intra-state conflict. At the same time, however, the article is legally speaking not without problems. So it says, as we saw, that the provisions of the article 'shall not affect the legal status of the parties to the conflict', which in the past raised problems as to the sovereignty of states in relation to liberation movements, and so on. Nevertheless article 3 at least can be seen as the beginning of an obligation to protect medical personnel being active during internal conflicts.

Second protocol 1977

Next to the common article 3 we have to look at the Second Protocol to the Geneva Conventions (1977), related to the protection of victims of non-international armed conflicts. The Protocol is to be seen as an elaboration on article 3 of the 1949 Conventions, especially the role of non-state actors.

So Protocol II, article 1 speaks in terms of conflicts which take place

in the territory of A High Contracting Party between its armed forces and dissident armed forces or other organized groups which, under responsible command, exercise such control over a part of its territory as to enable them to carry out sustained and concerted military operations (...).

In addition to this, the article explicitly deals with (types of) internal conflicts which are not covered by the Protocol. So the Protocol shall not apply 'to situations of internal disturbances and tensions, such as riots, isolated and sporadic acts of violence and other acts of a similar nature (...)'.
Article 9 of Protocol II, among others, deals with the protection of medical personnel: it ‘shall be respected and protected and [it] shall be granted all available help for the performance of [its] duties’. Next to this, the article says that medical personnel ‘shall not be compelled to carry out tasks which are not compatible with [its] humanitarian mission’ and it ‘may not be required to give priority to any person except on medical grounds’.

The main problem as to Protocol II is that a series of states did not ratify it so far. While the Geneva Conventions as such are ratified by almost every state worldwide, Protocol II has only been ratified by some two thirds of them. And while the Geneva Conventions as such are generally supposed to belong to the part of international law which is labelled as ‘ius cogens’, which means that they are also binding for non-Party States, the two Protocols so far are not. They are ‘only’ treaty law, which means: binding for those states who ratified them.

In general one can say, however, that the combination of article 3 of the four Conventions and Protocol II can serve as a sound legal basis for the protection of medical personnel in times of intra-state conflict. It is more or less a non controversial issue. It becomes controversial when medical relief organizations are (said to be) not neutral anymore in the conflict (which is another discussion, although related to the issue I am dealing with. I suppose others will deal with the topic).

Additional provisions

Concentrating on the Geneva Conventions and the Second Protocol thereto, it is important to keep in mind that next to the field of International Humanitarian Law, in international human rights law one can also find a series of provisions which are related to today’s issue, that is to say: to the right to adequate health care in general (and the corollary thereof: the right to medical assistance). Most of these provisions are also to be applied in ‘times of internal conflicts’. Mentioning some of these, I will concentrate on Conventional provisions, skipping non-legally binding declarations such as the 1978 WHO/UNICEF Declaration of Alma Ata or the 1995 Nijmegen Recommendations on Violations of Medical Neutrality.

So article 12 of the 1966 United Nations Convention on Economic, Social and Cultural Rights - now ratified by some 135 states⁴ - says that the States Parties recognize 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. The article, by the way, is based on article 55 of the Charter of the United Nations and article 25 of the Universal Declaration of Human Rights Article, both referring in general terms to the right to adequate health care.

In the 1966 Convention on Civil and Political Rights - now also ratified by some 135 states - one will, according to the scope of the Convention, not find references to adequate health care, but some articles are relevant to it, for instance the provisions in relation to 'torture or cruel, inhuman or degrading treatment or punishment' (article 7), or concerning the obligation to treat 'all persons deprived of their liberty' 'with humanity and with respect for the inherent dignity of the human person'. In relation to this Convention, it is also important to keep in mind that some of the rights are declared to be non-derogable, (even) in times of public emergency (article 4). Among these rights we find for instance the afore mentioned article 7.

In the 1966 Convention on the Elimination of All Forms of Racial Discrimination - now ratified by some 145 states - one can find an article, saying that States Parties undertake 'to prohibit and to eliminate racial discrimination' for instance in the field of 'the right to public health, medical care (...) (article 5, e, iv).

In other major United Nations Conventions, such as the one related to the Elimination of all forms of Discrimination against Women (1979, now ratified by some 140 states), to Torture and other Cruel, Inhuman or Degrading Treatment (1984, now ratified by some 90 states), and to the Rights of the Child (1989, now ratified by some 175 states), one can find comparable provisions. See, respectively, the articles 11 (1,f) and 12, 1, and 24. The last one for instance - article 24 of the 'Child Convention' - is a detailed elaboration on the right to adequate health care of children, as it should be fulfilled by the States, being parties to the Convention.

I will not elaborate on this - not exhaustive - list of provisions.⁵ I would like to underline, however, that all of the Conventions which have been mentioned here, have their own supervisory Committee of independent experts, which can also be activated as to violations of the right to adequate health care (be it under specific circumstances, as to admissibility criteria and so on). Thereby one should take into account that a right such as the right to adequate health care is legally speaking not

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⁴ Cf. the annual list of ratifications in the Netherlands Quarterly of Human Rights, most recently Vol. 13, no. 4, 1995 (situation as of 31 July, 1995).
(yet?) as 'hard' as some of the civil and political rights. Nevertheless, some of the Committees are doing their best to strengthen the relevant obligations.

Conclusion

The organizers of the meeting on Violations of Medical Neutrality asked me whether we are in need of a new Convention or something of the kind, for the protection of medical personnel in times of non-international conflicts. My answer would be very short: definitely not. The problem is mainly not of a legal character. What one could do, seen from a legal perspective, is dividing the right to adequate health care and the obligation to protect medical personnel into segments and see carefully to it whether all of these are - yes or no - protected under existing international standards. But today's problem is mainly not of a legal, standard-setting character, but it relates to the political will of states to protect medical personnel more effective. Basically, the texts are available, and it is better to use them - for instance by making a set of interpretations and recommendations - than to 'escape forwards' into the making a new draft Convention.

Willem van Genugten
Professor of Human Rights, Nijmegen University
Associate Professor of International Law, Tilburg University.
The Netherlands Armed Forces and Medical Impartiality.

Disclaimer

I would like to state that not everything written here is necessarily the opinion of the Department of Defense.

Introduction

After a period of relative stability during the Cold War, units and individual soldiers of the Netherlands Armed Forces are once again frequently being deployed, often for peace-keeping operations, humanitarian assistance or disaster relief. These missions have resulted in new plans, better equipment, modified training programs and reflections on the ethical aspects of these operations.\(^1\)

Politicians, officials in the Defense department and individual soldiers are aware of the impact of these operations, not only on these soldiers, but also on the local populations they serve.

The Netherlands want to contribute to the well-being and development of individuals, also abroad. The military organization, as an instrument of the government, may of course be used to secure political or economic interests. But it can also be used by our government to stabilize a country in distress and to relieve human suffering. The Dutch military involvement in Irak, Cambodia and Goma, Zaire, are proof of this.

This paper will focus on several military medical issues relating to medical impartiality which occurred during these deployments. Some of these problems relate to the interaction of military medical units and their operational commanders. Others relate to the circumstances in which the units had to work.

The Netherlands Defense department recognizes the importance of non-military individuals obtaining insight in and understanding and hopefully appreciation of how the military thinks and works. This is important, considering for example that Non Governmental Organizations (NGO's) and military units frequently meet in troubled areas abroad.

Some of the problems I will mention are not unique for the military; we share some of these problems with the NGO’s.

**Military health care**

Since ancient times the military medical profession has been responding to the demands of the military organization and the rights and needs of the military patient. This is done by:

- promoting working and living conditions;
- contributing to an optimum state of the health of soldiers;
- giving casualties - should they occur - the best possible care.

A healthy soldier is a prerequisite for the accomplishment of a mission and the safety of the unit. Therefore, medical officers when treating their military patients, will have to take into account the interaction of health and work. Unlike civilian customs in the Netherlands there is no distinction between curative medicine and occupational medicine in the military, especially when in military operational conditions.

To protect the interests of the individual patient, as the Hippocrates creed demands, the medical officer must be careful. He or she may not reveal the nature of any disease to anyone but the patient. However, the medical officer may have to report on the patients consequent ability to perform his job properly. For instance, even minor ailments could affect a fighter jet pilot but also a C130 Hercules pilot and thus the safety of both this pilot and many people on the ground.

The rights and interests of individuals are also protected by the ‘Geneva Conventions for the Treatment of the Sick and Wounded’. They prescribe, among other things, that military medical personnel must impartially treat patients, regardless of whether they are own or enemy troops. A point to consider is that the Geneva Conventions apply to conflicts between most states and not to conflicts within states with involvement of the civilian population. Also, the legal position of a third, intervening military party such as a UN peace-keeping force, has to my knowledge not been clarified completely yet. Although subject of dispute, for the UN it has become evident that the principles of the Geneva Conventions do apply in these situations: ‘where the Geneva conventions are not directly applicable the standards set out therein will be the minimum acceptable level of treatment’.  

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1. UN operational support Manual
A.J. VAN LEUSDEN

It is not possible to totally prevent a conflict of interests between patients and the organization, but it is possible to create conditions which minimize potential problems. I will come to this.

**Military humanitarian assistance and relief work**

The mission of a military organization is of course based on the potential of applying controlled force. In what way can such an organization be used in peace operations in low intensity conflicts? Various civilian aid organizations will often be present in these situations.

Military force may be helpful in separating fighting parties. It can protect civilian relief workers and civilian transport convoys if they so wish.

Only a decennium ago, any use of force was rejected by many. The tide has turned and this is evident even to several leaders of the peace movement. One of them contemplated openly as to whether it would be desirable to do away with despots like Mladic and Karadzic. The president of MfP in the Netherlands, Jacques de Milliano, was wondering not long ago how long the international community could stand by passively and watch barbarians kill innocent victims. And also in religious circles there is an ongoing discussion about the justifiability of war.

It has been said before: impartiality should not be confused with neutrality. We should have the courage to stand up for the defense of moral values. But we should do this regardless of which party infringes upon these values. This does leave room for debate on how far one may go in defending these values. The Netherlands military is very much aware of the prudence and cautiousness that has to be exercised in these operations.

Besides fighting power, the military also has the disposal of means that are primarily meant to support the troops, but which may very well be employed for humanitarian assistance and (disaster) relief. Water purification-, transportation- and medical units are at hand and frequently the question is raised as to whether it is justifiable not to use these means as they are readily available and can do so much good. It is my personal opinion that it is unethical not to use these means.

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Some recent experiences

Bosnia

As I have mentioned before, military medical units are primarily deployed to support military personnel. With adaptations, however, they may provide medical care to civilians.

In UNPROFOR (the previous UN operation in the former Yugoslavia), as in the UNTAC-operation in Cambodia, officially the UN-troops were not to provide medical assistance to the local population - other than for emergency care. Medical assistance to civilians was the responsibility of UNHCR. In practice, however, military medical support to civilians was given and it was even stimulated. A close cooperation existed between the military medical units and some NGO's. It not only meant the provision of badly needed medical care, it also resulted in good-will and thus increased the chances for success of the mission as a whole, which, in the case of peace operations is or should be beneficial to the local population. As a positive side effect, the amount of medical work also resulted in optimizing the level of proficiency of the medical unit.

During the siege and fall of Srebrenica in the summer of '95, Dutch military medical units in that town were faced with many problems. In retrospect, the medical problems focused around the following issue: how to deal with civilian casualties when:

- there is insufficient medical support from other sources,
- medical supplies are running low, and
- the risk of injuries to the soldiers is increasing.

This last point is important as commanders regard the safety of their troops as a priority.

In the discussions which followed afterwards it was made clear that medical officers are not to deny emergency medical care to non-UN-victims and that medical plans will have to deal with this contingency. This includes specific attention to continuously ensure:

- sufficient medical supplies - also for women and children;
- a timely decision to stop elective surgical operations, and thirdly that
- clear plans are made with local governmental and non-military aid organizations.

Some of the problems during military deployments are not really specific for the military. NGO's have problems as well when they offer to help on a location that is predominantly occupied by one of the belligerent factions; the other side may see
this as favouring their opponents. This is an example of the difference between impartiality and the perception of impartiality.

Goma

In Goma, the Dutch military was asked to assist with local authorities, UNHCR and NGO’s for emergency disaster relief to many thousands of Hutu and Tutsi refugees with cholera, dysentery and malnutrition. The civilian agencies were obviously overwhelmed by the extensiveness of the disaster. Besides the Dutch military involvement Israeli, US and French military units were visibly present in the area.

To stay with the subject of this symposium on impartiality a few points can be made. To start with: there was no argument for or opportunity to discuss whether it made sense to attempt to cure a warrior (either a Hutu or Tutsi) who might be capable of murdering again. Both parties were treated indiscriminately. However, in a mass casualty situation like Goma it is not possible to give everyone the required attention. You have to make decisions as to who to treat first. This is done on the basis of medical criteria only (triage). In triage, a selection is made of patients. Priority is given to patients with a reasonable chance of survival given proper treatment. In Goma, this triage sometimes seemed rather bizarre when local paramedics were seen to give priority to mothers over their children: the reason being that should the mother die the children would not stand much of a chance anyway.

A point to take into consideration is that during man-made disasters military units of one side or another could have been actively involved in atrocities. This might reflect upon foreign military units which are deployed for humanitarian support in that they are unjustly mistrusted or identified with local militia, even when wearing blue UN berets or Red Cross insignia. Some NGO’s see this as a reason not to cooperate closely with these military units. They are afraid this cooperation could violate their impression of impartiality. Armed military units may be associated with safety but they can only guarantee this if they are sufficiently armed and working under adequate rules of engagement. Sometimes, visibly carrying only light weapons may do more harm than good. In Goma the Dutch medical troops did not always carry their guns within the refugee camps. The Israeli, US and French troops did not show themselves at all within these camps; their facilities were at separate locations.

Maintaining impartiality can be very difficult at the level of the individual soldier as well. According to the Rules of Engagement, soldiers may be instructed not to intervene when confronted with violence especially when there is a risk to
their own safety. Intervention may be looked upon as favouring one side over the other. Not intervening, however, is in conflict with the very reason for our presence: contributing to the restoration of values and standards.

Cambodia

Impartiality does not infer either neutrality or indifference. Foreigners should respect cultural and economic local customs and standards. Care should be taken not to (temporarily) spoil the local economy. In Cambodia and elsewhere UN-officials sometimes overpaid for local services and only very few could benefit from their temporary wealth. We should also take care not to deliver a standard of health care that is too high to sustain after the western aid agencies have left.

(During our deployments to Cambodia, Goma and other places many more questions were raised such as: What are the long-term effects of external intervention on the way in which the community returns to normal? Due to the theme of this symposium I will not dwell upon these questions here.)

Conclusions

The military health service mediates between the interests of the military organization and the individual soldiers. Special care is taken to secure the rights of individuals. The principles of the Geneva Conventions are fundamental to the (unwritten) code of conduct for military personnel.1

The use of military units in humanitarian action and disaster relief requires that special considerations be given to planning. Clear arrangements should be made with local national and UN authorities and other (civilian) aid agencies, for instance, with regard to tasking, cooperation and the use of weapons. Factors that may help in making the decision on when and how to use the military include the following:

- a set duration of the operation,
- acceptable risks to own personnel,
- the possibility to withdraw properly with continuation of activities by local agencies,
- sufficient support from the populations concerned,
- a clear mission and
- exhaustion of non-military means.

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These factors are of course politically influenced, which, I must admit, could be a set-back but also advantageous. When these factors are taken into account, in my opinion it would not be ethical not to use military assets for humanitarian action and disaster relief. These assets are readily available and can do much good, especially in disaster situations. Moreover, the military organization, unlike NGO's, is at the disposal of the government. The military organization is especially capable of operating in high risk environments and it is also well equipped to handle potential or real disasters. The military may offer services in the area of security, mine clearing, levelling terrain, obtaining safe water and securing waste disposal. Many of these actions will promote the general health situation as well. Military medical units can effectuate public health measures and of course they can provide patient care.

Western military medical services treat patients regardless of their background, sex, age or affiliation. In planning for these peace operations this will have to be taken into account. Instructions should be clear and there must be sufficient supplies to treat civilian casualties in emergency situations. The UN Operational Support Manual states:

Medical obligations under international law will be particularly crucial to the management of non-UN personnel such as prisoners of war, civilian refugees, detainees and non-UN combatants. Medical plans must detail the degree of care to be offered to these groups and how continuity of care is to be provided when needed. In general terms only urgent medical treatment, not available in appropriate non-UN medical facilities will be offered to civilian refugees, detainees and non-UN-combatants. An alternative source of definitive treatment must be organized as part of the overall medical support plan.\(^1\)

The Netherlands Ministry of Defense has officially adopted this policy.\(^2\)

Colonel AJ van Leusden
MD Royal Netherlands Land Armed Forces

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\(^1\) UN operational support Manual

\(^2\) Chef Defensie Staf, 'Aanwijzingen voor de geneeskundige hulp aan de burgerbevolking tijdens operatie IFOR'. Brief 596/061/359 dd 310196 (Intern Defensie)
MsF reflections on the theme

Before starting my lecture, it is necessary to clarify two misunderstandings. Firstly, it sometimes has been stated that doctors of MsF made a call for war. This is not accurate. At the time of the genocide in Rwanda, MsF reminded the signatories of the 1948 Convention on Genocide of their obligations, i.e. to undertake action which is considered appropriate for the suppression of acts of genocide. In fact, MsF believed that only armed intervention could be considered as appropriate to stop the genocide in April 1994. MsF also objected strongly to the position of the United Nations peace-keeping force UNAMIR. Neutrality for the UNAMIR implied that it could not intervene and act only as bystanders, watching how hundreds of thousands were being slaughtered.

Secondly, according to some commentators, MsF has said that the time of neutral humanitarian aid is over. Again, this is an inaccurate statement. MsF has stated that it believes that there may be circumstances in which humanitarian organisations should consider to redefine their neutrality in the interest of the victims. Neutrality cannot imply that humanitarian organisations close their eyes for gross violations of human rights if these violations are committed in front of them.

The neutrality-debate

It is true, however, that the principle of neutrality has led to numerous debates in MsF; the main reason for these debates is that the principle has the negative connotation of an attitude of abstention, which is in contradiction to the active role a relief worker who through his work, tries to improve the plight of populations in danger.

In this presentation, I shall briefly outline two arguments which play an important role in the debate concerning neutrality. The first argument indicates why neutrality is still believed to be an useful concept, the second argument relates to the question why the concept neutrality has become problematic in the context of medical humanitarian assistance.

Definition of neutrality

Before we go into this debate, it may be good to look at the definition of neutrality, as it has been developed by the Red Cross. In designing the framework for humanitarian assistance, the Red Cross defined several principles which should facilitate the
work of the organisation. One of these principles is neutrality, which has been defined as: "in order to continue to enjoy the confidence of all, the Red Cross may not take sides in hostilities or at any time engage in controversies of a political, racial religious and ideological nature." The aim of this principle is to guarantee unimpeded access to the victims of a disaster.

**Access**

The advocates of neutrality, therefore, point at the practical use of the concept. In situations of armed conflict the medical personnel has been able to indicate to the combating parties that they were prepared to work on both sides of the conflict and that they did not favour one party over the other. The element of 'not taking sides' is still applicable today, especially in conflicts with clear distinguished patterns such as the conflict in Sri Lanka between the government and the LTTE (the Liberation Movement of Tamil Eelam). Although the Government of Sri Lanka has very strong control over the activities of international humanitarian organisations, it has repeatedly stated that it respects the humanitarian organisations and their principles and, on this basis, grants them access. In 1995, it was even agreed between the Government and the LTTE to 'neutralise' the hospital in Jaffna; that is to say that the hospital's medical facilities are safeguarded and that the parties to the conflict have accepted that they cannot use the hospital building for military purposes. Also, in other conflicts, the invocation of the principle at a roadblock makes neutrality a valuable asset.

**Difficulties with the concept of neutrality**

However, in an increased number of situations, the concept of neutrality as to facilitate access, has become less relevant. At the end of the sixties, the ICRC's neutrality did not lead to obtaining the permission of the Nigerian government to start a relief operation for Biafra. In reaction of the plans of Biafra to secede, Lagos installed a blockade and did not permit any relief going to that area. As a result, the only way to reach the victims in that part of Nigeria was through mounting a cross-border operation, an act which was seen as contradictory to the principle of neutrality. Moreover, five French Red Cross doctors spoke out about the situation, which was in contrast to the policy of discretion of the Red Cross. Also in other situations such as in southern Sudan and Afghanistan, MsF was obliged to mount cross-border operations in order to reach the victims.
Difficulties with access

Today, it is even more complex to achieve access since the conflict patterns are significantly different from the post World War II era. In many cases, wars are now fought between uncontrolled armed gangs which lack a clear authority and structure. What is the relevance of invoking the concept of neutrality to achieve access in the Liberian civil war where more than seven factions are combating? In situations like these, one can maintain the principle. Yet, the respect for humanitarian aid and the principles may be very different.

Problematic

The concept neutrality has become problematic in the context of medical humanitarian assistance when neutrality - understood as maintaining silence - may not be in the interest of the victims. Especially, the genocide in Rwanda and its aftermath, the camps in Zaire and Tanzania, gave rise to a moral dilemma: whether or not to assist the instigators of a genocide who also control the flow of relief goods and intimidate the population. MSF believed it necessary to make this dilemma visible by speaking out on it and calling for the prosecution of the criminals. Another example is the ethnic cleansing in Bosnia. After the fall of the Krajina, the Serb population flew to the Republic Srpska. Subsequently, the Bosnian Serb authorities forced the remaining Muslim and Croats minorities to flee. MSF was asked to set up way stations to provide the moving populations with clean drinking water and other minimal services. Thereby, MSF would facilitate the ethnic cleansing. MSF reacted by delivering the medical services, but also by speaking out. From these examples, it is clear that a policy of silence would lead to unacceptable situations, from an ethical and moral perspective. Neutrality for MSF does not imply to maintain silence at all costs.

Conclusion

In conclusion, neutrality is a useful principle as long as it serves the purpose of facilitating access. It is important to note that neutrality should remain a formula to be able to carry out one's task, the principle is not an aim in itself! MSF believes that the confidence in the phrase 'in order to continue to enjoy the confidence of all', should be first and foremost the confidence of the populations in danger.
Therefore, humanitarian organisations should be prepared to redefine the principle of neutrality, if it becomes clear that it does no longer serve the victims' interests.

Ed Schenkenberg van Mierop
MSF-Netherlands
The case of Xaman, Guatemala

The great World Wars, which conduced to the development of the concept of 'Medical Neutrality', do not constitute daily reality. Common however, are the regional conflicts, the civil wars and more often those situations between 'war' and 'peace' (not-war and neither peace) characterized by continuous violations of human rights. In those situations, where human rights are not respected, preconditions do exist for violation of the integrity of healthcare workers/medical neutrality.

From a small rural community, the village of Xaman in the highlands of Guatemala, several members of Medicos del Mundo, a humanitarian organisation from Spain, recently have been witnesses of several violations. In Guatemala, it appears as if effective realization of the right to health is more distant than ever before. Living conditions of the majority of the population, which already were poor, have worsened due to a predominant neo-liberal government policy. Illustrative in that sense were the opening remarks of a recent workshop of the European Commission for Development Cooperation on 'Conservation of Primary Health Care in Guatemala': 'Ethics is a luxury in health care delivery'.

What is or could be the significance of health care and medical neutrality within such a context? What could be the action taken by a humanitarian health NGO in its daily-to-day performance of activities against this violation of human rights?

Within delivery of health care a humanitarian NGO needs to consider social reality and to take up an active commitment. This however, is very different from adopting the objectives of one of the parties in the conflict. According to Medicos del Mundo, it is the responsibility of a humanitarian NGO to denounce violation of human rights whenever it is confronted with such violations. However, there is a need to examine carefully in each situation the best procedure, the best 'way to do this'.

Both in Guatemala as in other countries Medicos del Mundo from Spain has experienced situations which impeded or went against the performance of medical duties and responsibilities. Often these violations came from the side of the military.

Xaman, 5 octobre 1995

In Guatemala, and especially after the massacre in Xaman, health workers of Medicos del Mundo have become subject of intimidations. Xaman is a small peasant community; 80% of its inhabitants are refugees who recently returned to Guatemala.
after a long exile in Mexico. They are indians and pertain to five different ethnic tribes.

On 5 October 1995, on the eve of the first anniversary of the village, the army invaded the community, killed 11 and wounded 27 inhabitants; two of them were young children.

The presence of Medicos del Mundo - with possession of a mobile radio - in the village facilitated the enunciation as it enabled warning of the United Nations High Commissioner for Refugees (UNCHR) within a few minutes. The events in Xaman and the follow-up have had a great impact in Guatemala as for the first time in the country’s history it lead to the dismissal of the Minister of Defence.

The case of Xaman still constitutes up until the present day an important test for the new government, as it will demonstrate how far the government is willing or is able to combat impunity.

The background of the massacre probably was the fact that the returned refugee-population were considered to be guerrilleros by the army, although this is against the ‘8 October Agreements’ which do regulate the return of the refugees and were signed both by refugee organisations and the government of Guatemala. Article 3 (3,C) determines the ‘peaceful and civil character of the return/repatriation and the returning population’.

On the other hand, our presence in Xaman in relation to health care and (therefore) the denunciation of the violations has had consequences for all health professionals involved in health care in Guatemala through Medicos del Mundo. We have suffered threats and have been intimidated continuously after the events of 5 October. It is clear that the international accompaniment of Medicos del Mundo in the area of health care delivery, is considered a nuisance.

Another violation related to the same sequence of events in Xaman, was the intimidation of the forensic doctors during their judicial investigation. As a direct consequence their research results remained so superficial and contained so little judicial evidence, that most probably victims - already buried - will have to be re-examined. This is a very painful process for the families and the community.

Healthcare as neo-colonialism

Also in other parts of the world, eg. Ruanda, Medicos del Mundo has witnessed during the last year violations of medical neutrality when several hospitals and health centres were burnt. Apart of these clear violations, however, there is also a need to reflect on our own daily performance. How neutral is it to perform western medical practice in traditional indigenous communities? Convinced as we are of the suppo-
sedly greater effectiveness of western medical practice and of our vision of the process of health-disease, we actually are involved (we enable and we impose) a cultural and economical neo-colonisation of other people/populations.

In particular I do refer to the indigenous populations of Guatemala, with another cosmovision on life and death, on health and disease. We make them familiar with technical medical methodologies which may be economically difficult to afford. What role do European NGO's play in this process?

Finally, a few remarks on the meaning of 'medical' in the concept of medical neutrality. It could appear as if I refer primarily or only to those health workers with a professional background. There is a need to give a broader significance to this concept, in the sense that it should encompass all those working towards the protection and promotion of health. In countries such as Guatemala, this would also include those who work from a Maya-cosmovision perspective such as the 'shamans', bone-setters or traditional midwifes as well as those who work from a more western perspective.

The government may be in a difficult position to distinguish these persons, but at community level there is never any doubt on who to consult when health problems occur. The international recognition of health workers, based upon a broad interpretation, could have a certain positive impact in case of internal conflicts.

From the 'Health for All' perspective, which does take into account all determinants and recognises the importance of all sectors which contribute to health, it may be stated that health is a social matter and medical neutrality therefore can not be anything different than the demand to realize and respect human rights, including the right to health.

Jose Luiz Albizu
Medicos del Mundo
Health for all
Towards a new social contract and code of ethics

Medical Neutrality: Medical neutrality is conceived as the right of all people to health and the right of health workers to enjoy the protection and respect to fulfil corresponding duties

Health for all: the attainment by all the citizens of the world of a level of health that will permit them to lead a socially and economically productive life.

Successful implementation of Health for all-strategies: ...-> governments -> ministries of health -> individuals/communities -> health workers -> donor agencies -> NGO's -> 'private for profit' -> universities/others -> governments -> ...

There is similarity between the overall objective of 'Medical Neutrality' as defined in the documents for this meeting and that of Health for All. The Health for All (HFA) movement, which was set in motion by the World Health Assembly in the late 1970s, can be seen as a new health partnership - a partnership which involves the global community, countries, families and individuals in sharing resources and responsibilities to ensure health for all in a spirit of justice and mutual respect, and an intermingling of the consolidation of efforts and global support. I would like to raise two issues for consideration. First, what complimentary actions should be carried out by various partners in the social contract? Secondly, what should be the code of ethics for the social contract?

Role of the various partners

The government as a whole. HFA requires the assumption of responsibility by governments for the provision of the necessary conditions and environments to ensure that essential health care is delivered. Yet, at present, the primary participants in discussions on PHC policies and strategy development are ministry of health staff, who often lack the political clout to carry out extensive reforms. The government as a whole should adopt an overall national strategy for HFA.
The ministries of health. There are seven critical functions of ministries of health, which should be kept intact, irrespective of other efforts towards privatization.

Ministries of health are charged with the task of developing policies, strategies and plans which provide direction for national health care systems and overall health development. The many challenges and sometimes contradictory demands on governments and ministries of health call for a sense of purpose and plan of action.

Such plans will help a great deal, in mobilizing and coordinating activities of the private sector, nongovernmental organizations, and donor agencies. Unfortunately, few countries have well-developed health plans, with targets and financial implications. Many health plans have also not been updated in response to changing needs and challenges. It is strongly recommended that ministries of health carry out in-depth reviews of their plans at least once every five years. Support mechanisms, such as health boards and annual reports, which have faced neglect by many ministries of health, need to be regenerated.

Ministries of health need to ensure access to quality care for all. Large numbers of people remain with no access to essential health care, even in developed countries.

Ministries of health must mobilize resources. Two measures are necessary. New sources of money, and alternate ways of financing health care must be identified. The Alma Ata Conference emphasized reallocation of resources for PHC. In practice it is difficult to reallocate resources where there is no growth. Yet, a number of developing countries spend much less on health care per capita than the average for their level of income. The ministry of health and other health-related institutions need to press actively to obtain greater resources. Alternative ways of financing health care, whether through government taxation, insurance, user charges, or community financing involving revolving funds, need to be examined.

Ministries of health must play a more active role in coordinating support from external agencies. This becomes more possible when ministry priorities and plans are clear.

Minimum standards of service safety and quality must be set by ministries of health, even if they choose to exercise such controls through professional bodies. Regulations may be necessary to ensure compliance with set standards. Incentive structures may need to be adjusted.

Ministries of health, especially those in countries with high population growth rates, must spearhead the formulation of effective population, environment and urban health development policies.

Ministries of health are charged with the role of encouraging innovation and experimentation. Learning by doing needs to be a permanent feature of all future
efforts. Experimentation, such as studies in selected geographical areas, allows changes in health care provision, to be tested before they are introduced on a nationwide basis. Health systems research should be strengthened and applied in an expanded number of countries.

**Individuals and communities.** To increase participation in health project planning and execution by individuals and communities, action is required on several fronts. The top-down planning approach adopted by an increasing number of agencies has detracted from local initiative and responsibility. Too often, the objectives, strategies and organization of health projects are organized according to the priorities of the agencies. Also, while calling for community participation, agencies promote and finance piecemeal health projects which result in uncoordinated and confusing demands on communities. Enthusiasm must be regenerated by adopting a planning process that invites individuals and communities to define their common needs and problems. Communities should be encouraged to make individual and group plans, and partake in carrying them out by using their available resources, as well as government and other support, where necessary.

Then, too, effort should be made to demystify health knowledge, and to find more effective ways of communicating such knowledge to individuals and communities. Studies have shown that when provided with adequate information, any health problems such as pneumonia can be prevented, managed and treated by communities.

The role of community health workers (CHWs) and volunteers must be more precisely defined.

**Health Workers.** The role of health workers in promoting and supporting the HFA effort is crucial. Health workers, particularly in local health facilities, have to work more closely with local NGOs, churches, schools, mosques, clubs, and other social structures or groups as well as individuals and families. Five matters need attention.

First, a large number of health workers have not received training and continued education on the PHC philosophy and approach to allow them to work effectively within communities. A reorientation of traditional medical curricula towards community-orientated and community-based medical education is recommendable.

Second, innovative ways to provide incentives and motivation, including improved remuneration, are essential. Without such action, brain drain of health workers from poor to rich countries, as well as to other sectors, will continue unabated. Admittedly, a number of basic manpower issues, including decisions on
the appropriate numbers of personnel that can be properly remunerated, have to be tackled.

Third, there is a marked weakness in district-level management in many developing countries. In retrospect, it is clear that insistence on investing in and relying on one individual, the district medical officer, to spearhead PHC development was an error. It will be essential to mobilize additional district leaders for PHC. These can include district officers in charge of agriculture, education, public nursing, community development, and environmental sanitation. The development of appropriate leadership programmes will facilitate their participation.

Fourth, public health leadership, in general, requires strengthening. While Departments of Community Medicine have the primary responsibility for developing both national and middle-level leadership capacity in many developing countries, experience shows that this arrangement is untenable. It is gratifying to note that an increasing number of schools of public health are now appearing in developing countries to produce the needed cadres of public health professionals. However, an even greater expansion (maybe 12 times) in these institutes than is being witnessed at present, will be needed to provide the required leadership. The move to establish institutes of public health should be complementary to rather than competitive with current efforts to reform medical school, to make them more community-oriented.

Fifth, a related, but potentially more serious problem, is the fact that many developing countries use the public health institutes of developed countries, particularly the United States, as models. However, these institutions' focus on theoretical knowledge, to the detriment of field application, is inappropriate for the developing country setting. Developed countries' public health institutes also tend to be individualistic, with each school guarding its own identity and responsibility. A number of initiatives are being undertaken in developing countries to correct these deficiencies. These include the creation of a network to link the various types of PHC training and health development centres, including public health schools. Such complementarity is more likely to meet the public health leadership requirements at the national and intermediate levels.

Donor agencies. Prior to the 1970s, global leadership in the health field was provided by western governments and various medical groups. In the 1970s it became obvious that health programmes fashioned in the image of western services did not address the needs of developing countries. This recognition has led to drastic changes in global programmes.

Three areas of concern emerge from the review of the performance of donor agencies. The need to re-emphasize national capacity-building is evident. The series
of short missions, which offer the expertise of international consultants, supported by donor agencies, are of little use to developing countries. These nations now have large numbers of skilled personnel in different health areas. New ways of involving their collaboration need to be explored.

Few agencies are interested in promoting and supporting technical collaboration among developing countries. This is unfortunate, as learning from one another is one of the best tools available to facilitate the implementation of PHC in the developing world. Developing countries themselves need to push for improvements in this area.

Greater attention should be given to important questions of financing developing country health programmes. Financial support from donor agencies has been severely curtailed over the last 10 years due to world recession. Increased levels of monetary support are needed. While the response to such a request is not likely to be encouraging, one innovative strategy might be for donor agencies to assume responsibility for the recurrent cost of several countries. An example is the provision of a few essential drugs to least developed countries (or at least several of them) over long periods. A related challenge is how to use donor resources better. Coordination of financial, as well as, technical assistance demands attention. Indeed, international rivalries and lack of coordination of donor projects and governmental initiatives often result in wastage due to duplication. Then too, problems are created by the fact that donors often specify preferred programmes for resource allocation, rather than channelling funds in response to locally-defined priority needs. Finally, the question arises as to what can be done concerning those countries which presently do not figure on any agency’s list of countries eligible for assistance?

Nongovernmental organizations. The role of NGOs in the health sector is becoming more pronounced.

An increasing proportion (now about one third) of rich country development financing goes to NGOs. The situation has led to high levels of competition among NGOs in developing countries for the newly available funds. The danger exists that under these circumstances, NGOs may lose their strength and base within communities. This is an issue that should be addressed by developing country NGOs and their rich country supporters.

Private, for-profit providers. There is a wide diversity of for-profit providers: private doctors, nurses, midwives and paramedics, nursing homes, hospitals and traditional practitioners.

Some countries have consciously encouraged private providers to flourish. Others, until recently, have discouraged, or virtually banned them. It is now
acknowledged in practically all countries that the private sector brings additional resources for the provision of health care, thus alleviating pressure from already over-burdened government systems.

**Implementing the social contract**

The term 'code of ethics' is used here to mean a set of rules of conduct among partners in the social contract. The promotion of ethical values at all levels should be a feature of the contract. Codes of ethics are needed to provide guidance for procedures for achieving the goals of the contract. Such procedures might include definitions of how the eight partners ought to act in relation to each other. Provision should be made for assessing compliance with ethical standards.

What should be the code of ethics for the social contract for health for all? What is wanted is now fairly clear: (i) a health care focus on the underprivileged and a reduction in inequities in health and health care systems; (ii) an overall improvement in health, with reduced infant and maternal mortality rates, an increased life expectancy, and an improved quality of life; (iii) health care that satisfies individuals, families, and communities and in which they themselves participate; and (iv) development and satisfaction of providers of care. A number of countries have, or are in the process of developing national social contracts of various kinds. Experience from these countries is of global interest. The Malaysian government is moving towards a new social contract between the people and itself under the slogan of "Malaysia Incorporated". The main feature of this and similar contracts is liberty for all. A major goal is the resolution of inequalities in society so as to ensure the wellbeing of all.

Reference has already been made to the need for a legal framework to enhance health for all. Interventions should be designed to comply with basic ethical considerations, such as that interventions should at least not harm other partners in the social contract, or that all involved in an intervention should actively participate in its planning and execution. The precise scope of obligations of individual partners need to be worked out. For example, a donor agency that fails to analyze the needs of a country properly and rushes to support projects that are not viable or sustainable should be admonished.

The HFA contract should also impose certain constraints on each country. It might, for example, be expected to show evidence of preferential allocation of resources to underprivileged population groups. Periodically, each country should monitor its own progress and its compliance with HFA aspirations. Supplementary audits might be carried out by an independent body at regional and global levels.
with access to data from official country reports, nongovernmental organizations, and commissioned studies. Such audits may disclose glaring failings by countries in meeting their obligations to implement HFA. Disclosure can exert powerful pressure on countries to intensify their efforts. The International Labour Organisation has developed such a mechanism. The conference committee on the application of conventions and recommendations publicly debates these findings. Countries may also consider establishing similar independent mechanisms at the national and regional levels.

While a number of countries have updated their national HFA strategies, many others have not. Consideration should be given to using the framework of the 22 recommendations formulated at Alma Ata for updating HFA strategies at regional and global levels.

A conflict of responsibilities, duties and rights between the eight partners in the social contract is inevitable. It is not possible that one or two partners will be absolute winners - a compromise will always be necessary.

The creation of an independent global mechanism, such as a Global Advisory Council or Global Commission, is essential, in order to enhance the revision of strategies and provide overall supervision for HFA. The proposal for such a body was first proposed and then rejected in 1981. Since then the need for a mechanism of this nature has been alluded to by various bodies, including a subcommittee of the Executive Board.

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Three measures are needed to enhance the implementation of health for all: compliance with standards, regular reviews and updates of strategies, and the creation of a promotional and supervisory institution.

The PHC movement at present is essentially driven by interest and the good will of individual countries and the global community. This is the right approach. But
appropriate national and international regulatory and supervisory mechanisms can supplement the current effort.

Interventions should be designed to comply with basic ethical considerations. The precise scope of obligations of individual partners need to be worked out. For example, a donor agency which does not analyze properly the needs of a country and rushes to support projects which are not viable or sustainable, should be sanctioned.

Membership to the HFA contract should also impose certain constraints on each country. All countries might be expected to show evidence for preferential allocation of resources to underprivileged population groups.

Monitoring of progress and compliance with HFA aspirations should be carried out periodically by countries themselves. Supplementary audits by an independent mechanism, which will have access to data from official country reports, nongovernmental organizations, and commissioned studies, may disclose glaring failings by countries in meeting their obligations to implementing HFA. Disclosure can provide powerful pressure on countries to intensify their efforts. ILO has developed such a mechanism. The conference committee on the application of conventions and recommendations publicly debates these findings. Countries may also consider establishing similar independent mechanisms at the national and regional levels.

The creation of an independent global mechanism, such as a Global Advisory Council or Global Commission, is essential, in order to enhance the revision of strategies and provide overall supervision for HFA. The proposal for such a council was first proposed and rejected in 1981. Since then, the need for a mechanism of this nature has been alluded to by various bodies, including the Sub-Committee of the Executive Board.

Dr E. Tarimo
Director, Division of Strengthening of Health Services
World Health Organization, Geneva
The Nijmegen Recommendations on Medical Neutrality

Introduction

Medical neutrality is a complex concept. While it is clearly a human right, it has no legal status. Medical neutrality can be violated by all parties in a conflict, whether armed or not, which suggests that medical neutrality is in the first place a right. However, neutrality is also a duty, as laid down in the Geneva Convention and associated protocols, to which medical workers must adhere.

On 28 March 1992 a symposium on 'The violation of medical neutrality' was held at Nijmegen University. After introductory readings, round table discussions were organized on the role of the medical profession, development organisations and government policy. The outcome of these discussions constitute the nucleus of this publication: the so-called "Nijmegen Recommendations".

For the organizers of the Nijmegen symposium, the continuing violations of medical neutrality are sufficient reason to reopen the debate on this issue, and to again call attention to the Nijmegen Recommendations by distributing them more widely.

Nijmegen, The Netherlands, June 1995

The symposium on 'The violation of medical neutrality' was an initiative of the Medical Committee for El Salvador (Yamilet Foundation), the Johannes Wier Foundation (JWS), the Medical Group of Amnesty International Holland, the Nijmegen Institute for International Health (NIIH), the Medical Committee Palestine (MKP) and the Medical Committee for the Philippines, and followed an international conference on the same subject held the previous year in Maastricht.

The symposium was also attended by participants from various development organisations, Dutch and Belgian universities, research centres, solidarity groups, medical institutions and the Dutch government.

Introductory readings were given by Dr. W. Dolmans (NIIH), Dr. M. Meyer (Red Cross Holland), Dr. G. de Wildt (public health doctor), Prof. Dr. P. de Waart (professor of international law Free University of Amsterdam) and Prof. Dr. C. Flinterman (professor of international law University of Limburg), Dr. J. Oudejans (MKP), Dr. Th. Berkestijn (president of the Royal Dutch Medical Association),
Dr. A. Korver (Red Cross), Dr. A. van Es (president of JWS), Mr. J. Eshuis (Royal Institute for the Tropics), Dr. P. Kok (Memisa Medicus Mundi), Dr. F. Bar-ten (Nijmegen University-NIIH/Yamilet), Mr. Th. van Banning (Ministry of Foreign Affairs) and Mr. P. van Veenen (Humanistic Council on Human Rights).

*The Nijmegen Recommendations*

**Medical Institutions**

1: It is recommended to set up an independent professional organization on a global scale (the World Medical Association - WMA - could be re-created to this end). This new professional organization should be extended to health professional other than medical doctors, such as nurses and physiotherapists.

2: Public pressure should be exerted on countries where violations of (medical) human rights take place, alongside the quiet diplomacy between professional organizations.

3: Medical personnel who work in countries where violations of medical neutrality are committed should be able to turn to one central address (e.g. in the Netherlands) in order to receive support, advice and also preparation.

4: The practice of monitoring violations of medical neutrality should be organized in a systematic manner. In countries where violations of medical neutrality take place, the activities of corresponding organizations that expose these violations should be supported.

**Development Organizations**

1: On employing the notion of ‘medical neutrality’ one should realize that health development and politics can not always be separated, and therefore health workers cannot always be politically neutral. Therefore it is recommended to use only the notion of ‘medical neutrality in the case of international and internal armed conflicts.

2: It is recommended to create control mechanisms, or, where appropriate, to develop them further for purposes of medical neutrality. Organizations engaged in these matters, will be best served by examples from daily practice, passed on to them by NGOs. NGOs should realize that the part they play in gathering information, must be independent of governmental authorities.
3: The personal responsibility of health workers with regard to medical neutrality should be stressed. An organization that posts personnel abroad should in the first place support the position of individual employees when he or she is confronted with violations of medical neutrality.

4: There is a close relationship between the promotion and protection of human rights (including opposition to violations of medical neutrality), and development cooperation.

5: Within the framework of it's policy on the issue of development cooperation, governments should take into account the consequences for the targetgroup of a possible suspension of cooperation as a result of violations of medical neutrality. In this respect NGOs are an important source of information.

Politics
1: Governments should make the right to health care and access to health facilities one of the many aspects of 'medical neutrality', a point of special attention within its foreign policy.

2: The notion of 'medical neutrality' should be divided into several aspects. Both international humanitarian law and international law regarding human rights are relevant here.

3: In collaboration with professional groups outside the health care system, the medical profession should play an important role in combatting violations of human rights.

4: On the international level, the rules pertaining to the different aspects of medical neutrality need no further additions or reinforcement. However, further consideration should be given to whether a Declaration with regard to the independence (neutrality) of medical personnel can be effectuated in due course by the UN or WHO.

4a: There is no need for the creation of new bodies to counteract violations of medical neutrality. Rather, emphasis should be placed on a further reinforcement of the existing control mechanisms, to enable them to carry out their tasks. The necessary financial means are a first consideration.
Governments are justified in reducing or even stopping official aid to a developing country where violations of human rights take place. In such cases it is advisable to continue aid through NGOs, and where possible and desirable, to reinforce that aid.

Governments should play a more active role within multilateral bodies set up to report violations of 'medical neutrality'.

Reporting on the fulfilment of human rights should be carried out on the basis of reciprocity.

General Recommendations

The notion of 'medical neutrality' should be defined in a uniform manner. In this respect it should be examined whether the concept of 'medical neutrality' is the most appropriate one for these kinds of human rights violations. The notion of 'medical neutrality' implies, for instance, that the rules only concern medical professionals, while other health workers (such as voluntary health workers) should also be covered by the protection of these rules. The question whether the notion of 'medical neutrality' also includes the right to health, as defined in the Alma Ata declaration, deserves to be examined. For the moment the notion of 'neutrality' has different meanings for different people; the suggestion has been put forward that the term 'impartiality' should be used from now on.
The Nijmegen Recommendations on Medical Neutrality II

On 28 March 1992 the first Nijmegen Symposium on the Violation of Medical Neutrality was held at the University of Nijmegen (the Netherlands). This symposium led to "The Nijmegen Recommendations"¹ On 10 May 1996 a second conference on the theme took place at the same university.²

This booklet contains the most important recommendations of the Nijmegen II conference, and must be considered as an addition to the Nijmegen I Recommendations. The organizers hope that it will help to foster initiatives and programs for monitoring both the observations and reporting of violations of medical neutrality, and the adequate steps to be taken by existing institutions (supervisory committees, governments, international institutions, and others) to act according to already established norms and responsibilities.

The concept of medical neutrality

Violation of medical neutrality refers to all deviations from the ideal of non-discriminatory and unrestricted provision of medical care for all those in need, in all situations and circumstances, and to the corresponding respect for both the professional integrity and the inviolability of medical personnel and institutions. In this sense application of the concept of the ideal of medical neutrality can and must not be limited to situations armed conflicts (international and intra-state), but has to be put in practice in all situations of discriminations of health rights.

The role of the international development cooperation

The evolution of the world wide international economic relationships in the field of aid, trade, investment, lending and the monetary system has led during the eighties and the nineties of this century to the impoverishment and marginalisation of billions of people as well as to a further degradation of the environment. This creates new causes both for unequal opportunities in the fields of health and health care as for new armed conflicts. The peoples and governments of the so-called rich nations therefore have a special responsibility to stop the further processes of degradation of

¹ The Nijmegen Recommendations on Medical Neutrality, Catholic University Nijmegen, June 1995.
² For the proceedings of this second conference, see: Leo van Bergen, Françoise Barten (eds.), Medical neutrality revisited, Catholic University Nijmegen 1996
mankind, and to establish structural conditions for a real and worldwide medical neutrality.

An inventory of (the possible application of) the existing international conventions on violations of medical neutrality

There is no need of a new convention or so to formulate new international standards and regulations regarding the violations of medical neutrality. Existing conventions contain enough and adequate legal references. It yes could be of great importance to make an complete inventory of existing standards and regulations including references to their applicabilities and the supervisory committees and procedures.

A guide on medical neutrality

Many individuals, peoples and institutions are not aware of the need and possibilities to act on situations of violations of medical neutrality, notwithstanding the many violations that are taking place. Therefore it is recommended that a guide ‘How to act’ will be written and will be distributed worldwide. His guide should facilitate persons and institutions (professionals and non-professionals) to act in these cases. Such a guide could contain the following subjects: Explanations of the concept; description of the existing legal standards, regulations procedures and supervising bodies; informing of possible monitoring bodies, both governmental and non-governmental; elaborating practical techniques and models to facilitate the handing, observation and reporting of acts and situations of violations; elaborations of other means to combat violations (through publicity, political pressure, educational projects, and so on).

The global monitoring of medical neutrality

There is an urgent need to establish a worldwide institution to monitor reports and complaints on violations of medical neutrality, and to promote their handling, legally and politically, by the international authorities. This institution should be established in the city of Geneva (near the WHO, the International Committee on Human Rights, and the Red Cross) or in The Hague (near the International Court of Justice). Therefore it is proposed that a special international conference of the respective official entities and non-governmental organizations will be organized in
1997, preferably in the Netherlands, to prepare a proposal in this respect. Both the World Health Organization and the government of the Netherlands will be invited to endorse and support this initiative.