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INTERNATIONAL HUMANITARIAN LAW AND THE FIGHT AGAINST EPIDEMICS: AN ANALYSIS OF THE INTERNATIONAL NORMATIVE SYSTEM IN LIGHT OF THE COVID-19 PUBLIC HEALTH EMERGENCY

1. *Introduction*

The COVID-19[1] pandemic, which is currently affecting the international community[2], is an unprecedented phenomenon and, nonetheless, a harbinger of general questions that disregard and predate the spread of the coronavirus. This presentation aims to analyze the difficulties connected with the spread of epidemics in times of armed

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[1] COVID-19 («Coronavirus Disease - 2019») is scientifically called «SARS-CoV-2», acronym which stands for «Severe Acute Respiratory Syndrome Coronavirus 2». «Coronavirus Disease 2019» is the disease which induced such virus.

[2] The latest WHO situation report, dated 05th July 2020, attests almost 11.125.245 confirmed cases of contagion worldwide and about 528.204 total victims. In this regard, see Situation Report no. 167 of the World Health Organization of 05th July 2020, available in this link https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200617-covid-19-sitrep-149.pdf?sfvrsn=3b3137b0_4. In detail, in Africa, 356.666 cases, 6.746 deaths; in the Americas, 5.697.954 cases and 262.538 deaths; in the Eastern Mediterranean, 1.153.157 cases, 27.074 deaths; in Europe, 2.774.221 cases and 199.879 deaths; in Southeast Asia, 918.591 cases and 24.473 deaths; in the Western Pacific, 223.915 cases and 7.481 deaths. On the data relating to the diffusion of COVID-19, also consult the WHO geographic dashboard: https://covid19.who.int/ and the Organization's Global Research Database https://search.bvsalud.org/global-literature-on-novel-coronavirus-2019-ncov/.

conflict, which may be considered "an emergency within an emergency", and which involves difficult problems with no easy solutions from both a practical and legal point of view. The shortage of health infrastructure and facilities, their poor quality and the risk and difficulty of reaching and accessing them, are only a few of the reasons for the increase in morbidity and mortality rates in the population during war[3]. It is a context which greatly complicates the management of an epidemic. We may, therefore, ask how, given international law and practice in the affected States, it might be possible to prevent and contain the outbreak of a contagious disease in regions already devastated by armed conflict. This also raises the question whether the current international normative system can be considered adequate in dealing with such a complex event and better able to ensure that the right to health is guaranteed, even in times of war. These are complex issues, which require an overarching analysis, moving beyond international humanitarian law (IHL), which represents the basis of any legal analysis regarding armed conflict, to include the entire range of instruments, documents and agencies in charge of the fight against epidemic phenomena in times of war. Indeed, international legislation shall be combined with the vital importance of practical action by the many actors involved, from the International Movement of the Red Cross and Red Crescent to the United Nations system, in particular the World Health Organization, within a deeply varied and diverse framework. The present analysis will focus in particular on the normative aspects of the issue, while examining also the practice of the International Movement of the Red Cross and Red Crescent and paying specific attention to the International Committe of the Red Cross, which plays a decisive role in protecting health and fighting epidemics in times of war. Aware that the topic analyzed in the following pages involves several other aspects, such as the World Health Organizations's activities and the accountability perspective - including the international criminal justice system- the aim of this work is also to open a debate that can be further developed.

2. *Epidemics in international armed conflicts: requirements provided by the Four Geneva Conventions of 1949 and the I Additional Protocol of 1977*

For international humanitarian law is absolutely essential to mitigate, as far as possible, the inevitable suffering linked to armed conflict, by guaranteeing adequate protection for the wounded and the sick, including those, military or civilian, who are affected by epidemic disease. It is no coincidence that the wounded and the sick, along with the medical staff in charge of their care, were the first protected category to benefit

[3] On the increase in mortality and morbidity rate that occurs in theaters of war see C. J. L. MURRAY, G. KING, A. D. LOPEZ, M. TOMIJINA, G. KTUG, *Armed conflict as a public health problem*, in *BMJ*, Vol. 324 (7333), 2002, pp. 346–349, in which «Armed conflict between warring States and groups within States have been major causes of ill health and mortality for most of human history. Conflict obviously causes deaths and injuries on the battlefield, but also health consequences from the displacement of populations, the breakdown of health and social services, and the heightened risk of disease transmission». On the same theme see also: S. H. A. GHOBARAH, P. HUTH, B. RUSSETT, *Civil Wars Kill and Maim People-Long after the Shooting Source*, in *The American Political Science Review*, Vol. 97 (2), 2003, pp. 189-202; K. HILL, J . TRUSSEL, *Further Developments in Indirect Mortality Estimation*, in *Popul Stud (Camb)*, Vol. 31 (2), 1977, pp. 313-334; BS. LEVY, VW SIDEL, *War and public health*, in *International Journal of Epidemiology*, Vol. 38 (2), 2009, pp. 614–615.

from special legal protection under the 1864 Geneva Convention[4], in accordance with the principles of Solferino and with particular reference to the principle of humanity[5]. Since then, the legal status accorded to wounded and sick people has evolved through various stages, from the Hague Conventions in 1899 and 1907 - and its attached regulations – as well as the 1929 Conventions, up to the 1949 Geneva Conventions and the two 1977 Additional Protocols[6], which truly represent international humanitarian law, by extending protection to the civilian population and to those people who, generally speaking, are not actively involved in hostilities.

Starting from the principle of humanity, the Geneva Conventions regulate the conditions of the wounded and the sick[7], in a detailed and satisfactory way, by guaranteeing a solid protection also for healthcare facilities and healthcare personnel, thereby creating a complete legislative framework which is currently accepted and recognized also as part of customary international law[8]. In comparison to the great general attention paid by international humanitarian law to the condition of the sick, those provisions concerning epidemic diseases, as a specific phenomenon, seem to be lacking or less protective.

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[4] In this regard see D. A. LEWIS, N. K. MODIRZADEH, G. BLUM, *Medical Care in Armed Conflict: International Humanitarian Law and State Responses to Terrorism*, in *Harvard Law School Program on International Law and Armed Conflict*, Legal Briefing - Compendium, 2015, pp. 4-6, which highlights how, since 1864, States have agreed to place the care of sick people and, more broadly, the protection of health, at the heart of international humanitarian law. The compendium is available in the link: https://pilac.law.harvard.edu/medical-care-in-armed-conflict-international-humanitarian-law-and-state-responses-to-terrorism.

[5] In relation to the importance of the principle of humanity, see L. FAST, *Unpacking the principle of humanity: Tensions and implications*, in *International Review of the Red Cross*, Genève, Vol. 97 (897-898), 2016, pp. 111-131 in which «Humanity is at once the most universally and uncritically accepted humanitarian principle. It is not, however, without controversy». See also K. MACKINTOSH, *The Principles of Humanitarian Action in International Humanitarian Law*, in *Principled humanitarian Action in Practice Portal*, Humanitarian Policy Group Report, 2000, available in the following link: https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/305.pdf.

[6] For a complete analysis on the evolution of international humanitarian law, see, among others: C. SOMMARUGA, *Il Diritto internazionale umanitario e il suo rispetto: una sfida permanente*, in *Review of International Political Studies,* New Series, Vol. 79, n. 1 (313), 2012; F. BOUCHET SAULNIER, *The Practical Guide to Humanitarian Law*, Oxford, 2007; P. BUIRETTE, P. LAGRANGE, *Le droit international humanitaire*, Paris, 2008; J. CARIO, *Le droit des conflits armés*, Panazol, 2002; E. DAVID, *Principes de droit des conflits armés*, Bruxelles, 2008. The paper of the International Committee of the Red Cross, available in the following link https://www.redcross.org/content/dam/redcross/atg/PDF_s/International_Services/International_Humanitarian_Law/IHL_SummaryGenevaConv.pdf, offers a good summary of the principles provided by the four Geneva Conventions and their Additional Protocols as well as the main general requirements of international humanitarian law.

[7] A. BELLAL, *Who Is Wounded and Sick?*, in A. CLAPHAM, P. GAETA, M. SASSÒLI (eds.), *The 1949 Geneva Conventions: A Commentary*, Oxford, 2015, pp. 757–765; J. BENOIT, *Mistreatment of the Wounded, Sick and Shipwrecked*, ICRC Study on Customary International Humanitarian Law, in *YB. Int. Hum. Law*, Vol. 11, 2008, pp. 175 -219. The notion of wounded and sick people is quite broad and comprehensive. According to Article 8 of the I Additional Protocol of 1977 related to the protection of victims of international armed conflicts and the ICRC Commentary, "injured" and "sick" means people, whether military or civilian, who because of trauma, disease or other physical or mental disorder or disability are in need of medical care and who refrain from any act of hostility.

[8] According to F. M. BURKLE, A. L. KUSHNER, C. GIANNOU, M. A. PATERSON, S. M. WREN, G. BURNHAM, *Health Care Providers in War and Armed Conflict: Operational and Educational Challenges in International Humanitarian Law and the Geneva Conventions (Part II, Educational and Training iniziatives)*, in *Disaster Med Public Health Preparednes*, Vol. 13(3), 2018, pp. 383-396, the discipline relating to the right to health and the healthcare system was in turn influenced and contaminated by the complex of international humanitarian law, given the great attention paid to it which led almost to a mixture between the two systems.

Although the dramatic risks associated with the outbreak of an epidemic in times of war had already become apparent with the spread of the *Spanish Influenza Epidemic* at the end of World War I[9], neither the 1949 Geneva Conventions nor the 1977 additional Protocols provided a specific, organic and complete discipline, to prevent and to address these phenomena. The obligations regarding epidemics provided by Geneva law are few in number and all of them refer to international armed conflicts, whereas the particular nature of these diseases – along with the intensity and speed with which they spread - seems to testify to the necessity of a specific section dedicated to the question.

The terms "epidemic", "contagious disease" and "transmission" do not appear in the I Convention for the amelioration of the condition of the wounded and sick in armed forces in the field, or in the II Convention for the amelioration of the wounded, sick and shipwrecked members of the armed force at sea. Article 12 of both the Conventions refers to the concept of "transmission" and "infection", but with a very different objective from that of preventing or containing the outbreak of an epidemic. This provision, by prescribing that the members of the armed forces and the wounded and the sick must be respected and protected in all circumstances, prohibits deliberately leaving them without medical treatment or assistance or exposing them to contagion or infection thus created. According to the preparatory work of the Geneva Conventions and the 1949 Geneva Diplomatic Conference proceedings, the term "contagion" should apply to infectious diseases, communicable from one human being to another, while the term "infection" would refer specifically to an infection which was caused artificially. Art. 12, therefore, outlines a strict prohibition of intentional exposure of the wounded and the sick to transmission or infection, where it is intended as a weapon of war, and has as its aim the elimination of enemy forces, but it does not amount to an adequate condition for reacting sucessfully to the spread of contagious disease in a timely and effective manner[10].

Indeed, the general duty of States to care for the wounded and sick, outlined in art. 12 of the I and II Geneva Conventions, is expressed through a system of specific obligations - positive and negative - which is much wider than that of simply refraining from the use of contagion as a weapon of war, but which, in any case, seems not suitable or useful to the question of coping with an epidemic. The First Convention provides, among other steps, that the parties to conflict shall take any necessary measures to protect the sick from looting and inhumane treatment, by ensuring them proper care. The Convention prescribes the responsibility of the States to act with due diligence, in order to create the

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[9] According to the Italian National Institute of Health, the Spanish influenza Pandemic affected about a third of the world population in the two-year period 1918-1919, with a lethality greater than 2.5% and about 50 million deaths. For a complete analysis of the influenza, see, among others: M. MARTINI, V. GAZZANIGA, N. L. BRAGAZZI, I. BARBERIS, *The Spanish Influenza Pandemic: a lesson from history 100 years after 1918*, in *Journal of Preventive Medicine and Hygiene*, Vol. 60(1), 2019; PC. WEVER, L. VAN BERGEM, *Death from 1918 pandemic influenza during the first world war: a perspective from personal and anecdotal evidence,* in *Influenza Other Respir Viruses*, Vol. 8 (5), 2014, pp. 538-46.

[10] J. BOSKO, *The protection of the wounded and sick and the development of International Medical Law*, in *Int. Rev. Red Cr.*, Vol. 5 (48), 1965, pp. 115–122; G. GIACCA, *The Obligations to Respect, Protect, Collect, and Care for the Wounded, Sick, and Shipwrecked*, in A. CLAPHAM, P. GAETA, M. SASSÒLI (eds.), *The 1949 Geneva Conventions: A Commentary*, Oxford, 2015, pp. 781-806. The Article 12, starting from the principle of humanity, provides that the wounded and the sick must be treated with humanity by the Party that will have them in its power. These are provisions that hardly lend themselves to providing valid solutions or indications with reference to a contagious disease.

best hygienic conditions possible and to grant a special protected status to permanent health facilities and mobile medical units[11].

These are fundamental principles for dealing with a contagious disease, however, they do not furnish an effective solution in terms of prevention and control. The obligation for parties to the conflict to proceed, for example, with the identification and registration of the wounded and sick along with the dead (art.16 of I Convention and art.19 of II Convention)[12] is certainly useful in understanding the spread, both numerical and geographical, of an epidemic and in avoiding that any possible continuation of conflict may, in certain areas, contribute to amplifying it. Nonetheless, such registration should be accompanied by strict monitoring of the movements of patients if they are not placed in isolation, by requesting that they remain traceable and contactable. This action is not required by the first two Conventions and, therefore, is rarely applied by the parties to the conflict.

The I and II Geneva Conventions do not, as a result, appear to be entirely lacking in valuable and applicable provisions for preventing or controlling an epidemic, even if they are not intended to serve this specific purpose. However, the absence of principal requirements on epidemics in the two abovementioned Conventions does not imply a total lack of answers or possible solutions for dealing with them, especially where Parties in conflict, in the case of an eventual spread of contagious disease, can establish hospital zones and locations (art. 23 of the I Convention) or conclude special provisionary agreements (art. 6 of both Conventions). These two provisions do not prescribe obligations, but create optional legal institutions, whose implementation would anyway usefully contribute to the containment of any epidemic. In accordance with art. 23 of the I Convention[13], the parties to the conflict can establish organized hospital zones and

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[11] On the protection of health and hospital training in conflict, see N. GORDON, N. PERUGINI, *Hospital Shields and the limit of international law*, in *Eur. Jour. Int. Law*, Vol. 30 (2), 2019, pp. 439–463, which envisages the desirability of a reform of the Geneva system, leading to an absolute and peremptory ban on such attacks, under any circumstances and for any purpose. See also: K. H. FOOTER, L. S. RIBENSTEIN, *A human rights approach to health care in conflict*, in *Int. Rev. Red Cr.*, Vol. 95 (889), 2013; L. C. GREEN, *The contemporary Law of Armed Conflict*, Manchester, 2008. For a practical analysis on the subject, it is possibile to consult the Guide for the protection of health workers in war time https://healthcareindanger.org/wp-content/uploads/2017/05/hcid-guiding-tool-icrc-eng.pdf and the indications provided by the ICRC Adviser Service on International Humanitarian Law: *Respecting and Protecting Health Care in Armed Conflicts and in Situations Not Covered by International Humanitarian Law*, https://www.icrc.org/en/document/respecting-and-protecting-health-care-armed-conflicts-and-situations-not-covered.

[12] These are obligations that can certainly take on a significant weight in reference to epidemics. The two provisions provide, in detail, the obligation for States Parties to record, in the shortest possible time, all the indications relating to the injuries, illness or cause of death of those who belong to the opposing party but have fallen under their power. The Parties in conflict must also ensure that the burial or cremation of the dead, carried out individually to the extent that circumstances allow, is preceded by a diligent examination of the corps, if possible by a doctor, to ascertain the cause of death, to establish the identity and to be able to account for it. See: R. GEISS, *Name, rank, date of birth, serial number and the right to remain silent*, in *Int. Rev. Red Cr.*, Vol. 87 (860), 2005, pp. 721–735; M. KATZ, *The Central Tracing Agency of the ICRC*, in *Int. Rev. Red Cr.*, Vol. 17 (199), 1977, pp. 407–412; G. DJUROVIC, *The Central Tracing Agency of the International Committee of the Red Cross*, Genève, 1986.

[13] Article 23 is part of a larger system of protected areas, established by the Geneva Conventions of 1949 and further developed in Addtional Protocol I, which offers special protection also to non-defended locations and demilitarized areas. On the issue see: E.C. GILLARD, *Safe areas: The international legal framework*, in *Int. Rev. Red Cr.*, Vol. 99 (3), 2017, pp. 1075–1101; E. C. GILLARD, *Protection of Civilians in the Conduct of Hostilities*, in *Routledge Handbook on the Law of Armed Conflict*, New York, 2016; J.P. LAVOYER, *International Humanitarian Law,*

localities in their territory, in order to protect the wounded and sick and the staff in charge of the organization and administration of these areas. Although it is necessary to conclude agreements for the recognition of such areas[14], which are initially unilateral measures of the party establishing them, people and objects present in the area do not remain without protection, given that general rules of international humanitarian law shall be applied in any case. In the event of an epidemic, the establishment of a hospital zone, possibly to be used for the treatment of infected patients with facilities and staff specifically assigned for that purpose, would permit the containment of the outbreak, keeping it under control even while the armed conflict continued in the rest of the region. The establishment of neutralized areas, provided under art. 15 of the IV Geneva Convention and intended to protect wounded and sick people, combatant or non-combatant, from the dangers of fighting, might also significantly contribute to efforts to cope with contagious disease[15].

A different but equally effective solution might be the use of art. 6, which provides the possibility for High Contracting Parties to conclude special agreements on any matter for which they may deem it suitable to make separate provisions. It concerns different agreements[16] from those listed in the above-mentioned Conventions, which are more flexible and better able to deal with any matters which could arise, so long as the protection offered by the Conventions to the wounded, the sick and the shipwrecked are not limited or reduced under any circumstance. In the event of an epidemic, the conclusion of similar agreements, not necessarily made in writing, even though that is advisable, could be used to create suitable medical centers throughout any region affected by a health emergency, including by assigning specialized personnel and thereby providing a tangible contribution

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Protected Zones and the Use of Force, in W. BIERMANN, M. VADSET (eds.), *UN Peacekeeping in Trouble: Lessons Learned from the Former Yugoslavia: Peacekeepers' Views on the Limits and Possibilities of the United Nations in a Civil War-like Conflict*, London, 1998, p. 262 ss.; V. KECK, *What You Need to Know About Safe Zones*, in *Intercross Blog*, 2017, available in the following link: http://intercrossblog.icrc.org/blog/what-you-need-to-know-about-safezones; J. STERN, *Establishing Safety and Security at Protection of Civilians Sites: Lessons Learned from the United Nations Peacekeeping Mission in South Sudan, in Civilians*, Conflict Policy Brief n. 2, 2015, p. 5, https://www.stimson.org/wp-content/files/file-attachments/CIC-Policy-Brief_2_Sept-2015.pdf; J. EGELAND, *Protection of Civilian Sites: Lessons Learned from South Sudan for Future Operations*, in *Norwegian Refugee Council*, 2017, available in the following link: www.nrc.no/globalassets/pdf/reports/poc-sites_lessonsfrom-south-sudan-copy.pdf. For an interesting insight into the safety zones in Ukraine we suggest: *Safety Zones: Questions and Answers with Alain Aeschlimann, Head of the ICRC in Ukraine*, 10th July 2017, available here: http://ua.icrc.org/2017/07/10/safety-zones-questions-answers-alain-aeschlimannhead-icrc-ukraine.

[14] In order to establish, regulate and administer hospital areas, the Parties may take as a basis the draft agreement annexed to this Convention, possibly introducing any modifications they deem necessary.

[15] This is a possibility envisaged by the IV Geneva Convention. Art. 15 of the Convention provides that any Party to the conflict may, either direct or through a neutral State or some humanitarian organization, propose to the adverse Party to establish, in the regions where fighting is taking place, neutralized zones intended to shelter from the effects of war the wounded and sick, combatants or non-combatants and civilian persons who take no part in hostilities.

[16] Article 6 does not provide a particular and mandatory form for such agreements, which could take the form of written but also oral or tacit agreements, of both a bilateral and multilateral nature, limited or unlimited in their duration, or even concluded through the use of signals. Special agreements could possibly be stipulated through mutual and concordant declarations of intent, issued orally and without other formalities, but in that case they should be particularly clear and precise in order to be feasible. On this subject see: M. HAROFF TAVEL, *Do wars ever end? The work of the International Committee of the Red Cross when the guns fall silent*, in *Int. Rev. Red Cr.*, Vol. 85 (851), 2003, pp. 465-496; R. BAXTER, *Armistices and other forms of suspension of hostilities*, in *Collected Courses of the Hague Academy of International Law*, Vol. 149, 1976, pp. 353-400; C. OLIVIER, P. KLEIN, *The Vienna Convention on the Law of Treaties: A Commentary*, Oxford, 2011.

to the containment of an epidemic. The fact that these agreements may involve non-state entities, such as the International Committee of the Red Cross, constitutes a further indication of their importance.

Differently from the first two Conventions, the third Geneva Convention, relating to the treatment of prisoners of war, brings epidemics into consideration, by containing specific provisions and requirements, mostly in the Section on hygiene and medical care in the camps to which prisoners of war are transferred following their capture. Indeed, art. 29 provides that the Detaining Power will take all necessary hygienic measures to ensure the cleanliness and healthiness of the camps and to prevent epidemics[17]. The following art. 30 prescribes that each camp should have an adequate infirmary, in which prisoners of war will be able to receive appropriate treatment and that, in case of necessity, isolation rooms will be reserved for those affected by contagious or mental illness[18]. Given the poor practice of the States on this point, the 1960 ICRC Commentary does not provide significant additional elements in respect to the two abovementioned provisions which are, in any case, suitable and well formulated in their description of specific obligations for the States Parties, both for the prevention of epidemic (art. 29) or for resisting outbreaks (art. 30).

However, the cleanliness and healthiness of a camp is a necessary but not a sufficient condition for the prevention of an epidemic. First of all, it is fundamental that prisoners of war are vaccinated, at least against existing diseases or those which are at risk of spreading. If it is true, on the one hand, that the vaccination should have taken place before their

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[17] For a general overview of the status of prisoners of war, see the summary of the ICRC: https://www.icrc.org/en/doc/war-and-law/protected-persons/prisoners-war/overview-detainees-protected-persons.htm. Art. 29 of the III Convention specifically provides that prisoners of war shall have for their use, day and night, conveniences which conform to the rules of hygiene and are maintained in a constant state of cleanliness. In any camps in which women prisoners of war are accommodated, separate conveniences shall be provided for them. Also, apart from the baths and showers with which the camps shall be furnished, prisoners of war shall be provided with sufficient water and soap for their personal toilet and for washing their personal laundry; the necessary installations, facilities and time shall be granted them for that purpose. On this subject see: H. MCCOUBREY, *Protection of Prisoners of War*, in *International Humanitarian Law Modern Developments in the Limitation of Warfare*, 1998, p. 43; H. LEVIE, S. HOWARD, *Prisoners of War in International Armed Conflict*, in *International Law Studies*, U.S. Naval War College, Vol. 59, 1978, pp. 143-145; C. MAIA, R. KOLB, D. SCALIA, *La Protection des Prisonniers de Guerre en Droit International Humanitair*, Bruxelles, 2015; S. SANNA, *Treatment of Prisoners of War*, in A. CLAPHAM , P. GAETA, M. SASSÒLI (eds.), *The 1949 Geneva Conventions: A Commentary*, Oxford, 2015, pp. 977-1011.

[18] In accordance with art. 30, prisoners of war affected by serious illness or whose status requires special care, surgery or hospitalization, must be admitted to any suitable military or civil hospital in order to be treated and receive special facilities for their rehabilitation, while waiting for their repatriation. Prisoners of war cannot be prevented from going to the medical authorities for examination. The detaining authorities will issue, upon request, to every prisoner treated, an official statement indicating the nature of their wounds or illness and the duration and type of treatment received. On this subject: G. NOONE, *Prisoners of War in the 21st Century: Issues in Modern Warfare*, in *Naval War Review*, Vol. 50, 2004, pp. 1-69; WF. PAGE - C.M. TANNER, *Parkinson's disease and motor-neuron disease in former prisoners of war*, in *Lancet*, Vol. 355 (9206), 2000, pp. 355 ss; S. KRAHENMANN, *Protection of Prisoners in Armed Conflict*, in *The Handbook of International Humanitarian Law*, 2013, pp. 359-411; M. BRETONIERRE, *L'application de la Convention de Genève aux prisonniers français en Allemagne durant la seconde guerre mondiale*, Paris, 1949, pp. 120-121; N. HART, M.K.CROCK, M. MCCALLUM, *Making Every Life Count: Ensuring Equality and Protection for Persons with Disabilities in Armed Conflicts*, in *Monash University Law Review*, Vol. 40, n. 1, 2014, pp. 148-174; R.J. URSANO, J.R. RUNDELL, M.R. FRAGALA, *The prisoner of war*, in R.J. URSANO, A.E. NORWOOD (eds.), *Emotional aftermath of the Persian Gulf War: veterans, families, communities and nations*, Washington, 1996, pp 443–76.

capture, by the State of citizenship of the prisoner of war, it is also necessary that the Parties in conflict who capture prisoners examine them, before they enter the camp. After all, a disease could be endemic in the country that captures a prisoner of war but not be widespread - or qualified as endemic - in his home country, where the vaccine may therefore not be mandatory. Prophylaxis becomes fundamental, even if the conflict takes place in a third State, but prisoners of war are then transferred to another State affected by an epidemic. Furthermore, once a contagious disease has become established, it is necessary not only to isolate all infected patients, as is required by art. 30, but also to monitor, in a continuing manner, any health personnel assigned to their care, though this action is not covered by the Convention.

These lacunae are partially filled by art. 46, according to which it is forbidden to prevent prisoners of war from visiting medical authorities to be examined. To the contrary, it is expected that the detaining authorities will issue a formal declaration, indicating the nature of a patient's injuries or illness and the duration and type of care received[19], in regards to each prisoner treated. Since there is no active requirement for the Parties in conflict to provide medical examinations, but there is only a prohibition of the refusal to perform such checkups on those who request them, the above-mentioned requirement has intrinsic deficiencies, which are difficult to overcome solely through the interpretation of that provision.

Like the III Convention, also the IV Convention, concerning the protection of civilians, contain primary provisions on epidemics, not only in the Sections on hygiene and medical care, but also in that dealing with the occupation of territories. Based on the provisions of art. 91, every place of internment must have an adequate infirmary, under the authority of a qualified doctor, where internees can receive any treatment they need, as well as isolation rooms reserved for patients suffering from contagious or mental illnesses. It is also expected (art. 92) that medical examinations of internees shall be organized at least once a month, to ascertain the existence of contagious diseases, most particularly of tuberculosis, venereal infections and malaria. The list of diseases provided by art. 92 must deal with the needs - and emergencies - linked to the new and current forms of epidemic that have put into question the completeness of this list, raising completely new problems. Furthermore, the regime outlined in the IV Convention, while taking epidemics into consideration, provides protection against them only in reference to internees, thereby not embracing civilian population in general terms.

In relation to occupied territories, art. 56 of the same Convention is particularly significant. It prescribes for the Occupying Power the duty of ensuring in the occupied territory, with the help of national and local authorities, health facilities, hospital services, public health and hygiene and the adoption and application of the prophylactic and preventive measures deemed necessary to combat the spread of contagious diseases and epidemics. Such measures, according to the related ICRC Commentary, would involve fundamental activities such as: the supervision of public health, the education of the

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[19] M. LONGOBARDO, *The Duties of Occupying Powers in Relation to the Fight against Covid-19*, in *Blog of the European Journal of International Law*, 2020, available in the following link https://www.ejiltalk.org/the-duties-of-occupying-powers-in-relation-to-the-fight-against-covid-19/; M. LONGOBARDO, *The Relevance of the Concept of Due Diligence for International Humanitarian Law*, in *Wisconsin International Law Journal*, Vol. 37 (1), pp. 44-87. See also the General Comment no. 14 of the UN Committee for the monitoring of the Covenant on Economic, Social and Cultural Rights relating to the right to the highest Attainable standard of health (E/C.12/2000/4): https://www.refworld.org/pdfid/4538838d0.pdf.

population on medical issues, the distribution of medicines, the organization of medical tests and disinfection, the stockpiling of medical supplies, the sending of medical teams to those areas where epidemics had already spread, the isolation and hospitalization of people affected by communicable diseases, the opening of new hospitals and dedicated medical centers.

In conclusion, it may be said that the four Geneva Conventions of 1949, while not providing an organic and complete discipline for dealing with epidemics, do prescribe certain specific obligations which - if interpreted in a systematic and coherent way and respected by the parties in conflict - would help prevent and contain an epidemic outbreak. The 1977 First Additional Protocol related to the protection of victims of International Armed Conflicts[20], negotiated and adopted to integrate and update the four 1949 Conventions, provides under art. 16 that no person carrying out a medical activity may be forced to give information concerning a wounded or sick person who is - or was - treated by him. With specific reference to epidemics, however, in compliance with national regulations, it is mandatory to report instances of the diseases, including the data of the infected patients. The Protocol contains no other specific provisions on epidemics, but outlines in greater detail the protected status for wounded and sick people, as provided under the four Conventions of 1949.

3. *Epidemics in internal armed conflicts: the II Additional Protocol of 1977and article 3 common to the four Geneva Conventions of 1949 in light of a systematic and evolutionary interpretation*

With reference to internal armed conflicts, international humanitarian law seems to present much more substantial deficiencies, at least if we analyze the legal data in a strictly literal way. The II Additional Protocol relating to the protection of victims of non-international armed conflicts is characterized not only by gaps in its content but also by the limits of its applicability, since it does not include all internal armed conflicts but only those that «*take place on the territory of a High Party contractor between armed forces or dissident armed forces, as well as organized armed groups which, under the conduct of a responsible command, exercise, on a part of its territory, such control, in order to allow them to conduct extended and concerted military operations*»[21].

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[20] On the Protocol I additional to the four Geneva Conventions, see: F. POCAR, *Protocol I additional to the 1949 Geneva Conventions and customary international law*, in Y. DNSTEIN, F. DOMB (eds.), *The Progression of International Law: four decades of the Israel Years Book of Human Rights - An anniversary volume*, Boston, 2001, pp. 199-2002. The essay provides an interesting and complete analysis of the various provisions of the Protocol, analyzing how much these provisions can be recognized as customary international law, also taking into account the jurisprudence of the International Court of Justice on such subject.

[21] With regard to internal armed conflicts and their definition, see: S. VITÈ, *Typology of armed conflicts in international humanitarian law: legal concepts and actual situations*, in *Wisconsin*, Vol. 91 (873), pp. 69-94, 2009, available in the following link https://www.icrc.org/en/doc/assets/files/other/irrc-873-vite.pdf; J.G. STEWART, *Towards a Single Definition of Armed Conflict in International Humanitarian Law: a Critique of Internationalized Armed Conflict*, in *Int. Rev. Red Cr.*, Vol. 85 (850), pp. 323; A. CULLEN, *The Concept of Non International Armed Conflict*, in *International Humanitarian Law: A Study on Thresholds of Applicability*, Galway, 2007, pp. 229 ss.; D. SCHLINDER, *The Different Types of Armed Conflicts According to the Geneva Conventions and Protocols*, in *The Hague Academy Collected Courses*, Vol. 63, 1979, p. 131; H. P. GASSER, *International Humanitarian Law: an Introduction*, separate volume printing of *Humanity for All: the International Red Cross and Red Crescent Movement*, Genève, 1993; E. DAVID, *Principes de droit des conflits armès*, Bruxelles, 2008.

In addition to the restrictedness of its field of application, the Protocol - unlike the Geneva Conventions - has not achieved universal ratification, resulting in several States not currently being Party to it.[22]. Even if it were admitted that some of the Protocol's provisions, such as those aimed at the protection of the sick, constitute a declaration of existing customary international law and are therefore binding also for non-contracting States, these rules would remain imprecise and ineffective in preventing or suppressing an epidemic event. Indeed, Protocol II does not contain any explicit reference to contagious diseases and - differently from the first two Conventions - it does not even provide the possibility for States Parties to conclude special agreements aimed at dealing with them, as it limits itself to outlining some general principles which are also applicable to epidemics. Part III of the Protocol prescribes, for example, that wounded, sick and shipwrecked people must be respected and protected and should receive any necessary medical treatment requested to their condition, while additionally providing an obligation to protect medical staff, medical transport and medical missions. These are, quantitatively and qualitatively speaking, meager provisions which not only fail to explicitly take into account epidemic diseases, but also appear to be weak in reference to the general protection of the sick, especially in comparison with the four 1949 Conventions. The inadequacy of the protections provided by Protocol II, undoubtedly relates to the reluctance of States to create strict legal rules on internal armed conflicts, which are thought of as inherently falling under national sovereignty, particularly when it comes to matters which have always been considered to be firmly under national domain, such as health care. The principle of non-intervention by third States provided by art. 3 of Protocol II[23], if read in conjunction with other provisions, testifies the sovereign approach, expressed throughout the text of the Protocol, as well as the will of the States to minimize international regulation of internal armed conflicts.

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[22] The Protocol has been ratified by 169 States, and signed but not ratified by three States (Iran, Pakistan, United States of America). On the importance of the Protocol, see: C. FOCARELLI, *Common Article 1 of the 1949 Geneva Conventions: A Soap Bubble?*, in *Eur. Jour. Int. Law*, Vol. 1, 2010, pp. 125–171; C. CONDORELLI, B. DE CHAZOURNES, *Quelques Remarques à propos de l'obligation des Etats de "respecter et de faire respecter" le droit international humanitaire en toutes circonstances*, in *Studies and Essays on International Humanitarian Law and Red Cross Principles in Honour of Jean Pictet*, Parigi, 1984; N. LEVRAT, *Les conséquences de l'engagement pris par les Hautes Parties Contractantes de "faire respecter" les Conventions humanitaires*, in F. KALSHOVEN, Y. SANDOZ (eds.), *Implementation of International Humanitarian Law*, 1989.

[23] In accordance with art. 3, no provision of the Protocol shall be invoked for the purpose of affecting the sovereignty of a State or the responsibility of the government, by all legitimate means, to maintain or re-establish law and order in the State or to defend the national unity and territorial integrity of the State. Furthermore, no provision shall be invoked as a justification for intervening, directly or indirectly, for any reason whatever, in the armed conflict or in the internal or external affairs of the High Contracting Party in the territory of which that conflict occurs. With regards to art. 3 of the Protocol, see: P. L. SULLIVAN, J. KARRETH, *The conditional impact of military intervention on internal armed conflict outcomes*, in *Conflict Management and Peace Science*, Vol. 32 (3), 2015, pp. 269-288; D. CUNNINGHAM, *Preventing Civil War: How the Potential for International Intervention Can Deter Conflict Onset*, in World Pol, Vol. 68 (2), 2016, pp. 307-340; A. GRIGORIAN, *Third-Party Intervention and the Escalation of State-Minority Conflicts*, in Int. St. Quart., Vol. 54, 2010, pp. 1143-1174; A. KYYD, S. STRAUS, *The Road to Hell? Third-Party Intervention to Prevent Atrocities*, in *American Journal of Political Science*, Vol. 57, 2013, pp. 673-684; I. SALEHYAN, K. SKREDE GLEDITSCH, D. CUNNINGHAM, *Explaining External Support for Insurgent Groups*, in *Int. Org.*, Vol. 65, 2000, pp. 709-44. See also the summary analysis of the ICRC on non-international armed conflicts and art. 3: https://www.icrc.org/en/doc/resources/documents/misc/about-the-icrc-311298.htm.

This perspective takes a more encouraging and reassuring form, when analyzing art. 3 common to the 1949 Geneva Conventions, to which the following II Protocol was negotiated and adopted. Regardless of the nature of the conflict and indeed in any operational context, the basic humanitarian standards referred to in art. 3, whose scope is much wider than that of the II Protocol, shall always be recognized. This provision, which is recognized by the International Court of Justice also as a customary international norm[24], provides a series of general principles of absolute priority and prescribes a fundamental obligation which is also valid in internal armed conflicts: the wounded and the sick shall be gathered and treated. It is also implied that they shall be respected and protected, by ensuring the most appropriate protection for medical staff, structures and transport that are intended for their care. Such a duty, despite being brief and concise, if interpreted in conjunction with the other principles outlined in art. 3, provides the basis for a wider protection of wounded and sick people in internal armed conflicts. However, in order to cope with the spread of an epidemic, the provisions of art. 3 seems vague and ill-founded, especially if we consider the major difficulties encountered in the "gathering" and "treatment" of contagious patients. Such provision does not provide any indication on how to fulfill this obligation, as well as managing the spread of an epidemic, since, for example, no duty to register the sick and the dead is prescribed. In addition to this, it is not required to ensure hygiene and health in conflict areas, or to create special isolation facilities for infectious patients or to adopt the necessary prophylactic measures.

In the writer's opinion, the general obligation pursuant to art. 3, which is actuallly deficient and too general to deal with an epidemic event, acquires a strong and solid value if interpreted and applied in the light of those obligations deriving from the four Conventions. It is important to remember that art. 3 provides the parties to the conflict the possibility of committing, through the conclusion of specific agreements, to respecting the Geneva Conventions in their entirety, even in the context of an internal armed conflict. Starting from the civil war in Yemen in 1967 through the various regional conflicts that shocked the Federal Republic of Yugoslavia, before its dissolution, and up to more recent conflicts, there is no lack of practical examples of such agreements, to which unilateral declaration may be added. The parties in conflict, indeed, sometimes undertake, on a voluntary basis, to respect the entire complex of Geneva Conventions in the context of a civil war[25]. However, the widespread awareness of the importance to respect the four

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[24] The fact that Geneva Conventions, including common art. 3, are also part of the customary international law is affirmed by the International Court of Justice in its judgment of 27 June 1986 concerning Nicaragua's against the United States case (https://www.icj-cij.org/files/case-related/70/070-19860627-JUD-01-00-EN.pdf) wherein the Court qualifies these Conventions as the concrete expression of the general principles of humanitarian law, applicable even in the absence of international normative Conventions. According to the Court (paragraph 218 of the aforementioned judgment), the rules referred to in Common Article 3 reflect basic considerations related to the principle of humanity, applicable under customary international law to any armed conflict, whether internal or international. On this subject see M. TAMA NORREN, *Nicaragua v. United States: The Power of the International Court of Justice to Indicate Interim Measures in Political Disputes*, in *Penn State International Law Review*, Vol. 4, n. 1, 1985. https://elibrary.law.psu.edu/cgi/viewcontent.cgi?article=1036&context=psilr.

[25] With reference to the internal civil war in the Democratic Republic of the Congo, for example, in a public declaration issued in October 1964, the Prime Minister pledged to guarantee compliance with the four Geneva Conventions. Similarly, in 1987, the Salvadoran government, during the civil war that devastated the country, declared that it wanted to guarantee the provisions of the II Additional Protocol to the Geneva Conventions, considered as a development and completion of the article 3.

Conventions' fundamental rules, even in internal armed conflicts, cannot be automatically qualified as a *diuturnitas* or *opinio juris* of a relevant and already existing international customary norm. On the one hand, it is true that the regulation of non-international armed conflicts occurred on two different levels, one conventional and the other one customary, with the crystallization of two bodies of rules that support and complement each other. On the other hand, it is equally true that not all the complex of international humanitarian law, under the Geneva Conventions and their Additional Protocols, has become an integral part of international customary law. In particular, it is not reasonable to claim that customary international law can be extended beyond the objectives of conventional law, by proclaiming the validity of the 1949 four Geneva Conventions in internal armed conflicts. The aforementioned practice of special agreements and unilateral declarations, which starting from art. 3 extends the validity of the Conventions to internal armed conflicts, far from being quantitatively relevant and consolidated, should still be considered sporadic and excepting and, therefore, qualified, as a demonstration of the existence of a customary international norm working in the opposite direction[26].

Even if we wish to exclude the idea that the four Conventions automatically and fully apply to internal armed conflicts, it is difficult not to recognize that art. 3 should, at least, be interpreted and applied in this light. The duty to gather and to treat the sick, including contagious people, provided by art. 3 would thus materialize through the modalities prescribed by the four Conventions which represent a beacon for its correct interpretation and implementation. The prohibition of intentional exposure to contagion, the obligation to ensure clean and healthy internment camps for prisoners of war in order to prevent epidemics, along with the possibility of establishing hospital and sanitary localities[27], as well as all other provisions examined in reference to the four Conventions, would therefore have significant relevance also in the application of art. 3 and in the context of internal armed conflicts.

A broader framework is thereby revealed in respect to that which seems to emerge by analysing additional Protocol II and art. 3 separately from entire complex of the of four Conventions. This framework provides significant instruments for preventing and supressing epidemic phenomena, even in internal armed conflicts. Furthermore, according to the literal meaning of art. 3, which refers to the parties to the conflict and not to the parties of the Conventions, the obligation to collect and care for the wounded and the sick seems to apply also to non-state actors. It is worth pointing out that the military codes of practice of some non-state armed groups incorporate and reflect obligations to respect, protect and treat the wounded and the sick. The issue is strongly debated, especially in light

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[26] For an analysis of the applicability of international humanitarian law to internal armed conflicts, see, among others: M. J. ADAMS, R. GOODMAN, *De Facto and De Jure Non-international Armed Conflicts: Is It Time to Topple Tadiç?*, in *Just Security* https://www.justsecurity.org/33533/de-facto-de-jure-non-international-armed-conflicts-time-topple-tadic/. See also: S. DIETRICH, *The Different Types of Armed Conflicts According to the Geneva Conventions and Protocols*, in *Collected Courses of the Hague Academy of International Law*, n. 117, 1979; P. BERMAN, *When Does Violence Cross the Armed Conflict Threshold? Current Dilemmas*, in Proceedings of the 13th Bruges Colloquium, Scope of Application of International Humanitarian Law, Collegium N. 43, 2013, College of Europe–ICRC, p. 41.

[27] According to some views, including the interpretation provided by the ICRC Commentary, the insertion of the possibility of establishing health areas into the First Convention, which is the basis of the entire Geneva system, attaches to that possibility a specific weight, implicitly recommending that hospitals zones be established in practice in any type of conflict.

of the current presence of actors, such as Daesh that do not appear to respect any principle of international humanitarian law.

The arguments made thus far in reference to epidemics in civil wars, seem to be consistent with a general change in perspective of international law, which is no longer oriented only towards regulating or dealing with relations between States considered as sovereign entities, but also aimed at protecting and promoting the rights of individuals. The ongoing process of establishing the Roman legal precept, *«hominum causa omne jus constitum est»* at the international level too is increasingly mitigating the dichotomy between inter-state and civil wars, in favor of a discipline primarly aimed at the protection of human beings. In the case of epidemics which put at risk not only individual health - and the right to life - but that of entire populations, this trend should be even more marked: if prescriptions are provided against contagious diseases in international armed conflicts, even if sporadically and non-organically, it would seem ontologically inconsistent to deny similar protection in internal strife.

Although COVID-19 has caught the Geneva normative system unprepared, its systematic - and perhaps evolutionary - interpretation might, finally, confirm its validity for dealing with epidemics and pandemics, such as the coronavirus too.

4. *The International Movement of the Red Cross and Red Crescent in the prevention and containment of epidemics under the four Geneva Conventions of 1949 and the Additional Protocols of 1977*

The principles and prescriptions contained in the four Geneva Conventions and their additional Protocols, including those aimed at preventing and combating epidemic phenomena, are held in close and constant attention by the International Movement of the Red Cross and Red Crescent, the largest existing humanitarian network in the world[28]. The Movement, which is made up of the International Federation of the Red Cross and Red Crescent Societies (IFRC), the International Committee of the Red Cross and the 192 National Societies, aims to protect the life and health of all human beings, especially under conditions of armed conflict, and plays an essential role in the prevention and containment of epidemics in times of war.

Among the various components of the Movement, both the Geneva Conventions and their Additional Protocols assign an important role to the International Committee of

[28] The International Movement of the Red Cross and Red Crescent is made up of more than 80 million people. The Statute of the International Movement of the Red Cross and Red Crescent, adopted on the occasion of the 25th International Conference of the Red Cross and Red Crescent (1986) and amended in 1995 and in 2006, governs its objectives and functioning: https://www.icrc.org/en/doc/assets/files/other/statutes-en-a5.pdf. See also the *Handbook of the International Movement of Red Cross and Red Crescent*, 40th edition, ICRC publications, 2008, ref. 0962- ebook, which contains all the texts that serve as the basis for the actions of the ICRC, the IFRC and the Red Cross and Red Crescent Societies. Included are: the fundamental principles of the Movement; the main Conventions and other instruments that make up international humanitarian law; the main policies, strategies and action plans that guide the activities of the components of the Movement and a selection of important resolutions adopted during the statutory meetings of the Movement. Periodically updated, the Handbook is an essential support tool for the Movement.

the Red Cross[29]. Art. 9, common to the four Conventions, specifies that no provision of the Conventions can constitute an obstacle to the humanitarian activities that the International Committee of the Red Cross, or any other humanitarian body, carries out for the protection of the wounded and the sicks. This requirement implies the assertion of a fundamental principle: no provision of Geneva law can be interpreted as being aimed at limiting the possibility of humanitarian organizations, in particular the International Committee of the Red Cross, from offering services, as well as help and support to the parties to the conflict, including within health emergencies. The offer of humanitarian assistance, therefore, cannot - and should not - be limited to the activities expressly provided by the Conventions, since humanitarian organizations are authorized to offer any provision of service they deem necessary to better guarantee the safety and the protection of the civil population, even in the absence of a prior request by a party to that conflict[30]. While the consent of the party involved remains a legally necessary precondition for the provision of assistance[31], art. 9 allows humanitarian actors to move freely in what, in the early 1990's, was defined by the President of Doctors Without Borders, Rony Brauman, as a "humanitarian space", that is a place where humanitarian workers should be «free to evaluate needs, free to monitor the assistance provided, free to communicate with people».[32] This principle acquires specific importance in reference to the spread of epidemic phenomena, the containment of which requires the fixed will of all the actors involved. This is especially true given the great difficulties encountered by humanitarian assistance in reaching the end user during health emergencies, which could amount to a general reticence by the Parties in conflict to requesting needed humanitarian assistance to the civilian population.

To reassert what has been said so far, it is important to underline that, in order to provide assistance and support during an armed conflict, the International Committee of

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[29] The International Committee of the Red Cross is taken into particular consideration by the four Geneva Conventions which attach to ICRC a fundamental role. According to some authors, ICRC could therefore be considered as a subject of international law. On the debate on the status of the ICRC, see, among others, C. DOMINICÈ, *La personnalité juridique internationale du Comité international de la Croix-Rouge*, in P. REUTER (eds), *L'ordre juridique ingternational entre tradition et innovation*, Zurich, 1984, pp. 81-91; J. A. BARBERIS, *El Comité internacional de la Cruz Roja como sujeto del derecho de gentes*, in *Cuaderno de derecho internacional*, n. 9, Cordoba, 2014; A. RATHI, *Role of NGOs in application of International Humanitarian Law in Non-International Armed Conflicts*, in *International Research Journal of Management Sociology e Humanities*, Vol. 10 (4), 2019, available in the following link: http://www.irjmsh.com/article_pdf?id=8876.pdf.

[30] An offer of humanitarian assistance cannot be considered either a hostile act, or an illegal interference in the internal affairs of a State, with the consequences that, according to ICRC Commentaries, it cannot be prohibited or criminalized by legislative acts or other national regulations. In relation to the conditions for providing humanitarian assistance, see H. SPIEKER, *The Right to Give and Receive Humanitarian Assistance*, in H. J. HEINTZE, A. ZWITTER (eds.), *A Crosscut Through Legal Issues Pertaining to Humanitarianism*, in *International Law and Humanitarian Assistance*, 2011.

[31] The need for consensus is a highly debated issue in the doctrine: Y. SANDOZ, *Le Droit d'initiative du Comité international de la Croix Rouge*, in Germ. YB. Int. Law, Vol. 22, 1979, pp. 364-366; D. SCHINDLER, *Humanitarian Assistance, Humanitarian Interference and International Law*, in R. J. MACDONALD (eds.), *Essays in Honour of Wang Tieya*, 1993, p. 689-700; M. TORRELLI, *From humanitarian assistance to 'intervention on humanitarian grounds'?*, in *Int. Rev. Red Cr.,* Vol. 288, 1992, pp. 228-234; F. BUGNION, *The International Committee of the Red Cross and the Protection of War Victims*, 2003, p. 448; M. SASSÒLI, *When are states and armed groups obliged to accept humanitarian assistance?*, ICRC publications, ref. 053 ebook, 2013.

[32] The international community tried to clarify the framework of action of humanitarian workers, in the event of natural disasters and other emergencies in 1991 with the unanimous approval of resolution 46/182 of the United Nations General Assembly, available in following link: https://undocs.org/A/RES/46/182.

the Red Cross does not need to act in place of the Protecting Powers, as referred to in art. 10, which regulates the conditions under which the ICRC can be appointed as a substitute for the Protecting Powers[33]. If the ICRC were appointed to play such role, it would be called upon to perform a fundamental task in the responsibility of monitoring and respecting the Conventions and, more generally, for defending the interests of the protected Party and the protection of its civilian population. This possibility, also highlighted by the 2016 ICRC Commentary, does not affect, in any case, the assumption, pursuant to art. 9, according to which the Committee is free to provide humanitarian assistance, at any time or under any circumstance, always on the condition that the party to the conflict consents to receiving such assistance.

The possibility of offering humanitarian assistance, in particular drugs and medicines, without the need for a prior request from the party involved, is more important than ever in the face of the spread of epidemics within the context of an internal armed conflict. On this subject, paragraph 2 of art. 3 prescribes that an impartial humanitarian body, such as the ICRC, may offer its services to the parties in conflict. Unlike common art. 9, this provision does not explicitly prescribe the obligation to obtain the consent of the interested party to proceed with the delivery of humanitarian assistance but, according to the basic principles that apply to international law, including international humanitarian law, the need for a prior authorization would seem implicit in the provision itself[34]. In the absence of any indications in the Geneva Conventions, which do not consider the possibility of legitimately denying consent to an offer of humanitarian assistance, the refusal of the Party to the conflict would involve a strong and aggravated moral responsibility for the Party itsself, in particular in exceptional circumstances such as the spread of a contagious disease. According to the ICRC Commentary, consent could never be refused for arbitrary reasons,

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[33] The issue was widely debated during the 1949 Geneva Diplomatic Conference preparatory to the four Geneva Conventions. The Mexican delegate M. de Alba underlined, on several occasions, the importance of extending the functions of humanitarian organizations as much as possible - in particular that of the ICRC - in order to allow them to fully replace the Protective Powers. This position clearly emerges from the report of the Diplomatic Conference of Geneva, Final record of the Diplomatic Conference of 1949, Vol. II-B, p. 22, available in this link https://www.loc.gov/rr/frd/Military_Law/pdf/Dipl-Conf-1949-Final_Vol-2-B.pdf. See also M. SASSÒLI, A. BOUVIER, A. QUINTIN, *How does Law protect in war? Cases, Documents and Teaching Materials on Contemporary Practice*, in *International Humanitarian Law*, Vol. 1, III edition, ICRC, Genève, 2011, p. 366, which declares that «The ICRC, for its part, has no interest in acting as a substitute Protecting Power, as it can fulfil most of the latter's functions in its own right, without giving the impression that it represents only one State and not all the victims». Among others, see: M. SASSÒLI, *The Victim-Oriented Approach of International Humanitarian Law and of the International Committee of the Red Cross*, in M. C. BASSIOUNI (eds.), *International protection of victims*, Nouvelles Études Pénales, Toulouse, 1988, pp. 147-180. See also: *ICRC Q&A and lexicon on humanitarian access*, in *Int. Rev. Red Cr.*, Vol. 96 (893), 2014, pp. 359–375; the report "International Humanitarian Law and the Challenges of Contemporary Armed Conflicts", prepared for the 32nd International Conference of the Red Cross and Red Crescent.

[34] Consent can take written or oral form, it being understood that - in the absence of a clearly communicated approval - an impartial humanitarian organization can ensure that the Party in conflict consents at least implicitly, by acquiescence, to the humanitarian activities in question, duly notifiying to that Party in advance. In this regard, please consult, D. AKANDE, E. C. GILLARD, *Arbitrary Withholding of Consent to Humanitarian Relief Operations in Armed Conflict*, in *International Law Studies*, Vol. 92 (483), 2016, which also highlights how the recent evolution of international humanitarian law seems to have affirmed the assumption that there are some circumstances in which a Party in an internal armed conflict, be it a State or an actor, is not completely free to decide how to respond to an offer of humanitarian assistance. It would not be entitled to reject it, in particular, when it is unable to meet the basic humanitarian needs of the civilian population. In this case, the refusal would be considered arbitrary and therefore in violation of international law.

as it has to rely on valid justification. Moreover, the parties shall evaluate any offer of services in good faith and in line with its international legal obligations.

When it comes to non-international armed conflicts, paragraph 2 of common art. 3 is integrated by the provisions of the II Additional Protocol. However, the Protocol seems to pay little attention to humanitarian assistance, limiting itself to providing that the relief societes located in the territory of the High Contracting Party, such as the National Red Cross or Red Crescent Societes, can offer their services to perform their traditional duties towards the victims of the armed conflict (art 18).

The International Committee of the Red Cross is also referred to in some provisions, already examined above, which play a specific role in reference to epidemics. Under art. 23 of the I Convention, for example, the Protecting Powers and the International Committee of the Red Cross are invited to lend their good offices in order to facilitate the institution and recognition of the hospital zones and localities. In addition, in authorizing that prisoners of war receive deliveries containing foodstuffs, clothing, medicines and other useful supplies, art. 72 of the III Convention provides that the International Committee of the Red Cross, along with the protective powers concerned, can take the initiative to provide for the transportation of these deliveries, by using the most appropriate means. Finally, the 1949 IV Convention refers the ICRC, providing (art. 30) that people protected by the Convention must be able to access all the facilities necessary to contact the protective Powers, the International Committee of the Red Cross, the National Society of the Red Cross or Red Crescent of the country where they are located, as well as to any other organization that could be of help to them.

To the provisions examined so far, particularly those concerning the ICRC, it is important to add some specific provisions, relating to the National Red Cross and Red Crescent Societes. Art. 26 of the I Convention, extends to their staff - and to that of other Voluntary Aid Societes - the special protection granted by art. 24 to the official staff responsible for the research, gathering and care of wounded and sick people, provided that they are recognized and authorized by their government. This Convention (art. 27) prescribes the extension of this condition to the staff of Red Cross, and Red Crescent National Agencies of neutral States, with the prior consent of their Government or the party in conflict.

5. *The International Movement of the Red Cross and the Red Crescent's activity in the fight against epidemics and pandemics: profiles of practice*

All though the Geneva Conventions and their additional Protocols take the ICRC in particular into consideration, the entire International Movement of the Red Cross and Red Crescent is actually playing a decisive role in protecting health and fighting epidemics in times of war. Starting from the seven principles that inspire its spirit and action, i.e. Humanity, Impartiality, Neutrality, Independence, Voluntary Service, Unity and

Universality,[35] all the individual components of the Movement carry out a fundamental actions for the purposes of monitoring and promoting international humanitarian law, including the provisions related to the protection of the sick. Through its three main bodies, the International Conference, the Council of Delegates and the Standing Commission, the Movement contributes to the implementation and, in some ways, to the integration and innovation of the Geneva normative system, by producing and developing soft law documents, alongside the Geneva Conventions, which aim to keep them up to date, with the times and with emerging global challenges.

During the 33rd International Conference of the Red Cross and Red Crescent (Geneva, 9-12 December 2019), which brought together about 2000 delegates from the representatives of 170 Governments, 187 National Societies of the Red Cross and Red Crescent, as well as 75 observers, a resolution on the importance of preventing and fighting epidemics and pandemics was adopted[36].

This resolution was part of the broader work of the Conference, focusing on the contemporary challenges of the legal framework governing humanitarian action and on the global dimension of the vulnerability of populations, seventy years on from the adoption of the Geneva Conventions, taking as its starting point the theme "*act today, shape tomorrow*"[37]. The 33rd International Conference, therefore, helped to strengthen the role of the various components of the Movement in response to infectious diseases.

The VI resolution aims both to identify and suggest practical actions for improving national responses to epidemics and pandemics, by creating a holistic, coordinated, internationally effective approach, based on cooperation between all the actors involved. In this regard, the importance of a close synergy between States and the Red Cross National Societies is enjoined: on the one hand, by encouraging the States to consider National Societies as humanitarian actors auxiliary to public authorities for the creation of a multi-sectoral framework related to the preparation and response to epidemics; on the other hand, by encouraging National Societies to offer their maximum support to States to

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35 Check the handbook of The Fundamental Principles of the International Movement of the Red Cross and Red Crescent: Ethics and tools for humanitarian action https://reliefweb.int/sites/reliefweb.int/files/resources/0513_002_Fundamental_Principles_low.pdf which highlights how the Movement, starting from the seven fundamental principles, adopts practical measures in order to realize them in different contexts.

36 The III Resolution of the 33rd International Conference of Red Cross and Red Crescent can be found at the following link: https://rcrcconference.org/app/uploads/2019/12/33IC_R3-Epidemic_Pandemic-resolution-adopted-ENing-CLEAN-EN.pdf. The background documents of the resolution process also provides interesting insights: https://rcrcconference.org/app/uploads/2019/06/33IC_MHPSS-background-doc-final-EN.pdf.

37 For a complete overview of the Conference, consult the agenda https://rcrcconference.org/app/uploads/2019/12/6_Detailed-program_FINAL_ENG.pdf and the final report of the Conference https://rcrcconference.org/app/uploads/2020/05/33rd-IC-2019-COD-summary-outcome-website-English.pdf. The work was organized according to a particularly structured program: a session for discussion and debate on the main themes identified this year (divided into three plenary Commissions and some sub-commissions exploring specific aspects, in particular one dedicated to the respect of international humanitarian law and the protection of the civilians https://rcrcconference.org/app/uploads/2020/05/33IC-Commission-I-IHL-report_FINAL-EN-1.pdf); a session dedicated to the participants statements; the Drafting Committee, where n the seven resolutions were negotiated; and finally, a series of marginal events. The final reports are available in the following links: https://rcrcconference.org/app/uploads/2020/01/IC-Chairs-paper_final-EN.pdf
https://rcrcconference.org/app/uploads/2020/03/33IC-Conference-rapporteur-report-FINAL-EN-1.pdf.

strengthen their fundamental capacities in order to better respond to epidemics and pandemics, while remaining in compliance with the obligations of the International Health Regulations, which are repeatedly cited in this text.

The holistic approach that is the animating the principle of the resolution arises not only from its enjoinders to the importance of cooperation between the ICRC, the IFRC, the National Societies and public authorities, but also from other key health partners, and most particularly the World Health Organization. The result is a collaborative *multi-stakeholder* framework at full throttle, intended to enforce a series of prioritised activities, in order to respond to epidemic and pandemic phenomena through: exemplification, planning, preparation, coordination between local and international organizations, prevention and control, immunization, involvement and empowerment of local communities and communication with the public in response to emergencies. Indeed, the humanitarian work undertaken by the ICRC, the IFRC and the National Societies, in close collaboration with key partners, such as the WHO, has led to good results if we consider the response to recent epidemics and pandemics, including measles outbreaks, poliomyelitis, dengue fever and cholera, alongside Ebola and Zika epidemics. If we look carefully at the operations, it is undeniable that among the various components of the Movement, the National Societies are the most directly involved in the prevention of infectious diseases, by representing the first responder in each country and by providing strategies to face epidemics and pandemics[38]. The strategy of the Italian Red Cross for 2018-2030, for example, in setting the well-being and special needs of men, women, children and infants as an objective, aims to encourage the adoption of social habits and behaviour that will improve their health conditions, thus helping to «*prevent and manage future new threats for health as well as being able to cope with unforeseeable dangers, such as potential pandemics and infectious diseases*»[39].

In order to confirm and make the best use of the operational capacity of the whole Movement, the President of the International Federation of the Red Cross and Cred Crescent Societies, Francesco Rocca, and the President of the International Committee of the Red Cross, Peter Maurer, made a joint appeal for financing activities aimed at the prevention and mitigation of the humanitarian implications caused by the spread of COVID-19, with particular attention to the populations of the most vulnerable countries[40].

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[38] According to the principle of independence of the Movement, the National Societies are auxiliary to the public powers of their Governments in humanitarian services, by carrying out a wide range of programs, as well as humanitarian and development activities, according to the specific needs and context of relevant countries with the agreement or coordination of their public authorities. The European Guide on the auxiliary role of the National Red Cross and Red Crescent Societies highlights this function: https://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2017/12/1294600-Guide_Europe_En_LR.pdf

[39] The 2018-2030 Italian Red Cross Strategy is available in the following link: https://www.cri.it/flex/static/Toolkit_Strategia20182030/STRATEGIA%20Croce%20Rossa%20Italiana%20versione%20A4.pdf

[40] The Plan, available in the following link https://www.icrc.org/en/document/covid-19-movement-appeal, provides an initial requirement of 800 million Swiss Francs, of which 550 million for the IFRC and 250 for the ICRC, and may be updated from time to time in order to respond to new needs related to the evolution of the pandemic. As for the IFRC component, the funds will be necessary to support the National Red Cross and Red Crescent Societies in health care and prevention (150 million will be mobilized by the Headquarters, while the remaining 400 will be mobilized throughout the nation by the Societies). The 250 million requested by the ICRC, on the other hand, will be used to finance activities in places of conflict and violence, to support medical facilities and medical interventions where there is detention, so, to limit the spread of the virus. See the IFRC web page dedicated to COVID-19 and the interventions carried out by the Federation in

The five priorities of the plan are of great importance in the fight against COVID-19. They provide fast, pragmatic and flexible solutions to support National Societies; in keeping existing projects at an operational level, by helping them adjust to new difficulties created by the virus; by increasing outbreak response operations in detention sites or in those areas which are not under the control of state authorities; by continuing to discuss and to provide technical assistance to non-state armed groups, in order to prevent and to contain the virus and by preventing the stigmatization of foreigners or marginalized groups.

6. *Conclusions*

The protection of the right to health during armed conflicts is governed by an international regulatory system, which could be considered well-structured, existing on various levels, sometimes integrated, sometimes disjointed and with poor inter-communication, which results in a more complex reading and understanding picture for the fight against epidemics and pandemics, including COVID-19. The system of the Geneva Conventions and their additional Protocols, created and developed since 1949 to meet varying abjective needs, could hardly be expected to be ready or immediately proactive when faced with an unprecedented historical challenge such as the coronavirus, a challenge which seems to require a completely new response. Nevrethlesss, when analyzed and interpreted in an evolutionary, systematic and coherent manner, that system seems capable of providing a response to COVID-19 and, more broadly, to controlling epidemics in times of war. Indeed, the analysis conducted of the four Geneva Conventions and their Additional Protocols shows that international humanitarian law includes significant elements which may contribute to the prevention and the repression of epidemics, even in the context of internal armed conflicts. This is even more evident, if we consider that the literal meaning of art. 3, which refers to the parties in conflict and not to the Parties to the Conventions, admits of its applicability to non-state actors, thus responding to many of the problems characteristic of current conflicts. It would be then important to ask ourselves what would be useful to further developed or change.

The United Nations Secretary-General's appeal for a global ceasefire[41], made on the 23rd of March 2020, seems, almost, to have overshadowed the debate regarding the capacity of international humanitarian law to deal with epidemics. The laying down of arms and putting armed conflicts into *lockdown* would appear to be the best solution to permit a

response to the pandemic, also in coordination with the National Red Cross Societies: https://media.ifrc.org/ifrc/emergency/global-covid-19/.

[41] In the appeal (https://www.un.org/press/en/2020/sgsm20018.doc.htm), the General Secretary highlights how the coronavirus is completely careless of nationality, ethnicity, faction and faith, attacking everyone and especially the most vulnerable, including women and children, people with disabilities and refugees. The General Secretary then provided an update on the Appeal in May 2020, by stating that he was encouraged by the first positive signals he had received, and reiterating the importance of laying down arms to build more peaceful, resistant and prosperous societies, above all helping to create the right conditions for the delivery of humanitarian assistance to fight COVID-19. The High Representative for Foreign Affairs and Security Policy, Joseph Borrell, showed the full acceptance of the appeal by the European Union: https://www.consilium.europa.eu/en/press/press-releases/2020/04/03/declaration-by-the-high-representative-josep-borrell-on-behalf-of-the-eu-on-the-un-secretary-general-s-appeal-for-an-immediate-global-ceasefire/.

united fight against the true common enemy, COVID-19. However, support for the ceasefire appeal from many states, including Cameroon, the Central African Republic, Colombia, Libya, Myanmar, the Philippines, South Sudan, Sudan, Syria, Ukraine and Yemen, while offering an undoubtedly comforting perspective, can only really constitute the first step towards a concrete cessation of hostilities. On the one hand, there are cases in which armed conflicts seem to have been aggravated or have degenerated following the spread of the coronavirus; on the other hand, theatres of war today are witnessing the participation of new actors, especially of terrorist groups and non-state armed groups, which are difficult to categorize or include in any call for a global ceasefire which is supposed to be open to governmental entities.

As we must cope with the spread of epidemics in times of armed conflict, it is, therefore, fundamental to ensure the *accountability* of those responsible for serious violations of international humanitarian law, particularly in regard to deliberate attacks on hospitals and medical facilities. Following the rising demand for hospitalisation and treatment due to COVID-19, there is a risk, in some theatres of war, of seeing a decrease in the supply of these services. In this case, it would be of vital importance to strengthen the deterrent effects of international criminal law justice, in order to ensure a more solid compliance with the relevant rules. Additionally, the right to health, as well as being protected by international humanitarian law, is also internationally recognized among the most important human rights, being protected not only by several conventional instruments, but also by customary international law [42].

These factors help to highlight the complexity of the general response framework to COVID-19, by showing that the Secretary-General's appeal for a global ceasefire and the respect for international humanitarian law, may not be, in themselves, sufficient elements in defeating the virus in theaters of war, if not accompanied, in practice, by the vigorous collaboration of the entire international community. The "*COVID-19 Global Humanitarian Response Plan (GHRP)*"[43], a strategic humanitarian response plan, launched globally by the

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[42] The right to health was mentioned for the first time in 1946 in the Statute of the World Health Organization whose Preamble defines the concept of health as an overall state of physical, mental and social well-being, stating that the enjoyment of the best conditions of physical and mental health is one of the fundamental rights of every human being, without distinction of race, religion, political opinion, economic or social condition. The right to health was subsequently recognized in the Universal Declaration of Human Rights (1948) and in the International Covenant on Economic, Social and Cultural Rights (1966), as well as in many international treaties which expressly refer to it or to some specific corollaries, such as the right to medical treatment. On the right to health as a human right, see: P. HUNT, *Intrepreting the International Rights to Health in a Human Rights - Based Approach to Health*, in *Health and Human Rights Journal*, of 3rd December 2016 https://www.hhrjournal.org/2016/12/interpreting-the-international-right-to-health-in-a-human-rights-based-approach-to-health/; J. HARRINGTON, M, STUTTAFORD, *Global health and human rights: Legal and philosophical perspectives*, London, 2010; A. YAMIN, R. CANTOR, *Between insurrectional discourse and operational guidance: Challenges and dilemmas in implementing human rights-based approaches to health*, in *Journal of Human Rights Practice*, Vol. 6(3), 2014, p. 453; J. HAUSERMANN, *The right to highest attainable standard of physical and mental health: Conceptual framework, Working paper for WHO Informal Consultation on Health and Human Rights,* Genève, 1997; B. TOEBES, *The right to health as a human right in international law*, Cambridge, 1999.

[43] The plan was launched by the United Nations General Secretary at the Under-Secretary-General for Humanitarian Affairs, Mark Lowcock, the WHO Director-General, Tedros Adhanom Ghebreyesus, and UNICEF Executive Director, Henrietta Fore, the Global Humanitarian Response Plan (GHRP) and is available in this link: https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf. In May 2020, a second version of the GHRP was launched which seems to overcome some of the main critical issues of the first one, in particular those related to the non-homogeneity of the terms of

United Nations in March 2020 under the coordination of the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), could in this sense represent the correct move to complement, in practice, the theoretical framework examined above. This project aggregates systematically the response plans and appeals, previously introduced individually by the United Nations agencies, inviting Member States to contribute financially to the global response to the coronavirus, without suspending the previous humanitarian reaction planning. Such suspension might lead to additional catastrophic risks, such as the spread of cholera, measles and meningitis, as well as higher levels of childhood malnutrition. It is now, more than ever, necessary that the international community follows a multilateral approach and, on the basis of the spirit of the Solferino principles, takes concerted and coordinated action involving all relevant actors, including the UN system, in particular the World Health Organization[44].

The World Health Organisation, though it does not represent a center for implementing or monitoring the respect of international humanitarian law and human rights, does actually play a fundamental role in the prevention and containment of epidemics in times of war, through activity which, in some ways, can compensate the weaknesses and deficiencies of the Geneva normative system. The true added value of the Organization, far from manifesting itself in the issuing of guidelines and legal acts, consists in the elaboration of policy and political support which - with reference to contagious diseases - takes form especially in *ad-hoc* emergency declarations to signal and activate a state of high alert, as well as in providing technical and operative support to the most vulnerable and fragile Countries and their health systems, incuding through humanitarian and development initiatives financed by voluntary contributions of Member States. The more the level of global health is at risk, the more the WHO provides directions and suggestions on internal policies regarding the Member States such as the COVID-19 Strategic Preparadness and Response Plan (SPRP) issued in early February, both by adopting temporary recommendations and by supplying aid and health services to the various States. Notably, the World Health Assembly is also a key humanitarian and development partner and is providing lifeline support in several contexts, COVID-19 related and beyond, including in war-torn and conflict affected Countries like Syria, Lybia and Yemen. Although specific references to armed conflict are not found in a regulatory analysis of the WHO's numerous activities, the majority of international public health

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the many agencies involved. The Revised Plan also remedies the failure to refer to the most vulnerable categories, in particular women.

[44] WHO, established in Geneva in 1948 and currently made up of 194 states (all members of the United Nations excluding Liechtenstein and Niue and the Cook Islands, with Palestine and the Holy See as observers), performs the fundamental task of maintaining international coordination among health authorities and all relevant actors, in particular by conducting scientific and health research, by providing standards and guiding principles on global health issues, by adopting recommendations and address documents. On the organization and work of the World Health Organization, see: C. CLIFT, *The role of the World Health Organization in the International System*, in Centre of Global Health Security Working Group Papers, in Working Group on Governance, Paper 1: https://www.chathamhouse.org/sites/default/files/publications/research/2013-02-01-role-world-health-organization-international-system-clift.pdf; J. W. PEABODY, *An Organization Analysis of the Wolrd Health Organization: narrowing the gap between promises and performance*, in *Social Science and Medicine*, Vol. 40 (6), 1995, pp. 731-732; W. R. SHARP, *The New World Health Organization*, in Am. Jour. Int. Law, Vol. 41 (3), 1947, pp. 509-530; W.F BYNUM, R. PORTER, *The World Health Organization and its work*, in *Am. J Public Health*, Vol. 98 (9), pp. 1594-1597.

emergency declarations adopted from 2015 to the present day, refer to the spread of diseases in the context of civil wars, demonstrating that the organisation's activities also embrace - perhaps above all else - such situations[45]. The polio epidemic, which spread again during the Syrian civil war[46] is a paradigmatic demonstration of the effectiveness of WHO operations, which in collaboration with UNICEF, the Global Alliance for Vaccines and Immunicazione (GAVI) and various national authorities and international partners, along with numerous in situ interventions, has led to the containment of the epidemic.

In conclusion, the spread of coronavirus, which is likely to provoke devastating humanitarian consequences in fragile contexts characterized by weak health systems, has led to the emergence of new questions, to which it is difficult to give a confident or single answer immediately. Today, in addition to requiring greater respect for the rules of international humanitarian law, it would be certainly advisable to revise the relevant legal arrangements through an innovative, evolutionary and systemic reinterpretation which could occur in the manner demonstrated in this discussion. What is needed, above all else, is an unprecedented joint response and coordinated intervention capacity between all systems and at all levels. Currently, how far such coordination is practically achieved or to what extent it can be perfected, is an open question fated to persist for the foreseeable future.

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[45] With regards to the role of WHO in armed conflicts and emergency situations, see: *The World Health Organization Department of Emergency and Humanitarian Action Conflict and Health*, WHO Working Paper, presented during the International Seminar "Preventing Violent Conflict - The Search for Political Will, Strategies and Effective Tools ", 2000: https://www.who.int/hac/techguidance/hbp/Conflict.pdf https://apps.who.int/disasters/repo/5956.pdf.

[46] A reading of the WHO pages dedicated to Syria is suggested: https://www.who.int/countries/syr/en/; https://www.who.int/emergencies/crises/syr/en/; http://polioeradication.org/where-we-work/syrian-arab-republic/.