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I. INTRODUCTION

The provision of medical care to the sick and wounded during armed conflict is a foundational humanitarian law obligation. This can be seen in the genesis of the International Committee of the Red Cross (ICRC) with Henry Dunant's work following the 1859 Battle of Solferino.¹ Obligations regarding the collection, treatment, and care of the sick and wounded, both military and civilian, are firmly grounded in treaties such as the 1949 Geneva Conventions and their 1977 Additional Protocols.² During international armed conflict the First Geneva Convention provides a comprehensive regime for the protection of wounded and sick members of armed forces and other associated forces who have fallen into enemy hands, while Additional Protocol I expands these protections to civilians.³ The protection provided in non-international armed conflict is rooted in Common Article 3 of the 1949 Geneva Conventions, as well as Additional Protocol II. Further, as was noted in the 2005 ICRC *Customary International Humanitarian Law* study, State practice establishes that the search for, collection, and treatment of the

1. See *Founding and Early Years of the ICRC (1863-1914)*, ICRC (May 12, 2010), <https://www.icrc.org/en/document/founding-and-early-years-icrc-1863-1914>

The Red Cross came into being at the initiative of a man named Henry Dunant, who helped wounded soldiers at the battle of Solferino in 1859 and then lobbied political leaders to take more action to protect war victims. His two main ideas were for a treaty that would oblige armies to care of all wounded soldiers and for the creation of national societies that would help the military medical services.

2. Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, Aug. 12, 1949, 6 U.S.T. 3114, 75 U.N.T.S. 31 [hereinafter Geneva Convention I]; Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, Aug. 12, 1949, 6 U.S.T. 3217, 75 U.N.T.S. 85; Convention (III) Relative to the Treatment of Prisoners of War, Aug. 12, 1949, 6 U.S.T. 3316, 75 U.N.T.S. 135; Convention (IV) Relative to the Protection of Civilian Persons in Time of War, Aug. 12, 1949, 6 U.S.T. 3516, 75 U.N.T.S.; Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, Dec. 12, 1977, 1125 U.N.T.S. 3 [hereinafter Additional Protocol I]; Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts, Dec. 12, 1977, 1125 U.N.T.S. 609.

3. GEOFFREY CORN, KENNETH WATKIN & JAMIE WILLIAMSON, *LAW IN WAR: A CONCISE OVERVIEW* 90 (2018); see also Additional Protocol I, *supra* note 2, art. 8(1) (“‘Wounded’ and ‘sick’ means persons, whether military or civilian, who . . . are in need of medical assistance or care and who refrain from any act of hostility.”).

wounded, sick, and shipwrecked is “a norm of customary international law applicable in both international and non-international armed conflicts.”⁴

However, in the twenty-first century States and other participants in conflict are facing new challenges in meeting these humanitarian obligations. One area of particular concern is the shift of contemporary operations to urban population centers, which themselves are undergoing dramatic growth. Most of these urban-based conflicts are occurring in the context of terrorism and insurgencies, challenging the ability of the State to govern, contain the violence, and ultimately control those populations with peacetime human rights-based rules. A focus on “counterterrorism”⁵ that frequently includes a blend of policing and military responses has created a complex legal and operational situation in which medical care must be provided.

The following analysis of the provision of medical care in contemporary urban conflict will be addressed in five parts. Part II discusses the change in the operational environment to one increasingly taking place in urban areas. Part III addresses the determination of when an “armed conflict” actually exists and the impact of conflict characterization on the legal regime governing the provision of medical care. A particular focus will be the situation brought about by court rulings and State policy choices that frequently favor human rights-based law enforcement responses. The fourth Part addresses the availability of medical services to military personnel and civilians during armed conflict. Part V looks at the destructive impact of urban conflict, particularly on civilians found in that battlespace. Finally, Part VI provides an overview of the types of casualties that can result from urban combat.

4. 1 INTERNATIONAL COMMITTEE OF THE RED CROSS, CUSTOMARY INTERNATIONAL HUMANITARIAN LAW 396 (Jean-Marie Henckaerts & Louise Doswald-Beck eds., 2005) [hereinafter CIHL].

5. U.S. DEPARTMENT OF DEFENSE, DOD DICTIONARY OF MILITARY AND ASSOCIATED TERMS (2018), <http://www.jcs.mil/Portals/36/Documents/Doctrine/pubs/dictionary.pdf> (“Activities and operations taken to neutralize terrorists and their organizations and networks in order to render them incapable of using violence to instill fear and coerce governments or societies to achieve their goals.”).

II. URBAN CONFLICT AND THE CHANGING NATURE OF WARFARE

While humanitarian law is universal, how it is applied is by necessity contextual.⁶ From a treaty perspective, the requirement to provide medical care in armed conflict was primarily developed in the context of international armed conflict. However, even with respect to inter-State armed conflict, warfare has changed over the past century. As has been noted, “While statistics vary among studies, there is no question that beginning with World War II, the ratio of civilian to military casualties in war has steadily increased. Many experts believe that today 90 percent of casualties are civilian.”⁷ Since the end of the Cold War, there has been a proliferation of “non-international armed conflicts” resulting in military forces being engaged in a wide range of military operations. Those operations have spanned a spectrum from high-end conventional style combat in urban environments, such as Fallujah and Mosul in Iraq, Raqqa and Damascus in Syria, and Marawi in the Philippines, to United Nations-mandated peace support operations in Mali.

Of note, the conflict in Mali is representative of a unique aspect of contemporary conflict. While the jihadist groups involved do not pose a monolithic threat, at its heart the violence in Mali is part of a complex transnational, and therefore international, insurgent threat against the governments of the Sahel region of Africa.⁸ It was the threat of the seizure of the Malian capital of Bamako by jihadists that prompted French military intervention in 2013.⁹ Since then, the city has witnessed periodic terrorist violence.¹⁰

It is the transnational threat posed by non-State actors, ranging from criminal groups challenging State governance to a complex web of jihadist

6. Geoffrey S. Corn, *Humanitarian Regulation of Hostilities: The Decisive Element of Context*, 51 VANDERBILT JOURNAL OF TRANSNATIONAL LAW 763, 765 (2018).

7. *Id.* at 764.

8. Firlie Davies & Alistair Leithead, *The War in the Desert: Why the Sahara Is Terror's New Frontline*, BBC NEWS (June 21, 2018), https://www.bbc.co.uk/news/resources/idt-sh/war_in_the_desert. For an overview of the jihadist threat in the Sahel, see CHRISTOPHER S. CHIVVIS, *THE FRENCH WAR ON AL QA'IDA IN AFRICA* 7–8 (2016).

9. CHIVVIS, *supra* note 8, at 93–111.

10. *See, e.g.*, Mamadou Tapily, Peter Walker & Charlie English, *Mali Attack: More Than 20 Dead after Terrorist Raid on Bamako Hotel*, BBC NEWS (Nov. 20, 2015), <https://www.theguardian.com/world/2015/nov/20/mali-attack-highlights-global-spread-extremist-violence>; *see also Mali Takes Terrorist Threat Seriously, Especially in Bamako*, APA NEWS (Aug. 16, 2017), <http://apanews.net/index.php/en/news/mali-takes-terrorist-threat-seriously-especially-in-bamako>.

organizations seeking to establish a global caliphate that has made the operational environment so complex.¹¹ The security situation is further complicated by the link between criminal activity and terrorism/insurgency, and the degree to which urban areas in some parts of the world have become an operational magnet for warlords and others challenging government authority.¹² Importantly, conflict with non-State actors, whether internal to a State or transnational in character, has increased the requirement not only to consider international humanitarian law obligations, but also obligations imposed by human rights law. As will be discussed, this development can have significant impact on obligations regarding medical care.

There is considerable merit to the theory that champions the approach that “war is war” regardless of whether an armed conflict is fought in an intra-State, inter-State, or transnational context.¹³ This is particularly true regarding humanitarian obligations since human suffering is common to all types of conflict. Warfare conducted in the “regions of savagery” contemplated by jihadist doctrine¹⁴ can be just as vicious and destructive as conventional inter-State conflict. Traditionally, terrorism and insurgency were most often associated with guerrilla groups operating from inhospitable wooded and mountainous areas of a country, and therefore, more difficult places for State security forces to operate. However, the regions of savagery of contemporary conflict now extend to “a city, or a village, or two cities, or a district, or part of a large city.”¹⁵ There has been a dramatic shift over the past two decades to terrorists and insurgents operating in population centers.

The conduct of hostilities in these urban environments reflects the reliance on a three-stage guerrilla warfare strategy that culminates in a liberation stage where “guerrillas enter operations that are semi-regular and others that are regular, and they control some areas from which they launch operations

11. KENNETH WATKIN, *FIGHTING AT THE LEGAL BOUNDARIES: CONTROLLING THE USE OF FORCE IN CONTEMPORARY CONFLICT* 159–213 (2016).

12. ANTONIO GIUSTOZZI, *EMPIRES OF MUD: WARS AND WARLORDS IN AFGHANISTAN* 21 (2009).

13. HEW STRACHAN, *THE DIRECTION OF WAR* 207–09 (2013) (outlining the importance of a unitary vision of war).

14. ABU BAKR NAJI, *THE MANAGEMENT OF SAVAGERY: THE MOST CRITICAL STAGE THROUGH WHICH THE UMMA WILL PASS* [16] (William McCants trans., 2006), <https://azelin.files.wordpress.com/2010/08/abu-bakr-naji-the-management-of-savagery-the-most-critical-stage-through-which-the-umma-will-pass.pdf>.

15. *Id.*

to liberate the rest of the country.”¹⁶ The combat that occurred in the streets of Mosul, Raqqa, and Damascus resembles urban fighting within conventional armed conflict. In Afghanistan, the long-term U.S. military strategy, which hinges on defending population centers while ceding much of the remote countryside to the Taliban, inevitably means that clashes will occur within urban areas. This was graphically demonstrated in August 2018 in Ghazni with the Taliban assault on that city. While Ghazni was ultimately left in the hands of the Afghan government, the Taliban claimed, “the conquest of this city signifies the failure of yet the latest American strategy,” and “[t]he experience of Ghazni has proven that no defensive belts of cities can withstand the offensive prowess of the Mujahideen.”¹⁷ The war for the control of towns and cities of Afghanistan is far from over.

This increasing shift towards warfare in cities and towns is accelerated by a migration of the world’s population to urban environments. By 2008, 50 percent of the world population lived in cities.¹⁸ It is estimated that by 2050, this amount will increase to 66 percent.¹⁹ Further, a significant proportion of this population will live in less-developed countries.²⁰ For example, the Institute for Security Studies predicts that by 2030, “Lagos, Cairo and Kinshasa will each have to cater for over 20 million people, while Luanda, Dar es Salaam and Johannesburg will have crossed the 10 million mark.”²¹ Likewise, Sullivan notes, “[c]ontemporary megacities may include global cities and global slums (neighborhoods where transnational gangs dominate

16. BRYNJAR LIA, ARCHITECT OF GLOBAL JIHAD: THE LIFE OF AL-QAIDA STRATEGIST ABU MUS’AD AL-SURI 472 (2008); see also AL-QA’IDA’S DOCTRINE FOR INSURGENCY: ABD AL-AZIZ AL-MUQRIN’S “A PRACTICAL COURSE FOR GUERRILLA WAR” 12 (Norman Cigar trans., 2008); MICHAEL W. S. RYAN, DECODING AL-QAEDA’S STRATEGY: THE DEEP BATTLE AGAINST AMERICA 230 (2013); ALI SOUFAN, ANATOMY OF TERROR: FROM THE DEATH OF BIN LADEN TO THE RISE OF THE ISLAMIC STATE 286–87 (2017).

17. W. J. Hennigan, *Exclusive: Inside the U.S. Fight to Save Ghazni from the Taliban*, TIME (Aug. 23, 2018), <http://time.com/longform/ghazni-fight-taliban/>.

18. ANTHONY JAMES JOES, URBAN GUERRILLA WARFARE 1–2 (2007).

19. POPULATION DIV., U.N. DEP’T OF ECON. & SOC. AFFAIRS, WORLD URBANIZATION PROSPECTS: THE 2014 REVISION HIGHLIGHTS, at 1, U.N. Doc. ST/ESA/SER.A/352 (2014), <https://esa.un.org/unpd/wup/Publications/Files/WUP2014-Highlights.pdf>.

20. *Id.* at 2.

21. Julia Bello-Schünemann, *Africa’s Future Is Urban*, INSTITUTE FOR SECURITY STUDIES (Dec. 2, 2016), <https://issafrica.org/iss-today/africas-future-is-urban>.

local turf and are globally connected to transnational criminal networks).”²² This means warfare and associated insecurity occurring in cities and surrounding urban areas with up to three times the population of New York City.²³

Adding to the complexity of this operating environment is the fact that most of these people live in littoral regions.²⁴ This means providing security to urban areas must involve all components of military and security forces: land, air, and naval military forces, police forces, and the coast guard. The threat to littoral urban centers was most graphically displayed in Mumbai in 2008 where military, paramilitary, and police units were required to deploy to counter an exceptionally destructive sea borne attack on that city by the Pakistan based LeT terrorist group.²⁵ During that attack ten terrorists “were able to hold the world’s fourth largest city to ransom, killing 166 and injuring more than 300 over three nights of horror.”²⁶

Urban conflict in this century presents new challenges, while also resurrecting many old ones. In terms of new challenges, fighting among an urbanized civilian population means, “[m]edical intervention includes pre-hospital emergency medical services and in-hospital care. Responding to injuries caused by terrorism, insurgency, and war form a situation of ‘conflict disaster’ demanding new protocols such as tactical medics and ‘counterterrorism medicine.’”²⁷ Regarding the provision of medical care, State security forces must also interface with specific actors on the urban battlefield “where civil defense and non-governmental organizations—such as Médecins Sans Frontières (MSF), the International Committee of the Red Cross (ICRC), Syria’s

22. John P. Sullivan, *The Urban Imperative: War, Terrorism, and Insecurity in Mega Cities*, STRATFOR (Feb. 13, 2018), <https://worldview.stratfor.com/horizons/fellows/dr-john-p-sullivan/13022018-urban-imperative-war-terrorism-and-insecurity-megacities>.

23. James Barron, *New York City’s Population Hits a Record 8.6 Million*, NEW YORK TIMES (Mar. 22, 2018), <https://www.nytimes.com/2018/03/22/nyregion/new-york-city-population.html>.

24. DAVID KILCULLEN, *OUT OF THE MOUNTAINS: THE COMING OF AGE OF THE URBAN GUERRILLA* 30 (2013) (noting that 75 percent of the world’s cities are coastal and that 80 percent of the population lives within sixty miles of the coastline).

25. *Id.* at 57–60.

26. CATHY SCOTT-CLARK & ADRIAN LEVY, *THE SIEGE: 68 HOURS INSIDE THE TAJ HOTEL 277* (2013).

27. Sullivan, *supra* note 22.

White Helmets, and Save the Children (which was recently attacked in Jalalabad)—provide aid and care to the besieged and threatened populations.”²⁸ Elsewhere the siege of cities, such as that of the port city of Al Hudaydah, Yemen,²⁹ air and naval blockades occurring off the coast of that country,³⁰ and the naval blockade of Gaza³¹ are forcing participants to reassess older humanitarian law rules concerning the obligations of conflict participants towards the civilian population.³² Among the challenges in this context is access to life-saving medication for besieged or blockaded civilians.³³

III. WHICH LEGAL FRAMEWORK GOVERNS THE PROVISION OF MEDICAL CARE?

An essential, indeed foundational, question is what body of law governs the provision of medical care to those in need arising from violence in urban areas. Of course, an armed conflict must exist for international humanitarian law—and with it the obligations regarding medical care—to apply. In the absence of such conflict, the provision of medical care is governed exclusively by human rights law.³⁴ As the second decade of the twenty-first century ends, there has been a renewed focus by major military powers, such as the United States, on near peer warfare between States. However, international armed conflicts are not occurring directly between those powers, and con-

28. *Id.*

29. Mohammed Ali Kalfood & Margaret Coker, *Saudis Escalate Siege of Port in Yemen, Alarming Aid Groups*, NEW YORK TIMES (Aug. 2, 2018), <https://www.nytimes.com/2018/08/02/world/middleeast/yemen-saudi-hudaydah-missiles.html>.

30. *Yemen: Coalition Blockade Imperils Civilians: UN Should Sanction Senior Saudi Leaders*, HUMAN RIGHTS WATCH (Dec. 7, 2017), <https://www.hrw.org/news/2017/12/07/yemen-coalition-blockade-imperils-civilians> [hereinafter *Yemen: Coalition Blockade*].

31. 1 JACOB TURKEL ET AL., THE PUBLIC COMMISSION TO EXAMINE THE MARITIME INCIDENT OF 31 MAY 2010, ¶¶ 48–64, at 53–69 (2011), <http://turkel-committee.gov.il/files/wordocs//8707200211english.pdf>.

32. See, e.g., PHILLIP DREW, THE LAW OF MARITIME BLOCKADE: PAST, PRESENT AND FUTURE (2017).

33. *Yemen: Coalition Blockade*, *supra* note 30.

34. Katherine H.A. Footer & Leonard S. Rubenstein, *A Human Rights Approach to Health Care in Conflict*, 95 INTERNATIONAL REVIEW OF THE RED CROSS 167, 168 (2013) (“In some circumstances of political volatility or violence, attacks on health care providers, facilities, transports, and patients take place, but IHL does not apply at all, because no armed conflict exists.”).

flicts not of an international character remain the predominate form of warfare. This can be seen in *The War Report: Armed Conflicts in 2017*, which indicates that at least fifty-five armed conflicts occurred that year.³⁵ Thirty-eight of these were viewed as non-international ones, while ten of the remaining seventeen international armed conflicts between States were belligerent occupations, such as Israel's occupation of the Palestinian West Bank.³⁶ The international armed conflicts that occurred have included short-lived ones "between Libya and Egypt, Israel and Syria, as well as Turkey and Iraq."³⁷ As a result, it is non-international armed conflicts, many of which are protracted and transcend national borders, which continue to dominate the security dialogue.

The non-State actor threat encompasses a wide range of violence that can involve isolated terrorist incidents, insurgent groups engaging in guerrilla warfare, or armed conflict, such as has occurred with the Islamic State, which approximates conventional warfare. Not all non-State actor violence rises to the level of an armed conflict. One area of considerable debate in the post-9/11 security environment is when violence occurring between States and non-State actors crosses the armed conflict threshold. For much of the period following the attacks of 9/11 a segment of the international community focused on requiring a high threshold for the existence of an armed conflict in a non-international context. That threshold is primarily based on the *Tadić* criteria of "protracted armed violence between governmental authorities and organized armed groups or between such groups within a State."³⁸

The debate has largely centered on limiting when a determination is made that a conflict exists, particularly in relation to transnational terrorist attacks. Terrorism is equated with criminal activity to be controlled by States exercising sovereignty over their own territory. This has included suggestions that "individual acts of terrorism that have been occurring around the world, in Mumbai, London, Madrid, Casablanca, Glasgow, or Bali, to name just a

35. THE WAR REPORT: ARMED CONFLICTS IN 2017, at 17 (Annyssa Bella ed., 2018).

36. *Id.*

37. *Id.*

38. Prosecutor v. Tadić, Case No. IT-94-1-I, Decision on Defence Motion for Interlocutory Appeal on Jurisdiction, ¶ 70 (Int'l Crim. Trib. for the former Yugoslavia Oct. 2, 1995).

few places” would not meet the criteria for the application of Common Article 3.³⁹ However, this “individualized” approach towards assessing contemporary terrorism is significantly challenged by a transnational jihadist threat that is linked in a common cause to create its own system of governance.

Over-reliance on the *Tadić* threshold has at times seemed inconsistent with the broader interpretation applied to the applicability of Common Article 3 prior to 9/11. As was noted in *Abella v. Argentina*, a 1997 Inter-American Commission on Human Rights report,

[t]he most difficult problem regarding the application of Common Article 3 is not at the upper end of the spectrum of domestic violence, but rather at the lower end. The line separating an especially violent situation of internal disturbances from the “lowest” level Article 3 armed conflict may sometimes be blurred and, thus, not easily determined. When faced with making such a determination, what is required in the final analysis is a good faith and objective analysis of the facts in each particular case.⁴⁰

This interpretation seems at odds with one that seeks to set a high threshold for the existence of an armed conflict.

Further, in the post-9/11 period there has been a greater recognition of the transnational threat that jihadist groups can pose to international peace and security.⁴¹ Indeed, the threat posed by Al-Qaeda, the Islamic State, and other jihadist groups in various locations transcends multiple geographic borders.⁴² It is difficult to argue that the violence of these groups constitutes isolated or “individual” acts of terrorism when their linkage is perhaps more accurately being described as “Al Qaeda and Associated Movements (AQAM),”⁴³ or broadly as the “Jihadist Movement.”⁴⁴

39. Jelena Pejić, *The Protective Scope of Common Article 3: More Than Meets the Eye*, 93 INTERNATIONAL REVIEW OF THE RED CROSS 1, 8–9 (2011).

40. *Abella v. Argentina*, Case 11.137, Inter-Am. Comm’n H.R., Report No. 55/97, OEA/Ser.L/V/II.95, doc. 7 rev. ¶ 153 (1997), http://hrlibrary.umn.edu/cases/1997/argentina_55-97a.html.

41. *See, e.g.*, S.C. Res. 2249, pmbl. (Nov. 20, 2015) (recognizing the global nature of the Islamic State threat).

42. WATKIN, *supra* note 11, at 295–98.

43. ABDEL BARI ATWAN, AFTER BIN LADEN: AL QAEDA, THE NEXT GENERATION 15 (2012).

44. *See* WATKIN, *supra* note 11, at 198–99, for a discussion of the “Jihadist Movement.”

As has been noted by the ICRC, the question of whether an armed conflict exists can “make a vital difference to the survival, well-being, and dignity of the victims of a conflict.”⁴⁵ This is because Common Article 3 “ensures that the Parties to that conflict are under an international legal obligation to grant certain fundamental protections to the victims of the conflict and to respect the rules on the conduct of hostilities. Humanitarian law binds all Parties to the conflict, State and non-State alike.”⁴⁶ Over the history of the development of international humanitarian law, protections regarding medical care “have become more extensive and detailed.”⁴⁷ However, their applicability as a matter of law requires the existence of an armed conflict.

This is not to suggest “all IHL [international humanitarian law] medical-care measures are universally applicable to all armed conflicts.”⁴⁸ While many rules applicable to international armed conflicts are viewed as being customary in nature and applicable to non-international conflicts, some differences remain. For example, in non-international armed conflict there are no humanitarian law limitations on the detention or retention of medical personnel.⁴⁹ That said, the international humanitarian law provisions provide a more detailed and comprehensive set of protections for those requiring medical care since, “[u]nlike IHL, which has rules designed specifically to address the respect and protection of health care in armed conflict, HRL [human rights law] instruments are formulated in more general terms.”⁵⁰

It is widely accepted that human rights law protections regarding health do continue to apply during all types of armed conflict and other situations of violence. This includes Article 12 of the International Covenant on Economic, Social and Cultural Rights, which recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental

45. INTERNATIONAL COMMITTEE OF THE RED CROSS, COMMENTARY ON THE FIRST GENEVA CONVENTION OF 1949: CONVENTION (I) FOR THE AMELIORATION OF THE CONDITION OF THE WOUNDED AND SICK IN ARMED FORCES IN THE FIELD, ¶ 388, at 141 (2016) [hereinafter 2016 COMMENTARY ON THE FIRST GENEVA CONVENTION].

46. *Id.*

47. Footer & Rubenstein, *supra* note 34, at 168.

48. DUSTIN A. LEWIS, NAZ K. MODIRZADEH & GABRIELLA BLUM, MEDICAL CARE IN ARMED CONFLICT: INTERNATIONAL HUMANITARIAN LAW AND STATE RESPONSES TO TERRORISM 6 (2015), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2657036.

49. *Id.* at 7.

50. Footer & Rubenstein, *supra* note 34, at 171.

health.”⁵¹ This has been interpreted to require the “equitable distribution [of] and access to health facilities, goods and services,” the provision of “essential medicines,” and the formulation of a “national health plan or policy.”⁵² In this respect, “IHL does not generally cover these dimensions of health services, as it focuses on impartiality in responding to individuals in immediate need of care rather than on the structure and availability of services.”⁵³ The operational challenge is that not all States agree that international human rights treaty law has extraterritorial applicability, thereby limiting the extension of these rights for some participants during overseas operations.⁵⁴ Further, it is difficult to argue that customary human rights law, which does have universal application, encompasses this treaty right.

Questions regarding how human rights law is interpreted to ensure the provision of non-discriminatory and effective medical care also arise in “circumstances where no armed conflict exists, but where health workers, facilities, patients, and ambulances are subject to threats, attacks, and other forms

51. International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3.

52. UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS, PROTECTION OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS IN CONFLICT ¶ 35, at 11 (2015), <https://www.ohchr.org/Documents/Issues/ESCR/E-2015-59.pdf>; see also Footer & Rubenstein, *supra* note 34, at 180; U.N. Economic and Social Council, Committee on Economic, Social and Cultural Rights, Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social And Cultural Rights: General Comment No. 14, ¶ 34, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), http://www.un.org/en/ga/search/view_doc.asp?symbol=E/C.12/2000/4 (noting that among the obligations is for States to refrain from “limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law”).

53. Footer & Rubenstein, *supra* note 34, at 181.

54. Michael J. Dennis, *Application of Human Rights Treaties Extraterritorially in Times of Armed Conflict and Military Occupation*, 99 AMERICAN JOURNAL OF INTERNATIONAL LAW 119, 141 (2005) (“The obligations assumed by states under the main international human rights instruments were never intended to apply extraterritorially during periods of armed conflict.”); U.N. Human Rights Committee, Concluding Observations on the Fourth Periodic Report of the United States of America, ¶ 4, U.N. Doc. CCPR/C/USA/CO/4 (Apr. 23, 2014) (noting that the United States maintains the position that the Covenant does not apply to individuals under its jurisdiction, but outside its territory); Human Rights Committee, Draft General Comment No. 36 on Article 6 of the International Covenant on Civil and Political Rights – Right to Life, Comments by the Government of Canada, ¶ 7 (Oct. 23, 2017), <https://www.ohchr.org/EN/HRBodies/CCPR/Pages/GC36-Article6Righttolife.aspx> (then follow “Canada” hyperlink) (setting forth the Canadian view that the “jurisdictional competence of a State is primarily territorial,” and that an expansion beyond the territory of the State “would impinge on well-established principles of sovereignty”).

of interference and denial, HRL fills an important gap.”⁵⁵ Of particular note, it is solely human rights law that applies in those situations. Examples include the 2011 political unrest in Bahrain, the situation in Syria before a determination there was an armed conflict, and in the volatile regions of Nigeria where vaccination workers have been attacked.⁵⁶

However, setting a very high legal threshold for armed conflict can mean that State authorities are confronted with levels of violence that factually reach levels normally associated with warfare. In those situations, in order to provide proper medical care to the victims of that violence human rights law will likely have to begin to be interpreted in a fashion that approximates the more specific protective rules of international humanitarian law. The potential problem this creates is that important obligations regarding the provision of medical care integral to that body of law may be not be incorporated. Acknowledging the existence of an armed conflict in circumstances where the levels of violence factually indicate one exists provides the most robust and best articulated protections for both civilian populations and the participants in the conflict.

More recently, there has been a greater recognition of a “totality of the circumstances” approach that expands the criteria to be considered when assessing if an armed conflict with non-State actors is in existence.⁵⁷ This has included looking towards the standard of “internal disturbances and tensions, such as riots, isolated and sporadic acts of violence and other acts of a similar nature” found in Article 1(2) of Additional Protocol II as a dividing line between armed conflict and situations of ordinary crime that solely demand a human rights-based law enforcement response. Similarly, the requirement to deploy military forces, while not determinative on its own, provides another important factor that needs to be considered when assessing whether an armed conflict is occurring.

55. Footer & Rubenstein, *supra* note 34, at 187.

56. *Id.* at 168.

57. *See* Prosecutor v. Boškoski and Tarčulovski, Case No. IT-04-82-T, Judgment, ¶ 257 (Int'l Crim. Trib. for the Former Yugoslavia July 10, 2008) http://www.icty.org/x/cases/boskoski_tarculovski/tjug/en/080710.pdf (referencing the totality of circumstances); *see also* Laurie R. Blank & Geoffrey S. Corn, *Losing the Forest for the Trees: Syria, Law, and the Pragmatics of Conflict Recognition*, 46 VANDERBILT JOURNAL OF TRANSNATIONAL LAW 693, 731–45 (2013); Geoffrey S. Corn, *Legal Classification of Military Operations*, in U.S. MILITARY OPERATIONS: LAW POLICY, AND PRACTICE 67, 74–75 (Geoffrey S. Corn, Rachel E. VanLandingham & Shane R. Reeves eds., 2016); WATKIN, *supra* note 11, at 375–78.

The notion that an armed conflict can occur in a relatively short period of fighting is reflected in the 1997 *Abella v. Argentina* report, which found an armed conflict lasting only thirty hours.⁵⁸ It is an interpretation that has once again gained prominence as the world has struggled with transnational terrorism in the post-9/11 period. Applying a “totality of the circumstances approach” to incidents such as the 2000 Sierra Leone hostage rescue (4 hours), the 2008 Mumbai attack (68 hours), the 2012 assault on U.S. facilities in Benghazi (13 hours), and the 2013 Westgate Mall attack in Nairobi (80 hours) all point towards the existence of armed conflicts, either as part of a broader conflict, or as a “one-off” attack of a relatively short duration.⁵⁹

A more flexible approach towards conflict characterization is also reflected in the ICRC’s 2016 *Commentary on the First Geneva Convention* where it is noted that “hostilities of only a brief duration may still reach the intensity level of a non-international armed conflict if, in a particular case, there are other indicators of hostilities of a sufficient intensity to require and justify such an assessment.”⁶⁰ This *Commentary* incorporates the earlier Pictet *Commentary* reference to the use of State military forces as one of the criteria to be considered in assessing if an armed conflict exists.⁶¹ The 2016 *Commentary* indicates that “the requisite degree of intensity may be met . . . when the government is obliged to use military force against the insurgents, instead of mere police forces.”⁶² While some States, such as Canada, may also use their military forces in a domestic law enforcement role,⁶³ it remains that the use of military forces to counter threats posed by non-State actors is a relevant

58. *Abella v. Argentina*, *supra* note 40, ¶ 1.

59. WATKIN, *supra* note 11, at 293, 367–68; *see also* KILCULLEN, *supra* note 24, at 52–66 (outlining the Mumbai assault); MITCHELL ZUCKOFF, 13 HOURS: THE INSIDE ACCOUNT OF WHAT REALLY HAPPENED IN BENGHAZI 254–80 (2014); Daniel Howden, *Terror in Nairobi: The Full Story behind al-Shabaab’s Mall Attack*, *GUARDIAN* (London), (Oct. 4, 2013), <https://www.theguardian.com/world/2013/oct/04/westgate-mall-attacks-kenya>.

60. 2016 COMMENTARY ON THE FIRST GENEVA CONVENTION, *supra* note 45, ¶ 440.

61. *See* OSCAR M. UHLER ET AL., COMMENTARY TO GENEVA CONVENTION (IV) RELATIVE TO THE PROTECTION OF CIVILIAN PERSONS IN TIME OF WAR GENEVA 35 (1958) (noting specifically paragraph 1.A.2).

62. 2016 COMMENTARY ON THE FIRST GENEVA CONVENTION, *supra* note 45, ¶ 431.

63. BERND HORN, NO ORDINARY MEN: SPECIAL OPERATIONS FORCES MISSIONS IN AFGHANISTAN 59–62 (2016) (setting out the history of Joint Task Force 2 and its taking over the domestic hostage rescue role from the Royal Canadian Mounted Police in 1993).

factor in determining if an armed conflict is in existence.⁶⁴ The ICRC Commentary, in effect, supports the “totality of the circumstances” approach that additional and more flexible factors should be applied when assessing whether an armed conflict exists.

Despite this move towards a more flexible interpretation of the armed conflict threshold, there are additional conflict categorization issues that could have significant impact on the provision of medical care during contemporary conflict. In this context, viewing terrorism as a criminal matter can have a particularly important consequence in two ways.

The first is the degree to which “states penalize—during wartime (as well as peacetime)—diverse forms of support, sometimes including medical care, to terrorist organizations,” such that “counterterrorism policies recast medical care as a form of illegitimate support to the enemy,” or “reject the corollary proposition that a terrorist organization may assign a medical corps to work under its authority.”⁶⁵ The counterterrorism approach can often “prevent donors from affiliating with, funding or providing support to any NSAG-provided health activities,” and reduce “the ‘risk appetite’ of many faith-based humanitarian organizations to engage with certain armed groups.”⁶⁶ This outcome is entirely inconsistent with humanitarian need. As has been clearly stated in a study of humanitarian obligations, “no one may be harassed, harmed, prosecuted, convicted, or punished for having provided medical care to the wounded and sick, regardless of the nationality, religion, status or affiliation with a party to the conflict of the person receiving such care.”⁶⁷ What is required is an approach “for all armed conflicts: that once out of the fight, all wounded and sick fighters (and all wounded and sick civilians) should be cared for, and no one should be penalized for giving that care. In short, medical care should be above the conflict.”⁶⁸

64. *See also* Prosecutor v. Boškoski and Tarčulovski, *supra* note 57, ¶ 190 (emphasis added) (noting that the Court references the armed forces’ engagement with terrorists as a factor in determining whether an armed conflict exists).

65. LEWIS, MODIRZADEH & BLUM, *supra* note 48, at ii.

66. LOUIS LILLYWHITE, CHATHAM HOUSE, NON-STATE ARMED GROUPS, HEALTH AND HEALTHCARE 5 (2015), <https://www.chathamhouse.org/event/non-state-armed-groups-health-and-healthcare> (follow “Meeting Summary” hyperlink).

67. DAPO AKANDE & EMANUELA-CHIARA GILLARD, OXFORD GUIDANCE ON THE LAW RELATING TO HUMANITARIAN RELIEF OPERATIONS IN SITUATIONS OF ARMED CONFLICT ¶ 86, at 33 (2016), <https://www.unocha.org/sites/dms/Documents/Oxford%20Guidance%20pdf.pdf>.

68. LEWIS, MODIRZADEH & BLUM, *supra* note 48, at 146.

Second, there is the impact of both legal and policy approaches that treat threats by non-State actors to States as a “normal” criminal matter, often when States are being faced with robust insurgencies involving large-scale violence. Focusing on this second issue is especially important since the decision to apply human rights law, either as a matter of law or policy, can have a significant impact on the scope of medical care obligations and the degree of clarity with which they are articulated during counterterrorism and counterinsurgency operations. In practical terms, the legal source for the provision of medical care is not always immediately evident in the contemporary security environment. There are numerous situations, which, due to the nature of the groups and the intensity of the violence involved, can qualify as armed conflicts. This would suggest that humanitarian law, supported by human rights law would govern the provision of medical care. However, courts and States frequently assess these situations of violence solely through a human rights-based law enforcement lens.

The application of human rights law, particularly regarding the use of force can, and frequently should, be the preferred State approach from a policy perspective.⁶⁹ This preference is logical because a law enforcement response has the advantage of lowering the levels of violence, as well as maintaining an atmosphere of “normalcy” that ultimately serves as a key indicator of success in a struggle against groups seeking to undermine State governance.⁷⁰ The challenge is that at times the desire to maintain a human rights law/law enforcement response does not match the threat posed by the non-State actor, the overall levels of violence, or the nature of the State response. The levels of violence and the suffering experienced by the civilian population are not “normal” at all. This leads to the question of how, or even whether, in those situations the more protective international humanitarian law provisions regarding medical care could be applied during situations that qualify as armed conflict, but which may be viewed by a court or the State exclusively through a human rights lens.

69. See WATKIN, *supra* note 11, at 592–95, for a discussion of the policy choice frequently made by States to apply a law enforcement approach.

70. Adrian Gueleke, *Secrets and Lies: Misinformation and Counter-Terrorism*, in ILLUSIONS OF TERRORISM AND COUNTER-TERRORISM 95, 99 (Richard English ed., 2015) (noting that “criminalization” is identified as one of the phases of a State’s response to politically motivated violence. It is also noted that “[t]he attraction of this strategy in the context of internal challenge to the state is the implication that the state is sufficiently legitimate that the problem can be dealt with in the context of normal policing.”).

The best examples of a strict adherence to a human rights law approach can be found in the European Court of Human Rights (ECtHR) jurisprudence dealing with internal insurgencies and terrorist threats. While that Court has relied on international humanitarian law “as far as possible” to interpret its human rights law mandate regarding international armed conflict,⁷¹ it has chosen not to do so in respect of hostilities internal to its member States. Rather than overtly relying on humanitarian law when confronted with situations of internal armed conflict, it has chosen to apply a more expansive interpretation of human rights law.

For example, it has applied human rights law to military operations during the Chechen conflict, although in terms of the use of force, the Court has had to significantly increase the tolerance that body of law has traditionally displayed towards violence and civilian casualties. This has been done by borrowing humanitarian law concepts without actually applying that body of law. The Court applied this approach during the protracted Chechen-Russian conflict. Those hostilities had clearly crossed the threshold of armed conflict, including two highly destructive battles between 1994 and 1996 for the control of the city of Grozny. During a 1995 assault on that city “the intensity of artillery fire reached the level of World War II battles”⁷² and “Russian military actions displayed an almost complete indifference towards casualties.”⁷³ These elevated levels of violence continued into the twenty-

71. *See Varnava v. Turkey*, 2009-V Eur. Ct. H.R. 13, ¶ 185 (2009), <http://hudoc.echr.coe.int/eng/?i=001-94162> (noting that in a case arising from the 1974 Turkish invasion of Cyprus, the Court ruled Article 2 of the European Convention on Human Rights, the Right to Life, must be interpreted as far as possible in light of international humanitarian law provisions applicable during international armed conflict); *see also Hassan v. United Kingdom*, 2014-VI Eur. Ct. H.R. 1, ¶ 101–02, <http://hudoc.echr.coe.int/eng/?i=001-146501>. The *Hassan* decision dealt with the occupation of Iraq. By adopting the modifying words “as far as possible,” the Court appears to be suggesting that human rights law might perform a supervisory function altering the application of international humanitarian law during armed conflict. There is simply nothing in the development of those two bodies of law, or in respect of their practical application that suggests this to be the case. *See id.*

72. JOES, *supra* note 18, at 145.

73. *Id.* (citing RAYMOND FINCH, WHY THE RUSSIAN MILITARY FAILED IN CHECHNYA 7 (1998)).

first century as demonstrated by Russian military operations involving air and artillery strikes,⁷⁴ as well as the Moscow and Beslan hostage incidents.⁷⁵

Notably, the ECtHR has consistently dealt with State military and other security forces engaged in what can readily be described as combat as a “law enforcement body in a democratic society.”⁷⁶ Indeed, the Court assessed its actions against a “normal legal background.”⁷⁷ The Court took this position even for situations where the force included airpower and artillery employed to suppress an “illegal armed insurgency.”⁷⁸ Clearly, these military means and methods are most readily associated with the conduct of hostilities; they are not “normally” applied in law enforcement operations.

While sometimes relying on humanitarian law concepts, such as those found in the targeting proportionality test,⁷⁹ the Court has applied them within the restraining principles of human rights law: a strict and compelling test of necessity, using no more force than necessary, and the requirement that the force used be strictly proportionate.⁸⁰ This blending of principles, without acknowledging their grounding in the law governing hostilities, is also evident in the acceptance by the Court of significant levels of collateral casualties (129 hostages) that occurred during the 2002 Moscow theater hostage rescue.⁸¹ In contrast, the traditional human rights law approach has been very reluctant to accept any collateral casualties during a policing operation.

The ECtHR also incorporated the humanitarian law concept of indiscriminate weapons into its 2016 judgment regarding the 2004 Beslan school siege.⁸² The weapons used during this “counter-terrorist” operation included

74. *See* Isayeva v. Russia, App. Nos. 57947/00, 57948/00, 57949/00 (2005) (ECtHR), <http://hudoc.echr.coe.int/eng?i=001-68379>; Isayeva v. Russia, App. No. 57959/00 (2005) (ECtHR), <http://hudoc.echr.coe.int/eng?i=001-68381> [hereinafter Isayeva II].

75. *See* Finogenov v. Russia, 2011-VI Eur. Ct. H. R. 365; Tagayeva v. Russia, App. No. 26562/07 and 6 other applications (2017) (ECtHR), <http://hudoc.echr.coe.int/eng?i=001-172660>.

76. Finogenov, *supra* note 75; Tagayeva, *supra* note 75, ¶ 600 (emphasis added).

77. Kerimova v. Russia, App. Nos. 17170/04, 20792/04, 22448/04, 23360/04, 5681/05, 5684/05, ¶ 253 (2011) (ECtHR), <http://hudoc.echr.coe.int/eng?i=001-104662> (emphasis added).

78. *Id.* ¶ 246; *see also* Isayeva II, *supra* note 74, ¶¶ 190–91.

79. *See, e.g.,* Isayeva II, *supra* note 74, ¶ 176.

80. *Id.* ¶ 173; *see also* Ergi v. Turkey, 1998-IV Eur. Ct. H.R. 59, ¶ 79, <http://hudoc.echr.coe.int/eng?i=001-58200> (noting that a restrictive application of human rights law in an anti-terrorism context had been clearly articulated.).

81. Finogenov, *supra* note 75, ¶¶ 231–36.

82. Tagayeva, *supra* note 75, ¶ 609.

flamethrowers, grenade launchers, large-caliber machine guns, and tanks firing high-fragmentation shells.⁸³ However, in confirming a reluctance to view these incidents as occurring in an armed conflict, one judge noted in his partial dissent: “I am satisfied that the majority remained faithful to the Court’s standards on the use of lethal force in large-scale anti-terrorist operations, dealing with them as with *any other law-enforcement operation* and refusing to apply the paradigm of the law on armed conflicts to them.”⁸⁴ The result of this jurisprudence is that there is now significantly greater authority for the use of force than was traditionally authorized under the human rights paradigm, but a far more restrictive approach to the use of force than would ordinarily be authorized under the law governing the conduct of hostilities.

On one level, the approach of the ECtHR could be said to track the unique threat posed by many non-State actors. From a practical perspective, the normative gap between humanitarian and human rights law—particularly as it relates to use of force by State actors—is often significantly reduced during counterinsurgency and counterterrorism operations. When fighting “among the people” military forces frequently have to limit their use of force. For example, military forces may apply a threat-based response rather than one based on the status of the individual. In contrast, police agencies are often confronted with situations demanding a greater use of lethal force than ordinarily required. Moreover, other common counterinsurgency principles, such as adopting a police primacy approach⁸⁵ and privileging capture over killing insurgents/terrorists, reflect a different operational approach in which the use of lethal force is minimized.

However, as Sandesh Sivakumaran noted after his review of efforts by courts to use human rights law to directly regulate non-international armed conflict, “there should not be a rush to judgement that international human rights law holds the answer to all the problems.”⁸⁶ A particular challenge presented by this jurisprudence is the lack of flexibility that accompanies legal rulings such as those of the ECtHR. When a State makes a policy choice to adopt a police primacy approach during its counterterrorism operations it retains the option of conducting more traditional hostilities when warranted. What is left unaddressed in the jurisprudence of the Court is whether this

83. *Id.* ¶ 608.

84. *Id.* ¶ 1, at 168 (partial dissent by Pinto De Albuquerque, J.) (emphasis added).

85. DAVID H. BAYLEY & ROBERT M. PERITO, *THE POLICE IN WAR: FIGHTING INSURGENCY, TERRORISM, AND VIOLENT CRIME* 68–69 (2010).

86. SANDESH SIVAKUMARAN, *THE LAW OF NON-INTERNATIONAL ARMED CONFLICT* 99 (2012).

blended form of law can effectively address the full range of security threats posed by many non-State actors.

The more permissive international humanitarian law rules governing hostilities, including during non-international armed conflicts, and the humanitarian obligations enshrined in that body of law were developed out of necessity. It is difficult to see how the ECtHR approach could adequately address the violence that occurred in cities such as Grozny, Mosul, Fallujah, or Raqqa. With its individualized approach, human rights law is not well suited to address widespread and intensive violence, the nature of military operations, or the use of force frequently associated with armed conflict. At times, the Court's adherence to restrictive human rights principles appears to be disconnected from the realities of the security situation involved and the threat facing States, particularly during urban conflict. One commentator, noting the challenges caused by the ECtHR approach towards detention in non-international armed conflict, concludes that while due process requirements flowing from the European Convention on Human Rights cannot be abandoned, "it may mean being better prepared to engage the application of the law of armed conflict and for human rights courts to show some humility in engaging the interface between both legal systems."⁸⁷

If the decisions of courts are disconnected from the situation on the ground, there is a very real danger that the credibility of the legal paradigm involved, and its ability to control the violence, will be undermined. It could also have an adverse impact toward establishing and enforcing obligations on the provision of medical care. If what is needed is compliance with international humanitarian law rules, over reliance on human rights law could adversely affect the provision of humanitarian relief. In contrast, while a State may choose to apply a more restrictive policing approach during armed conflict, it will still be bound by its more protective legal obligations toward the victims of the conflict set out in international humanitarian law. The human rights law-dominate approach of the ECtHR can be contrasted with the example set by the Inter-American Court of Human Rights and the Inter-

87. Fionnuala Ni Aoláin, *To Detain Lawfully or Not to Detain: Reflections on UK Supreme Court Decision in Serdar Mohammed*, JUST SECURITY (Feb. 2, 2017), <https://www.justsecurity.org/37013/detain-lawfully-detain-question-reflection-uk-supreme-court-decision-serdar-mohammed/>; see also Kenneth Watkin, *Accountability Fatigue: A Human Rights Law Problem for Armed Forces?*, JUST SECURITY (Nov. 1, 2018), <https://www.justsecurity.org/61318/accountability-fatigue-human-rights-law-problem-armed-forces-petraeus-united-kingdom/>.

American Commission on Human Rights, both of which relied on international humanitarian law to interpret their human rights law mandate in assessing non-international armed conflict.⁸⁸

Applying human rights law to address the use of force by States during exceptional circumstances also raises the possibility of “human rights overreach.” Here, human rights law, developed to regulate society in peacetime, is applied to acts of violence associated with armed conflict. In doing so human rights law is altered to the point that it begins to reflect its humanitarian law counterpart.⁸⁹ In effect, the “militarization” of human rights law is like the contemporary militarization of police forces in that it has the potential to have a long-term negative impact on both the law and society.⁹⁰

What is not clear is how the ECtHR would rule regarding obligations for the provision of medical services in a conflict like Chechnya, which was internal to Russia. Fortunately, the consequence of militarizing this aspect of human rights law is less problematic than questions arising from the use of force. A key issue is one of clarity, and whether a court will go far enough to ensure the same level of protection under human rights law as is available for victims of conflict under international humanitarian law. In other words,

88. *See, e.g.*, *Bámaca Velásquez v. Guatemala*, Judgment, Merits, Inter-Am. Ct. H.R. (ser. C) No. 70, ¶¶ 208–09 (Nov. 25, 2000), http://www.corteidh.or.cr/docs/casos/articulos/seriec_70_ing.pdf

Although the Court lacks competence to declare that a State is internationally responsible for the violation of international treaties that do not grant it such competence, it can observe that certain acts or omissions that violate human rights, pursuant to the treaties that they do have competence to apply, also violate other international instruments for the protection of the individual, such as the 1949 Geneva Conventions and, in particular, common Article 3.

Indeed, there is a similarity between the content of Article 3, common to the 1949 Geneva Conventions, and the provisions of the American Convention and other international instruments regarding non-derogable human rights (such as the right to life and the right not to be submitted to torture or cruel, inhuman or degrading treatment). This Court has already indicated in the *Las Palmeras Case* (2000), that the relevant provisions of the Geneva Conventions may be taken into consideration as elements for the interpretation of the American Convention.

89. *See* WATKIN, *supra* note 11, at 252–59, for a more detailed discussion of “human rights overreach.”

90. RADLEY BALKO, *RISE OF THE WARRIOR COP: THE MILITARIZATION OF AMERICA’S POLICE FORCES* 333–36 (2013); *see also* AMERICAN CIVIL LIBERTIES UNION, *WAR COMES HOME: THE EXCESSIVE MILITARIZATION OF AMERICAN POLICING* (2014), https://www.aclu.org/sites/default/files/field_document/jus14-warcomeshome-text-rel1.pdf.

can it meet the humanitarian need? It is also not certain that medical services grounded in a human rights law-focused model would place the same obligations on all participants in the conflict. The traditional view is that international human rights law does not bind non-State actors, although arguments have been presented that it does, or at least should.⁹¹ The simplest approach, and one realistically grounded in the scope and scale of violence, as well as the degree of suffering of the victims of the conflict, would be to acknowledge the existence of an armed conflict and apply humanitarian law.

It is not, however, only judicial scrutiny of security operations that has highlighted the application of a human rights law-based response when addressing levels of violence more readily associated with armed conflict. It frequently arises with States deciding to apply a human rights-based law enforcement response to “terrorism” and other challenges to their authority. This approach may be motivated by a variety of considerations, including the traditional reluctance exhibited by States to acknowledge an armed conflict exists within its borders, a desire to demonstrate a successful strategy through the maintenance of an aura of normalcy and control, or a conscious decision by a State to apply a law enforcement response because it can, in the prevailing circumstances, limit the overall violence. To be certain, there are significant advantages from a policy perspective in adopting a law enforcement response to non-State actor threats, even when an armed conflict is in existence. States should be encouraged to default to this approach whenever possible.⁹² However, such an approach is only sustainable when a human rights law-based approach is feasible and effective in countering the threat actually being posed.

The iconic example where such a strategy was successfully applied over a significant period was the nearly thirty-year Northern Ireland “Troubles.” The United Kingdom consistently adopted the position that this complex security situation, which rose to the level of an insurgency,⁹³ was a criminal

91. See SIVAKUMARAN, *supra* note 86, at 95–97.

92. WATKIN, *supra* note 11, at 616.

93. See Mark Cochrane, *The Role of the Royal Ulster Constabulary in Northern Ireland*, in POLICING INSURGENCIES: COPS AS COUNTERINSURGENTS 107, 108 (C. Christine Fair & Sumit Ganguly eds., 2014); WILLIAM MATCHETT, SECRET VICTORY: THE INTELLIGENCE WAR THAT BEAT THE IRA 7 (2016) (“No one called it an insurgency, but it was.”); Steven Haines, *Northern Ireland 1968–1998*, in INTERNATIONAL LAW AND THE CLASSIFICATION OF CONFLICTS 117, 135 (Elizabeth Wilmshurst ed., 2012) (acknowledging the existence of an insurgency in Northern Ireland).

matter.⁹⁴ The UK's ability to do so was the direct result of robust and effective mechanisms of government, including police, lawyers, courts, and prisons, as well as reliance on local intelligence personnel.⁹⁵ While there was considerable controversy regarding the use of force, it continued to be assessed under a human rights law paradigm. In contrast, it has proven extremely difficult to replicate that success in seeking to counter insurgencies elsewhere, such as in Iraq and Afghanistan, where State governance is not as strong.⁹⁶

The relationship between a State's choice to apply a law enforcement or armed force approach can be complex for both legal and political reasons. For example, the UK's domestic experience can be contrasted with that of Colombia, which, with a change in government in 2011, altered its characterization of its engagement with the FARC to one of an "armed conflict" from an approach that did not recognize "drug dealing terrorists as belligerents."⁹⁷ For some States, the character of the conflict is masked behind a generic reference to "counterterrorism operations." The terrorists are treated as criminals, but the operations against them are frequently conducted as hostilities. In Turkey, efforts since 2015 to deal with a decision by the Kurdistan Workers' Party (PKK) to shift from rural guerrilla tactics to urban operations was initially addressed with counterterrorism operations using "police special operations units, Gendarmerie special operations units, commandos, and other special operations teams, as well as armored Army units."⁹⁸ A failure to restore order resulted in a shift "to mirror traditional military doctrine for urban warfare: besiege and isolate a city before an as-

94. Haines, *supra* note 93, at 130; TONY GERAGHTY, *THE IRISH WAR: THE MILITARY HISTORY OF A DOMESTIC CONFLICT* 74 (1998) (outlining how the "Irish Strategy" became one of treating acts of paramilitary violence as the scene of a crime); KIERAN MCEVOY, *PARAMILITARY IMPRISONMENT IN NORTHERN IRELAND: RESISTANCE, MANAGEMENT AND RELEASE* 15 (2001).

95. FRANK LEDWIDGE, *LOSING SMALL WARS: BRITISH MILITARY FAILURE IN IRAQ AND AFGHANISTAN* 219–21 (2011); MATCHETT, *supra* note 93, at 85–97; Cochrane, *supra* note 93, at 112; RICHARD DOHERTY, *THE THIN GREEN LINE: THE HISTORY OF THE ROYAL ULSTER CONSTABULARY GC 1922–2001*, at 216–18 (2012).

96. LEDWIDGE, *supra* note 95, at 164–65; MATCHETT, *supra* note 93, at 251–66.

97. Vanessa Paz Lecompte, *Santos, Uribe Clash over Colombia Conflict*, INSIGHTCRIME (May 5, 2011), <https://www.insightcrime.org/news/brief/santos-uribe-clash-over-colombia-conflict/>.

98. Anna Ronell, *Urban Warfare in the Turkey-PKK Conflict and Beyond*, CENTER FOR STRATEGIC STUDIES, THE FLETCHER SCHOOL, TUFTS UNIVERSITY (Feb. 26, 2018), <https://sites.tufts.edu/css/urban-warfare-in-the-turkey-pkk-conflict-and-beyond/>.

sault to cut logistical support to the enemy inside, undercutting their capabilities and will to continue fighting.”⁹⁹ These forms of mixed approaches can create confusion as to what principles of law are governing State action in terms of the use of force, as well as the extent of State obligations regarding the provision of humanitarian assistance.

Uncertainty can develop in other contexts. In December 2017, the Iraq government claimed final victory over the Islamic State,¹⁰⁰ which would ordinarily suggest the establishment of normalcy and peace. However, that non-State organization is far from defeated, with Iraq facing continued insurgent attacks¹⁰¹ from an estimated 15,500 to 17,100 Islamic State fighters.¹⁰² Likewise, Nigeria has been engaged in an armed conflict with Boko Haram from possibly as early as 2009,¹⁰³ with the government seeking to defeat the terrorist group militarily, while at the same time endeavoring to bring prosecutions against its members and supporters under criminal terrorism legislation.¹⁰⁴ In July 2018, the President of Nigeria announced that the northeast of the country was in a post-conflict stabilization phase, which again implies “a total end to hostilities.”¹⁰⁵ However, hostilities continue in a region beset with insecurity from various armed groups.¹⁰⁶ These situations

99. *Id.*

100. Ahmed Aboulenein, *Iraq Holds Victory Parade after Defeating Islamic State*, REUTERS (Dec. 10, 2017), <https://www.reuters.com/article/us-mideast-crisis-iraq-parade/iraq-holds-victory-parade-after-defeating-islamic-state-idUSKBN1E407Z>.

101. GLENN A. FINE, STEVE A. LINICK & ANN CALVARESI BARR, OVERSEAS CONTINGENCY OPERATIONS: OPERATION INHERENT RESOLVE, OPERATION PACIFIC EAGLE—PHILIPPINES 19–21 (2018), https://media.defense.gov/2018/Aug/07/2001951441/-1/-1/1/FY2018_LIG_OCO_OIR3_JUN2018_508.PDF.

102. *Id.* at 3.

103. THE WAR REPORT, *supra* note 35, at 83 (indicating the armed conflict has been occurring since at least 2013.). *But see* ANDREW WALKER, U.S. INSTITUTE FOR PEACE, WHAT IS BOKO HARAM? 3–6 (2012), <https://www.usip.org/sites/default/files/SR308.pdf> (outlining the history of Boko Haram violence, including significant acts as early as 2009).

104. Paul Carsten, *Nigeria Jails 45 Boko Haram Suspects in Mass Trial Held in Secret*, REUTERS (Oct. 13, 2017), <https://www.reuters.com/article/us-nigeria-security/nigeria-jails-45-boko-haram-suspects-in-mass-trial-held-in-secret-idUSKBN1CI2BN>.

105. *Buhari Says Boko Haram-Hit NE Nigeria Now 'Post-Conflict'*, DAILY MAIL (London) (July 6, 2018), <http://www.dailymail.co.uk/wires/afp/article-5926209/Buhari-says-Boko-Haram-hit-NE-Nigeria-post-conflict.html>.

106. Jane Flanagan, *Boko Haram Fighters Take Back Town from Military*, TIMES (London), (Sept. 10, 2018), <https://www.thetimes.co.uk/edition/world/weakened-boko-haram-captures-town-56jg858nv>; Emmanuel Akinwotu, *Deadly Lack of Security Plagues Nigeria as Buhari*

raise the question of at what point normalcy returns and whether State obligations, including the provision of medical care to victims of the violence, will or should be governed exclusively by human rights law.

For many Western States, the response to the jihadist threat outwardly reflects a bifurcated approach with the reliance on a human rights or humanitarian law framework being geographically dependent. For example, the French President declared the November 13, 2015 terrorist attacks in Paris to be “an act of war that was committed by a terrorist army, a jihadist army, Daesh, against France.”¹⁰⁷ However, the response, while including a call of military forces, invoked domestic emergency powers.¹⁰⁸ Externally, while already engaged in airstrikes in Iraq and Syria, the French military immediately retaliated by conducting increased bombing attacks against jihadist targets in Syria.¹⁰⁹ As has been noted by Gilles Kepel, “The struggle against ISIS in Syria and Iraq certainly requires military means—notably, the navy and the air force. But the fight against terrorism on French, Belgian, German or any other Western territory is first of all a matter for the police.”¹¹⁰

The reason France and other Western States are able to adopt this approach domestically is that their mechanisms of governance are robust and capable, albeit frequently with the assistance of emergency powers and the use of military forces,¹¹¹ and the threat remains at a level where such a response is effective. That they cannot do so internationally reflects the fact

Seeks Re-Election, NEW YORK TIMES (Aug. 15, 2018), <https://www.nytimes.com/2018/08/15/world/africa/nigeria-zamfara-violence-buhari.html>.

107. Adam Nossiter, Aurlien Breeden & Katrin Bennhold, *Three Teams of Coordinated Attackers Carried Out Assault on Paris, Officials Say; Hollande Blames ISIS*, NEW YORK TIMES (Nov. 14, 2015), <https://www.nytimes.com/2015/11/15/world/europe/paris-terrorist-attacks.html>.

108. *Id.*; see also Samuel Osborne, *France Declares End to State of Emergency Almost Two Years after Paris Terror Attacks*, INDEPENDENT (London) (Oct. 31, 2017), <https://www.independent.co.uk/news/world/europe/france-state-of-emergency-end-terror-attacks-paris-isis-terrorism-alerts-warning-risk-reduced-a8029311.html>.

109. Alisa J. Rubin & Anne Barnard, *France Strikes ISIS Targets in Syria in Retaliation for Attacks*, NEW YORK TIMES (Nov. 15, 2015), <https://www.nytimes.com/2015/11/16/world/europe/paris-terror-attack.html>.

110. GILLES KEPÉL, *TERROR IN FRANCE: THE RISE OF JIHAD IN THE WEST*, at xviii (2015).

111. Robert Booth, Vikram Dodd, Sandra Laville & Ewen MacAskill, *Soldiers on UK Streets as Threat Raised to Critical after Manchester Bombing*, GUARDIAN (London) (May 23, 2017),

that these States, and those they support, do not exercise the same level of control in the safe havens from which the threats are being generated.

While it might be tempting to dismiss President Hollande's declaration that the 2015 Paris attacks were an act of war as being merely rhetorical in nature, it has been posited that involvement in the Coalition fighting against ISIS in Iraq and Syria extends the application of international humanitarian law to the territory of the participating States.¹¹² In this regard, it has been suggested by the ICRC that international humanitarian law applies in the territory of assisting States involved in an extraterritorial non-international armed conflict since they "should not be able to shield themselves from the operation of the principle of equality of belligerents under IHL once they have become a party to this type of armed conflict beyond their borders."¹¹³ However, as noted previously, the State policy choice of remaining within a human rights law-based paradigm when it is feasible and effective has been the preferred option.

The threats to State security that potentially engage a human rights law and international humanitarian law interface extend beyond traditional insurgencies and jihadist terrorism to transnational criminal gangs. As noted by Ioan Grillo regarding the security situation in Central and South America,

the cartels spent their billions building armies of assassins who carry out massacres comparable to those in war zones and outgun police. They have diversified from drugs to a portfolio of crimes including extortion, kidnapping, theft of crude oil, and even wildcat mining. And they have grown to control the governments of entire cities and states in Latin America.¹¹⁴

<https://www.theguardian.com/uk-news/2017/may/23/salman-abedi-police-race-to-establish-if-manchester-suicide-bomber-acted-alone> (discussing the deployment of British troops during Operation Temperer following a terrorist attack in Manchester.).

112. Vaïos Koutroulis, *The Fight Against the Islamic State and Jus in Bello*, 29 LEIDEN JOURNAL OF INTERNATIONAL LAW 827, 848–49 (2016) ("Thus, it is plausible to consider attacks by ISIL in the territory of one of these states as falling within the context of the on-going armed conflict between the coalition and ISIL and, therefore, as regulated by IHL.").

113. INTERNATIONAL COMMITTEE OF THE RED CROSS, STRENGTHENING INTERNATIONAL HUMANITARIAN LAW PROTECTING PERSONS DEPRIVED OF THEIR LIBERTY: CONCLUDING REPORT 14 (2015), <https://www.justsecurity.org/wp-content/uploads/2015/11/2015-ICRC-Report-IHL-and-Challenges-of-Armed-Conflicts.pdf>.

114. IOAN GRILLO, GANGSTER WARLORDS: DRUG DOLLARS, KILLING FIELDS, AND THE NEW POLITICS OF LATIN AMERICA 6 (2016).

Although an estimated two hundred thousand persons were killed in Mexico between 2006 and 2017,¹¹⁵ the Mexican government has overtly asserted that it is not facing an insurgency¹¹⁶ even while periodically employing military forces in a manner that suggests the existence of an armed conflict. Indeed, although not all analysts would agree,¹¹⁷ the 2017 *War Report* concluded, “Mexico’s security forces were arguably engaged in non-international armed conflicts with at least the Sinaloa Cartel and the Jalisco Cartel New Generation.”¹¹⁸ If that analysis is correct, it is international humanitarian law that would directly govern the provision of medical care and services.

Ultimately, a State’s characterization of the response to violence within its borders will have a powerful impact on the legal framework under which the provision of medical care will be assessed. Where it has acknowledged an armed conflict is in existence humanitarian law clearly can be relied on. In other situations, either because of legal interpretation or because of a State decision to treat the conflict exclusively as a law enforcement matter, human rights law will govern. In this regard, the ECtHR has demonstrated it will not consider the applicability of international humanitarian law unless the State effectively raises the issue. This can be seen in case law dealing with the Chechen conflict. In its second *Isayeva* judgment, the Court stated that when determining if “a normal legal background” applies, “[n]o martial law and no state of emergency has been declared in Chechnya, and no derogation has been made under Article 15 of the Convention.”¹¹⁹ In similar fashion, the applicability of humanitarian law in the *Hassan* case dealing with international armed conflict was only ruled upon “where this is specifically pleaded by the respondent State.”¹²⁰

Not all courts will necessarily demonstrate such deference to the State position regarding their characterization of a conflict. Indeed, in respect of the Chechen conflict the ECtHR could have acknowledged that an armed

115. *Mexico Violence: Six Bodies Found Hanging from Bridges Near Resort*, BBC NEWS (Dec. 21, 2017), <http://www.bbc.com/news/world-latin-america-42439421>.

116. IOAN GRILLO, *EL NARCO: INSIDE MEXICO’S CRIMINAL INSURGENCY* 204 (2011).

117. *See, e.g.*, EMILY CRAWFORD, *IDENTIFYING THE ENEMY: CIVILIAN PARTICIPATION IN ARMED CONFLICT* 180–89 (2015).

118. *THE WAR REPORT*, *supra* note 35, at 83. However, the authors stress the controversial nature of this determination, stating, “It is important to note that this classification is controversial.” *Id.*

119. *Isayeva II*, *supra* note 74, ¶ 191.

120. *Hassan*, *supra* note 71, ¶ 107.

conflict was in existence notwithstanding the position of the Russian government, and then apply “the general principles of international law, including the rules of international humanitarian law which play an indispensable and universally accepted role in mitigating the savagery and inhumanity of armed conflict.”¹²¹ However, given the complex political and legal factors, for many contemporary struggles between States and non-State actors it is likely that the provision of medical services will have to rely, in whole or in part, on a human rights law basis for such activities.

In situations where a State has well developed medical infrastructure and services (most frequently in urban areas), and the violence is relatively well contained by the security forces, the provision of medical care under a human rights paradigm is likely not problematic. For example, while the medical services in Northern Ireland were confronted with a horrific human toll in the aftermath of significant incidents of violence, and at times were challenged by the number and types of injuries, it effectively provided the required medical care throughout the three decades of conflict.¹²² The same is true for Canada, the United States, the United Kingdom, France, Germany, Belgium, and other sufficiently developed States periodically facing jihadist attacks on their own soil. It would be expected that the medical services delivered under a human rights paradigm could meet the challenge, although adjustments may have to be made to provide effective care in terms of the number of injured and types of injuries.¹²³ However, the same cannot be said for the violence arising from external operations, such as those in Iraq and Syria, where humanitarian law would ordinarily have to be relied on.

When confronted with conflict in geographically remote areas or when experiencing higher levels of violence, States with less robust medical ser-

121. *Id.* ¶ 102.

122. See *Bloody Friday: How the Troubles Inspired Belfast's Medical Pioneers*, BBC NEWS (July 20, 2012), <https://www.bbc.com/news/uk-northern-ireland-18886867>; Peter Froggatt, *Medicine in Ulster in Relation to the Great Famine and “the Troubles”*, 319 BRITISH MEDICAL JOURNAL 1636 (1999), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1127095/>

On 17 May 1974 Alan Crockard, then a registrar at the Royal Victoria Hospital, Belfast, holding a Hunterian professorship, delivered his valedictory lecture on ‘Bullet injuries of the brain.’ He reviewed over 80 patients, most from Belfast, treated in his unit over 44 months. One has to go to Chicago—in fact to the whole of Cook County, in which Chicago stands—to find so large a peacetime series.

123. Pierre Carli et al., *The French Emergency Medical Services after the Paris and Nice Terrorist Attacks: What Have We Learnt?*, 390 THE LANCET 2735 (2017).

vices can be significantly more challenged to provide medical care. For example, the Nigerian representative to the UN indicated in May 2017 “that to prevent the commission of violations of international humanitarian law in armed conflict, the critical element to achieving that objective is the respect for international human rights and humanitarian law.”¹²⁴ Further, the Nigerian government established a presidential commission “to enhance the security conditions in the northeast of the country, facilitate the work of health personnel and ease the movement of medical equipment and supplies.”¹²⁵ This reliance on both human rights and international humanitarian law to address contemporary conflict is increasingly becoming a standard position adopted by States and the UN.

With many States relying exclusively on human rights-based law enforcement responses to violence, not clearly indicating an armed conflict is in existence, using a geographical basis for the application of each body of law, or suggesting both bodies of law apply, the legal basis for the provision of medical care and services in contemporary conflict will frequently be framed in terms of human rights law. Due to the more general provisions of human rights law and its focus on State rather than non-State actor responsibility, humanitarian advocates are presented with a challenge when seeking to provide the necessary medical support to victims of the conflict. It is a challenge that increases exponentially when the violence experienced in urban warfare resembles that of conventional armed conflict. Since these situations are factually, and could legally be assessed as, armed conflict, the human rights dialogue will increasingly have to be framed in terms of humanitarian legal norms to be effective. This is particularly the case if the existing medical infrastructure and services cannot address the need.

IV. THE PROVISION OF MEDICAL CARE

Reflecting the battlefield roots of the humanitarian movement, the law concerning the provision of medical care has historically placed special emphasis on the collection and care of injured soldiers. For many State armed forces medevac and the ability to evacuate soldiers within what has been described as the “golden hour” from injury to treatment in a well-equipped medical

124. *Nigeria Reaffirms Commitment to Protect Civilians in Armed Conflicts*, VANGUARD (Lagos) (May 26, 2017), <https://www.vanguardngr.com/2017/05/nigeria-reaffirms-commitment-protect-civilians-armed-conflicts/>.

125. *Id.*

facility is frequently a condition precedent for the conduct of military operations. As Major-General David Fraser noted in respect of Canadian operations in Afghanistan in 2006:

No soldier ever went outside the wire without ensuring that we had a med-evac helicopter within the golden hour. If that was not in the concept of operations . . . I wouldn't approve it. Every man or woman had to know that they or their fellow soldiers would be taken care of in the event they were injured.¹²⁶

This does not mean all States are capable of providing this level of medical care. In the same conflict, Afghans “were flown to Afghan medical centers with little equipment and comparatively abysmal standards of trauma care.”¹²⁷ Similarly, deployment on UN operations is often conditioned on the quality of medical services available to troop contributing countries, with some countries even bringing their own medical facilities rather than relying on those provided by the UN.¹²⁸ However, particularly problematic is that receiving medical care within the “golden hour” is not the reality for many civilians caught up in the violence of urban conflict.¹²⁹

The obligation that military forces provide non-discriminatory care to enemy wounded and sick, with treatment being based on urgent “medical reasons” alone, is clearly established.¹³⁰ However, in the context of counter-insurgency/counterterrorism operations, the reliance on paramilitary and police forces to conduct operations presents its own set of challenges since

126. DAVID FRASER, OPERATION MEDUSA: THE FURIOUS BATTLE THAT SAVED AFGHANISTAN FROM THE TALIBAN 156 (2018); see also Howard R. Champion et al., *A Profile of Combat Injury*, 54 THE JOURNAL OF TRAUMA INJURY, INFECTION, AND CRITICAL CARE S13, S17 (2003) (“Evacuation times for the IDF to medical facilities compare extremely favorably with urban American Level I trauma centers: an average of 53 minutes.”).

127. C. J. CHIVERS, THE FIGHTERS: AMERICANS IN COMBAT IN AFGHANISTAN AND IRAQ, at xxii (2018).

128. LESLEY CONNOLLY & HÅVARD JOHANSEN, MEDICAL SUPPORT FOR UN PEACE OPERATIONS IN HIGH-RISK ENVIRONMENTS 12 (2017), <https://www.ipinst.org/wp-content/uploads/2017/04/IPI-Rpt-Medical-Support-Final.pdf>.

129. INTERNATIONAL COMMITTEE OF THE RED CROSS, “I SAW MY CITY DIE”: VOICES FROM THE FRONT LINES OF URBAN CONFLICT IN IRAQ, SYRIA AND YEMEN 47 (2017), https://reliefweb.int/sites/reliefweb.int/files/resources/4312_002_Urban-Warfare_web_new_EN.pdf [hereinafter I SAW MY CITY DIE] (noting that a thirteen-year-old who was shot trying to flee Mosul could not be evacuated for three to four hours).

130. Geneva Convention I, *supra* note 2, art. 12.

these forces may not be trained or equipped to implement these obligations.¹³¹ The lack of training and equipment in turn places a particular demand on States to ensure that all security forces are properly trained to either provide or facilitate the provision of medical care to victims of the conflict before they are employed.

Even when military and other security forces are trained and equipped to address the humanitarian needs related to the wounded and sick, implementing these obligations can present an immense challenge to military commanders due to the concentration of civilians in urban environments. While steps may be taken to encourage the evacuation of most of the civilian population from a city, as happened in 2004 in Fallujah,¹³² this may not always be possible or desirable. For example, in Mosul in 2016, the Iraqi government told civilians to stay within the city in order to avoid a humanitarian crisis,¹³³ although by August 2017, an estimated 140,000 families had fled, with 100,000 families remaining in the city.¹³⁴

Security forces inevitably will have to conserve medical resources in any fight to retake a city. Accordingly, this conservation “may result in the prioritization of collection, care, and treatment of military wounded and sick,” although in respect of civilians “intervening in extreme cases, where failing to do so will result in loss of life, limb, or sight will almost always be an authorized action.”¹³⁵ In turn, this discrepancy raises the issue of what care and treatment is available to civilian wounded and sick.

The existence of a functioning medical infrastructure in urban areas can mitigate the inability of military forces to treat the civilian wounded and sick.

131. ANTONIO GIUSTOZZI & MOHAMMED ISAQZADEH, *POLICING AFGHANISTAN* 41 (2012) (noting that by 2007, “it was estimated that 70 per cent of Afghan National Police time was spent fighting the insurgency as opposed to law and order tasks”).

132. THOMAS E. RICKS, *FIASCO: THE AMERICAN MILITARY ADVENTURE IN IRAQ* 398–99 (2007) (finding that an estimated four hundred civilians remained in the city out of a population of 250,000).

133. Tim Arango, *Iraq Told Civilians to Stay in Mosul. Now They’re Paying with Their Lives*, *NEW YORK TIMES* (Nov. 24, 2015), <https://www.nytimes.com/2016/11/24/world/middleeast/iraq-mosul-isis-civilians.html>.

134. Lucy Rodgers, Nassos Stylianou & Daniel Dunford, *Is Anything Left of Mosul?: The Battle to Save the City and Its People*, *BBC NEWS* (Aug. 9, 2017), <https://www.bbc.co.uk/news/resources/idt-9d41ef6c-97c9-4953-ba43-284cc62ffdd0>.

135. CORN, WATKIN & WILLIAMSON, *supra* note 3, at 90; *see also* UNITED KINGDOM MINISTRY OF DEFENCE, *THE MANUAL OF THE LAW OF ARMED CONFLICT* ¶ 7.3.2, at 123 (2004) (“There is no absolute obligation on the part of the military medical services to accept civilian wounded and sick—that is to be done only so far as it is practicable to do so.”).

Those facilities might also be used to treat military casualties. What is not guaranteed, however, is that during combat operations civilian hospitals and clinics will be functioning, or even remain in existence. As the ICRC reported in December 2016, “only one of eastern Aleppo’s nine hospitals remains fully functional, and four are completely out of service. Medical staff are exhausted and stocks severely depleted.”¹³⁶ Compounding the problem can be the migration of civilians towards urban areas as the conflict unfolds. For example, in 2018 one Yemeni family fled to Mokha, which had a hospital. However, the hospital “had no surgeon, nor a proper intensive-care unit, oxygen or essential medicines.”¹³⁷ Care was finally provided by a MSF facility six hours away in Aden. There, civilians were “crowding into ill-equipped hospitals and clinics with diseases, malnourished babies and injuries from land mines and unexploded munitions.”¹³⁸

Accordingly, military commanders must understand and embrace the requirement to facilitate access to civilian facilities, prioritize cooperation with the ICRC, and permit the deployment of humanitarian assistance and non-governmental organization support in order to meet the needs of the wounded and sick. However, coordination with non-governmental organizations and other humanitarian entities can present challenges. As was reported in one study looking at the provision of medical services in the 2016–2017 battle for Mosul, the Iraqi military had limited capacity and the coalition States “were unable to supply medical teams to care for civilians.”¹³⁹ Further,

[i]nternational non-governmental organizations (NGOs), stung by recent attacks on health facilities and workers, initially struggled to find their footing amid the security risks and other programming; moreover, many argued that their role has not and is not to provide frontline care, which should

136. *Everyone Wounded or Sick During Armed Conflict Has the Right to Health Care*, ICRC (Dec. 9, 2016), <https://www.icrc.org/en/document/everyone-wounded-or-sick-during-armed-conflict-has-right-health-care>.

137. Sudarsan Raghavan, *Running on Empty: Could Yemen’s Humanitarian Crisis—the Most Dire in the World—Be about to Get Dramatically Worse?*, WASHINGTON POST (June 14, 2018), <https://www.washingtonpost.com/news/world/wp/2018/06/14/feature/yemen-crisis-saudi-led-attack-on-rebel-held-city-could-worsen-human-exodus-and-famine/>.

138. *Id.*

139. JOHN HOPKINS CENTER FOR HUMANITARIAN HEALTH, MOSUL TRAUMA RESPONSE: A CASE STUDY QUALITY AND EFFECTIVENESS EXECUTIVE SUMMARY – PART 2: QUALITY AND EFFECTIVENESS 2 (2018), http://www.hopkinshumanitarianhealth.org/assets/documents/Executive_summary_mosul_technical_Feb_15_2018_FINAL.PDF.

remain the responsibility of warring factions as set out in the Geneva Conventions and Additional Protocols.¹⁴⁰

Support was not available from Doctors Without Borders or the ICRC, and “[u]ltimately, WHO contracted other NGOs and a private medical company to manage the TSPs [trauma stabilization points] and field hospitals, drawing upon its experience dispatching emergency medical teams,” with funding provided by U.S., European and UN sources.¹⁴¹

One of the issues identified in the study regarding the use of frontline non-military medical services to treat civilians was “concern among many humanitarian NGOs that the WHO frontline strategy undermined the perceived independence and neutrality of all humanitarian groups, thereby eroding the protections conveyed by humanitarian principles.”¹⁴² Further, the insertion of the “trauma referral pathway,” which places humanitarian workers at substantial risk and may interrupt the provision of humanitarian aid, created a concern that more people could have ultimately been killed “[b]ecause most deaths in conflict settings are due to long-term, indirect, rather than direct trauma causes.”¹⁴³ An unwillingness by humanitarian groups to participate complicates the ability of States to ensure adequate medical care is provided during urban conflict since those groups have become a fixture on the modern battlefield. This highlights the need for broader consultation between States and humanitarian groups prior to conducting operations.

V. THE IMPACT OF THE CONCENTRATION OF CIVILIANS IN URBAN ENVIRONMENTS

The more civilians there are concentrated in an area of combat operations, the more likely that security forces will have to contend with civilian casualties. Of course, military commanders in such situations must implement all

140. *Id.*

141. *Id.*

142. JOHN HOPKINS CENTER FOR HUMANITARIAN HEALTH, MOSUL TRAUMA RESPONSE: A CASE STUDY APPLICATION OF HUMANITARIAN PRINCIPLES EXECUTIVE SUMMARY – PART 1: APPLICATION OF HUMANITARIAN PRINCIPLES 5 (2018), http://www.hopkinshumanitarianhealth.org/assets/documents/Executive_Summary_Mosul_Hum_Principles_Feb_15_FINAL.PDF.

143. *Id.*

feasible precautions to mitigate this risk. Such steps were taken by commanders in battles such as the 2004 retaking of Fallujah¹⁴⁴ and the 2016–2017 assault on Mosul,¹⁴⁵ although the same cannot be said in other situations of urban combat, such as Damascus.¹⁴⁶ Nonetheless, military assaults in urban centers remain very destructive.¹⁴⁷ For example, in Marawi it was reported that six months after Filipino and foreign fighters claiming allegiance to the Islamic State had stormed that urban area “[t]he heart of the city ha[d] been bombed and burned beyond recognition, its domed mosques pierced by mortar fire. Homes . . . [were] roofless, blackened.”¹⁴⁸ The combat left 200,000 inhabitants scattered across the southern Philippines.¹⁴⁹ In respect of Mosul, there have been claims of casualties ranging from 5,805 to 40,000 killed.¹⁵⁰ Elsewhere little or no concern was demonstrated. The six-week Russian assault on Grozny in December 1994 resulted in an estimated 27,000 to 35,000 civilians killed and close to one hundred thousand wounded.¹⁵¹ In Syria, during a forty-eight hour period in February 2018, it is reported that

144. Dick Camp, OPERATION PHANTOM FURY: THE ASSAULT AND CAPTURE OF FALLUJAH, IRAQ 152 (2009) (explaining the progression of force used to attack insurgent defenders).

145. Jackson Diehl, *There’s Good News in Mosul — for Now*, WASHINGTON POST (Dec. 25, 2016), https://www.washingtonpost.com/opinions/global-opinions/theres-good-news-in-mosul--for-now/2016/12/25/265ad37a-c876-11e6-85b5-76616a33048d_story.html.

146. Brent Eng & José Ciro Martínez, *Why the Syrian Regime Has Been Targeting Civilian Infrastructure*, WASHINGTON POST (Apr. 16, 2018), <https://www.washingtonpost.com/news/monkey-cage/wp/2018/04/16/why-the-syrian-regime-has-been-targeting-civilian-infrastructure/>.

147. Margaret Coker, *After Fall of ISIS, Iraq’s Second-Largest City Picks Up the Pieces*, NEW YORK TIMES (Dec. 10, 2017), <https://www.nytimes.com/2017/12/10/world/middleeast/iraq-isis-mosul.html> (estimating that in the nine month battle for Mosul one million persons were displaced, 60,000 homes were made uninhabitable, and 20,000 commercial and government buildings were destroyed); Susannah George & Lori Hinnant, *Few Ready to Pay to Rebuild Iraq after the Islamic State Group Defeat*, MILITARY TIMES (Dec. 28, 2017), <https://www.militarytimes.com/flashpoints/2017/12/28/few-ready-to-pay-to-rebuild-iraq-after-islamic-state-group-defeat/> (noting that in Ramadi “more than 70 percent of the city remains damaged or destroyed”).

148. Emily Rauhala, *Liberated and Angry*, WASHINGTON POST (Dec. 9, 2017), <https://www.washingtonpost.com/sf/world/2017/12/09/liberated-and-angry-in-marawi/>.

149. *Id.*

150. Rodgers, Stylianou & Dunford, *supra* note 134.

151. LOUIS DIMARCO, CONCRETE HELL: URBAN WARFARE FROM STALINGRAD TO IRAQ 187 (2012).

250 civilians were killed in the Damascus suburbs, including fifty-eight children, and another 1,000 wounded. In addition, “[a]t least 10 hospitals in eastern Ghouta were damaged by airstrikes or shelling.”¹⁵²

The danger posed to civilians has led to humanitarian efforts to limit the use of explosive or “wide area effect” weapons in urban areas,¹⁵³ although it has been noted, “explosive weapons—like bombs, rockets and shells—are not prohibited as such under humanitarian law.”¹⁵⁴ The increased risk to civilians associated with the use of high explosive munitions in urban operational environments must be included in targeting assessments. Further, the use of wide area effect weapons can raise concerns regarding the potential for indiscriminate targeting,¹⁵⁵ although certain multiple launch rocket systems can fire precision guided munitions.¹⁵⁶ Nonetheless, it is unrealistic to expect States to readily accept blanket restrictions or prohibitions. Advocating for this “remedy”¹⁵⁷ without addressing the potentially critical military value of the weapons systems being considered, their accuracy, the effect of

152. Philip Issa & Bassam Mroue, *Government Bombing of Damascus Suburbs Kills More Than 100*, AP NEWS (Feb. 20, 2018), <https://apnews.com/b286b967a78d4b2ab2bfb18369387b8c>.

153. See, e.g., ICRC *Q&A on the Issue of Explosive Weapons in Populated Areas*, 98 INTERNATIONAL REVIEW OF THE RED CROSS 97 (2016).

154. Vincent Bernard, *Editorial: War in the Cities: The Spectre of Total War*, 98 INTERNATIONAL REVIEW OF THE RED CROSS 1, 7–8 (2016).

155. PROTECTION OF CIVILIANS IN MOSUL: IDENTIFYING LESSONS FOR CONTINGENCY PLANNING, A CENTER FOR CIVILIANS IN CONFLICT (CIVIC) AND INTERACTION ROUNDTABLE 3 (2011), https://www.interaction.org/sites/default/files/civic-interaction-protection-of-civilians-in-mosul-october-2017_final.pdf.

156. MOSUL STUDY GROUP, U.S. ARMY, WHAT THE BATTLE FOR MOSUL TEACHES THE FORCE, NO. 17-24 U (2017), <https://www.armyupress.army.mil/Portals/7/Primer-on-Urban-Operation/Documents/Mosul-Public-Release1.pdf>.

157. *World at a Turning Point: Heads of UN and Red Cross Issue Joint Warning*, ICRC (Oct. 30, 2015), <https://www.icrc.org/en/document/conflict-disaster-crisis-UN-red-cross-issue-warning> (reporting on a joint appeal by the UN Secretary General and the President of the Red Cross to take concrete and urgent action to address human suffering, including stopping “the use of heavy explosive weapons in populated areas”); see also Hannah Bryce, *Stopping the Use of Explosive Weapons in Populated Areas*, CHATHAM HOUSE (Nov. 5, 2015), <https://www.chathamhouse.org/expert/comment/stopping-use-explosive-weapons-populated-areas> (referencing specifically the use of wide impact explosive weapons such as multi-barrelled rocket launchers).

targeting precautions, and the actual tactical situation in which they are intended to be used is a potential recipe for operational failure.¹⁵⁸ This is because the conduct of military operations in an urban environment is another area where “context” matters. As Geoffrey Corn has noted, banning certain weapons does not change what can be gained by an enemy operating in an urban environment, to the contrary, it will incentivize the “enemy use of such areas to gain tactical and strategic advantage.”¹⁵⁹

It is nearly certain that urban conflict will become more prevalent over time and that explosive weapons will have to be used during such conflicts, however, measures to limit the collateral effects of operations will be required. The motivation on the part of security forces to limit civilian casualties can be particularly evident in situations of counterinsurgency where mitigating civilian risk can itself provide a military advantage.¹⁶⁰ However, casualties in those situations will not be reduced to zero, nor are these counterinsurgency operations likely to be amenable solely to a human rights-based analysis even when conducted with a police primacy approach.

158. MOSUL STUDY GROUP, *supra* note 156, at 16 (discussing the effectiveness of artillery, mortar, and multiple launch rockets as counterfire against ISIS indirect fire). Although effective, these tactics require considerable planning.

The close fight required detailed planning to integrate and deconflict surface fires with aerial platforms. Counterfire in the dense urban environment required meticulous planning, with an emphasis on intelligence preparation of the battlefield (understanding the physical environment) and predictive and pattern analysis. In dense urban terrain, counterfire radar systems were cued with other intelligence, surveillance, and reconnaissance systems, such as MQ-1 and MQ-9, to be effective.

Id.

159. Corn, *supra* note 6, at 782.

First, enemy forces—often less capable than their opponents—gain a natural defensive advantage from the cover, concealment, maneuverability, and access to resources in urban terrain. Second, by increasing the perception of indifference to civilians resulting from the destructive effects of urban combat, the enemy is able to exploit the civilian population in the knowledge that the infliction of casualties and the destruction of civilian property will undermine the legitimacy of the legitimate opponent’s efforts.

Id.

160. WATKIN, *supra* note 11, at 254–58; *see also* LAURENT GISEL, INTERNATIONAL COMMITTEE OF THE RED CROSS, THE PRINCIPLE OF PROPORTIONALITY IN THE RULES GOVERNING THE CONDUCT OF HOSTILITIES UNDER INTERNATIONAL HUMANITARIAN LAW 61–62 (2018), <https://www.icrc.org/en/document/international-expert-meeting-report-principle-proportionality> (follow PDF icon under “Download the Report”) (noting that this report resulted from an international expert meeting hosted by the University of Laval on June 22–23, 2016).

Urban centers not only present operational challenges due to the sheer numbers of civilians located there, they also are unique in terms of the interconnected nature of city life. As one senior U.S. military officer has noted, “preparing for operations in dense urban areas includes not only training [to improve] the ability to fight in cities, but also to better understanding [the] ‘flow’” of “people, resources, information, or things in and out of the city.”¹⁶¹ This means understanding “the social infrastructure, demography, governance, economics, power hierarchies, and security systems of how a city works.”¹⁶² Services vulnerable to the effects of destruction associated with military operations “include electricity, *health care*, water, waste-water collection and treatment, and solid waste disposal.”¹⁶³ For example, the destruction of the water supply infrastructure “is likely to have a domino effect on other services (e.g., health).”¹⁶⁴ In the context of pre-planned attacks, it makes sense for military commanders “to consult experts prior to the attack, such as their medical or engineering branch, in order to estimate the incidental damage of the attack.”¹⁶⁵ Indeed, such consultation should be expanded to all aspects of mission planning in order to avoid damage to the greatest extent possible to the infrastructure crucial to civilian survival, or, if necessary, be prepared to rehabilitate those services.

In addition, “medical units,” military or civilian, “must be protected at all times” and must never be deliberately attacked.¹⁶⁶ The only exception to this rule is when medical personnel forfeit their protection. For example, civilian medical units being used to commit acts harmful to the enemy, but even then a cease and desist warning is required.¹⁶⁷ Such units can include “hospitals and other similar units, blood transfusion centres, preventative

161. Claudia ElDib & John Spencer, *Commentary: The Missing Link to Preparing for Military Operations in Megacities and Dense Urban Areas*, ARMY TIMES (July 20, 2018), <https://www.armytimes.com/opinion/commentary/2018/07/20/commentary-the-missing-link-to-preparing-for-military-operations-in-megacities-and-dense-urban-areas/> (statement of Lt. Gen. Stephen J. Townsend, Commander of Operation Inherent Resolve).

162. *Id.*

163. Mark Zeitoun & Michael Talhami, *The Impact of Explosive Weapons on Urban Services: Direct and Reverberating Effects Across Space and Time*, 98 INTERNATIONAL REVIEW OF THE RED CROSS 53, 56 (2016) (emphasis added).

164. *Id.* at 63.

165. Isabel Robinson & Ellen Nohle, *Proportionality and Precautions in Attack: The Reverberating Effects of Using Explosive Weapons in Populated Areas*, 98 INTERNATIONAL REVIEW OF THE RED CROSS 107, 139 (2016).

166. Additional Protocol I, *supra* note 2, art. 12(1).

167. *Id.* art. 13(1).

medicine centres and institutes, medical depots and the medical and pharmaceutical stores of units.”¹⁶⁸ In an urban context, the marking of medical units and transports can provide a particularly important means of helping to ensure their protection. However, “[p]ractice has shown that the failure to wear or display the distinctive emblem does not of itself justify an attack on medical or religious personnel and objects when they are recognized as such.”¹⁶⁹ The protection is provided by the function that is performed, the symbols only facilitate identification.¹⁷⁰ In any event, even if a medical unit is “unauthorized,” it must be “regarded as being protected according to the rules on the protection of civilian objects.”¹⁷¹

Unfortunately, the Syrian conflict has witnessed numerous allegations of attacks on medical facilities.¹⁷² A commission established by the UN Human Rights Council reporting in June 2018 found

[a] rise in attacks against official and makeshift hospitals throughout eastern Ghouta also markedly increased during the period under review. As hostilities escalated in February, reports emerged that 28 health facilities had been attacked, destroying vital lifesaving equipment. Near constant bombardment often rendered the transport of victims impossible, which compounded their suffering, and, in some cases, led to preventable deaths.¹⁷³

One of the challenges for participants in urban conflict is the location of medical facilities. As Additional Protocol I indicates, whenever possible they should be located so that “attacks against military objectives do not imperil their safety.”¹⁷⁴ This has obvious applicability to temporary medical facilities. Among the challenges of providing medical care in an urban environment is the level of destruction, the unclear separation between the warring factions, quickly changing front lines, and the need to operate as close as possible to

168. CIHL, *supra* note 4, at 95.

169. *Id.* at 103–04.

170. *Id.*

171. *Id.* at 95.

172. *Syria War: Hospitals Being Targeted, Aid Workers Say*, BBC NEWS (Jan. 6, 2018), <https://www.bbc.com/news/world-middle-east-42591334>.

173. Independent International Commission of Inquiry on the Syrian Arab Republic, U.N. Human Rights Council, *The Siege and Recapture of Eastern Ghouta*, ¶ 44, U.N. Doc. A/HRC/38/CRP.3 (June 30, 2018), <https://www.ohchr.org/EN/HRBodies/HRC/IICI/Syria/Pages/Documentation.aspx> (follow “Conference Room Paper (A/HRC/38/CRP.3)” hyperlink under “Reports 2018”) [hereinafter Syria Commission of Inquiry].

174. Additional Protocol I, *supra* note 2, art. 12(4).

areas where combat is taking place. For security reasons, temporary medical facilities may have to be co-located with military personnel, including locations that are in the immediate vicinity of lawful targets, thereby increasing the risk to those facilities.

It has also been noted that “[i]n low-intensity urban conflict, it is difficult to identify a casualty and get immediate qualified care.”¹⁷⁵ Further, medical facilities and transports may not be marked for tactical reasons. This can make the identification of the injured, medical facilities, and transports difficult. However, this alone does not account for the troubling tendency of attacks on such facilities and transports. As the UN Independent Commission on Syria noted, the “pattern of attack strongly suggests that pro-Government forces systematically targeted medical facilities, repeatedly committing the war crime of deliberately attacking protected objects, and intentionally attacking medical personnel.”¹⁷⁶ What needs to occur is the investigation of all incidents for which credible allegations are made that such targeting has taken place.

On occasion, an investigation may not be able to reach definitive conclusions, or multiple investigations may result in different conclusions concerning the same incident. One investigation carried out by a UN Board of Inquiry looked at a September 19, 2016 aerial attack that killed ten, injured twenty-two, and destroyed \$650,000 worth of humanitarian supplies being transported by a joint UN-Syrian Arab Red Crescent [SARC] humanitarian convoy near Urem al-Kubra, Syria.¹⁷⁷ A summary of that investigation indicates that the Board of Inquiry did not have access to the data that would allow it to definitively identify the party responsible for conducting the strike.¹⁷⁸ However, the Board summary also indicated it “did not have evidence to conclude the incident was a deliberate attack on a humanitarian target,”¹⁷⁹ and, at least in that instance, “[d]espite initial reports that a medical clinic had been destroyed, the Board found no evidence of a medical clinic neighbouring the SARC compound.”¹⁸⁰

175. Champion et al., *supra* note 126, at S17.

176. Syria Commission of Inquiry, *supra* note 173, ¶ 50.

177. U.N. Secretary-General, Letter dated 21 December 2016 from the Secretary-General addressed to the President of the Security Council, Annex, ¶¶ 30–32, U.N. Doc. S/2016/1093 (Dec. 21, 2016), <https://reliefweb.int/sites/reliefweb.int/files/resources/N1645820.pdf>.

178. *Id.* ¶¶ 35–40.

179. *Id.* ¶ 41.

180. *Id.* ¶ 33.

In contrast, a subsequent investigation of this incident by the Independent International Syria Commission determined that the munitions used, area attacked and duration “strongly suggest that the attack was meticulously planned and ruthlessly carried out by the Syrian air force to purposefully hinder the delivery of humanitarian aid and target aid workers, constituting the war crimes of deliberately attacking humanitarian relief personnel, denial of humanitarian aid and targeting civilians.”¹⁸¹

Despite the potential in some instances for differences in result it remains essential that the accountability process is invoked. Investigations may confirm or absolve liability. Where the existence of a war crime is established, appropriate enforcement action needs to be taken. They also heighten public awareness of the actions taken by conflict participants. Even if no crime is believed to have occurred, an investigation may identify changes to operational decision making, tactics, techniques, and procedures, or doctrine that can reduce future incidents.

It is also important to note that medical facilities and equipment may be misused by participants to a conflict. Protection provided to medical units ceases only if “they are used to commit, outside their humanitarian function, acts harmful to the enemy.”¹⁸² Allegations regarding the misuse of hospital facilities arose in the context of the 2014 conflict between Israel and Hamas where it was reported the Shifa Hospital in Gaza City had “become a de facto headquarters for Hamas leaders, who can be seen in the hallways and offices.”¹⁸³ Israel also alleged that that “Hamas commandeered ambulances and launched attacks from hospital compounds during the conflict.”¹⁸⁴

181. Report of the Independent International Commission of Inquiry on the Syrian Arab Republic, ¶ 88, U.N. Doc. A/HRC/34/64 (Feb. 2, 2017), <https://undocs.org/A/HRC/34/64>.

182. Additional Protocol I, *supra* note 2, art. 13(1).

183. William Booth, *While Israel Held Its Fire, the Militant Group Hamas Did Not*, WASHINGTON POST (July 15, 2014) https://www.washingtonpost.com/world/middle-east/while-israel-held-its-fire-the-militant-group-hamas-did-not/2014/07/15/116fd3d7-3c0f-4413-94a9-2ab16af1445d_story.html.

184. Helena Kennedy, *The 2014 Conflict Left Gaza's Healthcare Shattered. When Will Justice Be Done?*, GUARDIAN (London) (June 29, 2015), <https://www.theguardian.com/commentisfree/2015/jun/29/2014-conflict-gaza-healthcare-hospitals-war-crime-israel-hamas>.

During the conflict, “17 hospitals, 56 primary healthcare facilities, and 45 ambulances were damaged or destroyed.”¹⁸⁵ Still, even when harmful acts are carried out by civilian medical units, their protection only ceases “after a warning has been given setting, where appropriate, a reasonable time limit, and after such warning has remained unheeded.”¹⁸⁶ Further, when targeting a military object near a medical facility careful consideration needs to be given to the proportionality assessment of incidental loss of civilian life, injury to civilians, or damage to civilian objects.¹⁸⁷

VI. TYPES OF INJURIES IN URBAN ENVIRONMENTS

Combat in urban centers also raises the issue of whether the injuries suffered by military and civilians are greater or different from those occurring in a more rural setting. As has been noted recently, the focus of humanitarian groups has been on limiting the use of explosive weapons in urban settings. It does appear that the nature of armed conflict within urban settings, including the concentration of fighters and civilians, is such that greater casualties are likely to result. For military forces, cities present complex areas within which to operate. They traditionally demand a greater involvement of infantry forces and present difficult terrain to use the heavily armored vehicles that have been developed to protect those forces.

As one 2003 report noted, “[m]odern urban combat continues to be highly lethal.”¹⁸⁸ The result can be a higher number of infantry casualties with one 1997 study reporting on the 1982 battle for Beirut indicating “[t]he chances of being injured in this operation was 49 times higher than any other operation.”¹⁸⁹ At that time artillery was seen as the greatest single cause of injury,¹⁹⁰ with death by sniper fire being greater in non-urban environments

185. *Id.*; see also Charlotte Alfred, *Hospitals Are Supposed to be for Healing. In Gaza, They’re Part of the War Zone*, HUFFINGTON POST (Dec. 6, 2017), https://www.huffingtonpost.ca/entry/hospitals-bombed-gaza_n_5630606.

186. Additional Protocol I, *supra* note 2, art. 13(1).

187. *Id.* art. 57(2).

188. Champion et al., *supra* note 126, at S17.

189. RA LEITCH, HR CHAMPION & JF NAVEIN, ANALYSIS OF CASUALTY RATES & PATTERNS LIKELY TO RESULT FROM MILITARY OPERATIONS IN URBAN ENVIRONMENTS 29 (1997) (unpublished U.S. Marine Corps Commandant Warfighting Laboratory study: CWL/TechMed/11/97), <http://smallwarsjournal.com/documents/urbancasstudy.pdf>.

190. *Id.*; see also Andrew J. Schoenfeld & Philip J. Belmont, *Traumatic Combat Injuries, in MUSCULOSKELETAL INJURIES IN THE MILITARY* 11, 15 (Kenneth L. Cameron & Brett D.

due, it was argued, to the cover provided by the “three dimensional” less open terrain of cities.¹⁹¹ Later studies witnessed a change: “Compared with previous IDF [Israel Defense Forces] urban combat in Lebanon, the recent IDF data . . . show an increase in the number of bullet wounds from 13% to 48% and a decrease in the number of shrapnel wounds from 74% to 17% of all injury types.”¹⁹²

Consistent with more recent studies, overall advances in protective equipment reduced the types of injuries with shrapnel injury more prevalent in lower extremities and other exposed areas.¹⁹³ As the authors of another study of traumatic muscular skeletal combat injuries indicate, at least with respect to those injuries: “advances in personnel protective equipment, medical evacuation, and surgical care have culminated in the fact that besides being survivable, most battle injuries can be treated to the point where there is at least the possibility of a return to duty.”¹⁹⁴

As with military casualties, the loss of civilian life resulting from combat operations in urban areas is significantly greater than in rural areas.¹⁹⁵ Those civilian injuries result from artillery fire, aerial bombing, and crush injuries from collapsing buildings and urban infrastructure. As one resident of Mosul stated, “[w]e could die either by ISIS sniper or IED [improvised explosive device] or shelled or buried by bombs.”¹⁹⁶ Doctors working in Syria are reported to have “described patient injuries consistent with the use of bombs, shrapnel from mortars, artillery, IEDs, and gunshots.”¹⁹⁷ Civilians also suffer from a particular disadvantage in comparison to military personnel. They do

Owens eds., 2016) (noting that this finding is consistent with the finding that “[e]xplosive mechanisms of injury, including improvised explosive device (IED), explosively formed projectiles, rocket-propelled grenade, and landmine, have been found to account for 75–81 % of all musculoskeletal casualties incurred in Afghanistan or Iraq”).

191. Leitch, Champion & Navein, *supra* note 189, at 29.

192. Champion et al., *supra* note 126, at S17.

193. Leitch, Champion & Navein, *supra* note 189, at 29.

194. Schoenfeld & Belmont, *supra* note 190, at 11.

195. I SAW MY CITY DIE, *supra* note 129, at 12 (“Civilian casualty rates are notably high: according to some estimates, they represent 92% of the deaths and injuries caused by the use of explosive weapons in populated areas, compared to 34% when these are used in other areas.”).

196. *Id.*

197. Sahr Muhammedally, *Lessons from Mosul: How to Reduce Civilian Harm in Urban Warfare*, JUST SECURITY (July 20, 2017), <https://www.justsecurity.org/43382/lessons-mosul-reduce-civilian-harm-urban-warfare/>.

not have the same level of personal protection (e.g., body armor) available to soldiers of well-equipped armed forces.

Finally, as has been noted, the reverberating effects of explosive weapons on urban services can have considerable effect on the civilian population.¹⁹⁸ In this respect,

the greatest impact of explosive weapons on urban services is a function of the extent of the damage to upstream or midstream infrastructure (i.e., that which produces or delivers the bulk of the service), the nature and extent of the reverberations downstream of the elements of any service component, the “domino effect” onto other services, and the time required to restore the service.¹⁹⁹

The effect on the physical and mental health of civilians has the potential to be significantly longer term than might traditionally be thought of by military planners and commanders.²⁰⁰ This means the requirement to provide medical care and other health services to civilians impacted by urban combat will extend far beyond the end of hostilities.

VII. CONCLUSION

As the world’s population continues to migrate towards cities, the potential for urban violence, including armed conflict, will increase. This can already be seen with insurgent groups seizing—or attempting to seize—control of cities such as Damascus, Raqqa, Mosul, Marawi, Ramadi, and Fallujah. Urban conflict against non-State actors covers a wide range of violence from ordinary crime, to terrorism and transnational crime, to near conventional military operations. In addition, urban areas have become the site of violent attacks carried out by, or on behalf of, transnational terrorist groups as part of an effort to extend the conflict into countries its perpetrators see as a “far enemy.”²⁰¹ At its most violent, urban conflict has proven to be especially deadly for combatants and the civilians impacted by the violence. Inevitably, it becomes necessary to consider whether that violence has risen to the level

198. See sources cited *supra* notes 163–65 and accompanying text.

199. Zeitoun & Talhami, *supra* note 163, at 68.

200. I SAW MY CITY DIE, *supra* note 129, at 61 (“In nearly all the cities undergoing conflict, the collapse of local economies or increasing demands have also affected mental health services. These are normally under-resourced at the best of times, but conflict exacerbates the problem as professionals are among those forced to flee the fighting.”).

201. FAWAZ GERGES, THE FAR ENEMY: WHY JIHAD WENT GLOBAL 1 (2005).

of an armed conflict. Such a determination forms the basis for the application of international humanitarian law, which has a particular protective focus on the provision of medical care and humanitarian relief to those in need.

Characterizing a security operation as an armed conflict will determine whether international humanitarian law will apply. This characterization is rarely straightforward, especially outside the context of inter-State conflicts. The challenge may be somewhat reduced by the trend away from the post-9/11 debate that initially focused on setting a high threshold definitional standard for armed conflict towards a broader “totality of the circumstances” standard, which appears better suited to address legal classification in an era of complex non-State security threats. However, even where an armed conflict appears to exist, consideration must also be given to human rights law. This can occur for a number of reasons, including its general continued applicability during armed conflict, rulings by a court that view that body of law solely applicable to counterterrorism operations, a State’s refusal to acknowledge the existence of an armed conflict, or a policy decision that a law enforcement approach will be exclusively applied to counter the terrorist or insurgent threat. The complexity of the current threat environment confronted by many States has increasingly resulted in an acknowledgement of the applicability and relevance of both bodies of law.

One downside to relying on a human rights framework is that humanitarian law provides a more comprehensive and specific body of rules governing the provision of medical care that is non-discriminatory and applies to all parties to a conflict. This does not mean that human rights law does not have a role to play, particularly since it better addresses the broader dimensions of health care. In addition, in situations where the State has robust medical services, and a law enforcement approach can be effectively applied, victims of what is in reality an armed conflict are likely to be well cared for under a human rights law paradigm. The prevalence of States using a human rights-based law enforcement approach to address non-State actor violence means that there likely will be a trend towards incorporating humanitarian-based obligations into human rights law considerations, including the provision of medical care in urban conflict.

Ideally, State military forces will be trained and equipped to provide effective medical care regardless of which legal framework they apply, or whether they are operating in an urban or rural environment. However, the challenge of dealing with civilians who are increasingly finding themselves the victims of urban conflict and other security operations will remain. While ordinarily it could be expected that medical facilities in urban areas would be

able to meet the need, there is no assurance those facilities will be functioning or that health care professionals will be available during highly destructive combat operations. This is particularly true given the mounting evidence that such facilities and services are being purposely targeted. These attacks, and the nature of urban combat, have led to a paucity of humanitarian groups operating in some areas of conflict. As a result, States have sometimes contracted with private medical service providers for the provision of front line trauma care. This, in turn, has raised questions concerning the impact on the neutrality and independence principles relied on by humanitarian groups.

There can be no doubt that the concentration of civilians in urban environments will lead to an increase in collateral injuries and death as military operations extend into the world's cities. This has led to calls for limiting the use of explosive weapons in that environment, as well as consideration being given by military commanders to the reverberating effects of damage to infrastructure such as water and electrical facilities. However, the desire to limit the collateral effects of these weapons cannot ignore their continuing relevance to military operations in urban environments.

The large number of attacks that appear to have been directed against hospitals, clinics, and medical personnel have also led to calls for investigations of these possible war crimes. Further, injuries to military personnel operating in urban environments appear to have changed over the years to an increasing percentage of bullet wounds rather than shrapnel wounds. Civilians are even less protected and are at considerable risk of suffering injuries from bombing, artillery and mortar rounds, IEDs, and gunshot wounds. With the effects of these wounds on civilians, and the general destruction of civilian infrastructure in cities likely to have a long-term effect, it is more important than ever to reinforce the detailed international humanitarian law obligations for the provision of medical care. Whether these rules are applied under that body of law or through the interpretation of human rights law, the focus should be on ensuring both military personnel and civilians are equally protected under the law.