Global Initiative to Galvanize Political Commitment to International Humanitarian Law – Second state consultation on achieving meaningful protection for hospitals in armed conflict (Workstream 5)

I would like express our appreciation to the ICRC and the co-sponsors of this workstream for organizing today's consultation. Allow me to start with some general remarks.

The IHL rules on the protection of medical facilities, medical personnel and persons receiving medical care are the starting point for our discussion, and ensuing, factual protection is dependent upon the manner in which these rules are applied in practice. It is effectively translating the law into clear, practical procedures and guidelines for military forces, that leads to real world outcomes.

Whereas the substantive rules of IHL originate from our common moral commitment to the safeguarding of the provision of medical care even during the most horrific of circumstances, they reflect the lower limit of protection to be afforded. Nothing prevents parties from providing greater protection, whether that may result from political, moral, operational, or other considerations.

Lastly, internal military regulations play a role in institutionalizing a *culture* of protection, ensuring that the protection of civilians and civilian objects, including those afforded specific protections, is not seen as a constraint, but as a goal in itself and an integral part to the military profession and conduct.

Let me now share a few practices from our perspective.

(Session 1)

The basis to our military thinking is laid down in The Netherlands Defence Doctrine. It mentions that IHL sets the legal framework for military operations and that the protective provisions of IHL will be applied as a matter of policy even where IHL is not formally applicable.

Armed forces are trained on the rules of IHL and are taught the specific/special protections for hospitals. Military legal advisers assist commanders in targeting operations, making legal assessments as to the status of objects to be attacked and the necessary precautions to prevent or at least minimize civilian casualties and damage.

The substantive rules of IHL (in the context of armed conflict) and the substantive rules of human rights law (in operations outside the context of an armed conflict or where necessary to supplement the rules of IHL) form the basis for the ROE and Targeting Directives which are drafted carefully for the specific mission or operation at hand.

During the planning stage of operations, information is collected on the location and functioning of medical facilities and the essential services that enable their functioning. These locations will be marked on planning tools and inform additional measures, such as 'no fire areas', in order to prevent their inadvertent attack and to prevent or minimize incidental damage. Such 'fire support coordination measures' should not only be developed and continually updated, they should also be actively disseminated to all troops and incorporated at all levels of planning and execution of operations.

Where feasible, military staff may seek to establish and maintain positive two-way communication between the military headquarters and medical facilities in the area of operations. Points of contact could be used to directly relate information regarding the general security situation, current and future military operations, measures to protect the medical facility, seeking clarification in the event of alleged use to commit, outside their humanitarian duties, acts harmful to the enemy" of the medical facility, and communicating warnings in the event this use of the medical facility is verified.

Lastly, damage to medical facilities does not always occur as a result of deliberate targeting. Medical facilities may also suffer unintended damage by misidentification, weapon malfunction or countermeasures that have unintended consequences.

Parties should take the necessary precautions to protect civilian objects under a party's control against the dangers resulting from military operations (passive precautions). This may include avoiding locating military objectives near medical facilities by determining a minimum distance to stay clear of medical facilities and seeking, to the extent feasible, to avoid using countermeasures to attacks that may result in unintended damage to medical facilities.

(Session 2)

Even only a one-time use of a medical facility for military operational purposes which would be discovered by the enemy, may lead to significant deterioration of the (future) protection of medical facilities as the enemy may lose its trust in the party adhering to IHL and may be tempted to think that misuse may also occur in other circumstances.

Parties should therefore avoid to the maximum extent feasible any misuse of medical facilities.

(Session 4)

As stated in the previous round of consultations, The Netherlands would like to stress again the need to apply great care in interpreting which type of acts would fall within the remit of ‘acts harmful to the enemy’. In addition, we also underline the importance of applying equal great care in verifying whether certain acts which would qualify as acts harmful to the enemy, are indeed being performed. We reiterate the general obligation to take precautionary measures, including that those who plan or decide upon an attack shall do everything feasible to verify that the objectives to be attacked are neither civilians nor civilian objects and are not subject to special protection. Particular scrutiny must be applied when assessing whether the conditions exist that would lift a specific protection, such as assessing whether “acts harmful to the enemy” are performed. This may include a necessity to seek information or clarification from health authorities and/or the enemy regarding the alleged misuse.