Talk Is Cheap: Security Council Resolution 2286 & the Protection of Health Care in Armed Conflict

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In May 2016, as attacks on health care in armed conflicts were increasing globally, the United Nations Security Council adopted Resolution 2286, demanding warring parties comply with their international obligations to prevent and address such attacks. The resolution was adopted unanimously by the Council and cosponsored by eighty-five UN member states. New data collection and public attention on attacks against health care at the time signaled that, contrary to scholarly expectation, the Council might use tools already at its disposal to ensure compliance with the resolution. Yet in the years that followed, the Security Council and states took few concrete steps to implement Resolution 2286. In this essay, we identify and analyze barriers that prevented the use of existing structures and mechanisms to influence the conduct of war. We contend that the experience of Resolution 2286 can tell us a great deal about the value of such resolutions as a response to pressing issues of humanitarian concern.

In May 2016, as attacks on health care personnel, facilities, and transport in armed conflicts were increasing around the world, the United Nations (UN) Security Council adopted Resolution 2286 on the protection of medical care in armed conflict.[1] The resolution condemned attacks on medical care and demanded that warring parties comply with their obligations under international humanitarian and human rights law to prevent and address attacks against medical care in situations of armed conflict. The resolution was adopted unanimously by the Council's fifteen members and cosponsored by eighty-five UN member states. Some state representatives said Resolution 2286 sent "a strong message" and "a clear signal" from the Council of the need to protect health care.[2] The then-president of the International Committee of the Red Cross (ICRC), Peter Maurer, described it as a "momentous step in the international community's effort to draw attention to a problem that we otherwise risk getting used to through the sheer frequency of its occurrence."[3]

While active scholarly discussion tells us the UN rarely uses enforcement mechanisms or its full powers to bring about compliance with its resolutions –

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for example, by referring individuals to the International Criminal Court for war crimes – there seemed to be reason to hope for change in the years preceding the adoption of Resolution 2286.[4] New data collection and high-profile attacks on health care were putting significant public pressure on both the Security Council and individual member states to act to prevent and enforce international humanitarian law (IHL).[5] In 2015, an attack by United States forces on the Médecins Sans Frontières (MSF) trauma center at Kunduz in Afghanistan became the latest high-profile episode in a litany of attacks on health care personnel, facilities, and transport. These stretched beyond Afghanistan to the Central African Republic (CAR), the Democratic Republic of the Congo (DRC), Iraq, Libya, South Sudan, Syria, Ukraine, Yemen, and elsewhere.[6] During debates on Resolution 2286, Joanne Liu, international president of MSF at the time, reported that four of the five permanent members of the Security Council were "implicated" in attacks against health care in Yemen and Syria.[7] In light of this global attention, the Security Council seemed to be poised to address illegal conduct in war.

But in the years that followed, the UN Security Council and member states took few concrete steps to implement Resolution 2286, according to the secretary-general's reports and UN Secretariat. In his 2021 report to the Security Council on the protection of civilians in armed conflict, UN Secretary-General António Guterres noted that persistent violence, threats, and attacks against medical care, combined with the effects of conflict and the COVID-19 pandemic, had intensified human suffering, and placed enormous strain on weakened health care services.[8] He further noted that while some states had developed and implemented good practices to protect medical care, much more needed to be done. Others have noted the "unhappy consensus" that Resolution 2286 "has made little difference on the ground."[9]

The experience of Resolution 2286 can tell us a great deal about the value of UN Security Council resolutions as a response to pressing issues of humanitarian concern. In this essay, we outline and critically analyze tools the UN Security Council and member states have available to shape the conduct of war and consider why these often go unused. Rather than finding that the Security Council and member states lacked the prevention and enforcement mechanisms to alter the behavior of warring parties, we contend that mechanisms at their disposal gathered dust. We identify and analyze a set of barriers that prevent the use of existing structures and mechanisms to influence the conduct of war.

Our analysis of efforts to protect health care since the passage of Resolution 2286 in 2016, while attacks have continued to rise, has useful potential implications for how we understand the Security Council's willingness and ability to influence the conduct of parties to a conflict and to protect civilians.[10] We also highlight the ways in which Resolution 2286 was particularly politicized because Security Council members were implicated in attacks. We suggest this is a potential

explanation for both the Security Council member states' failures to turn talk into action and the diffuse and limited implementation of Resolution 2286 by a handful of other member states/non-Security Council member states, nonstate actors, and nongovernmental organizations (NGOs) that followed.

Resolution 2286 was drafted by representatives from Egypt, Japan, New Zealand, Spain, and Uruguay (the "penholders"). They were supported in their efforts by the ICRC, MSF, and the UN, all organizations with first-hand, field-based experience and understanding of the problem of attacks against health care. These organizations were also instrumental in drawing attention to attacks. For example, since 2011, the ICRC-established Health Care in Danger project has aimed to influence the doctrine and practice of weapon bearers, document interruptions of health service and the frequency of violent incidents, and monitor the impacts of attacks on the effectiveness and sustainability of health care. This initiative also sought to mobilize a "community of concern" to address the issue and increase accountability for attacks through effective state investigations and prosecution of crimes committed against health care personnel, facilities, and transport.[11]

As a result, the resolution's analysis of the problem and the possible responses to it were solidly grounded in the experience of key actors engaged in settings of armed conflict. Peter Mauer remarked on this publicly at a Security Council meeting:

> Every comma [in the resolution] has been carefully considered and negotiated and the result is strong. . . . In clear language, the Council has underlined the importance of international humanitarian law and called on all States and all parties to armed conflict to comply with their obligations and develop effective measures to protect people's lives by preventing and addressing violence against medical personnel, facilities, transport and humanitarian personnel engaged exclusively in medical duties.[12]

The resolution's language was also reviewed and revised through rounds of negotiation.

What the resolution says – and does not say – falls into three parts, with calls to action outlined in its final paragraphs. First, the resolution recalls legal obligations and reminds parties of the relevant IHL. The resolution's preambular paragraphs recall the specific IHL obligations of parties to a conflict to respect and protect medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, and hospitals and other medical facilities, and to ensure that the wounded and sick receive medical care and attention. They recall the obligation to distinguish between civilian populations and combatants, the prohibition against indiscriminate attacks, and obligations to do everything feasible to verify that targets are neither civilians nor civilian objects and are not subject to spe-

cial protection, including medical personnel, their means of transport and equipment, and hospitals and other medical facilities. These opening paragraphs also recall the obligation parties to a conflict have to take all feasible precautions to avoid and minimize harm to civilians and civilian objects.

Second, reminders turn to condemnation as the resolution points to rules that are not being followed, and identifies some of the most significant areas where human lives are being lost as a result of attacks on health care. Having laid out the legal framework, the resolution expresses the Security Council's deep concern that "despite these obligations, acts of violence, attacks and threats against medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities, are being perpetrated in situations of armed conflicts and that the number of such acts is increasing."[13] It further and rightly observes that "locally recruited medical personnel and humanitarian personnel exclusively engaged in medical duties account for the majority of casualties among such personnel in situations of armed conflict" and that "the delivery of humanitarian assistance, including medical assistance, to populations in need is being obstructed by parties to armed conflicts in many conflict situations."[14]

Finally, the resolution turns to questions of what is to be done. Here, the resolution shifts to softer language when calling for action on practical measures for protecting health care and accountability for the perpetrators of attacks. The operative paragraphs of the resolution provide a series of actions to be taken by parties to a conflict, and member states, to keep health care safe from attack. The resolution "demands" that parties to a conflict comply with relevant IHL and human rights law (HRL) obligations, and that parties to a conflict and member states develop effective measures to prevent and address acts of violence, attacks, and threats, including at the domestic level and in the conduct of military operations. The resolution also calls upon member states to ensure that their armed forces integrate practical measures for the protection of the wounded and sick and medical services into the planning and conduct of their operations. What these practical measures might entail is left up to individual states. The text of the resolution further urges member states to conduct independent and impartial investigations into incidents affecting the protection of medical care in conflict that may fall within their jurisdiction, with a view to reinforcing preventive measures and addressing the grievances of victims. It aims to end impunity for violations.

One interpretation of the resolution's call to action, without any specification of *what action* should be taken, is that it acknowledges the diverse and context-specific measures needed to protect health care in different types of conflict. A less charitable characterization of the resolution is that, by failing to ask state and other actors to undertake specific actions, it gives conflict parties a way out of tangible behavioral change.

The challenges of turning talk into action were noted at the time of the resolution's adoption by Joanne Liu, who insisted that the Council "must translate this resolution into action. It must recommit unambiguously to the norms that govern the conduct of war. [The] resolution must lead to all State and non-State actors stopping the carnage."[15] And since the adoption of Resolution 2286, a range of actions has been undertaken by different state and nonstate actors in support of the protection of health care in armed conflict. From 2017 to 2021, the secretary-general's reports on the protection of civilians have documented various efforts to strengthen the protection of health care, including state-led reviews of national legal frameworks, efforts to improve the collection of data on attacks against health care, and the development and sharing of good practices. However, our analysis of the secretary-general's reports during this period also shows that the actions taken by states have focused predominantly on debate and advocacy, with only limited reporting of any new state-developed "effective measures to prevent and address acts of violence, attacks and threats against medical personnel and humanitarian personnel" that Resolution 2286 calls for.[16] Since 2016, NGOs have been the primary actors that have taken, or been handed, responsibility in moving the issue forward. However, these organizations do not conduct war, nor can they change its conduct themselves.

The period of 2017 to 2021 saw a range of intergovernmental initiatives purportedly in support of Resolution 2286. In 2016, Canada and Switzerland established an "informal group of friends" of Resolution 2286, which includes Australia, Austria, Belgium, Brazil, France, Germany, Italy, Japan, Liechtenstein, Luxembourg, the Netherlands, Norway, Portugal, the United Kingdom, and Uruguay. Members of the group made statements at the annual open debates on the protection of civilians in armed conflict, advocating respect for IHL and HRL and protection of health care by parties to a conflict and full implementation of Resolution 2286. Here, states were engaged in advocacy that repeated much of what was already called for in Resolution 2286. These states, with a few exceptions, were not engaged in active conflict.

In a similar vein, France proposed a "Declaration on the Protection of Medical and Humanitarian Personnel" in 2017, which was subsequently endorsed by eleven other UN member states. The endorsing states pledged to take "practical measures to enhance the protection of, and prevent acts of violence against, the medical and humanitarian personnel, and to better ensure accountability for violations."[17] The initiative was welcomed at the time as a "concrete step" toward implementation of Resolution 2286.[18] In terms of substance, however, the declaration covers similar ground to the resolution and raises the question of why these states felt the need to adopt a declaration committing themselves to actions already called for under Resolution 2286.

Much of the state action taken during this period layered new promises on top of those that were articulated in Resolution 2286. These statements and declarations did not introduce new implementation mechanisms and, perhaps as an unintended consequence, distracted the global community from ongoing inaction. As reported by the secretary-general, some national armed forces have adopted measures to better protect medical care. For example, these national militaries factored in the location of medical facilities when establishing defense and attack zones and movements of troops and material, refrained from using medical objects to support the military effort, took precautions in the conduct of war (for example, by issuing warnings), separated evacuation routes and areas from those intended for armed forces, verified that rules of engagement were in line with international humanitarian law, and ensured the presence of a legal adviser to counsel the chain of command.[19]

Some nonstate armed groups have demonstrated greater openness and transparency regarding attacks on health care than UN member states involved in armed conflict. In 2018, the NGO Geneva Call launched a "Deed of Commitment on Protecting Health Care in Armed Conflict," which seeks to ensure that armed groups provide and maintain access for affected populations to essential health care facilities, goods, and services, without adverse distinction – that is, ensuring civilian facilities are identified and not attacked – and that armed groups facilitate the provision of health care by impartial humanitarian organizations.[20] At the time of writing, four armed groups have signed the deed of commitment and, in doing so, agreed to allow and cooperate in the monitoring and verification of their commitments by Geneva Call.[21] This could include visits and inspections in all areas where they operate, and the provision of the necessary information and reports. Thus far, states have accepted much less scrutiny and oversight in relation to implementation of their IHL obligations in general, let alone in relation to the protection of health care.

The various actions and initiatives discussed above notwithstanding, it should be noted that the extent to which state and nonstate actors have been motivated by and acted in response to Resolution 2286 is not clear. Actions may have stemmed from the concerted efforts of organizations, such as the ICRC, to engage the concerned actors, and promote and support such measures in the context of its Health Care in Danger project. It might also be the case that these actions were part and parcel of broader efforts to implement IHL or were taken for altogether different reasons.

Nonetheless, the secretary-general's reports between 2017 and 2021 have continued to emphasize the need for parties to a conflict to comply with IHL and ensure the protection of health care personnel, facilities, and transport; and for member states in particular to step up their efforts to implement the provisions of Resolution 2286. Other analysts and commentators have been even more direct in

their assessment of the degree to which the resolution has been implemented. Referring to the "global onslaught of violence against health workers, facilities, and transport from 2016 through 2020," the Safeguarding Health Care in Conflict Coalition chastised the Security Council and member states for their "abject failure … to take any meaningful measures to prevent attacks or hold those responsible to account" as required by Resolution 2286.[22]

The sources of this failure are twofold and connected. First, the Security Council did not use the mechanisms already at its disposal to prevent attacks against and enforce protections of health care. Resolution 2286 did not include a formal process for ensuring monitoring, reporting, or accountability, although there are precedent-setting resolutions that do so and thus could have served as models. Second, diffuse implementation by a few cannot make up for a general avoidance of responsibility, particularly by Security Council members but also by other member states. As existing mechanisms go unused, a culture of state impunity is encouraged, and so too is a willingness to shift state responsibility to others, such as NGOs.

Beginning with the most general mechanisms available, the Security Council has at its disposal tools for promoting and ensuring implementation of its resolutions and compliance with IHL and for sanctioning noncompliance. It has increasingly used targeted sanctions in response to some violations of IHL and HRL. The designation criteria for sanctions regimes – which determine who is subject to sanctions – in the Central African Republic, the Democratic Republic of the Congo, Mali, Somalia, and South Sudan expressly include individuals or entities responsible for attacks on hospitals (which might initially appear rather limiting but could be interpreted broadly by the sanctions committees to apply to health care personnel, facilities, and transport).[23] The designation criteria for Libya, Sudan, and Yemen are less specific but include planning, directing, or committing acts that violate IHL and HRL, which could potentially include attacks on health care.[24]

The Security Council also has the authority to establish commissions of inquiry to further examine situations involving serious violations of IHL and HRL, as it did in relation to Darfur in 2004 and the Central African Republic in 2013.[25] It can refer such situations to the International Criminal Court for further investigation and prosecution of alleged perpetrators, as it has done in relation to Darfur in 2005, on the basis of the report of the commission of inquiry, and Libya in 2011.[26] Again, there is scope within these measures for the Security Council to address attacks against health care, should it choose to do so.

What is more, along with attacks against schools, attacks against hospitals are one of the six grave violations of children's rights that are subject to the Security Council's monitoring and reporting mechanism (MRM) on children and armed conflict (CAAC).[27] For more than fifteen years, the MRM has "worked to document

and verify failures to protect children in armed conflict – namely, instances where there have been grave violations against them – and has encouraged dozens of parties to conflict to engage with the UN toward making concrete changes that have positively affected the lives of children living through conflict."[28]

Established pursuant to Security Council Resolution 1612, the MRM systematically gathers information on the six grave violations.[29] In addition to attacks against hospitals and schools, these include killing and maiming children; recruitment or use of children by armed forces or armed groups; sexual violence against children; abduction of children; and denial of humanitarian access for children. The mechanism is automatically activated by the listing of a party to an armed conflict in the annexes to the UN secretary-general's annual reports on children and armed conflict. These and country-specific reports are then reviewed by the Security Council Working Group on Children and Armed Conflict and used to inform its conclusions and recommendations.[30] These can range from referrals to sanction committees, recommendations to governments and armed actors, or even suggested referral by the Security Council of a given situation to the International Criminal Court. No such formal process was embedded in Resolution 2286, but processes under the MRM do seek to protect humanitarian access and hospitals. For example, in the secretary-general's 2022 CAAC reports, parties are listed for attacks on schools and hospitals, alongside other violations.[31] While criticisms in recent years have suggested that the listing mechanism has been politicized, allowing some states to remain off the list and avoid scrutiny, these are measures "with teeth" that work, however imperfectly, to encourage compliance with international law.[32]

Last but not least, the option also exists for the Security Council to request that the secretary-general appoint a special representative on the protection of health care who would be mandated to monitor, support, and report on the implementation of Resolution 2286 by member states and parties to a conflict. Special representatives of the secretary-general have been appointed with respect to children and armed conflict and conflict-related sexual violence at the request of the Security Council. The Council has, so far, not chosen to do so for the protection of health care.

Resolution 2286's failure to alter the conduct of war can also be attributed to the politicization of attacks on health care and the diffuse implementation of the resolution. Ultimately, implementation rests on the willingness of individual parties to a conflict, states, and the UN secretary-general – to whom the resolution's operative paragraphs are addressed because existing prevention and enforcement mechanisms go unused, and new mechanisms are not formally embedded in Resolution 2286.

This reliance on political will appears to have emerged in part because the conditions we see at play during the drafting of Resolution 2286 differ from those that

allowed for the formalization of enforcement mechanisms in Resolution 1612 and subsequent resolutions on CAAC. The CAAC resolutions focused on strengthening protection for children in armed conflict, which is a topic that can easily gather broad agreement and be discussed without quickly implicating Security Council members, member states, and other parties to a conflict. By contrast, documentation of attacks on health care, calls for prevention, and demands for accountability strike at the heart of state conduct in war. Recall that in 2016, during debates on Resolution 2286, the UN Security Council was reminded that four out of five of its members had perpetrated attacks on health care. At the time, the United States and Russian Federation were also engaged in war by proxy on multiple fronts, in which attacks on health care were consistently reported. Restraint was therefore likely perceived as a potential source of disadvantage in ongoing conflicts, making it unlikely that Resolution 2286 would include formalized enforcement mechanisms.

As discussed above, implementation of the resolution was taken on by a few states engaged primarily in debate and advocacy, as well as by nonstate armed groups and NGOs. Additionally, rather than formalizing state and warring party responsibilities and accountability, the resolution asked the secretary-general to provide country-specific situation reports, to report on the issue of the wounded and sick, medical personnel, and humanitarian personnel (that is, their transport, equipment, and medical facilities), and to recommend prevention and accountability measures. This meant that the secretary-general was a key player in the implementation of Resolution 2286, but the demands quickly overwhelmed his office.

The UN secretary-general was mandated to follow-up in a range of ways, but directives proved difficult to fulfill due to a series of structural barriers, including missing information, impediments to information sharing, and limited political will from the Security Council. The secretary-general was encouraged by Resolution 2286 to alert the Security Council of any situation in which the delivery of medical assistance to populations in need is being obstructed by parties to the armed conflict – an action he has yet to take. He was further requested to use both his regular country-specific reports and his annual report on the protection of civilians to document specific acts of violence against health care, remedial actions taken by parties to conflict and other relevant actors to prevent similar incidents, and actions taken to identify and hold accountable those who commit such acts.[33] The Security Council also requested that the secretary-general provide briefs every twelve months on the implementation of the resolution.

One key challenge is related to the availability of the kind of detailed data requested by the Council and the abilities of the secretary-general's office to report on it. Data collection initiatives are ongoing, such as the World Health Organization's Surveillance System for Attacks Against Health Care, which was launched in December 2017, and Insecurity Insight data on attacks against health care,

published by the Safeguarding Health in Conflict Coalition (SHCC). UN field-based data also inform the secretary-general's annual reports. However, country-specific situation reports and protection of civilians reports, which are limited in length, cannot accommodate additional detailed information while also meeting other mandated reporting requirements on, for example, the protection of journalists, missing persons, persons with disabilities, and conflict-related food insecurity or emerging protection of civilians issues.[34] With the exception of his 2021 report, which focused on implementation of Resolution 2286 to mark its fifth anniversary, the secretary-general's annual protection of civilians reports have been limited to providing general information pertaining to attacks against health care without identifying alleged perpetrators.

Furthermore, detailed and specific discussion of the measures taken by states and other actors to enhance the protection of health care and implement the provisions of Resolution 2286 are often absent for a variety of reasons. This may indicate that information is not (yet) available or may reflect the limited political will of parties to a conflict and states to report on their lack of progress in implementing the resolution. For example, in 2018, the UN Secretariat canvassed the members of the informal "Group of Friends" of Resolution 2286 on steps they had taken to implement the resolution. Only one state responded.[35] A similar survey of all 193 UN member states in advance of the 2021 report focusing on implementing Resolution 2286 received only fourteen responses.[36]

We see limited political will at the Security Council as well. In August 2016, the secretary-general submitted a comprehensive and detailed set of recommendations in response to the request contained in Resolution 2286 that the secretary-general outline "measures to enhance the protection of, and prevent acts of violence against, the wounded and sick, medical personnel and humanitarian personnel."[37] The recommendations sought to establish a framework to prevent attacks and promote the practical implementation of precautionary measures throughout military operations, and ensure documentation of acts of violence, attacks, and threats, as well as accountability for violations and redress for those affected. There was "wide agreement" among humanitarian, human rights and health organizations, and many governments that the secretary-general's recommendations "could, if implemented, dramatically increase protection of health care on the ground."[38] To date, however, the Security Council has not raised the recommendations for consideration despite having itself requested them. The Council is not willing to act. And yet its responsibility for the protection of health care cannot be delegated to institutions or NGOs that do not take part in war.

There are things that the Security Council *could* be doing. Regarding the protection of civilians, attacks against health care are essentially problems of state and nonstate parties to a conflict not complying with their existing le-

gal obligations, and specifically international humanitarian law. There is no doubt that the next penholders on resolutions that address the conduct of war will have their work cut out for them should they wish to successfully strengthen and ensure respect for IHL. They will need to overcome a fundamental problem of power: how to get someone to do something they otherwise would not do. The reasons for complying with IHL or not, for attacking or not attacking health care, are myriad. They can change from one context, one day, one party to the conflict, one military unit, or one combatant to the next.[39] What is clear is that merely reaffirming existing commitments to international law, as Resolution 2286 does, will do little to address this state of affairs without the Security Council taking more concrete and direct steps to promote and ensure implementation of the resolution. For example, the Security Council could impose targeted sanctions or refer situations involving attacks against health care to the International Criminal Court. However, in the contemporary era, with a divided Council and a veto-wielding member continuing to carry out attacks against health care in Ukraine, the opportunities for progress in this regard are slim.

We agree with the Safeguarding Health in Conflict Coalition when they highlight the need for states (and, one would add, parties to a conflict) to be held to account for failing to carry out their commitments under Resolution 2286. However, we question SHCC calls for additional UN secretary-general reporting or for the secretary-general to appoint a special representative to monitor and report on state performance, as well as make recommendations to ensure greater compliance with Resolution 2286.[40] It is admirable to increase the secretary-general's ability to report in this way, but we are not convinced that this will be achievable given the current political climate and structural barriers at the Security Council. First, this appointment would require a Security Council request, which returns us to the issue of political will, which is currently lacking. Second, without a formal agreement from the Security Council, it is not clear what status the new reports of the special representatives of the secretary-general would have and whether and how they would be considered by the Council and member states.

Our assessment suggests that we turn to the future and ensure that penholders and advocates for new resolutions on issues of humanitarian concern focus, at the time of drafting, on formally tying new issues to existing mechanisms that hold states and nonstate actors to account. This would reduce strain on the secretary-general's office, prevent too much reliance on implementation by a willing few, and place responsibility back in the hands of the states – who have the greatest power to alter conduct in war. In the meantime, to protect health care, the secretary-general's resources would be better spent using – and showing a willingness to use – existing mechanisms, such as those that protect against the six grave violations against children. Demonstrating a willingness to turn talk into action would hold states avoiding responsibility to public and formal account, and begin to undermine a culture of impunity.

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ENDNOTES

[1] United Nations Security Council, *Resolution 2286 (2016)* (S/RES/2286), May 16, 2016, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N16/125/06/PDF/N1612506.pdf?OpenElement.

[2] Quoted from the statements of representatives from Japan and the United Kingdom, respectively, during the Security Council open debate on the protection of civilians in armed conflict, following the adoption of Resolution 2286. See Motohide Yoshikawa, "On the Security Council Draft Resolution on the 'Health Care in Armed Conflict,'" The Permanent Mission of Japan to the United Nations, May 3, 2016, https://www.un.emb-japan.go.jp/statements/yoshikawa050316.html; and Matthew Rycroft, "A Hospital Should Be a Safe Haven, Not a Target," The Foreign and Commonwealth Office, The Parliament of the United Kingdom, May 3, 2016, https://www.gov.uk/government/speeches/a-hospital-should-be-a-safe-haven-not-a-target.

[3] Remarks of Peter Maurer, president of the International Committee of the Red Cross, during the Security Council open debate on the protection of civilians in armed conflict, following the adoption of Resolution 2286. *United Nations Security Council 7685th Meeting* (New York: United Nations, 2016), 5, https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/S_PV_7685.pdf.

[4] Rebecca Barber, "Accountability for Crimes against the Rohingya," *Journal of International Criminal Justice* 17 (3) (2019): 557–584, https://doi.org/10.1093/jicj/mqz031. See also, for example, Ruth Wedgwood, "The Enforcement of Security Council Resolution 687: The Threat of Force Against Iraq's Weapons of Mass Destruction," *American Journal of International Law* 92 (4) (1998): 724–728, https://doi.org/10.2307/2998137; Benjamin Habib, "The Enforcement Problem in Resolution 2094 and the United Nations Security Council Sanctions Regime: Sanctioning North Korea," *Australian Journal of International Affairs* 70 (1) (2016): 50–68, https://doi.org/10.1080/10357718.2015.1095278; and Vera Gowland-Debbas, "Security Council Enforcement Action and Issues of State Responsibility," *International and Comparative Law Quarterly* 43 (1) (1994): 55–98, https://doi.org/10.1093/iclqaj/43.1.55.

[5] Robin Coupland, Christina Wille, Nathan Taback, and Simon Regard, *A Sixteen-Country Study: Health Care in Danger* (Geneva: International Committee of the Red Cross, 2011), https://www.icrc.org/en/doc/assets/files/reports/4073-002-16-country-study.pdf; Preeti Patel, Fawzia Gibson-Fall, Richard Sullivan, and Rachel Irwind, "Documenting

Attacks on Health Workers and Facilities in Armed Conflicts," *Bulletin of the World Health Organization* 95 (1) (2017): 79–81, https://doi.org/10.2471/BLT.15.168328; Jason-Louis Carmichael and Mohammad Karamouzian, "Deadly Professions: Violent Attacks against Aid-Workers and the Health Implications for Local Populations," *International Journal of Health Policy and Management* 2 (2) (2014): 65–67, https://doi.org/10.15171/ijhpm.2014.16; Elise Baker and Widney Brown, *Doctors in the Crosshairs: Four Years of Attacks on Health Care in Syria* (New York: Physicians for Human Rights, 2015), https://phr.org/wp-content/uploads/2015/03/doctors-in-the-crosshairs.pdf; and Larissa Fast, *Aid in Danger: The Perils and Promise of Humanitarianism* (Philadelphia: University of Pennsylvania Press, 2014).

[6] See further, for example, Coupland, Wille, Taback, and Regard, *A Sixteen-Country Study*.

[7] *United Nations Security Council 7779th Meeting* (New York: United Nations, 2016), 3, https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/s_pv_7779.pdf.

[8] United Nations Security Council, *Protection of Civilians in Armed Conflict*, Report of the Secretary-General (S/2021/423), May 5, 2021, 5, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N21/110/87/PDF/N2111087.pdf?OpenElement.

[9] Leonard Rubenstein, "Five Years after Security Council's Resolution to Protect Health Care in Conflict: Still at Zero?" *Health and Human Rights Journal*, June 29, 2021, https://www.hhrjournal.org/2021/06/five-years-after-security-councils-resolution-to-protect-health-care-in-conflict-still-at-zero.

[10] Emily K. M. Scott, "Compromising Aid to Protect International Staff: The Politics of Humanitarian Threat Perception after the Arab Uprisings," *Journal of Global Security Studies* 7 (1) (2022): ogab024, https://doi.org/10.1093/jogss/ogab024.

[11] The International Committee of the Red Cross, "Health Care in Danger Initiative," http://healthcareindanger.org/hcid-project (accessed June 1, 2019).

[12] *United Nations Security Council 7685th Meeting*, 5–6.

[13] Red Cross, Médecins Sans Frontières Heads, Secretary-General Brief Members, "Security Council Adopts Resolution 2286 (2016), Strongly Condemning Attacks against Medical Facilities, Personnel in Conflict Situations," May 3, 2016, https://www.un.org/press/en/2016/sc12347.doc.htm.

[14] United Nations Security Council, *Resolution 2286*.

[15] *United Nations Security Council 7685th Meeting*, 8.

[16] Red Cross, Médecins Sans Frontières Heads, Secretary-General Brief Members, "Security Council Adopts Resolution 2286," 4.

[17] Permanent Mission of France to the United Nations in New York, "Protection of Medical and Humanitarian Personnel," July 19, 2017, https://onu.delegfrance.org/Protection-of-medical-and-humanitarian-personnel.

[18] Safeguarding Health Care in Conflict Coalition, "France and Eleven Other Countries Pledge to Protect Health Care," Safeguarding Health Care in Conflict, October 31, 2017, https://www.safeguardinghealth.org/france-and-eleven-other-countries-pledge-protect-health-care.

[19] United Nations Security Council, *Protection of Civilians in Armed Conflict*.

[20] Geneva Call, "Deed of Commitment on Protecting Health Care in Armed Conflict," November 2018, https://www.genevacall.org/wp-content/uploads/2019/07/Deed-of-Commitment-for-the-protection-of-health-care-in-armed-conflict-final-version-4.pdf.

[21] Geneva Call, "What We Do," https://www.genevacall.org/what-we-do (accessed March 16, 2023).

[22] Safeguarding Health Care in Conflict Coalition, "The UN Security Council's Resolution on the Protection of Health Care: A Five Year Review of Ongoing Violence and Inaction to Stop It," May 5, 2021, https://www.safeguardinghealth.org/un-security-councils-resolution-protection-health-care-five-year-review-ongoing-violence-and.

[23] See United Nations Security Council, *Resolution 2399: The Central African Republic* (S/RES/2399), January 30, 2018, https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/s_res_2399.pdf; United Nations Security Council, *Resolution 2293: The Democratic Republic of the Congo* (S/RES/2293), June 23, 2016, https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/s_res_2293.pdf; United Nations Security Council, *Resolution 2374: Mali* (S/RES/2374),September 5, 2017, https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/s_res_2374.pdf; United Nations Security Council, *Resolution 2002: Somalia* (S/RES/2002), July 29, 2011, https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/Somalia%20S%20RES%202002.pdf; United Nations Security Council, *Resolution 2093: Somalia* (S/RES/2093), March 6, 2013, https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/s_res_2093.pdf; and United Nations Security Council, *Resolution 2521: South Sudan* (S/RES/2521), May 29, 2020, https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/s_res_2521.pdf.

[24] See United Nations Security Council, *Resolution 1970: Libya* (S/RES/1970), February 26, 2011, https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/Libya%20S%20RES%201970.pdf; United Nations Security Council, *Resolution 1591: Sudan* (S/RES/1591), March 29, 2005, https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/Sudan%20SRES1591.pdf; and United Nations Security Council, *Resolution 2140: Yemen* (S/RES/2140), February 26, 2014, https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/s_res_2140.pdf.

[25] United Nations Security Council, *Protection of Civilians in Armed Conflict: Report of the Secretary-General* (S/2019/373), May 7, 2019, https://digitallibrary.un.org/record/3802544.

[26] Ibid.

[27] Office of the Special Representative of the Secretary-General for Children and Armed Conflict, "Monitoring and Reporting on Grave Violations," United Nations, https://childrenandarmedconflict.un.org/tools-for-action/monitoring-and-reporting.

[28] Anna de Courcy Wheeler, "The Precedent and Potential of the MRM for the Full Protection of Civilians," Article 36, April 13, 2022, https://article36.org/wp-content/uploads/2022/04/MRM-and-protection-of-civilians.pdf.

[29] United Nations Security Council, *Resolution 1612: Protection of Children Affected by Armed Conflict* (S/RES/1612), July 26, 2005, https://digitallibrary.un.org/record/554197?ln=en.

[30] United Nations Security Council, "Working Group on Children and Armed Conflict: The Security Council Working Group Pursuant to Resolution 1612 (2005)," https://www.un.org/securitycouncil/subsidiary/wgcaac (accessed March 16, 2023).

[31] See Office of the Special Representative of the Secretary-General for Children and Armed Conflict, *Report of the Secretary-General on Children and Armed Conflict in Iraq* (S/2022/46), January 26, 2022, https://childrenandarmedconflict.un.org/document/report-of-the-secretary-general-on-children-and-armed-conflict-in-iraq-4; and Office of the Special Representative of the Secretary-General for Children and Armed Conflict, *Report of the Secretary-General on Children and Armed Conflict in Somalia* (S/2022/397), May 16, 2022, https://childrenandarmedconflict.un.org/document/report-of-the-secretary-general-on-children-and-armed-conflict-in-somalia-6.

[32] Amnesty International, CARE International, Center for Civilians in Conflict, et al., "Re: 2022 Annual Report on Children and Armed Conflict," May 31, 2022, https://watchlist.org/wp-content/uploads/2022-open-letter-to-sg-guterres-_final.pdf.

[33] United Nations, "Security Council Adopts Resolution 2286 (2016), Strongly Condemning Attacks against Medical Facilities, Personnel in Conflict Situations," May 3, 2016, https://press.un.org/en/2016/sc12347.doc.htm.

[34] United Nations Security Council, *Resolution 1738* (S/RES/1738), December 23, 2006, http://unscr.com/en/resolutions/1738; United Nations, "Security Council Adopts First-Ever Resolution on Persons Reported Missing during Armed Conflict, as Speakers Call for Greater Political Will to Address Problem," June 11, 2019, https://www.un.org/press/en/2019/sc13835.doc.htm; United Nations, "Security Council Unanimously Adopts Resolution 2475 (2019), Ground-Breaking Text on Protection of Persons with Disabilities in Conflict," June 20, 2019, https://www.un.org/press/en/2019/sc13851.doc.htm; and United Nations, "Adopting Resolution 2417 (2018), Security Council Strongly Condemns Starving of Civilians, Unlawfully Denying Humanitarian Access as Warfare Tactics," May 24, 2018, https://www.un.org/press/en/2018/sc13354.doc.htm.

[35] Authors' interview with former UN Secretariat staff, May 20, 2022.

[36] Ibid.

[37] United Nations Security Council, *Letter Dated 18 August 2016 from the Secretary-General Addressed to the President of the Security Council* (S/2016/722), August 18, 2016, https://digitallibrary.un.org/record/839216?ln=en.

[38] Leonard Rubenstein, *Perilous Medicine: The Struggle to Protect Health Care from the Violence of War* (New York: Columbia University Press, 2021), 297.

[39] See Daniel Muñoz-Rojas and Jean-Jacques Frésard, *The Roots of Behaviour in War: Understanding and Preventing IHL Violations* (Geneva: The International Committee of the Red Cross, 2004), 8–10, https://www.icrc.org/en/publication/0853-roots-behaviour-war-understanding-and-preventing-ihl-violations; and Leonard Rubenstein, *Perilous Medicine*.

[40] Safeguarding Health Care in Conflict Coalition, "The UN Security Council's Resolution on the Protection of Health Care: A Five Year Review of Ongoing Violence and Inaction to Stop It," May 5, 2021, https://www.safeguardinghealth.org/un-security-councils-resolution-protection-health-care-five-year-review-ongoing-violence-and.