

Medical and Humanitarian Challenges in Urban Operations

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Urban operations embrace a range of policing and military operations that challenge commanders and operators conducting successful interventions intended to preserve legitimate state (military and security) objectives and protect of civilians and civilian objects. Meeting these challenges is of increasing importance as military, police, fire service, medical, civil defense, and humanitarian actors converge in urban conflict settings. These operations include law enforcement, counterterrorism, counterinsurgency, and conventional warfare in locales that range from small built-up areas, to complex megacities and megacity clusters.

The urban environment is densely populated and includes the necessities of human habitation, commerce, and social life. Complex and often integrated structures including home, shops, cultural facilities, factories, warehouses, banks, and businesses, transportation modes, house of worship, and hospitals are concentrated in the conurbation to maximize efficiency and interaction. Coastal cities add shipping and ports to the mix, enhancing complexity with the potential to merge the challenges of urban and littoral warfare, which has been described as the worst of both worlds. As David Kilcullen noted, the age of urban guerrillas is upon us and conflict is coming "Out of the Mountains." This essay explores the challenges surrounding access to, and provision of medical care in the urban conflict environment.

Medical Care in Urban Armed Conflict

Urban armed conflict presents unique challenges to military forces, the police and fire services, and medical care providers. Due to population density and complex terrain, arms bearers and the populace are often intermingled enhancing the destructive forces that accompany urban fighting. Both operational and legal considerations can mitigate the human toll of urban warfare. From an operational perspective this means ensuring the deployment of emergency medical care for participants in hostilities and the civilian population. This care ranges from prehospital care through treatment in hospital. Practically, this means ensuring the presence of functioning civilian emergency medical services systems, complete with ambulances with adequate numbers of personnel to access, assess, triage, treat, extricate or evacuate injured persons to a location (casualty care point, hospital, or specialty treatment centre, i.e., trauma centre, burn care centre) to receive definitive care. All of this must occur with potentially large numbers of casualties while under fire.

Ensuring access to and the provision of medical care in armed conflict is a fundamental humanitarian obligation. This includes access to care (treatment) and the protection of care providers and facilities. The requirement to collect, care, and treat the sick and wounded extend to both military personnel and to civilians. This can include permitting humanitarian organizations to participate, and possibly calling on the assistance of the civilian population. In treaty terms these obligations are articulated in the Geneva Conventions (1949) and its Additional Protocols (1977). In respect of International Armed Conflicts (IACs), Additional Protocol I (AP I) is noteworthy in its recognition of civilian medical personnel and medical units, as well as those assigned to civil defence. During Non-International Armed Conflicts (NIACs) the requirements to provide medical care is found in Common Article 3 and Additional Protocol II (AP II). State practice related to medical care confirms these obligations under customary International Humanitarian Law (IHL).

Nevertheless, the increased potential for urban armed conflict and the unique challenges of urban warfare demand that additional attention be paid to implementing protections for civilians and access to humanitarian care. Mortality is greater for both military and civilian casualties in urban settings due to the influences of explosives, including blunt and penetrating trauma, blast and crush injuries, and burns. As Sir Antony Beevor, author of *Stalingrad*, observed (at 6-7) when commenting on contemporary urban conflict:

“Today, civilians in cities are in the middle of war once again – trapped, wounded, hungry, impoverished, held as hostages, used as human shields and often prevented from fleeing. Essential urban services like water, health care, electricity and schools are damaged, degraded and sometimes deliberately attacked. The ancient strategy of siege has returned. Tunnels, booby traps and snipers meet drones and digital warfare in the new form of protracted urban conflict which looks set to be the new normal in the years ahead.”

Among civilians, these issues are exacerbated by a lack of personal protective equipment (PPE) and more importantly training. First, urban communities need on-going access to medical care and emergency medical services. Personnel providing this care must have the skills, knowledge, and tools necessary to provide acute care during battles and on-going care during prolonged campaigns or conflicts. This ranges from acute trauma care, through treating exposure to chemical and biological weapons, to ensuring access to care for refugees and internally displaced persons fleeing the consequences of urban conflict. Tactical medical considerations are complicated by the austere and hostile operating environment frequently found in urban combat. Long term consequences of environmental exposures during conflict are have yet to be calculated, but consider, that since the 2003 Fallujah invasion a sharp rise in birth defects among the city’s children has been reported. The cause is unknown.

From a practical perspective attacks on hospitals and medical facilities, medical units, ambulances, and care providers, as well as injured persons (persons *hors de combat*), and protected civilian objects are proscribed at law. However, these protections are at times ignored as can be seen in allegations of war crimes in Syria. These allegations demand investigation and accountability—including prosecution.

From a legal standpoint both IHL and International Human Rights Law (IHRL) mandate access to medical care. Human rights law obligations especially arise in situations of violence not reaching the level of an armed conflict, while parties to an armed conflict are required to meet very specific IHL obligations. Therefore, foundational questions raised include identifying the conditions that constitute armed conflict. When does terrorism, criminal insurgency, or crime wars trigger a state of conflict? Where is the boundary between civil strife and armed conflicts—especially in situations of NIAC?

Consequences of Urban Conflict

The devastating face of urban combat has been seen in Sarajevo, Fallujah, Mosul, Raqqa, Damascus, Aleppo, Marawi, as well as in Mumbai, Paris, and cities in Mexico, Brazil and beyond. Conventional military and security forces, as well as Armed Non-State Actors (ANSAs) including Criminal Armed Groups (CAGs) are potential combatants or arms bearers. The consequences of these varied battles which range from ‘classic siege’ to a metaphorical networked ‘urban siege’ on the Mumbai-Paris template include significant impact on the civilian populace.

This impact includes a high rate of civilian casualties and civilian exposure to humanitarian catastrophe. From a medical perspective, the necessary care includes not only traditional combat medicine, but also humanitarian medical aid to civilians including pre-hospital care (Emergency Medical Services or EMS), triage, emergency department, and in-hospital care for trauma, burns, and the range of typical to complex health care issues. This includes intensive care, critical care, psychiatric and mental health care, as well as epidemiological surveillance and public health interventions culminating in the effective provision of care in conflict disaster. This requires skills used to address the medical response to terrorism as well as tactical EMS. The provision of care in urban terrain includes a need to effectively operate on the streets, among diverse communities, underground in tunnels and subway systems, and in high-rise buildings. Fires, rubble from bombing, environmental hazards from broken sewer lines, and power outages can strain a response. Degraded police, fire service, and medical services can also present difficulties in providing care. Of course, mass casualties and providing care under fire further complicate matters.

Uniquely, in situations of armed conflict IHL binds all parties. The ICTY (International Court for the Former Yugoslavia) in *Tadi?* (T*he Prosecutor v. Tadi?*) found that a state of NIAC exists when there is protracted armed conflict between a government and organized armed groups, or between such groups within a state. Assessing when an armed conflict exists becomes especially complicated in the case of terrorism since determining when the threshold into such hostilities is met may not be immediately evident. The same complications exist with internal situations of civil strife as seen in the case of cartels and gangs (CAGs). In these situations, the groups may lack sufficient organization, or engage in a level of sustained violence. Thus, the threshold of sustained, organized high intensity action may not be reached. As a result, IHL obligations are not triggered. Nevertheless, IHRL and domestic human rights law (HRL) obligations still come into play. When no armed conflict exists human rights law fills the void in addressing attacks on health care: situations where health workers, patients, hospitals and ambulances are attacked. The impact of such attacks are amplified during states of NIAC.

Legal Complications of Urban Conflict

The complexities of applying IHRL (HRL) and IHL in situations of NIAC—or those approaching NIAC—are critical evolving aspects of jurisprudence and lawmaking. These emerging concerns parallel the rise of both non-state conflict and the increasing potential for urban warfare. In "Medical Care in Urban Conflict," Kenneth Watkin provides an in depth assessment of this evolving legal landscape. Watkin's analysis should become required reading for defining command and legal understanding of the boundaries of urban operations—especially when considering access to and provision of medical care. Watkin observes that the law is evolving in the gray area of small wars: that is insurgency, terrorism, criminal insurgencies, and crime wars by blending and embracing components of IHRL/HRL and humanitarian law (i.e., the law of armed conflict, LOAC or IHL) into the new conflict/new wars setting.

The application of human rights law to military operations has been seen in jurisprudence of the European Court of Human Rights (ECtHR) in terrorism and internal conflict situations as addressed in *Varnava v. Turkey*. Using the example of Grozny, it is clear internal conflict can cross the threshold for armed conflict due to significant increases in violence and concerted military response. However, the ECtHR viewed military action in Grozny between 1994-1996 through a law enforcement lens where the military was supporting civil authority to suppress illegal armed insurgency. Watkin notes (at 64-69), the ECtHR sees internal conflict as being amenable to law enforcement action whether considering hostage taking by Chechen rebels (see *Finogenov v. Russia* which addressed the Dubrovka, Moscow theatre incident), or through means such as aerial bombardment and artillery going far beyond policing into combat (see Kerimova v. Russia), which can result in as a high incidence of collateral casualties.

The level of violence seen in these high intensity, irregular internal conflicts demand tests of proportionality, and challenges principles of civilian protection—especially when collateral casualties result. These were recognized by the ECtHR in Tagayeva v. Russia when they incorporated IHL concepts addressing indiscriminate weapons, such as flamethrowers, grenade launchers, tanks, and fragmentary shells at Beslan. In contrast to the ECtHR, the Inter-American Court of Human Rights and Inter-American Commission on Human Rights have more directly relied on IHL to interpret human rights law, as seen in *Ba?maca Vela?squez v. Guatemala*, when assessing NIAC. The Inter-American Court applied IHL while the ECtHR incorporated IHL principles. The latter court applied a "blended" approach. The appropriate legal regime for ensuring protection for persons not involved in hostilities deserves greater discussion. Both human rights law and IHL offer protections, but the specific protections afforded under IHL may afford a higher degree of respect for humanitarian obligations provided all parties to the conflict adhere to customary humanitarian norms.

Protecting the Populace

Protecting the populace—civilians and civilian objects—is a persistent need throughout the evolving legal landscape. Whichever legal regime(s) gain traction, enabling access to and providing of medical care and humanitarian assistance to all parties in armed conflict is essential. Situations of *de facto* armed conflict favour framing these issues through a humanitarian legal lens. This also engages operational medical considerations including the traditional collection and care of casualties. This requires building capabilities and capacity to provide care in hostile urban environments. These requirements apply to all parties to conflict. This demands access to and provision of non-discriminatory care, as well as humanitarian care for civilians.

Indiscriminate care must be provided based upon medical need, not affiliation or combatant status of the casualty. Police and paramilitary forces need to be trained to recognize and meet these obligations. This also applies to rebels, insurgents, and CAGs as reinforced by the efforts of Geneva Call for ANSAs to respect humanitarian norms. While optimal care (or evacuation to avoid risk exposure) is not always possible it is essential that the care available be based upon capacity,

prioritization of resources and treatment based on medical need.

Ethical challenges prevail when seeking to optimize care. It is essential to balance the provision of care among both civilians and the military to preserve military capacity while ensuring access to humanitarian care for civilians. This implies a need to preserve access for NGOs providing care which demands force protection and Civil-Military co-ordination. As such NGOs, such as Médecins Sans Frontières and organizations like the International Committee of the Red Cross (ICRC), as well as other humanitarian private voluntary organizations need to be viewed as partners with governments and armed groups in setting evolving standards and norms of humanitarian law and practice. These standards and norms should address the destructive and indiscriminate effects of explosives in populated areas, as well as other means and methods of fighting in cities.

Obligations for Commanders

The general principles of humanitarian access and treatment apply in all urban conflicts. This includes cases of high intensity crime or civil strife, situations that rise to the level of NIAC, and certainly international armed conflicts involving cities. The location and protection of medical facilities, units, and personnel for targeting and the effects of military operations is imperative to both mitigate the risks to civilians and protect medical facilities and personnel. Mitigating the risks to civilians in urban operations places obligations on commanders and their staff. This involves rigorously applying the traditional requirements for Distinction, Proportionality, Precautions, and Military Necessity. Both defenders and attackers are bound by these considerations. Care providers are also ethically bound to follow the humanitarian precepts of impartiality and neutrality when providing care. The ability to distinguish belligerents and civilians can be particularly challenging in an urban combat setting. This applies to both offensive and defensive operations. Defending forces may be in a better position to protect the civilian population due to superior awareness of the terrain, population distribution, and location of infrastructure. Nevertheless, all belligerents—both attackers and defenders—must actively take steps to protect and not target civilians and civilian objects. This includes infrastructure containing dangerous forces (dams, dykes, nuclear facilities), and lifelines such as water, electric power, gas, transportation, and communications infrastructure. It is imperative to avoid locating military objectives within densely populated areas. Along with this, it is expected that the location of military objectives should be situated to limit damage and achieve the least danger to civilians and civilian objects. Together the duty of commanders to take precautions to limit the effects of attacks in urban areas is significant.

Yet, according to Horowitz (para. 3) writing at *Humanitarian Law & Policy*, “in urban combat, even the best resourced armies find it difficult to determine who they can lawfully target and how they can carry out attacks in a manner that avoids, or at least minimizes, civilian harm.” This makes the use of Intelligence Preparation for Operations (IPO) / Urban Intelligence Preparation of the Battlefield (Urban IPB) essential to understanding the effects of operating in dense urban terrain.

Conducting intelligence preparation and on-going assessments is a command priority in advance of conducting attacks. All feasible steps to ensure legal criteria are met. In both IACs and NIACs the weapons used and tactics employed must be applied with constant care to avoid or minimize civilian harm, and protect the environment in a manner that is proportional to military necessity. This requires "active sensing" or on-going monitoring of the environment and population as well as the continuous monitoring and assessment of all available intelligence, surveillance, and reconnaissance products. This intelligence should identify and monitor the presence and concentrations of civilians. Such monitoring is especially crucial in locating civilians proximate to military objectives, identifying the nature and character of built-up areas and their land use patterns, locating civilian objects and protected civilian objects; and the impact of potential attacks on the environment. These assessments require baseline and continuous evaluation of the location and operational status of medical facilities, units, and personnel to adapt to fluid and changing circumstances.

Conclusion

Urban conflict brings the potential for profound levels of urban suffering. A general lack of respect for IHL (or the law of armed conflict) exacerbates this situation. A lack of effective medical care in urban conflict environments also enhances suffering. An awareness of responsibilities to ensure protections during targeting is one side of the coin. The other is developing effective medical care capacity for urban operations.

Command accountability—at all levels—as well as a robust information flow through all echelons of the chain-of-command is necessary to ensure consequence assessment, legal obligations, and accountability. Engineers; geospatial mapping specialists (employing visualization and GeoINT); as well as embedded urban operations specialists to provide expert analysis of population movement, critical infrastructure and lifelines, medical facilities and capabilities, and civil defense capacity (including urban search and rescue and firefighting resources) are needed to assess conditions and evaluate potential courses of action. This includes prioritiaing humanitarian precautions during sieges, evacuations, and urban warfare in general.

Building the medical care capacity for conflict in cities requires multilateral civil-military interaction. Mutual training, planning, and doctrine development for humanitarian/medical providers, military, and state security forces—especially the police—during the full spectrum of urban conflicts is essential. This includes training and equipping emergency medical personnel to effectively operate in tactical situations. Such operations include applying combat medicine/trauma care skills, and developing the capacity for civil and military medical care teams to work together through common training and acute care protocols. Special attention should be given to ensuring access to adequate staff, supplies, and medicines throughout the conflict period. At strategic and operational levels, this requires the development of urban medical care doctrine and furthering the development of combat care practice. Civil-military-humanitarian operations centres must emphasize effective medical care co-operation during conflict and exercise these skills during wargames to enhance integration of civilian medical care with adequate capacity during urban operations.

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